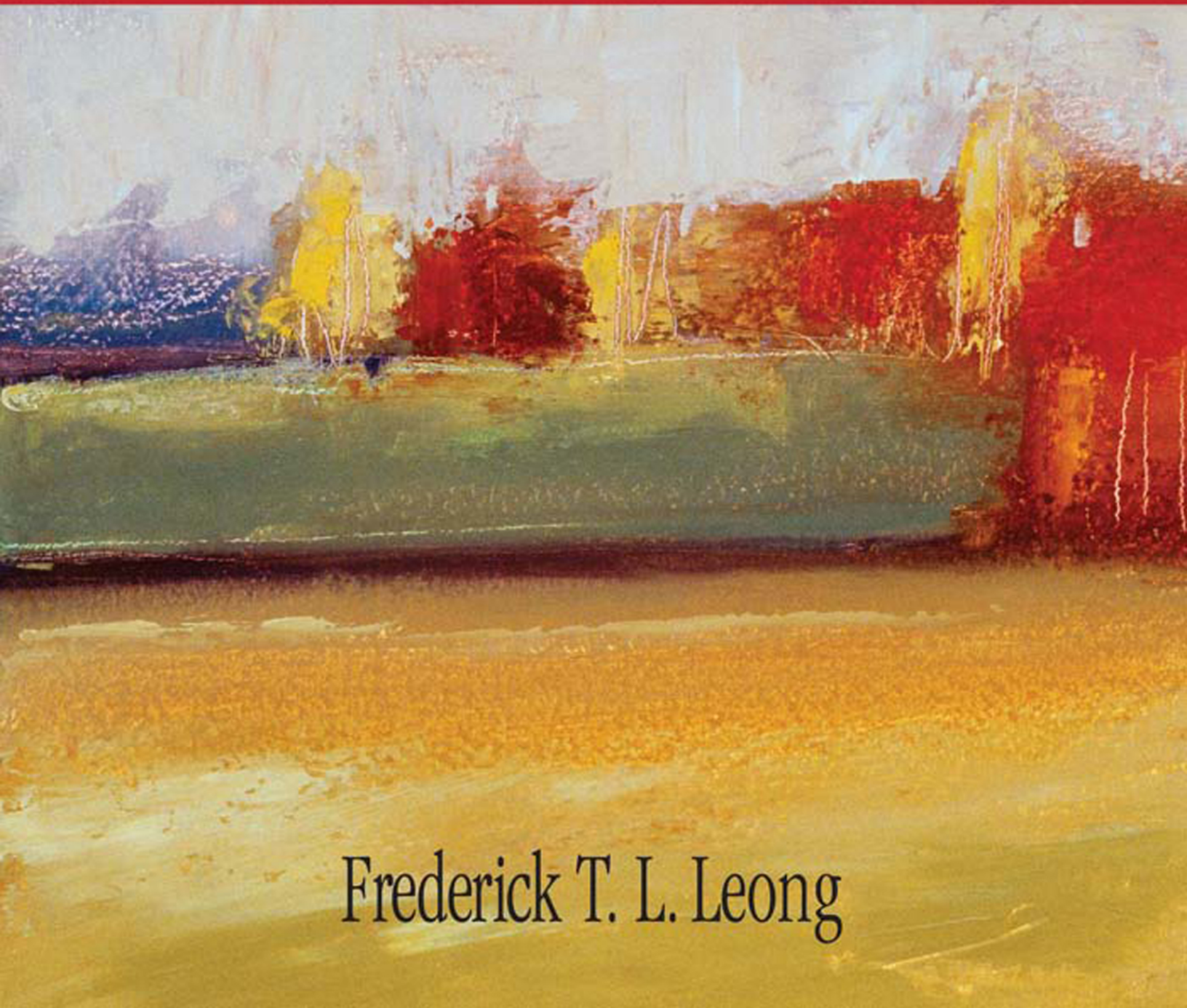


*Encyclopedia of*  
*Counseling*



Frederick T. L. Leong



*Encyclopedia of*  
*Counseling*







# *Encyclopedia of Counseling*

*Editor-in-Chief*

Frederick T. L. Leong

*Michigan State University*

*Senior Editor*

Elizabeth M. Altmaier

*University of Iowa*

*Associate Editor*

Brian D. Johnson

*University of Northern Colorado*



Los Angeles • London • New Delhi • Singapore

---

A SAGE Reference Publication



Copyright © 2008 by SAGE Publications, Inc.

All rights reserved. No part of this book may be reproduced or utilized in any form or by any means, electronic or mechanical, including photocopying, recording, or by any information storage and retrieval system, without permission in writing from the publisher.

---

*For information:*



SAGE Publications, Inc.  
2455 Teller Road  
Thousand Oaks, California 91320  
E-mail: [order@sagepub.com](mailto:order@sagepub.com)

SAGE Publications India Pvt. Ltd.  
B 1/I 1 Mohan Cooperative Industrial Area  
Mathura Road, New Delhi 110 044  
India

SAGE Publications Ltd.  
1 Oliver's Yard  
55 City Road  
London EC1Y 1SP  
United Kingdom

SAGE Publications Asia-Pacific Pte. Ltd.  
33 Pekin Street #02-01  
Far East Square  
Singapore 048763

Printed in the United States of America.

*Library of Congress Cataloging-in-Publication Data*

Encyclopedia of counseling/Frederick T. L. Leong, general editor  
v. cm.

“A SAGE reference publication.”

Includes bibliographical references and index.

Contents: v. 1. Changes and challenges for counseling in the 21st century, A-Z/editor, Elizabeth M. Altmaier—v. 2. Personal and emotional counseling, A-Z/editor, Howard E.A. Tinsley—v. 3. Cross-cultural counseling, A-Z/editor, Madonna G. Constantine—v. 4. Career counseling, A-Z/editor, W. Bruce Walsh.

ISBN 978-1-4129-0928-0 (cloth : alk. paper)

1. Counseling—Encyclopedias. I. Leong, Frederick T. L. II. Altmaier, Elizabeth M.

BF636.54.E53 2008

158'.303—dc22

2007045854

This book is printed on acid-free paper.

08 09 10 11 12 10 9 8 7 6 5 4 3 2 1

---

<i>Publisher/Acquiring Editor:</i>	Rolf A. Janke
<i>Developmental Editors:</i>	Sara Tauber, Carole Maurer
<i>Reference Systems Manager:</i>	Leticia Gutierrez
<i>Reference Systems Coordinator:</i>	Laura Notton
<i>Production Editor:</i>	Tracy Buyan
<i>Copy Editor:</i>	Cate Huisman
<i>Typesetter:</i>	C&M Digital (P) Ltd.
<i>Proofreader:</i>	Kevin Gleason
<i>Indexer:</i>	Julie Sherman Grayson
<i>Cover Designer:</i>	Michelle Kenny
<i>Marketing Manager:</i>	Amberlyn Erzinger



# Contents

---

Editorial Board, *vi*

List of Entries, *xi*

Reader's Guide, *xxiii*

About the Editors, *xxxi*

Contributors, *xxxix*

Introduction, *lxiii*

## **Entries**

Volume 1, Changes and Challenges for  
Counseling in the 21st Century: A–Z

*1–442*

Volume 2, Personal and Emotional Counseling: A–Z

*443–940*

Volume 3, Cross-Cultural Counseling: A–Z

*941–1390*

Volume 4, Career Counseling: A–Z

*1391–1688*

Index *1689–1870*



# Editorial Board

---

## Editor-in-Chief

Frederick T. L. Leong, Ph.D.  
*Michigan State University*

## Volume 1 Editors

### Senior Editor

Elizabeth M. Altmaier, Ph.D.  
*University of Iowa*

### Associate Editor

Brian D. Johnson, Ph.D.  
*University of Northern Colorado*

## Advisory Board Members

Patricia Arredondo, Ed.D.  
*Arizona State University*

Francis G. Lu, M.D.  
*University of California, San Francisco*

Charles J. Gelso, Ph.D.  
*University of Maryland*

Paula S. Nurius, Ph.D.  
*University of Washington*

Puncky Paul Heppner, Ph.D.  
*University of Missouri–Columbia*

Derald Wing Sue, Ph.D.  
*Columbia University*



### **Editor-in-Chief**

Frederick T. L. Leong, Ph.D.  
*Michigan State University*

### **Volume 2 Editors**

#### **Senior Editor**

Howard E. A. Tinsley, Ph.D.  
*Southern Illinois University, Carbondale*

#### **Associate Editor**

Suzanne H. Lease, Ph.D.  
*University of Memphis*

### **Advisory Board Members**

Patricia Arredondo, Ed.D.  
*Arizona State University*

Francis G. Lu, M.D.  
*University of California, San Francisco*

Charles J. Gelso, Ph.D.  
*University of Maryland*

Paula S. Nurius, Ph.D.  
*University of Washington*

Puncky Paul Heppner, Ph.D.  
*University of Missouri–Columbia*

Derald Wing Sue, Ph.D.  
*Columbia University*



### **Editor-in-Chief**

Frederick T. L. Leong, Ph.D.  
*Michigan State University*

### **Volume 3 Editors**

#### **Senior Editor**

Madonna G. Constantine, Ph.D.  
*Teachers College, Columbia University*

#### **Associate Editor**

Roger L. Worthington, Ph.D.  
*University of Missouri–Columbia*

### **Advisory Board Members**

Patricia Arredondo, Ed.D.  
*Arizona State University*

Francis G. Lu, M.D.  
*University of California, San Francisco*

Charles J. Gelso, Ph.D.  
*University of Maryland*

Paula S. Nurius, Ph.D.  
*University of Washington*

P. Paul Heppner, Ph.D.  
*University of Missouri–Columbia*

Derald Wing Sue, Ph.D.  
*Teachers College, Columbia University*



### **Editor-in-Chief**

Frederick T. L. Leong, Ph.D.  
*Michigan State University*

### **Volume 4 Editors**

#### **Senior Editor**

W. Bruce Walsh, Ph.D.  
*Ohio State University*

#### **Associate Editor**

Paul J. Hartung, Ph.D.  
*Northeastern Ohio Universities College of Medicine*

### **Advisory Board Members**

Patricia Arredondo, Ed.D.  
*Arizona State University*

Francis G. Lu, M.D.  
*University of California, San Francisco*

Charles J. Gelso, Ph.D.  
*University of Maryland*

Paula S. Nurius, Ph.D.  
*University of Washington*

Puncky Paul Heppner, Ph.D.  
*University of Missouri–Columbia*

Derald Wing Sue, Ph.D.  
*Columbia University*







# List of Entries

---

## Volume 1

Accreditation by the American Psychological Association  
Accreditation by the Council for Accreditation of Counseling and Related Educational Programs  
Adult Development  
Adventure Therapy  
Aging  
Alcoholics Anonymous  
Altmaier, Elizabeth M.  
Americans with Disabilities Act  
Art Therapy  
Asperger's Syndrome. *See* Autism/Asperger's Syndrome  
Attention Deficit/Hyperactivity Disorder  
Autism/Asperger's Syndrome

Behavioral Observation Methods, Assessment  
Behavior Assessment System for Children, Second Edition  
Behavior Rating Scales  
Bereavement  
Bingham, Rosie Phillips  
Bullying

Cancer Management  
Caregiver Burden  
Caregiving  
Child Maltreatment  
Children With Chronic Illness  
Chronic Illness  
Chronic Pain  
Cigarette Smoking  
Community-Based Action Research  
Community-Based Health Promotion  
Compulsive Sexual Behavior  
Conduct Disorder

Conferences, Counseling Psychology  
Conferences in Counseling  
Conners' Rating Scales—Revised  
Continuing Education  
Continuous Performance Tests  
Conversion Therapy  
Corrections Applications  
Counseling, Definition of  
Counseling, History of  
Counseling Psychology, Definition of  
Counseling Psychology, History of  
Counseling the Elderly  
Couple and Marital Counseling  
Courtois, Christine A.  
Credentialing Individuals  
Custody Evaluations

Death and Dying  
Delworth, Ursula  
Department of Veterans Affairs  
Developmental Disorders  
Disasters, Impact on Children  
Distance Education/Dispersed Learning  
Douce, Louise

E-Counseling  
EMDR. *See* Eye Movement Desensitization and Reprocessing  
Empirically Based Professional Practice  
Ethical Codes  
Ethical Decision Making  
Ethical Dilemmas  
Ethics in Computer-Aided Counseling  
Ethics in Research  
Eugenics  
Exercise and Sport Psychology  
Externalizing Problems of Childhood  
Eye Movement Desensitization and Reprocessing



- Family Counseling
- Feedback in Counseling, Immediate
- Feminist Therapy
- Feminization of Psychology
- Forensic Applications
- Fretz, Bruce
- Friedlander, Myrna L.
- Functional Behavioral Assessment
  
- Gambling
- Genetic Counseling
- Gerontology
  
- Health Belief Model
- HIV/AIDS
- Homeless Youth
- Hospice
- Human Subjects Review in an Online World
- Hypnosis
  
- Impairment
- Individuals with Disabilities Education Act
- Industrial/Organizational Psychology
- Internalizing Problems of Childhood
- International Developments, Counseling
- International Developments, Counseling Psychology
- International Test Commission
- Ivey, Allen E.
  
- Kitchener, Karen Strohm
  
- Learning Disorders
- Legal Issues in Parenting
- Low-Incidence Disabilities
  
- Mediation
- Medication Adherence
- Mental Health Issues in the Schools
- Mental Retardation and Developmental Disabilities
- Mentoring
- Mindfulness
- Mixed Methodology Research
- Music Therapy
  
- Norcross, John C.
  
- Occupational Stress
- Oppositional Defiant Disorder
  
- Parent–Adolescent Relations
- Parenting
- Parenting Stress Index
- Phrenology
- Play Therapy
- Postdegree/Prelicensure Supervision
- Postdoctoral Training
- Predoctoral Internships
- Prescription Privileges
- Professional Associations, Counseling
- Professional Degrees
  
- Qualitative Methodologies
- Quantitative Methodologies
  
- Recruitment: History and Recent Trends in Diversity
- Retirement, Implications of
- Roelhke, Helen J.
- Rural Practice, Challenges of
  
- School Counseling
- School Psychology
- School Refusal Behavior
- Scientist–Practitioner Model of Training
- Sexual Violence and Coercion
- Sleep Disorders
- Smoking. *See* Cigarette Smoking
- Specialization Designation
- Stress-Related Disorders
- Sue, Derald Wing
- Suicide Postvention
- Supervision
  
- Technology and Treatment
- Teenage Parents
- Translation and Adaptation of Psychological Tests
- Traumatic Brain Injury and Rehabilitation
- Treatment Compliance
- Tyler, Leona Elizabeth
  
- University Counseling Centers
  
- Vasquez, Melba J. T.
- Virtue Ethics



## Volume 2

Abuse  
Academic Achievement  
Adaptive Behavior Testing  
Adlerian Therapy  
Affect (Mood States), Assessment of  
Anxiety Disorders. *See* Panic Disorders  
  
Bandura, Albert  
Beck, Aaron T.  
Behavior Therapy  
Bipolar Disorder  
Brief Therapy  
  
Client Attitudes and Behaviors  
Clinical Interview as an Assessment Technique  
Clinical Presenting Issues  
Code of Ethics and Standards of Practice  
Cognition/Intelligence, Assessment of  
Cognitive-Behavioral Therapy and Techniques  
Cognitive Therapy  
Common Factors Model  
Computer-Assisted Testing  
Confidentiality and Legal Privilege  
Constructivist Theory  
Consultation  
Coping  
Costa, Paul T., and McCrae, Robert R.  
Counseling Process/Outcome  
Counseling Skills Training  
Counseling Theories and Therapies  
Counselors and Therapists  
Crisis Counseling  
Critical Incident Stress Debriefing  
Csikszentmihalyi, Mihaly  
Current Procedural Terminology

Deci, Edward L., and Ryan, Richard M.  
Defenses, Psychological  
Dementia  
Depression  
Developmental Counseling and Therapy  
*Diagnostic and Statistical Manual of Mental Disorders (DSM)*  
Dialectical Behavior Therapy  
Discrimination and Oppression  
Duty to Warn and Protect  
  
Eating Disorders  
Ego Strength  
Ellis, Albert  
Evidence-Based Treatments  
Expectations About Therapy  
  
Facilitative Conditions  
False Memories  
Forgiveness  
Free Association  
Freud, Sigmund  
  
Gay, Lesbian, and Bisexual Therapy  
Gelso, Charles J.  
Goldberg, Lewis R.  
Goldman, Leo  
Group Therapy  
  
Happiness/Hardiness  
Harmful Psychological Treatments  
Heppner, Puncky Paul  
Hill, Clara E.  
Homework Assignments  
Hope  
Humanistic Approaches



- Individual Therapy
- Informed Consent
- Integrative/Eclectic Therapy
- Intelligence
- Interpersonal Learning and Interpersonal Feedback
- Intrinsic Motivation
  
- Jung, Carl
  
- Language Difficulties, Clinical Assessment of
- Leisure
- Life Transitions
  
- McCrae, Robert R. *See* Costa, Paul T., and McCrae, Robert R.
- Meaning, Creation of
- Meehl, Paul E.
- Memory, Assessment of
- Mental Status Examination
- Metaphors, Use of
  
- Narrative Therapy
- Neuropsychological Functioning
- Normative Issues
  
- Optimism and Pessimism
- Outcomes of Counseling and Psychotherapy
- Overdiagnosis. *See* Underdiagnosis/Overdiagnosis
  
- Panic Disorders
- Paradoxical Interventions
- Perceived Competence. *See* Self-Efficacy/Perceived Competence
- Personality Assessment
- Personality Disorders
- Personality Theories
- Personality Theories, Behavioral
- Personality Theories, Cognitive
- Personality Theories, Evolutionary
- Personality Theories, Five-Factor Model
- Personality Theories, Phenomenological
- Personality Theories, Psychodynamic
- Personality Theories, Social Cognitive
- Personality Theories, Traits
- Person–Environment Interactions
- Pessimism. *See* Optimism and Pessimism
- Physical Activity Counseling
- Physical Health
- Positive Psychology
  
- Positivist Paradigm
- Posttraumatic Stress Disorder
- Problem-Solving Appraisal
- Projective Techniques
- Psychoanalysis and Psychodynamic Approaches to Therapy
- Psychoeducation
- Psychological Well-Being, Dimensions of
- Psychometric Properties
- Psychopathology, Assessment of
- Psychopharmacology, Human Behavioral
- Psychotherapy, Outcomes of. *See* Outcomes of Counseling and Psychotherapy
  
- Quality of Life
  
- Rational Emotive Behavior Therapy
- Reframing
- Rehabilitation Counseling
- Relationships With Clients
- Resilience
- Rogers, Carl R.
- Ryan, Richard M. *See* Deci, Edward L., and Ryan, Richard M.
- Ryff, Carol D.
  
- Schizophrenia, Adult
- Secondary Trauma
- Self-Disclosure
- Self-Efficacy/Perceived Competence
- Self-Esteem
- Self-Esteem, Assessment of
- Self-Help Groups
- Seligman, Martin E. P.
- Skinner, B. F.
- Social Support
- Socratic Method
- Solution-Focused Brief Therapy
- Spirituality/Religion
- Stress
- Stress Management
- Strong, Stanley R.
- Substance Abuse and Dependence
- Suicide Potential
  
- Taxonomy of Helpful Impacts
- Test Interpretation
- Therapist Interpretation
- Therapist Techniques/Behaviors
- Therapists. *See* Counselors and Therapists



---

Therapy Process, Individual

Thurstone, Louis L.

Tracey, Terence J. G.

Transactional Analysis

Transference and Countertransference

Tyler, Leona E.: Human Multipotentiality

Underdiagnosis/Overdiagnosis

Wampold, Bruce E.

Wechsler, David

Weiss, David J.

Working Alliance







### Volume 3

Acculturation  
Acculturative Stress  
Achievement Gap  
Adaptation  
Adoption, Transracial. *See* Transracial Adoption  
Affirmative Action  
African Americans  
Afrocentricity/Afrocentrism  
Alaska Natives  
Allocentrism  
American Indians  
American Jews  
Antisemitism  
Arab Americans  
Arredondo, Patricia  
Asian American Psychological Association  
Asian Americans  
Assimilation  
Association of Black Psychologists  
Atkinson, Donald Ray  
  
Barriers to Cross-Cultural Counseling  
Bernal, Martha E.  
Bias  
Bicultural  
Bilingual Counseling  
Bilingualism  
Biracial  
Black English  
Black Psychology  
Black Racial Identity Development  
Bureau of Indian Affairs  
  
Casas, Jesús Manuel  
Certificate of Degree of Indian Blood  
Change Agent

Civil Rights  
Clark, Kenneth Bancroft  
Clark, Mamie Phipps  
Classism  
Collectivism  
Colonialism  
Color-Blind Racial Ideology  
Communication  
Confucianism  
Constantine, Madonna G.  
Critical Race Theory  
Cross, William E., Jr.  
Cross-Cultural Psychology  
Cross-Cultural Training  
Cultural Accommodation and Negotiation  
Cultural Encapsulation  
Cultural Equivalence  
Cultural Mistrust  
Cultural Paranoia  
Cultural Relativism  
Cultural Values  
Culture  
Culture-Bound Syndromes  
Culture-Free Testing  
Culture Shock  
  
Deficit Hypothesis  
Demographics, United States  
Discrimination  
Diversity  
Dragnetomania  
  
Empowerment  
Enculturation  
Espiritismo  
Ethnic Cleansing  
Ethnic Identity  
Ethnicity



- Ethnic Minority
- Ethnic Pride
- Ethnocentrism
- Etic–Emic Distinction
- Eurocentrism
  
- Familismo
- Fatalism
- Filial Piety
  
- Healthy Paranoia
- Helms, Janet E.
- Help-Seeking Behavior
- High-Context Communication
- Hispanics, Hispanic Americans. *See* Latinos
  
- Identity
- Identity Development
- Idiocentrism
- Immigrants
- Indian Health Service
- Indigenous Healing
- Individualism
- Intelligence Tests
- Interracial Comfort
- Interracial Marriage
- Ivey, Allen E.: Counseling Theory and Skills Training
  
- Kwanzaa
  
- LaFromboise, Teresa Davis
- Latinos
- Learned Helplessness
- Leong, Frederick T. L.
- Locus of Control
- Loss of Face
- Low-Context Communication
  
- Machismo
- Marianismo
- Marsella, Anthony J.
- Model Minority Myth
- Monocultural
- Multicultural Counseling
- Multicultural Counseling Competence
- Multiculturalism
- Multicultural Personality
- Multicultural Psychology
- Multiracial Families
  
- National Association for the Advancement of Colored People
- Nationalism
- National Latina/o Psychological Association
  
- Oppression
- Organizational Diversity
- Orthogonal Cultural Identification Theory
  
- Pacific Islanders
- Pedersen, Paul Bodholdt
- Personal Space
- Pluralism
- Political Correctness
- Poverty
- Power and Powerlessness
- Prejudice
  
- Race
- Racial Identity
- Racial Microaggressions
- Racial Pride
- Racism
- Refugees
- Religion/Religious Belief Systems
- Reversed Racism
  
- Santería
- Second Culture Acquisition
- Sexism
- Social Identity Theory
- Social Justice
- Society for the Psychological Study of Ethnic Minority Issues
- Society of Indian Psychologists
- Socioeconomic Status
- Sojourner
- Spirituality
- Stereotype
- Stereotype Threat
- Sue, Derald Wing: Contributions to Multicultural Psychology and Counseling
- Sue, Stanley
  
- Third World
- Tokenism
- Translation Methods
- Transracial Adoption
- Trimble, Joseph E.



Universalism

Visible Racial/Ethnic Groups

Vontress, Clemmont Eyvind

White, Joseph L.

White Americans

White Privilege

White Racial Identity Development

Worldview

Xenophobia







## Volume 4

Academic Achievement, Nature and Use of  
Achievement, Aptitude, and Ability Tests  
Action Theory  
Adult Career Concerns Inventory  
Adults in Transition  
Armed Services Vocational Aptitude Battery  
Assessment  
Attachment Theory

Biodata  
Brown's Values-Based Career Theory  
Bureau of Labor Statistics

Campbell Interest and Skill Survey  
Card Sorts  
Career Advancement  
Career Attitudes and Strategies Inventory  
Career Barriers Inventory  
Career Beliefs Inventory  
Career Construction Theory  
Career Counseling  
Career Counseling, African Americans  
Career Counseling, Asians Americans  
Career Counseling, Gay and Lesbian  
Career Counseling, History of  
Career Counseling, Immigrants  
Career Counseling, Latinos  
Career Counseling, Native Americans  
Career Counseling in Colleges  
and Universities  
Career Counseling in Organizations  
Career Counseling in Schools  
Career Counseling Process  
Career Decision-Making Difficulties Questionnaire  
Career Decision Scale  
Career Decision Self-Efficacy Scale

Career Development Inventory  
*Career Development Quarterly*  
Career Education  
Career Exploration  
Career Factors Inventory  
Career Indecision  
Career Interventions  
Career/Life  
Career Mastery Inventory  
Career Maturity  
Career Maturity Inventory  
Career Occupational Preference System  
Career Planning  
Career Planning Survey  
Career Resource Centers  
Career Services Model  
Career Style Interview  
Career Thoughts Inventory  
Career Transitions Inventory  
Cognitive Information Processing Model  
College Student Experiences Questionnaire  
Competencies. *See* Standards and Competencies  
Computer-Assisted Career Counseling  
Constructivist Career Counseling  
Contract Work  
Crites, John O.

Dawis, René Villanueva  
Decision Making  
*Dictionary of Occupational Titles*  
Disability. *See* Persons With Disabilities  
DISCOVER  
Diversity Issues in Career Development  
  
Employee Aptitude Survey  
Environmental Assessment Technique  
Expressed, Manifest, Tested, and Inventoried  
Interests



- General Aptitude Test Battery
- Hall Occupational Orientation Inventory
- Holland, John L.
- Holland's Theory of Vocational Personalities and Work Environments
- International Approaches
- International Association for Educational and Vocational Guidance
- Jackson Vocational Interest Inventory
- Job Loss
- Job Satisfaction and General Well-Being
- Job Sharing
- Journal of Career Assessment*
- Journal of Career Development*
- Journal of Vocational Behavior*
- Krumboltz, John D.
- Krumboltz Happenstance Learning Theory
- Kuder, Frederic
- Kuder Career Search
- Life-Role Balance
- Lofquist, Lloyd Henry
- Minnesota Importance Questionnaire
- Multicultural Career Assessment Models
- Multicultural Career Counseling Checklist
- My Vocational Situation Scale
- Narrative Career Counseling
- National Career Development Association
- National Survey of Student Engagement
- Occupational Health Psychology
- Occupational Information
- Occupational Information Network
- Osipow, Samuel H.
- Parsons, Frank
- Part-Time Work
- Pay Equity
- Performance Modeling
- Personal and Career Counseling
- Personality Assessment and Careers
- Person-Environment Fit
- Person Matching
- Persons With Disabilities
- Prescreening, In-Depth Exploration, and Choice Model
- Private Practice Career Counseling
- Process and Outcome Research
- Retirement
- Roe, Anne
- Roe's Theory of Personality Development and Career Choice
- School-to-Work Transition
- Self-Directed Search
- Sexual Harassment
- Sexual Orientation
- SIGI. *See* System of Interactive Guidance Information
- Social Class
- Social Cognitive Career Theory
- Social Discrimination
- Society for Vocational Psychology
- Spirituality and Career Development
- Standards and Competencies
- Strong, Edward Kellogg, Jr.
- Strong Interest Inventory
- Super, Donald Edwin
- Super's Theory
- System of Interactive Guidance Information
- Tests. *See* Achievement, Aptitude, and Ability Tests
- Theory of Work Adjustment
- Tiedeman's Decision-Making Theory
- Tinsley, Howard E. A.
- Training in Organizations
- Trait-Factor Counseling
- Transition Behavior Scale
- Unemployment. *See* Job Loss
- Unisex Edition of the ACT Interest Inventory
- Values Scale
- Vocational Identity
- Walsh, W. Bruce
- Williamson, Edmund Griffith
- Work-Bound Youth
- Work-Family Balance
- Work Stress
- Work Values



# Reader's Guide

---

This list is provided to assist readers in locating entries on related topics. Some entry titles appear in more than one category.

## **Assessment, Testing, and Research Methods**

- Academic Achievement (Vol. 2)
- Academic Achievement, Nature and Use of (Vol. 4)
- Achievement, Aptitude, and Ability Tests (Vol. 4)
- Adaptive Behavior Testing (Vol. 2)
- Adult Career Concerns Inventory (Vol. 4)
- Affect (Mood States), Assessment of (Vol. 2)
- Armed Services Vocational Aptitude Battery (Vol. 4)
- Assessment (Vol. 4)
- Behavioral Observation Methods,  
Assessment (Vol. 1)
- Behavior Assessment System for Children,  
Second Edition (Vol. 1)
- Behavior Rating Scales (Vol. 1)
- Biodata (Vol. 4)
- Campbell Interest and Skill Survey (Vol. 4)
- Card Sorts (Vol. 4)
- Career Attitudes and Strategies Inventory (Vol. 4)
- Career Barriers Inventory (Vol. 4)
- Career Beliefs Inventory (Vol. 4)
- Career Decision-Making Difficulties  
Questionnaire (Vol. 4)
- Career Decision Scale (Vol. 4)
- Career Decision Self-Efficacy Scale (Vol. 4)
- Career Development Inventory (Vol. 4)
- Career Factors Inventory (Vol. 4)
- Career Mastery Inventory (Vol. 4)
- Career Maturity Inventory (Vol. 4)
- Career Occupational Preference System (Vol. 4)
- Career Planning Survey (Vol. 4)
- Career Services Model (Vol. 4)
- Career Style Interview (Vol. 4)
- Career Thoughts Inventory (Vol. 4)
- Career Transitions Inventory (Vol. 4)
- Clinical Interview as an Assessment  
Technique (Vol. 2)
- Cognition/Intelligence, Assessment of (Vol. 2)
- Cognitive Information Processing Model (Vol. 4)
- College Student Experiences Questionnaire (Vol. 4)
- Common Factors Model (Vol. 2)
- Community-Based Action Research (Vol. 1)
- Computer-Assisted Testing (Vol. 2)
- Conners' Rating Scales—Revised (Vol. 1)
- Continuous Performance Tests (Vol. 1)
- Culture-Free Testing (Vol. 3)
- DISCOVER (Vol. 4)
- Employee Aptitude Survey (Vol. 4)
- Environmental Assessment Technique (Vol. 4)
- Expressed, Manifest, Tested, and Inventoried  
Interests (Vol. 4)
- Functional Behavioral Assessment (Vol. 1)
- General Aptitude Test Battery (Vol. 4)
- Hall Occupational Orientation Inventory (Vol. 4)
- Health Belief Model (Vol. 1)
- Human Subjects Review in an Online World (Vol. 1)
- Intelligence Tests (Vol. 3)
- Jackson Vocational Interest Inventory (Vol. 4)
- Kuder Career Search (Vol. 4)
- Language Difficulties, Clinical  
Assessment of (Vol. 2)
- Memory, Assessment of (Vol. 2)
- Mental Status Examination (Vol. 2)
- Minnesota Importance Questionnaire (Vol. 4)
- Mixed Methodology Research (Vol. 1)
- Multicultural Career Assessment Models (Vol. 4)
- Multicultural Career Counseling Checklist (Vol. 4)



My Vocational Situation Scale (Vol. 4)  
National Survey of Student Engagement (Vol. 4)  
Parenting Stress Index (Vol. 1)  
Performance Modeling (Vol. 4)  
Personality Assessment (Vol. 2)  
Personality Assessment and Careers (Vol. 4)  
Person–Environment Fit (Vol. 4)  
Person Matching (Vol. 4)  
Prescreening, In-Depth Exploration, and Choice Model (Vol. 4)  
Problem-Solving Appraisal (Vol. 2)  
Process and Outcome Research (Vol. 4)  
Psychometric Properties (Vol. 2) Psychopathology, Assessment of (Vol. 2)  
Qualitative Methodologies (Vol. 1)  
Quantitative Methodologies (Vol. 1)  
Self-Directed Search (Vol. 4)  
Self-Esteem, Assessment of (Vol. 2)  
Strong Interest Inventory (Vol. 4)  
System of Interactive Guidance Information (Vol. 4)  
Test Interpretation (Vol. 2)  
Transition Behavior Scale (Vol. 4)  
Translation and Adaptation of Psychological Tests (Vol. 1)  
Unisex Edition of the ACT Interest Inventory (Vol. 4)  
Values Scale (Vol. 4)

## **Biographies**

Altmaier, Elizabeth M. (Vol. 1)  
Arredondo, Patricia (Vol. 3)  
Atkinson, Donald Ray (Vol. 3)  
Bandura, Albert (Vol. 2)  
Beck, Aaron T. (Vol. 2)  
Bernal, Martha E. (Vol. 3)  
Bingham, Rosie Phillips (Vol. 1)  
Casas, Jesús Manuel (Vol. 3)  
Clark, Kenneth Bancroft (Vol. 3)  
Clark, Mamie Phipps (Vol. 3)  
Constantine, Madonna G. (Vol. 3)  
Costa, Paul T., and McCrae, Robert R. (Vol. 2)  
Courtois, Christine A. (Vol. 1)  
Crites, John O. (Vol. 4)  
Cross, William E., Jr. (Vol. 3)  
Csikszentmihalyi, Mihaly (Vol. 2)  
Dawis, René Villanueva (Vol. 4)  
Deci, Edward L., and Ryan, Richard M. (Vol. 2)  
Delworth, Ursula (Vol. 1)  
Douce, Louise (Vol. 1)  
Ellis, Albert (Vol. 2)  
Fretz, Bruce (Vol. 1)  
Freud, Sigmund (Vol. 2)  
Friedlander, Myrna L. (Vol. 1)  
Gelso, Charles J. (Vol. 2)  
Goldberg, Lewis R. (Vol. 2)  
Goldman, Leo (Vol. 2)  
Helms, Janet E. (Vol. 3)  
Heppner, Puncky Paul (Vol. 2)  
Hill, Clara E. (Vol. 2)  
Holland, John L. (Vol. 4)  
Ivey, Allen E. (Vol. 1)  
Ivey, Allen E.: Counseling Theory and Skills Training (Vol. 3)  
Jung, Carl (Vol. 2)  
Kitchener, Karen Strohm (Vol. 1)  
Krumboltz, John D. (Vol. 4)  
Kuder, Frederic (Vol. 4)  
LaFromboise, Teresa Davis (Vol. 3)  
Leong, Frederick T. L. (Vol. 3)  
Lofquist, Lloyd Henry (Vol. 4)  
Marsella, Anthony J. (Vol. 3)  
Meehl, Paul E. (Vol. 2)  
Norcross, John C. (Vol. 1)  
Osipow, Samuel H. (Vol. 4)  
Parsons, Frank (Vol. 4)  
Pedersen, Paul Bodholdt (Vol. 3)  
Roe, Anne (Vol. 4)  
Roelhke, Helen J. (Vol. 1)  
Rogers, Carl R. (Vol. 2)  
Ryff, Carol D. (Vol. 2)  
Seligman, Martin E. P. (Vol. 2)  
Skinner, B. F. (Vol. 2)  
Strong, Edward Kellogg, Jr. (Vol. 4)  
Strong, Stanley R. (Vol. 2)  
Sue, Derald Wing (Vol. 1)  
Sue, Derald Wing: Contributions to Multicultural Psychology and Counseling (Vol. 3)  
Sue, Stanley (Vol. 3)  
Super, Donald Edwin (Vol. 4)  
Thurstone, Louis L. (Vol. 2)  
Tinsley, Howard E. A. (Vol. 4)  
Tracey, Terence J. G. (Vol. 2)  
Trimble, Joseph E. (Vol. 3)  
Tyler, Leona E. (Vol. 1)  
Tyler, Leona E.: Human Multipotentiality (Vol. 2)  
Vasquez, Melba J. T. (Vol. 1)  
Vontress, Clemmont Eyvind (Vol. 3)  
Walsh, W. Bruce (Vol. 4)  
Wampold, Bruce E. (Vol. 2)



Wechsler, David (Vol. 2)  
 Weiss, David J. (Vol. 2)  
 White, Joseph L. (Vol. 3)  
 Williamson, Edmund Griffith (Vol. 4)

## Coping

Abuse (Vol. 2)  
 Acculturative Stress (Vol. 3)  
 Adaptation (Vol. 3)  
 Bereavement (Vol. 1)  
 Cancer Management (Vol. 1)  
 Career Indecision (Vol. 4)  
 Caregiver Burden (Vol. 1)  
 Coping (Vol. 2)  
 Culture Shock (Vol. 3)  
 Decision Making (Vol. 4)  
 Disasters, Impact on Children (Vol. 1)  
 Forgiveness (Vol. 2)  
 Healthy Paranoia (Vol. 3)  
 Job Loss (Vol. 4)  
 Normative Issues (Vol. 2)  
 Occupational Stress (Vol. 1)  
 Poverty (Vol. 3)  
 Sexual Violence and Coercion (Vol. 1)  
 Social Support (Vol. 2)  
 Stereotype Threat (Vol. 3)  
 Stress (Vol. 2)  
 Stress Management (Vol. 2)  
 Work–Family Balance (Vol. 4)  
 Work Stress (Vol. 4)

## Counseling—General

Barriers to Cross-Cultural Counseling (Vol. 3)  
 Career Counseling Process (Vol. 4)  
 Change Agent (Vol. 3)  
 Client Attitudes and Behaviors (Vol. 2)  
 Clinical Presenting Issues (Vol. 2)  
 Counseling Process/Outcome (Vol. 2)  
 Counselors and Therapists (Vol. 2)  
 Current Procedural Terminology (Vol. 2)  
*Diagnostic and Statistical Manual of Mental Disorders (DSM)* (Vol. 2)  
*Dictionary of Occupational Titles* (Vol. 4)  
 Empirically Based Professional Practice (Vol. 1)  
 Expectations About Therapy (Vol. 2)  
 Facilitative Conditions (Vol. 2)  
 Occupational Information (Vol. 4)  
 Occupational Information Network (Vol. 4)

Outcomes of Counseling and Psychotherapy (Vol. 2)  
 Relationships With Clients (Vol. 2)  
 Self-Disclosure (Vol. 2)  
 Taxonomy of Helpful Impacts (Vol. 2)  
 Technology and Treatment (Vol. 1)  
 Therapist Interpretation (Vol. 2)  
 Therapy Process, Individual (Vol. 2)  
 Treatment Compliance (Vol. 1)  
 Underdiagnosis/Overdiagnosis (Vol. 2)  
 Working Alliance (Vol. 2)

## Economic/Work Issues

Affirmative Action (Vol. 3)  
 Americans with Disabilities Act (Vol. 1)  
 Career Indecision (Vol. 4)  
 Caregiving (Vol. 1)  
 Contract Work (Vol. 4)  
 Corrections Applications (Vol. 1)  
*Dictionary of Occupational Titles* (Vol. 4)  
 Forensic Applications (Vol. 1)  
 Homeless Youth (Vol. 1)  
 Job Loss (Vol. 4)  
 Job Satisfaction and General Well-Being (Vol. 4)  
 Job Sharing (Vol. 4)  
 Occupational Information (Vol. 4)  
 Occupational Information Network (Vol. 4)  
 Occupational Stress (Vol. 1)  
 Part-Time Work (Vol. 4)  
 Pay Equity (Vol. 4)  
 Poverty (Vol. 3)  
 Socioeconomic Status (Vol. 3)  
 Stress-Related Disorders (Vol. 1)  
 Training in Organizations (Vol. 4)  
 Work-Bound Youth (Vol. 4)  
 Work Stress (Vol. 4)  
 Work Values (Vol. 4)

## Human Development and Life Transitions

Adult Development (Vol. 1)  
 Adults in Transition (Vol. 4)  
 Aging (Vol. 1)  
 Black Racial Identity Development (Vol. 3)  
 Career Advancement (Vol. 4)  
 Career Education (Vol. 4)  
 Career Exploration (Vol. 4)  
 Career/Life (Vol. 4)  
 Career Maturity (Vol. 4)  
 Career Planning (Vol. 4)



Death and Dying (Vol. 1)  
Identity Development (Vol. 3)  
Leisure (Vol. 2)  
Life-Role Balance (Vol. 4)  
Life Transitions (Vol. 2) Parent–  
Adolescent Relations (Vol. 1) Par-  
enting (Vol. 1)  
Racial Identity (Vol. 3)  
Retirement (Vol. 4)  
Retirement, Implications of (Vol. 1)  
School-to-Work Transition (Vol. 4)  
Teenage Parents (Vol. 1)  
Vocational Identity (Vol. 4)  
White Racial Identity Development (Vol. 3)  
Work–Family Balance (Vol. 4)

## **Legal and Ethical Issues**

Affirmative Action (Vol. 3)  
Americans with Disabilities Act (Vol. 1)  
Civil Rights (Vol. 3)  
Classism (Vol. 3)  
Code of Ethics and Standards of Practice (Vol. 2)  
Colonialism (Vol. 3)  
Color-Blind Racial Ideology (Vol. 3) Con-  
fidentiality and Legal Privilege (Vol. 2)  
Credentialing Individuals (Vol. 1)  
Cultural Relativism (Vol. 3)  
Custody Evaluations (Vol. 1)  
Duty to Warn and Protect (Vol. 2)  
Ethical Codes (Vol. 1)  
Ethical Decision Making (Vol. 1)  
Ethical Dilemmas (Vol. 1)  
Ethics in Computer-Aided Counseling (Vol. 1)  
Ethics in Research (Vol. 1)  
Ethnic Cleansing (Vol. 3)  
Human Subjects Review in an Online  
World (Vol. 1)  
Individuals with Disabilities Education  
Act (Vol. 1)  
Informed Consent (Vol. 2)  
Legal Issues in Parenting (Vol. 1)  
Oppression (Vol. 3)  
Political Correctness (Vol. 3)  
Prejudice (Vol. 3)  
Prescription Privileges (Vol. 1)  
Racism (Vol. 3)  
Reversed Racism (Vol. 3)  
Sexism (Vol. 3)  
Sexual Harassment (Vol. 4)

Social Class (Vol. 4)  
Social Justice (Vol. 3)  
Virtue Ethics (Vol. 1)

## **Organizations**

Accreditation by the American Psychological  
Association (Vol. 1)  
Accreditation by the Council for Accreditation of  
Counseling and Related Educational  
Programs (Vol. 1)  
Alcoholics Anonymous (Vol. 1)  
Asian American Psychological  
Association (Vol. 3)  
Association of Black Psychologists (Vol. 3)  
Bureau of Indian Affairs (Vol. 3)  
Bureau of Labor Statistics (Vol. 4)  
Department of Veterans Affairs (Vol. 1)  
Indian Health Service (Vol. 3)  
International Association for Educational and  
Vocational Guidance (Vol. 4)  
International Test Commission (Vol. 1)  
National Association for the Advancement of  
Colored People (Vol. 3)  
National Career Development Association (Vol. 4)  
National Latina/o Psychological Association (Vol. 3)  
Society for the Psychological Study of Ethnic  
Minority Issues (Vol. 3)  
Society for Vocational Psychology (Vol. 4)  
Society of Indian Psychologists (Vol. 3)

## **Physical and Mental Health**

Attention Deficit/Hyperactivity Disorder (Vol. 1)  
Autism/Asperger's Syndrome (Vol. 1)  
Bipolar Disorder (Vol. 2)  
Cancer Management (Vol. 1)  
Child Maltreatment (Vol. 1)  
Children With Chronic Illness (Vol. 1)  
Chronic Illness (Vol. 1)  
Chronic Pain (Vol. 1)  
Cigarette Smoking (Vol. 1)  
Community-Based Health Promotion (Vol. 1)  
Compulsive Sexual Behavior (Vol. 1)  
Conduct Disorder (Vol. 1)  
Culture-Bound Syndromes (Vol. 3)  
Defenses, Psychological (Vol. 2)  
Dementia (Vol. 2)  
Depression (Vol. 2)  
Developmental Disorders (Vol. 1)



*Diagnostic and Statistical Manual of Mental Disorders (DSM)* (Vol. 2)

Drapetomania (Vol. 3)  
 Eating Disorders (Vol. 2)  
 Externalizing Problems of Childhood (Vol. 1)  
 False Memories (Vol. 2)  
 HIV/AIDS (Vol. 1)  
 Hospice (Vol. 1)  
 Impairment (Vol. 1)  
 Indigenous Healing (Vol. 3)  
 Internalizing Problems of Childhood (Vol. 1)  
 Job Satisfaction and General Well-Being (Vol. 4)  
 Learning Disorders (Vol. 1)  
 Low-Incidence Disabilities (Vol. 1)  
 Medication Adherence (Vol. 1)  
 Mental Health Issues in the Schools (Vol. 1)  
 Mental Retardation and Developmental Disabilities (Vol. 1)  
 Neuropsychological Functioning (Vol. 2)  
 Oppositional Defiant Disorder (Vol. 1)  
 Panic Disorders (Vol. 2)  
 Personality Disorders (Vol. 2)  
 Persons With Disabilities (Vol. 4)  
 Physical Health (Vol. 2)  
 Posttraumatic Stress Disorder (Vol. 2)  
 Psychological Well-Being, Dimensions of (Vol. 2)  
 Psychopharmacology, Human Behavioral (Vol. 2)  
 Schizophrenia, Adult (Vol. 2)  
 Secondary Trauma (Vol. 2)  
 Sleep Disorders (Vol. 1)  
 Stress-Related Disorders (Vol. 1)  
 Substance Abuse and Dependence (Vol. 2)  
 Suicide Postvention (Vol. 1)  
 Suicide Potential (Vol. 2)  
 Traumatic Brain Injury and Rehabilitation (Vol. 1)

## **Professional Development and Standards**

*Career Development Quarterly* (Vol. 4)  
 Code of Ethics and Standards of Practice (Vol. 2)  
 Conferences, Counseling Psychology (Vol. 1)  
 Conferences in Counseling (Vol. 1)  
 Confidentiality and Legal Privilege (Vol. 2)  
 Consultation (Vol. 2)  
 Continuing Education (Vol. 1)  
 Counseling Skills Training (Vol. 2)  
 Credentialing Individuals (Vol. 1)  
 Distance Education/Dispersed Learning (Vol. 1)  
 Duty to Warn and Protect (Vol. 2)

Ethical Codes (Vol. 1)  
 Ethical Decision Making (Vol. 1)  
 Ethical Dilemmas (Vol. 1)  
 Ethics in Computer-Aided Counseling (Vol. 1)  
 Ethics in Research (Vol. 1)  
 Informed Consent (Vol. 2)  
 International Developments, Counseling (Vol. 1)  
 International Developments, Counseling Psychology (Vol. 1)  
*Journal of Career Assessment* (Vol. 4)  
*Journal of Career Development* (Vol. 4)  
*Journal of Vocational Behavior* (Vol. 4)  
 Mentoring (Vol. 1)  
 Multicultural Counseling Competence (Vol. 3)  
 Postdegree/Prelicensure Supervision (Vol. 1)  
 Postdoctoral Training (Vol. 1)  
 Predoctoral Internships (Vol. 1)  
 Prescription Privileges (Vol. 1)  
 Professional Associations, Counseling (Vol. 1)  
 Professional Degrees (Vol. 1)  
 Rural Practice, Challenges of (Vol. 1)  
 Scientist–Practitioner Model of Training (Vol. 1)  
 Specialization Designation (Vol. 1)  
 Standards and Competencies (Vol. 4)  
 Supervision (Vol. 1)  
 Virtue Ethics (Vol. 1)

## **Psychosocial Traits and Behavior**

Bullying (Vol. 1)  
 Ego Strength (Vol. 2)  
 Empowerment (Vol. 3)  
 Espiritismo (Vol. 3)  
 Familismo (Vol. 3)  
 Fatalism (Vol. 3)  
 Gambling (Vol. 1)  
 Happiness/Hardiness (Vol. 2)  
 Help-Seeking Behavior (Vol. 3)  
 Hope (Vol. 2)  
 Identity (Vol. 3)  
 Intelligence (Vol. 2)  
 Intrinsic Motivation (Vol. 2)  
 Learned Helplessness (Vol. 3)  
 Locus of Control (Vol. 3)  
 Machismo (Vol. 3)  
 Marianismo (Vol. 3)  
 Meaning, Creation of (Vol. 2)  
 Multicultural Personality (Vol. 3)  
 Optimism and Pessimism (Vol. 2)  
 Personal Space (Vol. 3)



Power and Powerlessness (Vol. 3)  
Quality of Life (Vol. 2) Religion/Religious  
Belief Systems (Vol. 3) Resilience (Vol. 2)  
School Refusal Behavior (Vol. 1)  
Self-Esteem (Vol. 2)  
Spirituality (Vol. 3)  
Spirituality and Career Development (Vol. 4)  
Spirituality/Religion (Vol. 2)

## **Society, Race/Ethnicity, and Culture**

Acculturation (Vol. 3)  
Achievement Gap (Vol. 3)  
Affirmative Action (Vol. 3)  
African Americans (Vol. 3) Afro-  
centricity/Afrocentrism (Vol. 3)  
Alaska Natives (Vol. 3)  
Allocentrism (Vol. 3)  
American Indians (Vol. 3)  
American Jews (Vol. 3)  
Antisemitism (Vol. 3)  
Arab Americans (Vol. 3)  
Asian Americans (Vol. 3)  
Assimilation (Vol. 3)  
Bias (Vol. 3)  
Bicultural (Vol. 3)  
Bilingualism (Vol. 3)  
Biracial (Vol. 3)  
Black English (Vol. 3)  
Black Racial Identity Development (Vol. 3)  
Career Counseling, African Americans (Vol. 4)  
Career Counseling, Asian Americans (Vol. 4)  
Career Counseling, Gay and Lesbian (Vol. 4)  
Career Counseling, Immigrants (Vol. 4)  
Career Counseling, Latinos (Vol. 4)  
Career Counseling, Native Americans (Vol.  
4) Certificate of Degree of Indian Blood (Vol.  
3) Civil Rights (Vol. 3)  
Classism (Vol. 3)  
Collectivism (Vol. 3)  
Colonialism (Vol. 3)  
Color-Blind Racial Ideology (Vol. 3)  
Communication (Vol. 3)  
Cross-Cultural Training (Vol. 3)  
Cultural Accommodation and Negotiation (Vol. 3)  
Cultural Encapsulation (Vol. 3)  
Cultural Equivalence (Vol. 3)  
Cultural Mistrust (Vol. 3)  
Cultural Paranoia (Vol. 3)  
Cultural Relativism (Vol. 3)  
Cultural Values (Vol. 3)  
Culture (Vol. 3)  
Demographics, United States (Vol. 3)  
Discrimination (Vol. 3)  
Discrimination and Oppression (Vol. 2)  
Diversity (Vol. 3)  
Diversity Issues in Career Development (Vol. 4)  
Enculturation (Vol. 3)  
Ethnic Cleansing (Vol. 3)  
Ethnic Identity (Vol. 3)  
Ethnicity (Vol. 3)  
Ethnic Minority (Vol. 3)  
Ethnic Pride (Vol. 3)  
Ethnocentrism (Vol. 3)  
Eugenics (Vol. 1)  
Eurocentrism (Vol. 3)  
Feminization of Psychology (Vol. 1)  
Filial Piety (Vol. 3)  
Idiocentrism (Vol. 3)  
Immigrants (Vol. 3)  
Individualism (Vol. 3)  
Interracial Comfort (Vol. 3)  
Interracial Marriage (Vol. 3)  
Kwanzaa (Vol. 3)  
Latinos (Vol. 3)  
Model Minority Myth (Vol. 3)  
Monocultural (Vol. 3)  
Multiculturalism (Vol. 3)  
Multiracial Families (Vol. 3)  
Nationalism (Vol. 3)  
Oppression (Vol. 3)  
Organizational Diversity (Vol. 3)  
Pacific Islanders (Vol. 3)  
Pluralism (Vol. 3)  
Political Correctness (Vol. 3)  
Prejudice (Vol. 3)  
Race (Vol. 3)  
Racial Identity (Vol. 3)  
Racial Microaggressions (Vol. 3)  
Racial Pride (Vol. 3)  
Racism (Vol. 3)  
Recruitment: History and Recent Trends  
in Diversity (Vol. 1)  
Refugees (Vol. 3)  
Reversed Racism (Vol. 3)  
Santería (Vol. 3)  
Second Culture Acquisition (Vol. 3)  
Sexism (Vol. 3)  
Sexual Harassment (Vol. 4)  
Sexual Orientation (Vol. 4)  
Social Class (Vol. 4)



Social Discrimination (Vol. 4)  
 Social Justice (Vol. 3)  
 Sojourner (Vol. 3)  
 Stereotype (Vol. 3)  
 Third World (Vol. 3)  
 Tokenism (Vol. 3)  
 Transracial Adoption (Vol. 3)  
 Universalism (Vol. 3)  
 Visible Racial/Ethnic Groups (Vol. 3)  
 White Americans (Vol. 3)  
 White Privilege (Vol. 3)  
 Worldview (Vol. 3)  
 Xenophobia (Vol. 3)

## Subdisciplines

Bilingual Counseling (Vol. 3)  
 Black Psychology (Vol. 3)  
 Career Counseling (Vol. 4)  
 Career Counseling, History of (Vol. 4)  
 Career Counseling in Colleges and Universities (Vol. 4)  
 Career Counseling in Organizations (Vol. 4)  
 Career Counseling in Schools (Vol. 4)  
 Career Resource Centers (Vol. 4)  
 Computer-Assisted Career Counseling (Vol. 4)  
 Constructivist Career Counseling (Vol. 4)  
 Counseling, Definition of (Vol. 1)  
 Counseling, History of (Vol. 1)  
 Counseling Psychology, Definition of (Vol. 1)  
 Counseling Psychology, History of (Vol. 1)  
 Counseling the Elderly (Vol. 1)  
 Couple and Marital Counseling (Vol. 1)  
 Crisis Counseling (Vol. 2)  
 Cross-Cultural Psychology (Vol. 3)  
 E-Counseling (Vol. 1)  
 Exercise and Sport Psychology (Vol. 1)  
 Family Counseling (Vol. 1)  
 Genetic Counseling (Vol. 1)  
 Gerontology (Vol. 1)  
 Industrial/Organizational Psychology (Vol. 1)  
 Mediation (Vol. 1)  
 Multicultural Counseling (Vol. 3)  
 Multicultural Psychology (Vol. 3)  
 Narrative Career Counseling (Vol. 4)  
 Occupational Health Psychology (Vol. 4)  
 Personal and Career Counseling (Vol. 4)  
 Physical Activity Counseling (Vol. 2)  
 Positive Psychology (Vol. 2)  
 Private Practice Career Counseling (Vol. 4)  
 Rehabilitation Counseling (Vol. 2)

School Counseling (Vol. 1)  
 School Psychology (Vol. 1)  
 Trait-Factor Counseling (Vol. 4)  
 University Counseling Centers (Vol. 1)

## Theories

Action Theory (Vol. 4)  
 Attachment Theory (Vol. 4)  
 Brown's Values-Based Career Theory (Vol. 4)  
 Career Construction Theory (Vol. 4)  
 Common Factors Model (Vol. 2)  
 Confucianism (Vol. 3)  
 Constructivist Theory (Vol. 2)  
 Counseling Theories and Therapies (Vol. 2)  
 Critical Race Theory (Vol. 3)  
 Deficit Hypothesis (Vol. 3)  
 Etic–Emic Distinction (Vol. 3)  
 High-Context Communication (Vol. 3)  
 Holland's Theory of Vocational Personalities and Work Environments (Vol. 4)  
 Krumboltz Happenstance Learning Theory (Vol. 4)  
 Low-Context Communication (Vol. 3)  
 Model Minority Myth (Vol. 3)  
 Orthogonal Cultural Identification Theory (Vol. 3)  
 Personality Theories (Vol. 2)  
 Personality Theories, Behavioral (Vol. 2)  
 Personality Theories, Cognitive (Vol. 2)  
 Personality Theories, Evolutionary (Vol. 2)  
 Personality Theories, Five-Factor Model (Vol. 2)  
 Personality Theories, Phenomenological (Vol. 2)  
 Personality Theories, Psychodynamic (Vol. 2)  
 Personality Theories, Social Cognitive (Vol. 2)  
 Personality Theories, Traits (Vol. 2)  
 Person–Environment Interactions (Vol. 2)  
 Positivist Paradigm (Vol. 2)  
 Roe's Theory of Personality Development and Career Choice (Vol. 4)  
 Self-Efficacy/Perceived Competence (Vol. 2)  
 Social Cognitive Career Theory (Vol. 4)  
 Social Identity Theory (Vol. 3)  
 Super's Theory (Vol. 4)  
 Theory of Work Adjustment (Vol. 4)  
 Tiedeman's Decision-Making Theory (Vol. 4)

## Therapies, Techniques, and Interventions

Adlerian Therapy (Vol. 2)  
 Adventure Therapy (Vol. 1)



- Art Therapy (Vol. 1)
- Behavior Therapy (Vol. 2)
- Brief Therapy (Vol. 2)
- Career Interventions (Vol. 4) Cognitive-Behavioral Therapy and Techniques (Vol. 2)
- Cognitive Therapy (Vol. 2)
- Conversion Therapy (Vol. 1)
- Corrections Applications (Vol. 1)
- Crisis Counseling (Vol. 2)
- Critical Incident Stress Debriefing (Vol. 2) Developmental Counseling and Therapy (Vol. 2)
- Dialectical Behavior Therapy (Vol. 2) Evidence-Based Treatments (Vol. 2) Expectations About Therapy (Vol. 2)
- Eye Movement Desensitization and Reprocessing (Vol. 1)
- Feedback in Counseling, Immediate (Vol. 1)
- Feminist Therapy (Vol. 1)
- Forensic Applications (Vol. 1)
- Free Association (Vol. 2)
- Gay, Lesbian, and Bisexual Therapy (Vol. 2)
- Group Therapy (Vol. 2)
- Harmful Psychological Treatments (Vol. 2)
- Homework Assignments (Vol. 2)
- Humanistic Approaches (Vol. 2)
- Hypnosis (Vol. 1)
- Individual Therapy (Vol. 2)
- Integrative/Eclectic Therapy (Vol. 2)
- International Approaches (Vol. 4)
- Interpersonal Learning and Interpersonal Feedback (Vol. 2)
- Metaphors, Use of (Vol. 2)
- Mindfulness (Vol. 1)
- Music Therapy (Vol. 1)
- Narrative Therapy (Vol. 2)
- Outcomes of Counseling and Psychotherapy (Vol. 2)
- Paradoxical Interventions (Vol. 2)
- Phrenology (Vol. 1)
- Play Therapy (Vol. 1)
- Projective Techniques (Vol. 2)
- Psychoanalysis and Psychodynamic Approaches to Therapy (Vol. 2)
- Psychoeducation (Vol. 2)
- Rational Emotive Behavior Therapy (Vol. 2)
- Reframing (Vol. 2)
- Self-Help Groups (Vol. 2)
- Socratic Method (Vol. 2)
- Solution-Focused Brief Therapy (Vol. 2)
- Therapist Interpretation (Vol. 2)
- Therapist Techniques/Behaviors (Vol. 2)
- Therapy Process, Individual (Vol. 2)
- Transactional Analysis (Vol. 2)
- Transference and Countertransference (Vol. 2)
- Translation Methods (Vol. 3)



# About the Editors

---

## Volume 1

### Editor-in-Chief



**Frederick T. L. Leong, Ph.D.**, is Professor of Psychology (Industrial/Organizational and Clinical Psychology Programs) and Director of the Center for Multicultural Psychology Research at Michigan State University. He has authored or co-authored more than 110 arti-

cles in various psychology journals, as well as 70 book chapters. In addition, he has edited or co-edited 10 books. Dr. Leong is a Fellow of the APA (Divisions 1, 2, 12, 17, 45, 52), Association for Psychological Science, Asian American Psychological Association, and the International Academy for Intercultural Research. His major research interests center around culture and mental health, cross-cultural psychotherapy (especially with Asians and Asian Americans), and cultural and personality factors related to career choice and work adjustment. He is past president of APA's Division 45 (Society for the Psychological Study of Ethnic Minority Issues), the Asian American Psychological Association, and the Division of Counseling Psychology in the International Association of Applied Psychologists. He is currently serving on the APA Board of Scientific Affairs, the Minority Fellowship Program Advisory Committee, and the Commission on Ethnic Minority Recruitment, Retention, and Training (CEMRRAT2) Task Force. He is the 2007 co-recipient

of the APA Award for Distinguished Contributions to the International Advancement of Psychology.

### Senior Editor



**Elizabeth M. Altmaier, Ph.D.**, is Professor of Counseling Psychology in the College of Education and a Professor of Community and Behavioral Health in the College of Public Health, University of Iowa. She received her master's in psychology and her doctorate in Counseling Psychology from Ohio State University. Her bachelor's in

psychology was from Wheaton College, Illinois. She has an extensive record of research in health applications of counseling psychology, focusing primarily on the role of coping resources (e.g., optimism, coping responses, spirituality/religiosity) in long-term adjustment after treatment for cancer and chronic pain. Altmaier has been involved in professional issues in the psychology community, serving on such boards/committees as the Committee on Accreditation and the Joint Designation Committee of ASPPB/National Register. She is currently associate editor of *The Counseling Psychologist*; she previously was associate editor of the *Journal of Counseling Psychology* and editor of *Clinician's Research Digest*.



### Associate Editor



**Brian D. Johnson, Ph.D.**, is Professor in the School of Applied Psychology and Counselor Education at the University of Northern Colorado in Greeley, CO. He is also the coordinator and director of training for his university's APA accredited Counseling Psychology

Program. Johnson received his doctorate in Counseling Psychology at the University of Iowa. His scholarship focuses on the assessment and treatment of childhood disorders, parenting and health psychology. He has served as a reviewer for the *Journal of Counseling Psychology*, *The Counseling Psychologist* and the *Journal of Clinical Child and Adolescent Psychology*. He is a licensed psychologist in the state of Colorado.



---

## Volume 2

### Editor-in-Chief



**Frederick T. L. Leong, Ph.D.**, is Professor of Psychology (Industrial/Organizational and Clinical Psychology Programs) and Director of the Center for Multicultural Psychology Research at Michigan State University. He has authored or co-authored more than 110 arti-

cles in various psychology journals, as well as 70 book chapters. In addition, he has edited or co-edited 10 books. Dr. Leong is a Fellow of the APA (Divisions 1, 2, 12, 17, 45, 52), Association for Psychological Science, Asian American Psychological Association, and the International Academy for Intercultural Research. His major research interests center around culture and mental health, cross-cultural psychotherapy (especially with Asians and Asian Americans), and cultural and personality factors related to career choice and work adjustment. He is past president of APA's Division 45 (Society for the Psychological Study of Ethnic Minority Issues), the Asian American Psychological Association, and the Division of Counseling Psychology in the International Association of Applied Psychologists. He is currently serving on the APA Board of Scientific Affairs, the Minority Fellowship Program Advisory Committee, and the Commission on Ethnic Minority Recruitment, Retention, and Training (CEMRRAT2) Task Force. He is the 2007 co-recipient of the APA Award for Distinguished Contributions to the International Advancement of Psychology.

### Senior Editor



**Howard E. A. Tinsley, Ph.D.**, is Professor Emeritus of Psychology at Southern Illinois University at Carbondale, a professor in the WLRA International Centre of Excellence at Wageningen University in the Netherlands, and a member of the Mukilteo, Washington,

City Council. He has taught at the University of Oregon, University of Florida, and Southern Illinois University at Carbondale (where he was director, graduate training program in counseling psychology) and he has held appointments as a visiting scholar at the University of Texas at Austin, the University of Minnesota–Twin Cities, and the University of Washington. He received his Ph.D. in psychology from the University of Minnesota and was a licensed psychologist in Illinois (now inactive) and a Diplomate of the American Board of Vocational Experts (now inactive). Tinsley has served as the Editor of the *Journal of Vocational Behavior* and *Passages*, Guest Editor of the *Journal of Counseling Psychology* and *Leisure Sciences*, Advisory Editor of *Contemporary Psychology*, Associate Editor of the *Encyclopedia of Career Decisions and Work Issues*, and Associate and Book Review Editor of the *Journal of Leisure Research*. He has served on the Editorial Boards of nine prominent psychology journals and the Editorial Advisory Board of the Test Corporation of America, and reviewed manuscripts for 26 psychology research journals. He is the lead editor of the



*Handbook of Applied Multivariate Statistics and Mathematical Modeling*, author of 19 book chapters and more than 150 publications dealing with leisure, vocational psychology, and psychological measurement. Tinsley is a recipient of the research award of the American Rehabilitation Counseling Association and the Allen V. Sabora Research Award for research excellence in leisure psychology. A Fellow of the American Psychological Association, Western Psychological Association, and American Psychological Society, he is a former Chair of the American College Personnel Association Commission on Assessment, a former member of the Board of the Council of Counseling Psychology Training Programs, and a former President and secretary-treasurer of the Academy of Leisure Sciences.

### Associate Editor



**Suzanne H. Lease, Ph.D.**, is Associate Professor and Training Director of Counseling Psychology in the Department of Counseling, Educational Psychology, and Research at the University of

Memphis. She also taught at Luther College in Decorah, Iowa. She received her Ph.D. in Psychology (Counseling) from Southern Illinois University at Carbondale and is a licensed psychologist (Health Service Provider) in the state of Tennessee. Her teaching interests include Theories of Counseling, Vocational Psychology, Multicultural Counseling, and Practicum supervision. Her research topics address career development; multiculturalism; masculinity; and gay, lesbian, and bisexual (GLB) issues. Current manuscripts focus on cross-cultural and cross-racial understandings of masculinity in work and intimate partner relationships and family influences on career development. She received the 2006 Dean's Excellence in Research and Scholarship award from the College of Education, University of Memphis. She serves on the Editorial Board for the *Journal of Counseling Psychology* and is an ad-hoc reviewer for several other journals.



---

## Volume 3

### Editor-in-Chief



**Frederick T. L. Leong, Ph.D.**, is Professor of Psychology (Industrial/Organizational and Clinical Psychology Programs) and Director of the Center for Multicultural Psychology Research at Michigan State University. He has authored or co-authored more than 110 articles in

various psychology journals, as well as 70 book chapters. In addition, he has edited or co-edited 10 books. Dr. Leong is a Fellow of the APA (Divisions 1, 2, 12, 17, 45, 52), Association for Psychological Science, Asian American Psychological Association, and the International Academy for Intercultural Research. His major research interests center around culture and mental health, cross-cultural psychotherapy (especially with Asians and Asian Americans), and cultural and personality factors related to career choice and work adjustment. He is past president of APA's Division 45 (Society for the Psychological Study of Ethnic Minority Issues), the Asian American Psychological Association, and the Division of Counseling Psychology in the International Association of Applied Psychologists. He is currently serving on the APA Board of Scientific Affairs, the Minority Fellowship Program Advisory Committee, and the Commission on Ethnic Minority Recruitment, Retention, and Training (CEMRRAT2) Task Force. He is the 2007 co-recipient of the APA Award for

Distinguished Contributions to the International Advancement of Psychology.

### Senior Editor



**Madonna G. Constantine, Ph.D.**, is Professor of Psychology and Education in the Department of Counseling and Clinical Psychology at Teachers College, Columbia University. She received her doctorate in Counseling Psychology from the University of Memphis and completed bachelor's and master's degrees from Xavier University of New Orleans.

Constantine is a highly esteemed researcher in the areas of Black psychology and multicultural counseling. The scope of her work includes exploring the psychological, educational, and vocational issues of African Americans; developing models of cross-cultural competence in counseling, training, and supervision; and examining the intersections of variables such as race and ethnicity in relation to mental health and educational processes and outcomes. Constantine is currently serving as associate editor for the *Journal of Counseling Psychology* and *Cultural Diversity & Ethnic Minority Psychology*. She also is involved in various leadership capacities in counseling and psychological associations across the country.



## Associate Editor



**Roger L. Worthington, Ph.D.**, currently serves as Interim Chief Diversity Officer at the University of Missouri–Columbia (MU), where he directs the Chancellor’s Diversity Initiative. He is a member of the Board of Directors of the National Association of Diversity Officers in Higher Education (NADOHE) and

serves on the editorial board of the *Journal of Diversity in Higher Education*. In the past he has also served on the editorial boards of the *Journal of Counseling Psychology* and *The Counseling Psychologist*. Worthington has an extensive record of scholarship, including theoretical and empirical articles and book chapters related to race/ethnicity, gender, sexual orientation identity, social class, and religious expression.

He has been a principal investigator or co-investigator on nearly \$500,000 in internal and external grants. He is the principal investigator and project director of the MU Difficult Dialogues Program, a project funded by a prestigious Ford Foundation grant. The focus of the MU Difficult Dialogues Program is to promote greater understanding of the relationships among academic freedom, academic responsibility, and intellectual pluralism in a climate characterized by divisiveness and mistrust among those holding differing cultural, religious, and political viewpoints. In addition to his role directing the Chancellor’s Diversity Initiative, he is a licensed psychologist (MO) and an associate professor of Educational, School, and Counseling Psychology at MU, where he has taught courses to undergraduate and graduate students on counseling skills, ethics and law for professional psychology, research design, measurement, and human diversity.



### Editor-in-Chief



**Frederick T. L. Leong, Ph.D.**, is Professor of Psychology (Industrial/Organizational and Clinical Psychology Programs) and Director of the Center for Multicultural Psychology Research at Michigan State University. He has authored or coauthored more than 110 arti-

cles in various psychology journals, as well as 70 book chapters. In addition, he has edited or co-edited 10 books. Dr. Leong is a Fellow of the APA (Divisions 1, 2, 12, 17, 45, 52), Association for Psychological Science, Asian American Psychological Association, and the International Academy for Intercultural Research. His major research interests center around culture and mental health, cross-cultural psychotherapy (especially with Asians and Asian Americans), and cultural and personality factors related to career choice and work adjustment. He is past president of APA's Division 45 (Society for the Psychological Study of Ethnic Minority Issues), the Asian American Psychological Association, and the Division of Counseling Psychology in the International Association of Applied Psychologists. He is currently serving on the APA Board of Scientific Affairs, the Minority Fellowship Program Advisory Committee, and the Commission on Ethnic Minority Recruitment, Retention, and Training (CEMRRT2) Task Force. He is the 2007 co-recipient of the APA Award for Distinguished Contributions to the International Advancement of Psychology.

### Senior Editor



**W. Bruce Walsh, Ph.D.** (University of Iowa), is Professor Emeritus in the Department of Psychology at Ohio State University and currently involved in consulting activities. Walsh is the founder and charter

editor of the *Journal of Career Assessment* and the *Biennial Review of Counseling Psychology*. He has coauthored and coedited 24 books, including *Tests and Assessment*, *Tests and Measurements*, *Career Counseling*, *Career Counseling for Women*, *Career Counseling for African Americans*, the *Handbook of Vocational Psychology*, the *Handbook of Career Counseling*, *Counseling Psychology and Optimal Human Functioning*, and *Person-Environment Psychology*. Walsh currently serves on the editorial boards of the *Journal of Vocational Behavior* and the *Career Development Quarterly*. In 1998 he served as President of the Society of Counseling Psychology (Division 17) and from 2001–2007 served as the APA Council Representative for Division 34 (Population and Environment). From 1990 to 2002 he served as the Director of Training for the Counseling Psychology Program at Ohio State. In 2004 he received the Leona Tyler Award from the Society of Counseling Psychology in recognition of outstanding accomplishments. He holds Fellow status in the American Psychological Association and the Association of Psychological Science and is licensed as a psychologist in Ohio.



### Associate Editor



**Paul J. Hartung, Ph.D.**, is Professor of Behavioral Sciences at Northeastern Ohio Universities Colleges of Medicine and Pharmacy, and Adjunct Professor of Counseling at the University of Akron. His scholarship focuses on developmental

career theory and practice, work–life integration, career decision making, medical career development, and communication in medicine. Hartung serves on the editorial boards of *Journal of Vocational Behavior*, *Journal of Career Assessment*, *Career Development Quarterly*, and *Journal of Counseling and Development*. He is a licensed professional counselor in the state of Ohio and a National Certified Counselor.



# Contributors

---

## Volume 1

Sylvia J. Acosta  
*Colorado State University*

Stefania Ægisdóttir  
*Ball State University*

Elizabeth M. Altmaier  
*University of Iowa*

Jeffrey S. Ashby  
*Georgia State University*

Michelle S. Athanasiou  
*University of Northern Colorado*

Krystle M. Balhan  
*Colorado State University*

Nick Barnecko  
*New Mexico State University*

James Bartee  
*West Virginia University*

Ann Batcheler  
*Oklahoma State University*

Dorothy S. Becvar  
*Saint Louis University*

Robinder P. Bedi  
*University of Victoria*

Joshua D. Bernstein  
*Slippery Rock University*

Donald W. Black  
*University of Iowa Carver College of Medicine*

Linda L. Black  
*University of Northern Colorado*

Steven A. Branstetter  
*West Virginia University*

Natalie E. Brescian  
*Colorado State University*

Pamela Brouillard  
*Texas A&M—Corpus Christi*

Daniel Bruns  
*Health Psychology Associates*

Richard Bunce  
*University of Northern Colorado*

Mali Bunde  
*University of Iowa*

Robert Burke  
*Miami University*

Melissa McGhee Butler  
*University of Memphis*

Linda F. Campbell  
*University of Georgia*

Deniz Canel Çınarbaş  
*Colorado State University*

Jenn Capps  
*University of Northern Colorado*



Cheryl N. Carmin  
*University of Illinois at Chicago*

Jean A. Carter  
*Independent Practice*

Patricia Celaya  
*Washington State University*

Gillian Chapman  
*University of Nevada, Las Vegas*

Eileen Chaves  
*University of Denver*

Brandi L. Chew  
*Colorado State University*

Graham Chumley  
*University of Northern Colorado*

Kathleen Chwalisz  
*Southern Illinois University*

Robert W. Clausen  
*University of Notre Dame*

Daniel L. Clay  
*Auburn University*

Frank L. Collins, Jr.  
*Oklahoma State University*

Merith Cosden  
*University of California, Santa Barbara*

Lesley Cottrell  
*West Virginia University*

David R. Cox  
*American Board of Professional Psychology*

Susan C. M. Crane  
*Aurora Mental Health*

Franci Crepeau-Hobson  
*University of Northern Colorado*

James M. Croteau  
*Western Michigan University*

Rik Carl D'Amato  
*University of Northern Colorado*

Steven J. Danish  
*Virginia Commonwealth University*

José F. Domene  
*Trinity Western University*

Alissa F. Doobay  
*University of Iowa*

J. Rico Drake  
*University of Missouri–Kansas City*

Rhiannon Ducey  
*University of Northern Colorado*

Patrick Dulin  
*San Francisco VA Medical Center*

Monica M. Durette  
*Virginia Commonwealth University*

Timothy R. Elliott  
*Texas A&M University*

Val Farmer  
*MeritCare Health Systems*

Elizabeth Fauth  
*Utah State University*

Kate Fitzpatrick  
*Colorado State University*

Paul Flaspohler  
*Miami University*

Lisa Y. Flores  
*University of Missouri*

Kimberly P. Foley  
*West Virginia University*

Tanya Forneris  
*Queens University*

Rebecca H. Foster  
*Virginia Commonwealth University*



Dale R. Fuqua  
*Oklahoma State University*

Monica R. Geist  
*University of Northern Colorado*

Lawrence H. Gerstein  
*Ball State University*

Dina E. Goldstein  
*Veterans Administration Health Care System*

Gina M. Graham  
*University of Oklahoma*

David Gonzalez  
*University of Northern Colorado*

Debra A. Govan  
*University of Northern Colorado*

Libbe A. Gray  
*University of Northern Colorado*

Robin H. Gurwitch  
*University of Oklahoma Health Sciences Center*

Linda Guthrie  
*Tennessee State University*

Norman C. Gysbers  
*University of Missouri–Columbia*

Sarah C. Haag  
*University of Iowa*

Dennis C. Harper  
*University of Iowa*

Ashley M. Heintzelman  
*University of Missouri–Kansas City*

Carolyn A. Heitzmann  
*University of Notre Dame*

Heather M. Helm  
*University of Northern Colorado*

Patricia Henderson  
*Henderson Consulting*

P. Paul Heppner  
*University of Missouri–Columbia*

Robyn S. Hess  
*University of Northern Colorado*

Jennifer M. Hill  
*University of Iowa*

Robert D. Hill  
*University of Utah*

Erica Hope  
*University of Northern Colorado*

Robyn A. Howarth  
*University of Iowa*

David M. Hulac  
*University of Northern Colorado*

Li-Ching Hung  
*Mississippi State University*

Jody Huntington  
*University of Northern Colorado*

Susan R. Hutchinson  
*University of Northern Colorado*

Michael J. Huxford  
*University of Northern Colorado*

Sue C. Jacobs  
*Oklahoma State University*

Julie Jenks Kettmann  
*St. Ambrose University*

Len Jennings  
*University of St. Thomas*

Brian D. Johnson  
*University of Northern Colorado*

Dau-shen Ju  
*Iowa City VA Medical Center*

Bradley E. Karlin  
*Department of Veterans Affairs*



Nadine J. Kaslow  
*Emory University*

Christopher A. Kearney  
*University of Nevada, Las Vegas*

W. Gregory Keilin  
*University of Texas at Austin*

Julie A. Kellaway  
*Colorado State University*

Susan L. Kessner  
*University of Northern Colorado*

Jeffrey J. Klibert  
*Oklahoma State University*

Amy La  
*Washington State University*

Maria K. E. Lahman  
*University of Northern Colorado*

Nicholas C. Larma  
*Federal Bureau of Prisons*

Michael H. LeBlond  
*University of Northern Colorado*

Yan Li  
*University of Northern Colorado*

Jessica Lohnberg  
*University of Iowa*

Laurie MacDonald  
*University of Northern Colorado*

Michael B. Madson  
*University of Southern Mississippi*

Sandy Magnuson  
*University of Northern Colorado*

Cathy Malchiodi  
*Amer Art Therapy Association*

Jessica L. Manning  
*Western Michigan University*

James L. Martin  
*North Georgia College and State University*

Kate L. Martin  
*Colorado State University*

Ryan C. Martin  
*University of Wisconsin–Green Bay*

J. Barry Mascari  
*Kean University*

Joshua J. Masse  
*West Virginia University*

Elise D. Massie  
*University of Illinois at Chicago*

Miles Matise  
*North Range Behavioral Health*

Louise Maxfield  
*London Health Sciences Centre*

Cheryl B. McNeil  
*West Virginia University*

Cynthia McRae  
*University of Denver*

Marge Katherine Mercurio  
*University of Northern Colorado*

S. Bennett Mercurio  
*Bellevue University*

Thomas V. Merluzzi  
*University of Notre Dame*

Patricia L. Mestas Vigil  
*Colorado State University*

Kimberly A. Miller  
*Colorado State University*

Nancy L. Murdock  
*University of Missouri–Kansas City*

Peter E. Nathan  
*University of Iowa*



Jody L. Newman  
*University of Oklahoma*

Cassandra N. Nichols  
*Washington State University*

Ken Norem  
*University of Northern Colorado*

Mary Sean O'Halloran  
*University of Northern Colorado*

Thomas Oakland  
*University of Florida*

Raymond L. Ownby  
*University of Miami Miller School of Medicine*

Terry M. Pace  
*University of Oklahoma*

Laura Palmer  
*Seton Hall University*

Carl E. Paternite  
*Miami University*

Suni Petersen  
*California School of Professional Psychology*

Anna R. Powe  
*University of Southern Mississippi*

Loreto R. Prieto  
*Iowa State University*

Joseph F. Rath  
*New York University School of Medicine*

Cynthia A. Riccio  
*Texas A & M University*

Lynn C. Richman  
*University of Iowa*

Kathryn Rickard  
*Colorado State University*

Lee A. Rosén  
*Colorado State University*

Lawrence B. Rosenfeld  
*University of North Carolina at Chapel Hill*

Russell A. Sabella  
*Florida Gulf Coast University*

Varunee Sangganjanavanich  
*University of Northern Colorado*

Enedelia Saucedo  
*Oklahoma State University*

Susan Schneeberger  
*University of Northern Colorado*

Donna E. Palladino Schultheiss  
*Cleveland State University*

Casey R. Shannon  
*University of Northern Colorado*

Cary Stacy Smith  
*Mississippi State University*

Kimberly D. Smith  
*University of Southern Mississippi*

R. Clare Smith  
*Sisters of the Holy Spirit*

Basilina (Lia) Softas-Nall  
*University of Northern Colorado*

Marilyn Stern  
*Virginia Commonwealth University*

Amanda H. Stoeckel  
*University of Northern Colorado*

Cal D. Stoltenberg  
*University of Oklahoma*

Samantha R. Strife  
*Colorado State University*

Erin A. Sullivan  
*University of Denver*

Jerry Suls  
*University of Iowa*



Cindy Tidwell  
*Community Counseling Services*

Tammi Vacha-Haase  
*Colorado State University*

Kristin M. Vespia  
*University of Wisconsin–Green Bay*

Theodore L. Wagener  
*Oklahoma State University*

Stephanie M. Wagner  
*West Virginia University*

Sara Walker  
*University of California, Santa Barbara*

Ian J. Wallace  
*Virginia Commonwealth University*

Jane Webber  
*Seton Hall University*

Adrianna R. Wechsler  
*University of Nevada, Las Vegas*

Arlene Weimer  
*Centennial Mental Health Center*

Mark D. Weist  
*University of Maryland*

I. David Welch  
*University of St. Thomas*

Barbara L. Wheeler  
*University of Louisville*

S. Allen Wilcoxon  
*University of Alabama*

Tammy Wilgenbusch  
*University of Iowa*

Deborah E. Witsken  
*University of Northern Colorado*

Kevin Wood  
*University of Iowa*

Ernie Zullo  
*University of Northern Colorado*



---

## Volume 2

Ricardo Ainslie  
*University of Texas at Austin*

James A. Archer, Jr.  
*University of Florida*

Stephen M. Auerbach  
*Virginia Commonwealth University*

Ann Westcot Barich  
*Lewis University*

James W. Bartee  
*West Virginia University*

Theodore R. Bashore  
*University of Northern Colorado*

Kristen N. Bast  
*University of Kansas*

Norman L. Berven  
*University of Wisconsin–Madison*

Sonya Bettendorf  
*Southern Illinois University Carbondale*

Nancy E. Betz  
*Ohio State University*

Larry E. Beutler  
*Pacific Graduate School of Psychology*

Pamela Kay Bjorklund  
*College of St. Scholastica*

Monte Bobele  
*Our Lady of the Lake University*

Sara K. Bridges  
*University of Memphis*

Jeff E. Brooks-Harris  
*University of Hawaii at Manoa*

Steven D. Brown  
*Loyola University Chicago*

Charles E. Byrd  
*University of Florida*

Emma Childs  
*University of Chicago*

Anne M. Cleary  
*Colorado State University*

David Clinton  
*Pacific Graduate School of Psychology*

Pamela Cogdal  
*University of Memphis*

Bertram J. Cohler  
*University of Chicago*

Michael J. Constantino  
*University of Massachusetts*

Stephen W. Cook  
*Texas Tech University*

Robert J. Craig  
*Roosevelt University*



David Dahlbeck  
*University of Memphis*

Matthew Dahlsten  
*University of New Mexico*

Thomas Daniels  
*Sir Wilfred Grenfell College*

Maria U. A. Darcy  
*University of West Florida*

Pamela E. Davis-Kean  
*University of Michigan*

Harriet de Wit  
*University of Chicago*

Jerry L. Deffenbacher  
*Colorado State University*

David N. Dixon  
*Ball State University*

Yvonne Dolan  
*Solution-focused Brief Therapy Association*

Michael J. Donahue  
*Institute for the Psychological Sciences*

E. Thomas Dowd  
*Kent State University*

David J. A. Dozois  
*University of Western Ontario*

Mardis D. Dunham  
*Murray State University*

William D. Ellison  
*Pennsylvania State University*

Amber Esping  
*Indiana University*

Xiaoyan Fan  
*Loyola University Chicago*

Giovanni Fava  
*University of Bologna*

Aurelio José Figueredo  
*University of Arizona*

Dora Finamore  
*Northcentral University*

William Fleeson  
*Wake Forest University*

Suzanne Forrest  
*University of California, San Diego*

Mary A. Fristad  
*Ohio State University*

Thomas C. Gannon  
*University of Nebraska–Lincoln*

Howard N. Garb  
*Wilford Hall Medical Center; Lackland Air Force Base*

Nicola Gazzola  
*University of Ottawa*

Elaine Gierlach  
*Pacific Graduate School of Psychology*

Janet F. Gillespie  
*State University of New York Brockport*

Brian Glaser  
*University of Georgia*

Laura Ann Glass  
*University of Central Missouri*

Michelle S. Goddard  
*University of Memphis*

Kristine Goto  
*Arizona State University*

Gail Hackett  
*Arizona State University*

Fran Hagstrom  
*University of Arkansas*

Jeffrey A. Hayes  
*Penn State*



Yuhong He  
*University of Missouri–Columbia*

Karla A. Henderson  
*North Carolina State University*

P. Paul Heppner  
*University of Missouri–Columbia*

Juanita R. Hernandez  
*University of Northern Colorado*

Katherine M. Hertlein  
*University of Nevada, Las Vegas*

Stevan E. Hobfoll  
*Kent State University*

Mary Ann Hoffman  
*University of Maryland*

Joshua N. Hook  
*Virginia Commonwealth University*

Derek R. Hopko  
*University of Tennessee*

John J. Horan  
*Arizona State University*

Sharon G. Horne  
*University of Memphis*

Lisa Tsoi Hoshmand  
*Lesley University*

Erin E. Howard  
*Lehigh University*

William T. Hoyt  
*University of Wisconsin–Madison*

Li-Ching Hung  
*Mississippi State University*

Zac E. Imel  
*University of Wisconsin–Madison*

Arpana G. Inman  
*Lehigh University*

Allen E. Ivey  
*University of Massachusetts, Amherst*

Richard K. James  
*University of Memphis*

Robert W. Johnson  
*University of Nebraska, Lincoln*

Suzanne O. Kaasa  
*University of California, Irvine*

Fadhel Kaboub  
*Drew University*

Patricia L. Kaminski  
*University of North Texas*

Juihsien Kao  
*University of Minnesota*

Todd B. Kashdan  
*George Mason University*

Terence M. Keane  
*VA Boston Healthcare System & Boston University*

Jeanmarie Keim  
*University of New Mexico*

Walter A. Kendall  
*University of Albany–New York*

Kathleen M. Kirby  
*University of Louisville*

David Scott Klajic  
*Pacific Graduate School of Psychology*

Wendy Kliewer  
*Virginia Commonwealth University*

Sarah Knox  
*Marquette University*

Pamela L. Knox  
*Middle Tennessee State University*

Bogdan Kostic  
*Colorado State University*



Nicholas Ladany  
*Lehigh University*

Macy M. Lai  
*Workers' Compensation Board*

Kevin Lanning  
*Florida Atlantic University*

Kathleen A. Lawler-Row  
*East Carolina University*

Suzanne H. Lease  
*University of Memphis*

Jarrold M. Leffler  
*Nationwide Children's Hospital*

Robert W. Lent  
*University of Maryland*

Kenneth N. Levy  
*Pennsylvania State University*

James W. Lichtenberg  
*University of Kansas*

Owen Richard Lightsey, Jr.  
*University of Memphis*

Scott O. Lilienfeld  
*Emory University*

Yi-Jiun Lin  
*University of Missouri–Columbia*

Dawn Lindeman  
*Indiana University*

Nancy H. Liu  
*University of Nebraska, Lincoln*

Elizabeth F. Loftus  
*University of California, Irvine*

TK Logan  
*University of Kentucky*

Shane J. Lopez  
*University of Kansas*

David Lubinski  
*Vanderbilt University*

Malcolm Macmillan  
*University of Melbourne*

Brent Mallinckrodt  
*University of Tennessee*

Roger Mannell  
*University of Waterloo*

Christopher J. McCarthy  
*University of Texas at Austin*

J. Jeffries McWhirter  
*Arizona State University*

Scott T. Meier  
*University at Buffalo*

Greg Meissen  
*Wichita State University*

Thomas V. Merluzzi  
*University of Notre Dame*

Andrea J. Miller  
*Virginia Commonwealth University*

L. Stephen Miller  
*University of Georgia*

Mark W. Miller  
*VA Boston Healthcare System and Boston University*

Vaughn S. Millner  
*University of South Alabama*

Takuya Minami  
*University of Utah*

Jeffrey T. Mitchell  
*International Critical Incident Stress Foundation*

Carolyn Morgan  
*University of Wisconsin, Whitewater*

D. Keith Morran  
*Indiana University–Purdue University Indianapolis*



Edward K. Morris  
*University of Kansas*

Nancy L. Murdock  
*University of Missouri–Kansas City*

Nanette Mutrie  
*University of Strathclyde*

Rick A. Myer  
*Duquesne University*

Jane E. Myers  
*University of North Carolina, Greensboro*

Roberta L. Nutt  
*Texas Woman's University*

Anthony D. Ong  
*Cornell University*

Timothy M. Osberg  
*Niagara University*

Steven J. Osterlind  
*University of Missouri–Columbia*

James C. Overholser  
*Case Western Reserve University*

Rachel Oxnard  
*Indiana University*

Christopher Peterson  
*University of Michigan*

Colleen M. Peterson  
*University of Nevada, Las Vegas*

Jonathan A. Plucker  
*Indiana University*

Andrew M. Pomerantz  
*Southern Illinois University Edwardsville*

Susaye S. Rattigan  
*Kent State University*

Robert P. Reiser  
*Pacific Graduate School of Psychology*

William Revelle  
*Northwestern University*

Sarah M. C. Robertson  
*University of Tennessee*

Richard W. Robins  
*University of California, Davis*

Lee Thomas Rode  
*Diablo Valley College*

James R. Rogers  
*University of Akron*

Nancy Felipe Russo  
*Arizona State University*

Nicholas Salsman  
*University of Washington*

Caridad Sanchez-Leguelinel  
*John Jay College of Criminal Justice, City University  
of New York*

Carol Sansone  
*University of Utah*

Roberta A. Schriber  
*University of California, Davis*

Mary J. Schwendener-Holt  
*Earlham College*

Lori N. Scott  
*Pennsylvania State University*

William B. Scott  
*College of Wooster*

Jon Adam Sefcek  
*University of Arizona*

Linda Seligman  
*Walden University*

Barbara B. Shadden  
*University of Arkansas*

Thomas Skovholt  
*University of Minnesota*



Brandy Smith  
*University of Memphis*

Cary Stacy Smith  
*Mississippi State University*

Rita Sommers-Flanagan  
*University of Montana*

William D. Spaulding  
*University of Nebraska, Lincoln*

Christopher M. Spofford  
*University of Massachusetts, Amherst*

Kimberly Stark-Wroblewski  
*University of Central Missouri*

Tres Stefurak  
*Auburn University at Montgomery*

Michael F. Steger  
*George Mason University*

Alan E. Stewart  
*University of Georgia*

Sue Strong  
*Eastern Kentucky University*

Raymond Swisher  
*Cornell University*

Gary Michael Szirony  
*University of Arkansas*

Nicole E. Taylor  
*University of Maryland*

Howard E. A. Tinsley  
*Southern Illinois University, Carbondale*

Selena Tramayne  
*Loyola University Chicago*

Michelle J. Trotter  
*University of Minnesota*

Kali H. Trzesniewski  
*University of Western Ontario*

Chia-Lin Tsai  
*University of Missouri–Columbia*

Tracy L. Tylka  
*Ohio State University*

Geneva Vásquez  
*University of Arizona*

Teraesa S. Vinson  
*Columbia University*

Jonathan Wai  
*Vanderbilt University*

Robert Walker  
*University of Kentucky*

Lisa C. Walt  
*Kent State University*

Kristen H. Walter  
*Kent State University*

Mei-Chuan Wang  
*University of Memphis*

Chia-Chih D. C. Wang  
*University of Missouri–Kansas City*

David T. Wasieleski  
*Valdosta State University*

C. Edward Watkins, Jr.  
*University of North Texas*

Gerald R. Weeks  
*University of Nevada, Las Vegas*

David J. Weiss  
*University of Minnesota*

Susan C. Whiston  
*Indiana University*

Noelle S. Giffin Wiersma  
*Whitworth College*

Scott Wituk  
*Wichita State University*



James M. Wood  
*University of Texas at El Paso*

Matthew E. Young  
*Ohio State University*

Everett L. Worthington, Jr.  
*Virginia Commonwealth*

Peter Zachar  
*Auburn University Montgomery*

Ashley Wynne  
*University of Nebraska, Lincoln*







---

### Volume 3

Aimee-Nicole Adams  
*Lehigh University*

Noah E. Adrians  
*Marquette University*

Muninder K. Ahluwalia  
*Montclair State University*

Vanessa Alleyne  
*Montclair State University*

Alvin N. Alvarez  
*San Francisco State University*

Julie R. Ancis  
*Georgia State University*

Jesus (Jesse) R. Aros  
*Texas A&M International University*

Germine H. Awad  
*University of Texas at Austin*

Amanda L. Baden  
*Montclair State University*

Nick Barneclo  
*New Mexico State University*

Fred Bemak  
*George Mason University*

Kimberly Bena  
*Loyola University Chicago*

Sara Bennett  
*Idaho Dept. of Health and Welfare*

Gregory Benson  
*University of Wisconsin–Milwaukee*

Sha’kema M. Blackmon  
*Loyola University Chicago*

Caryn J. Block  
*Teachers College, Columbia University*

Raymond D. Brock-Murray  
*Fairleigh Dickinson University*

Jeff E. Brooks-Harris  
*University of Hawaii at Manoa*

Leon D. Caldwell  
*University of Memphis*

Taisha L. Caldwell  
*Southern Illinois University*

Scott C. Carvajal  
*University of Arizona*

Elif Celebi  
*University of Missouri*

Anne Chan  
*Stanford University*

Catherine Y. Chang  
*Georgia State University*

Ruth Chao  
*University of Denver*



Eric C. Chen  
*Fordham University*

Chun-Chung Choi  
*University of Florida*

Stephanie Clouse  
*University of Georgia*

M. Nicole Coleman  
*University of Houston*

Noah M. Collins  
*Teachers College, Columbia University*

Madonna G. Constantine  
*Teachers College, Columbia University*

Donelda A. Cook  
*Loyola College in Maryland*

Megan Correia  
*Wells College*

Shannon Curry  
*Pepperdine University*

Edward A. Delgado-Romero  
*University of Georgia*

Laura Dick  
*Loyola University Chicago*

Matthew A. Diemer  
*Michigan State University*

Chandra M. Donnell  
*Michigan State University*

Peter C. Donnelly  
*Teachers College, Columbia University*

Cristina Dorazio  
*Teachers College, Columbia University*

Lisa M. Edwards  
*Marquette University*

Jose Eluvathingal  
*University of Wisconsin–Milwaukee*

Angela D. Ferguson  
*Howard University*

Pamela F. Foley  
*Seton Hall University*

Donna Y. Ford  
*Vanderbilt University*

Elizabeth D. Fraga  
*Teachers College, Columbia University*

Miguel E. Gallardo  
*Pepperdine University*

Maritza Gallardo-Cooper  
*Private Practice*

Edmund W. Gordon  
*Teachers College, Columbia University*

Sheila V. Graham  
*Teachers College, Columbia University*

Teresa Granillo  
*University of Michigan*

Jacqueline S. Gray  
*University of North Dakota*

India Gray-Schmiedlin  
*University of Milwaukee*

Arpana Gupta  
*University of Tennessee, Knoxville*

Tonisha Hamilton  
*Seton Hall University*

Shelly P. Harrell  
*Pepperdine University*

Jon M. Harvey  
*University of Georgia*

Yuhong He  
*University of Missouri–Columbia*

Ashley Heintzelman  
*University of Missouri–Kansas City*



P. Paul Heppner  
*University of Missouri–Columbia*

Jill S. Hill  
*Cornell University*

Cheryl Holcomb-McCoy  
*University of Maryland*

Farah A. Ibrahim  
*Oregon State University*

Arpana G. Inman  
*Lehigh University*

Margo A. Jackson  
*Fordham University*

Morris L. Jackson  
*American University*

Linda James-Myers  
*New College of California*

Asma Jana-Masri  
*University of Wisconsin–Milwaukee*

Terri L. Jashinsky  
*University of Wisconsin–Milwaukee*

Brenda K. Johnson  
*Cleveland State University*

Kamau R. Johnson  
*Teachers College, Columbia University*

Janice E. Jones  
*Cardinal Stritch University*

Pamela Jumper Thurman  
*Colorado State University*

Anju Kaduvettoor  
*Lehigh University*

Bryan S. K. Kim  
*University of Hawai‘i at Hilo*

Mai M. Kindaichi  
*Teachers College, Columbia University*

Erica King-Toler  
*John Jay College of Criminal Justice–City University  
of New York*

Heather Knox  
*Tennessee State University*

Kwong-Liem Karl Kwan  
*University of Missouri at Columbia*

Nicholas Ladany  
*Lehigh University*

Teresa LaFromboise  
*Stanford University*

Richard M. Lee  
*University of Minnesota, Twin Cities*

Szu-Hui Lee  
*Massachusetts General Hospital*

Jennifer L. Lemkuil  
*University of Wisconsin–Milwaukee*

Frederick T. L. Leong  
*Michigan State University*

Ma’at E. Lewis-Coles  
*John Jay College of Criminal Justice*

Noriel E. Lim  
*University of Illinois at Urbana-Champaign*

Jun-chih Gisela Lin  
*Texas A&M University*

William Ming Liu  
*University of Iowa*

Michael I. Loewy  
*University of North Dakota*

Ané M. Mariñez-Lora  
*University of Illinois at Chicago*

Jaya Mathew  
*Fordham University*

Elizabeth P. McCadden  
*Marquette University*



Laurie D. McCubbin  
*Washington State University*

Brenda X. Mejia  
*Teachers College, Columbia University*

Marie L. Miville  
*Teachers College, Columbia University*

Debra Mollen  
*Texas Woman's University*

Ruth Montero  
*University of Wisconsin–Madison*

Eduardo Morales  
*California School of Professional Psychology*

Kevin L. Nadal  
*Teachers College, Columbia University*

Sylvia C. Nassar-McMillan  
*North Carolina State University*

Rachel L. Navarro  
*New Mexico State University*

Hammad S. N'cho  
*Boston College*

Helen A. Neville  
*University of Illinois at Urbana-Champaign*

Johanna Nilsson  
*University of Missouri–Kansas City*

Michael S. Nystul  
*New Mexico State University*

Ezemenari M. Obasi  
*Southern Illinois University*

Sumie Okazaki  
*University of Illinois at Urbana-Champaign*

Yanina Paoliello  
*Pepperdine University*

Yong S. Park  
*University of California, Santa Barbara*

Jennie Park-Taylor  
*Fordham University*

John J. Peregoy  
*Morehead State University*

Ruperto M. (Toti) Perez  
*Georgia Institute of Technology*

Ani Pezeshkian  
*University of California, Berkeley*

Wade E. Pickren  
*Ryerson University*

Alex L. Pieterse  
*George Mason University*

Emily Pimpinella  
*Antioch University New England*

Joseph G. Ponterotto  
*Fordham University*

Paul E. Priester  
*Cardinal Stritch University*

Stephen M. Quintana  
*University of Wisconsin–Madison*

Kilynda V. Ray  
*Howard University*

Rebecca M. Redington  
*Teachers College, Columbia University*

Amy L. Reynolds  
*University at Buffalo*

Charles R. Ridley  
*Texas A&M University*

Luis A. Rivas  
*VA Caribbean Healthcare System*

David P. Rivera  
*Teachers College, Columbia University*

Rockey R. Robbins  
*University of Oklahoma*



David Rollock  
*Purdue University*

Andrea J. Romero  
*University of Arizona*

LeLaina Romero  
*Teachers College, Columbia University*

Rocio Rosales  
*University of Missouri*

Daniel C. Rosen  
*Arizona State University*

Gargi Roysircar  
*Antioch University New England*

Alexandra Rutherford  
*York University*

Lisa A. P. Sanchez-Johnsen  
*University of Chicago*

Anne Saw  
*University of Illinois at Urbana-Champaign*

María R. Scharrón-del Río  
*City University of New York–Brooklyn College*

Joshua Scherer  
*University of Wisconsin–Milwaukee*

Lewis Z. Schlosser  
*Seton Hall University*

Sara Schwarzbaum  
*Northeastern Illinois University*

Nicholas C. Scull  
*University of Wisconsin–Madison*

Sheetal Shah  
*Southern Illinois University*

Kimber L. Shelton  
*University of Georgia*

Frances C. Shen  
*Southern Illinois University*

Laura Smith  
*Teachers College, Columbia University*

Melissa K. Smothers  
*University of Wisconsin–Milwaukee*

Lisa B. Spanierman  
*University of Illinois at Urbana-Champaign*

Jesse A. Steinfeldt  
*Indiana University–Bloomington*

Francis L. Stevens  
*Tennessee State University*

Robbie J. Steward  
*Michigan State University*

Lisa A. Suzuki  
*New York University*

Michelle A. Swagler  
*Independent Practice, Athens, Georgia*

Vivian L. Tamkin  
*Southern Illinois University*

Nita Tewari  
*University of California, Los Angeles*

Chalmer E. Thompson  
*Indiana University–Purdue University, Indianapolis*

Ivory A. Toldson  
*Howard University*

Alisia G. T. T. Tran  
*University of Minnesota*

Joseph E. Trimble  
*Western Washington University*

Chia-Lin Tsai  
*University of Missouri–Columbia*

Sherri Turner  
*University of Minnesota*

Allison Ventura  
*Fordham University*



Elizabeth M. Vera  
*Loyola University Chicago*

Adam M. Voight  
*Michigan State University*

Rebecca Wagner  
*Tennessee State University*

Rheeda L. Walker  
*Southern Illinois University*

Barbara C. Wallace  
*Teachers College, Columbia University*

Bruce E. Wampold  
*University of Wisconsin–Madison*

Yu-Wei Wang  
*Southern Illinois University at Carbondale*

Eliza M. Wells  
*University of Georgia*

Arthur L. Whaley  
*Russell Sage Foundation*

Gilman W. Whiting  
*Vanderbilt University*

Carmen B. Williams  
*University of Colorado*

Frank C. Worrell  
*University of California, Berkeley*

Roger L. Worthington  
*University of Missouri*

Kuang-ming Wu  
*Tennessee State University*

Billy Yarbrough  
*University of Georgia*

Carlos P. Zalaquett  
*University of South Florida*



---

## Volume 4

Jacqueline E. Akhurst  
*York St. John University*

James T. Austin  
*Ohio State University*

Nancy E. Betz  
*Ohio State University*

Rosie P. Bingham  
*University of Memphis*

Fred H. Borgen  
*Iowa State University*

Nicole J. Borges  
*Wright State University School of Medicine*

Hande Sensoy Briddick  
*South Dakota State University*

William C. Briddick  
*South Dakota State University*

Steven D. Brown  
*Loyola University Chicago*

Ric Brown  
*Private Consultant*

Duane Brown  
*UNC Chapel Hill*

Shawn T. Bubany  
*University of Minnesota*

NiCole T. Buchanan  
*Michigan State University*

Ilene M. Buck  
*Indiana University*

Emily E. Bullock  
*University of Southern Mississippi*

Louis A. Busacca  
*Cuyahoga Community College*

Elif Celebi  
*University of Missouri*

Robert C. Chope  
*San Francisco State University*

Y. Barry Chung  
*Georgia State University*

Dulin W. Clark  
*Penn State*

Edward Anthony Colozzi  
*Career Development and Counseling Services*

Patrick D. Converse  
*Florida Institute of Technology*

Robert Kelly Crace  
*College of William & Mary*

Sara E. Cummings  
*Florida State University*

René V. Dawis  
*University of Minnesota*



Diane W. DeWitt  
*Collaborative Vocational Services Northwest*

Ryan D. Duffy  
*University of Maryland*

Donald E. Eggerth  
*CDC/NIOSH*

Jeffrey L. Elder  
*Brigham Young University*

Brian Engdahl  
*Veterans Affairs Medical Center*

Levon T. Esters  
*Iowa State University*

Jinyan Fan  
*Hofstra University*

Lisa Y. Flores  
*University of Missouri*

Pamela F. Foley  
*Seton Hall University*

Suzanne M. Friedman  
*Howard Community College*

William S. Froilan  
*Ohio State University*

Itamar Gati  
*Hebrew University of Jerusalem*

Kurt F. Geisinger  
*University of Nebraska*

William A. Gentry  
*Center for Creative Leadership*

Kevin W. Glavin  
*Kent State University*

Jane Goodman  
*Oakland University*

Paul A. Gore  
*University of Utah*

Kathy E. Green  
*University of Denver*

Arpana Gupta  
*University of Tennessee, Knoxville*

Norman C. Gysbers  
*University of Missouri*

Gail Hackett  
*Arizona State University*

Michael E. Hall  
*Private Practice*

Marie S. Hammond  
*Tennessee State University*

Jo-Ida C. Hansen  
*University of Minnesota*

Erin E. Hardin  
*Texas Tech University*

Charles K. Hees  
*Southern Illinois University at Carbondale*

Lisa J. Heiser  
*Johns Hopkins University*

Sheila J. Henderson  
*Stanford University*

Mary J. Heppner  
*University of Missouri–Columbia*

Edwin L. Herr  
*Pennsylvania State University–University Park*

Jeanne M. Hinkelman  
*JA Worldwide*

Aaron P. Jackson  
*Brigham Young University*

Margo A. Jackson  
*Fordham University*

Shiloh E. Jordan  
*University of Missouri, Columbia*



Cindy L. Juntunen  
*University of North Dakota*

Neeta Kantamneni  
*University of Wisconsin–Milwaukee*

Kevin R. Kelly  
*Purdue University*

Mary E. Kelly  
*Seton Hall University*

Lisa Knapp-Lee  
*EdITS*

John D. Krumboltz  
*Stanford University*

George Kuh  
*Indiana University*

Kristen Lamp  
*Loyola University Chicago*

Mark M. Leach  
*University of Southern Mississippi*

Robert W. Lent  
*University of Maryland*

Janet G. Lenz  
*Florida State University*

Frederick T. L. Leong  
*Michigan State University*

Wade C. Leuwerke  
*Drake University*

William Ming Liu  
*University of Iowa*

Margaretha S. Lucas  
*University of Maryland*

Paul Martin  
*Howard Community College*

Lynda Matthews  
*University of Sydney*

Marilyn Maze  
*ACT, Inc.*

Monique M. Mendoza  
*University of Missouri, Columbia*

Enmanuel Mercedes  
*Seton Hall University*

Elias Mpofu  
*Pennsylvania State University*

Jennifer Nieman-Gonder  
*Farmingdale State College*

Spencer G. Niles  
*Pennsylvania State University*

Alayne J. Ormerod  
*University of Illinois, Urbana-Champaign/Chicago*

Samuel H. Osipow  
*Ohio State University*

Frederick L. Oswald  
*Michigan State University*

Christopher E. Peck  
*Brigham Young University*

Gary W. Peterson  
*Florida State University*

Susan D. Phillips  
*University at Albany, State University of New York*

Mark Pope  
*University of Missouri–St. Louis*

Erik J. Porfeli  
*University of North Carolina at Charlotte*

Jeffrey P. Prince  
*University of California, Berkeley*

Joshua S. Quist  
*Florida Institute of Technology*

Patricia M. Raskin  
*Teachers College, Columbia University*



Jack R. Rayman  
*Pennsylvania State University*

Robert C. Reardon  
*Florida State University*

Mark C. Rehfuss  
*Regent University*

Hazel L. Reid  
*Canterbury Christ Church University*

Lourdes M. Rivera  
*Queens College City University of New York*

Rocio Rosales  
*University of Missouri*

Patrick J. Rottinghaus  
*Southern Illinois University Carbondale*

James P. Sampson, Jr.  
*Florida State University*

Denise E. Saunders  
*Private Practice*

Mark L. Savickas  
*Northeastern Ohio University*

Donna E. Palladino Schultheiss  
*Cleveland State University*

Lisa E. Severy  
*University of Colorado*

Michael Shahnasarian  
*Career Consultants of America*

V. Scott Solberg  
*University of Wisconsin–Milwaukee*

Kyle B. Swaney  
*ACT*

Brian Taber  
*Oakland University*

Shiri Tal  
*Tel Aviv University*

Linda JC Taylor  
*IAEVG*

Kyle Telander  
*Loyola University Chicago*

Howard E. A. Tinsley  
*Southern Illinois University, Carbondale*

David M. Tokar  
*University of Akron*

Jerry Trusty  
*Pennsylvania State University*

Femina P. Varghese  
*Texas Tech University*

Marc Verhoeve  
*Sigma Assessment Systems*

W. Bruce Walsh  
*Ohio State University*

David J. Weiss  
*University of Minnesota*

Susan C. Whiston  
*Indiana University*

Krystle C. Woods  
*Michigan State University*

Richard A. Young  
*University of British Columbia*

Donald G. Zytowski  
*Kuder, Inc.*



# Introduction

---

## The Field

Counseling is a professional activity that involves helping clients, individually or in groups, or as couples and families, deal with various career, vocational, educational, and emotional problems. From the depressed and lonely college student to the business executive at midlife experiencing decreasing levels of career satisfaction to the couple where one partner has been unfaithful in the relationship, counseling is the intervention that numerous individuals turn to each year as the challenges and stress of daily living exceed their normal coping abilities. Counseling is practiced by counselors, social workers, psychiatric nurses, psychologists, and psychiatrists. While the demarcation is not absolute, counseling is sometimes differentiated from psychotherapy in that the latter deals more with mental illnesses and psychological disorders while the former is more concerned with normative stresses, adjustment difficulties, and life transitions (e.g., adjusting to unemployment or going through a divorce). Yet others have maintained that counseling and psychotherapy are quite similar activities and represent different sides of the same coin. In the current encyclopedia, we have adopted this latter perspective and counseling and psychotherapy are used interchangeably depending on the problem being treated as well as the context of the intervention.

Within the United States, traditionally, there have been four recognized mental health professions, which include Psychiatry, Psychology, Social Work, and Nursing in terms of insurance reimbursement of mental health services. Counseling can be provided to their clients by each of these mental health professionals. Within the field of Psychology, there are four major applied specialties in professional psychology which include Counseling Psychology, Clinical Psychology, School Psychology, and Industrial/Organizational

Psychology. Counseling, Clinical, and School Psychology are considered health service specialties while Industrial/Organizational Psychology is not. There is considerable overlap in the training and practice of Clinical and Counseling Psychology, and a few clinical and counseling training programs are housed within the same university department.

Both Clinical Psychology and Counseling Psychology can be differentiated from Psychiatry by the fact that the latter professionals are first trained to be physicians (receiving a medical degree) who go on to obtain specialty training (psychiatric residencies and fellowships) and can prescribe medications. Until recently, psychologists could not prescribe medications while psychiatrists could. This difference has changed considerably with the movement towards gaining prescription privileges for psychologists with special post-doctoral training. Another important distinction between psychiatrists and psychologists is that the majority of the former group tends to have admitting privileges in hospitals for their patients while the latter group does not, important for mental health professionals treating patients with severe mental illnesses who often require hospitalization.

As an applied specialty in Psychology that focuses on health and mental health, Counseling Psychology uses an extensive array of assessment and intervention strategies to help individuals, families, groups and organizations with their educational, developmental, and adjustment difficulties. While a small subset of counseling psychologists do focus on health issues, the majority of them focus instead on mental health in either their research or practice. The breadth of the activities undertaken by counseling psychologists has often resulted in their being referred to as the “general practitioners” of psychological specialties.

With a long-standing tradition of focusing more on clients’ strengths and assets as opposed to their



deficits and pathology, counseling psychologists are different from clinical psychologists along four main inter-related dimensions: (a) they tend to provide interventions and treatment for persons who are experiencing adjustment difficulties and moderate levels of psychological problems as opposed to severe psychopathology, (b) they are more likely to use short-term interventions, (c) they tend to provide these interventions in outpatient as opposed to inpatient facilities, and (d) they are unique among applied psychologists in providing individual career counseling and educational interventions. However, in providing individual counseling and psychotherapy, they are quite similar to clinical psychologists in using some of the same theories, models, and approaches.

The Social Work degree is primarily a practitioner degree with limited training in conducting science. As a mental health profession, most social workers complete the MSW (Master's of Social Work) which is a two-year master's degree. Most social workers eventually seek certification, to provide mental health services in private practice or various mental health agencies. Like clinical and counseling psychologists, social workers can provide therapy to clients with mental health problems, and similar to a majority of their psychology colleagues, social workers also cannot prescribe medicines for mental health problems. Social workers and psychiatrists can also be distinguished from counseling psychologists by the fact that they do not receive any training in psychological testing and assessment. In psychiatric hospitals, VA's, and community mental health centers, clinical and counseling psychologists are charged with engaging in the bulk of the psychological testing and test report preparation.

Within Nursing, only those who are trained as psychiatric nurses are considered mental health professionals and can engage in private practice of counseling and psychotherapy. Even though psychiatric nurses can engage in such private practice, the majority of them tend to work in mental health hospitals or agencies. As a health profession, psychiatric nursing is closely aligned with the medical specialty of psychiatry and is an integral member of the interdisciplinary mental health team in most psychiatric hospitals. As such, they are more likely to be found in inpatient than outpatient mental health facilities, though nurse-practitioners (those who can prescribe certain psychotropic medications) are becoming more common in some mental health agencies to alleviate the workload burden on psychiatrists. Like social workers,

they do not obtain any training in scientific research or psychological testing when contrasted with counseling or clinical psychologists.

A fifth profession, which is closely aligned with Counseling Psychology and often confused with it, is that of the Counseling field. Unlike counseling psychologists who are trained primarily as psychologists, masters and doctoral degree counselors receive training in counseling programs that are not accredited by the American Psychological Association and therefore cannot be licensed as psychologists. Instead, counselors are trained in counseling programs typically accredited by the Council on Counseling and Related Educational Programs (CACREP). These counselors typically go on to achieve state licensure as professional counselors. While the training between the two groups is quite similar, a majority of the counselors are trained at the masters level whereas counseling psychologists are required to have a doctorate in order to be licensed and to practice independently. While some are active in both, counseling psychologists tend to belong to and participate in the American Psychological Association whereas counselors tend to belong to and participate in the American Counseling Association.

### **Rationale for the Encyclopedia**

When Nancy Hale from Sage approached me about editing the encyclopedia back in 2002, I hesitated since I knew that editing an encyclopedia would be very time consuming and would take away from my program of research and other professional activities. Yet, I accepted the invitation because of two of my strongest beliefs regarding psychology. First, I had learned and remembered in graduate school Kurt Lewin's famous dictum: "There is nothing so practical as a good theory." Second, as I became involved in the American Psychological Association, I learned about this wonderful idea from George Miller in his 1969 Presidential address about "Giving Psychology Away." The idea that Psychology should not be locked in academic journals and research labs but given away freely to the public so that we could fulfill the APA mission of "promoting human welfare" made a great deal of sense to me. Therefore, the primary rationale for this encyclopedia is the combination of those two powerful ideas of "giving psychology away" and sharing "practical theories" with the public.



Whether performed by psychologists, psychiatrists, social workers, psychiatric nurses or counselors, thousands of professionals throughout this country and elsewhere in the world are providing counseling services to their fellow human beings in helping them address and resolve the variety of problems of living that exceeds their coping resources and social support. The purpose of the current *Encyclopedia of Counseling* is to provide a comprehensive overview of the theories, models, techniques and challenges involved in this professional activity called counseling. It was designed to be the definitive resource for members of the public who are interested in learning about the science and practice of counseling. It will also be a useful resource for undergraduate and graduate students as well as professionals from other specialties to learn about counseling in all its forms and manifestations.

## Content and Organization

By covering all of the major theories, approaches, and contemporary issues in counseling, the encyclopedia includes close to 600 entries. To enable the reader to understand the major approaches and themes within the field of counseling, the current encyclopedia has been divided into four volumes: (1) changes and challenges facing counseling, (2) personal and emotional counseling, (3) cross-cultural counseling, and (4) career counseling. However, each volume will also contain a cross-volume Reader's Guide and a cross-referencing system to entries in other volumes. In this way, we have created a flexible encyclopedia that can be used together as a set or separately by volume depending on the need of the user.

### ***Volume 1: Changes and Challenges for Counseling in the 21st Century*** **(Elizabeth Altmaier, Senior Editor;** **Brian Johnson, Associate Editor)**

In the first volume of the encyclopedia, we provide counselors, psychologists, scientists and students with a broad overview of contemporary applications in the field of counseling. Professional counselors come from a variety of disciplines including medicine, psychology, religion, social work, and education. Understanding our varying perspectives will help us better define who we are. Consequently, we provide a review of different

types of counselors, their different professional identities and their different models of graduate education. We also review important historical developments that have shaped the evolution of the counseling profession into its current form. Throughout these discussions, we keep an eye on how these past events continue to influence the field today and into the future.

As we continue through the 21st century, counseling is undergoing tremendous change. Forces within and outside the profession are changing the way counselors practice, select treatments, conduct research, and conceptualize clients. Counselors are working in a wider range of environments and with more clients. They are encountering new technologies and ethical dilemmas that a decade ago would not have even been considered. Charles Gelso and Bruce Fretz have noted that, for any field to avoid stagnation, it must be in a state of flux. Counseling is definitely in a state of flux. This volume's contents reflect both past history and newer applications. Topics will be of interest to both the practitioner and the scientist. Some topics reflect generally accepted ideas/practices while others will be controversial. All of the entries define the topics being discussed and also show how these topics are impacting professional counselors today and in the future.

We also identified numerous topics related to the application of treatment approaches and therapeutic techniques within a counseling relationship. Also included in this volume are special applications in the areas of Health, Life Transitions, Assessment, Youth/Families and Innovative Treatment Approaches. All of these special applications describe treatments in terms of current practice and also in terms of best practice. Empirical support for these treatments, when available, will be reviewed.

Our intent for this volume is to provide a look back at influential theories, models, persons and trends as well as look forward to likely paradigm shifts in research, theory and practice.

### ***Volume 2: Personal and Emotional Counseling*** **(Howard E. A. Tinsley, Senior Editor;** **Suzanne Lease, Associate Editor)**

Volume 2 of the *Encyclopedia of Counseling* provides psychologists, counselors, scholars, behavioral scientists, students and the public with a comprehensive compilation of contemporary information about



established and emerging topics in mental health and personal and emotional counseling.

Mental health professionals who provide personal and emotional counseling possess expert knowledge of the social, cultural and biological differences among individuals and the factors that contribute to human diversity. They have a detailed understanding of the major theories and empirical research findings that illuminate the dynamic influence of biological, cognitive, social, cultural, and environmental forces on mental health and life-span development. They understand the principles of psychological measurement and are skilled in the use of assessment techniques to determine the nature of their clients' concerns. They are trained in the use of therapeutic interventions to ameliorate those concerns. They view those who seek their services as clients rather than patients and they interact with their clients as coaches, educators and mentors to promote client learning.

The problems addressed in personal and emotional counseling range from those arising from concerns about normal developmental processes and common life transitions to debilitating problems of great severity (e.g., depression, suicidal thoughts or personality disorders). The problem may be chronic or acute, and it may have a social, cultural, or biological etiology.

Personal and emotional counseling encompasses a broad array of interventions that are used to provide assistance to single individuals, families, and groups of individuals having similar concerns. Many interventions involve some form of "talking therapy" (typically referred to as psychotherapy, or therapy) designed to help the client gain insight into the nature and causes of their concerns. Other interventions involve some form of behavioral rehearsal, the prescription of medication (most often by a psychiatrist or general medical practitioner), or a combination of approaches.

Interventions may be designed to prevent future problems, develop needed skills, or correct problems (i.e., restore mental health and effective functioning; APA, 1999). The overarching goals of personal and emotional counseling are to help the client make a choice (i.e., make a decision), change a troublesome behavior, or reduce cognitive confusion. Achieving these goals may necessitate acquiring new knowledge, modifying beliefs and values, learning new behaviors, understanding and adjusting to changing life circumstances, learning new emotional reactions, developing new interests, or resolving a crisis. Counseling helps clients view their concerns from a

new perspective, explore their options, and make decisions that bring about change.

Volume Two covers issues related to: (a) the healthy personality, (b) factors that affect mental health (cause difficulties), (c) assessment and diagnosis, (d) interventions, (e) outcomes of counseling and therapy.

**Volume 3: *Cross-Cultural Counseling* (Madonna Constantine, Senior Editor; Roger Worthington, Associate Editor)**

Volume 3 of the *Encyclopedia of Counseling* provides students, educators, practice professionals, and service consumers with a comprehensive overview of contemporary conceptual, scientific and applied topics in cross-cultural counseling. We acknowledge that human diversity is multifaceted with respect to dimensions of race, ethnicity, culture, language, gender expression, sexual orientation, ability and disability, religious and spiritual beliefs, and socioeconomic status, among others. Our charge for this volume is to focus narrowly on the topics of race, culture, and ethnicity, and allow the other dimensions of diversity to be infused throughout this volume and other volumes of the encyclopedia.

Cross-cultural counseling and psychotherapy have become highly influential in practice, training, and scholarship. Following decades of efforts to respond to social, political and demographic forces, multiculturalism has been identified as the fourth force in psychology. Demographic changes in the United States due to birthrates and immigration have increased the rapidity of response from the counseling profession in addressing the needs of racial, ethnic, cultural, and linguistic minorities. Changes to the field have occurred in the recruitment and training of graduate students, an increased emphasis on addressing cross-cultural topics in the scholarly discourse, and an expansion of service delivery models to make counseling more accessible. The professions have become increasingly concerned with issues of advocacy, civil rights, and social justice in order to combat the impact of oppressions on the lives of individuals. As a result, counseling roles and activities have expanded beyond the consultation room and into communities, educational systems and governmental agencies.

In this volume, we address the major social, scientific, and professional forces that have shaped the evolution of cross-cultural counseling and psychotherapy.



Progress is charted via coverage of historical developments that occurred in professional associations, journals, books, conferences, as well as national and world events. We address the roots of the field, as well as major changes in its development across time to the present. We identify major scientific, conceptual and practical advances, as well as the major contributors and architects in the field. We highlight important concepts, and address the impact of cross-cultural counseling and psychotherapy to the counseling profession more broadly. Emerging issues and topics are also identified.

**Volume 4: Career Counseling**  
(**W. Bruce Walsh, Senior Editor;**  
**Paul Hartung, Associate Editor**)

This volume of the encyclopedia provides psychologists, counselors, academics, researchers, and students with complete and contemporary information about established and emerging topics in career counseling. We define career counseling as efforts to facilitate satisfying and realistic decision-making and career adjustment throughout the life span. The task of the career counselor is to facilitate the learning of skills, interests, beliefs, values, work habits, and personal qualities that enable each client to create a satisfying life within a constantly changing work environment (Krumboltz, 1996). Career counselors may be seen as coaches, educators, and mentors.

We have chosen to use Walsh's definition of career counseling which makes three important assumptions. First, all career counseling models assume that the exchanges between counselors and clients lead to a change in client's vocational behavior and attitudes. In theory, career counseling promotes career decision-making, choice, adjustment, and a better life. A second assumption is that all models of career counseling involve information gathering. Any information about individuals or their environments that contributes to understanding vocational behavior, attitudes, and emotions needs to be considered in the career assessment and counseling process. Self-report interview data, psychometric assessment data, behavioral data, perceptions of others, and any other relevant information need to be considered. A third assumption is that all career counseling models involve a learning process—cognitive, behavioral, and affective learning. The learning process leads to changes in career cognitions, career behavior, and career emotions. The task of career counseling is to promote client learning.

In structuring a framework for career counseling, Mark Savickas identified six different questions that career clients ask: (a) How do I get a job? (b) What shall I choose? (c) Who am I? (d) How do I shape my career? (e) How can work help me grow as a person? (f) How can I do better? Each of these questions calls for different kinds of career counseling interventions, often offered by different kinds of agencies. Well-trained career counselors are prepared to offer services to address each of these career-related questions.

### How the Encyclopedia Was Created

Nancy Hale from Sage contacted Frederick Leong about the possibility of editing an *Encyclopedia of Counseling* in the summer of 2002. Following on some preliminary e-mail exchanges, Nancy moved over to the Journals Division of Sage and Arthur Pomponio took over as the Acquisition Editor for the encyclopedia. After additional discussions between Leong and Pomponio, it was decided that given the breadth of the Counseling field, the encyclopedia would consist of 4 volumes and approximately 150 entries per volume. Leong also suggested the novel approach of organizing the encyclopedia so that each volume covered a specific area of Counseling while maintaining the alphabetical ordering of entries within each volume.

Since Leong had also served as Associate Editor for International and Cross-Cultural entries under the senior editorship of Anthony Marsella for the *APA/Oxford Encyclopedia of Psychology* (8 volumes, Alan Kazdin served as Editor-in-Chief), he suggested using a similar organizational structure for the *Encyclopedia of Counseling*. Specifically, Leong would serve as Editor-in-Chief with the assistance of a Senior Editor to oversee each volume. The Senior Editor would in turn appoint an Associate Editor to help with the volume. In addition, this editorial team of 9 individuals would be guided by an Advisory Board.

Once the focus of the encyclopedia and the organizational structure of the four volumes were in place, Leong submitted a formal proposal to Sage which sent it out for external review. Upon receiving positive review of the proposal, Rolf Janke, then-Executive Editor of Sage, met with Frederick Leong at the University of Tennessee in December 2003 to review and sign the contract to initiate the project. In consultation with Janke and Pomponio, Leong appointed some of the leading figures of the field to serve on the



Advisory Board. The Board consisted of individuals from a variety of groups within the Counseling field. Members of the Board include Patricia Arredondo (incoming President of the American Counseling Association at that time), Charles Gelso (former editor of the *Journal of Counseling Psychology* and eventually Editor of *Psychotherapy: Theory, Research, Practice and Training*), Punccky Heppner (incoming President of the Society for Counseling Psychology of the American Psychological Association at that time), Francis Lu (Professor of Psychiatry at University of California, San Francisco and leading authority on cross-cultural competence training in Psychiatry), Paula Nurius (Professor of Social Work at the University of Washington and an author of several books with Sage), and Derald Wing Sue (leading author and authority on cross-cultural counseling).

With the Advisory Board in place, the Senior Editors of the volumes were appointed next with Elizabeth Altmaier (University of Iowa) serving as Editor of Volume 1, Howard E. A. (Tony) Tinsley (Professor Emeritus, Southern Illinois University) serving as Editor of Volume 2. Madonna Constantine (Teachers College, Columbia University) was appointed as Editor of Volume 3 and W. Bruce Walsh (Professor Emeritus, Ohio State University) accepted the appointment to be Editor of Volume 4. Each of these Volume Editors then appointed their Associate Editors: Brian Johnson (Volume 1), Suzanne Lease (Volume 2), Roger Worthington (Volume 3), and Paul Hartung (Volume 4).

The next step involved generating the headword list of entries of the encyclopedia. Based on a review of the leading textbooks and handbooks in Counseling and Counseling Psychology, an initial list was generated by the Editor-in-Chief. This list was then sent to each of the Senior and Associate Editors for the 4 volumes for their review as to which entries fit best in their volume. As a result of this review, some entries were dropped and new ones were added. Based on this review and consultation across volumes, the penultimate list of entries for each volume was decided upon and then sent to the Advisory Board for their comment and suggestion. Using the feedback from the Board, another round of additions and deletions was conducted which resulted in the final list of entries. Next the challenge of recruiting the hundreds of contributors to write the entries began.

When the *Encyclopedia of Counseling* began in earnest in 2004 with the appointment of the editorial team and advisory board, Sage had just implemented their Web-based tool for their Reference Division, the Sage Reference Tracking (SRT) system. The SRT was to prove to be an invaluable tool for the editorial team since it allow the management of contracts, submissions, revisions and acceptance of entries via the Web. Just a few years before, Leong had had to manage the entries assigned to him for the *Encyclopedia of Psychology* (APA/Oxford University Press) via hard copies and the U.S. Postal Service!

As a massive undertaking (9 editors, 4 volumes, almost 600 entries and over 1 million words), the encyclopedia took 4 years to complete and was finally published in 2008.

It was truly a team effort harnessing the efficiency of the Internet and involving hundreds of scholars, researchers, practitioners and editorial staff at Sage.

## Acknowledgments

As indicated above, the major undertaking of producing a four-volume encyclopedia would not be possible without the host of dedicated individuals. It is only fitting to acknowledge here the important contributions of all these individuals. To begin with, the encyclopedia is the product of the hundreds of contributors who wrote the entries and our acknowledgements should appropriately start with them. The contributors were ably guided by the editorial team who provided numerous hours of consultation and editing of the entries (Elizabeth Altmaier, Howard E. A. Tinsley, Madonna Constantine, Bruce Walsh, Brian Johnson, Suzanne Lease, Roger Worthington, and Paul Hartung). Both the editorial team and I owe much to the Advisory Board who provided important input into both the structure of the encyclopedia as well as the selection of the entries (Patricia Arredondo, Charles Gelso, Punccky Heppner, Francis Lu, Paula Nurius, and Derald Wing Sue).

Within Sage, there were many individuals who were pivotal in the launching of the encyclopedia (Nancy Hale, Arthur Pomponio, Kassie Graves, Rolf Janke) and seeing it through to production (Eileen Gallaher, Sara Tauber, and Carole Maurer), and we are grateful for their contributions as well as the scores of individuals in production, contracts, copyediting, typesetting, and cover design. Please know that we could not have done it without you. Thank you.



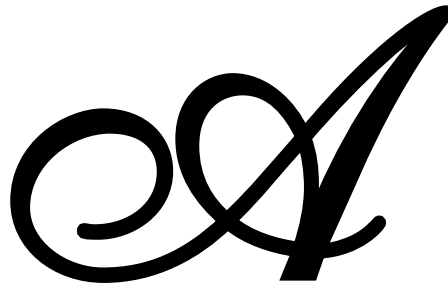
I have also been fortunate to have good colleagues and support within the Psychology Department at Michigan State University to carry out this project. While at the University of Tennessee, I was very ably assisted by my secretary Kim Kirby as well as talented graduate students (Annie Gupta, Huaiyu Zhang, Dwight Tolliver) and helpful colleagues (John Lounsbury and Mike Nash).

Finally, I would like to thank my wife, Sandy, and my daughters, Kate and Emily, who supported me throughout this project and only occasionally asked, "It's Saturday, why are you going to the office?" I also want to thank my Mom and Dad who instilled in me the work ethic to see projects to completion.

## References

- Gelso, C., & Fretz, B. (2001). *Counseling psychology* (2nd ed.). Orlando, FL: Harcourt.
- Krumboltz, J. D. (1996). Learning theory of career counseling. In M. L. Savickas & W. B. Walsh (Eds.), *Handbook of career counseling and practice*. Palo Alto, CA: Davies-Black.
- Savickas, M. L. (1996). A framework for linking career theory and practice. In M. L. Savickas & W. B. Walsh (Eds.), *Handbook for career counseling theory and practice*. Palo Alto, CA: Davies-Black.
- Walsh, W. B. (1996). Career counseling theory: Problems and prospects. In M. L. Savickas & W. B. Walsh (Eds.), *Handbook of career counseling theory and practice*. Palo Alto, CA: Davies-Black.





---

## ACCREDITATION BY THE AMERICAN PSYCHOLOGICAL ASSOCIATION

---

Counseling psychology training programs in the United States, Canada, and Puerto Rico may be accredited by the American Psychological Association (APA) and, if they are, must indicate so in their published materials. APA accreditation is a designation that publicly indicates that the accredited program, through a voluntary self-study and an external review, meets certain expected standards of quality and engages in ongoing evaluation and enhancement. The process of accreditation protects the interests of counseling psychology students and the general public through improving the quality of teaching, learning, research, and professional practice. Only graduate programs in professional psychology (counseling, clinical, or school psychology) at the doctoral level are accredited by the APA, not master's or specialist's level programs. Doctoral programs in counselor education are also not accredited by the APA; they may instead be accredited by the Council for Accreditation of Counseling and Related Educational Programs (CACREP). The APA, which has given the responsibility for accreditation of professional psychology programs to its Committee on Accreditation (CoA), also accredits professional psychology internship programs and postdoctoral residencies in professional psychology. The CoA carries out accreditation responsibilities consistent with the recognition provisions of the Council for Higher Education Accreditation (CHEA), which provides a list of accredited institutions and

programs to the U.S. Secretary of Education, who publishes it annually.

### Structure of the Accreditation Process

#### ***Committee on Accreditation***

In 1991, the APA outlined the foundation of a committee that would oversee the accreditation process in the *Policies for Accreditation Governance*. The committee members must represent a balance among graduate educators, practicing clinicians, and well-informed community citizens. Such a balance gives the committee the ability to scrutinize concerns from each of the three populations, thus creating a comprehensive accreditation process. The policy says that the CoA must consist of no fewer than 21 committee members. Four members must be graduate educators from psychology departments, ten members represent professional schools and training programs, four members are practicing professionals, two members are from the general public, and one member is a representative of graduate students. Of the ten members from professional schools and training programs, two each must be solicited by the Council of University Directors of Clinical Psychology, Council of Counseling Psychology Training Programs, Council of Directors of School Psychology Programs, National Council of Schools of Professional Psychology, and Association of Psychology Postdoctoral and Internship Centers.

The purpose of the CoA is to oversee formulation and implementation of accreditation policies and



procedures, render final accreditation decisions on education and training, evaluate accreditation policies and procedures, provide guidance and information regarding accreditation, establish guidelines for site visitors (see below), establish developmental and evaluative research on the accreditation process, establish task forces and review panels, and implement other responsibilities. The CoA proposes changes in policy after allowing for a period for public comment, finalizes the proposed changes, and sends them to the APA Board of Directors to adopt. A recent change was to the operating procedures of the CoA; these went into effect in 2005.

### ***Site Visitors***

Site visitors serve as representatives of the CoA in reviewing the quality and specific functions of the professional psychology program in question. They are professional clinical, counseling, and school psychologists or generalists who are psychologists in nonprofessional or nonpractice psychology disciplines. Site visitors who are professional psychologists must have earned a doctoral degree and have 5 years of experience working in a psychology field, hold an appropriate license or certification, and be active members of professional research organizations. Depending on the domain in which the professional psychologist works, he or she must also be associated with a doctoral training program, must have some association with a doctoral training program, or must be deemed to have adequate knowledge about educational, professional, and scientific issues in psychology. Site visitors who are generalists must have received a doctoral degree from a regionally accredited institution, have at least some professional experience, have some type of involvement with an institution that has an accredited training program, and be deemed to have adequate knowledge about educational, professional, and scientific issues in psychology. Site visitors must all be trained to be a site visitor or a site visit chairperson. They are evaluated postvisit by the program's training director and other site visitors. Although expenses are reimbursed by APA, neither members of the CoA nor site visitors receive any monetary compensation; they do this as an important professional service.

Site visitors represent the CoA but are not decision makers. They look at the training program based on the program materials and their actual visit. Materials include the self-study report that the program submits to the CoA and any material the CoA requests in

addition. During the visit, site visitors serve as the "eyes and ears" of the CoA. Site visitors observe the program and its quality in terms of the program's philosophy, goals, implementation of goals, and expected and documented outcomes. Site visitors review the training program based on the guidelines and policies in the *Guidelines and Principles for Accreditation of Programs in Professional Psychology*. After the visit and review of materials, the team writes a report to the CoA based on their observations. The program is given an opportunity to respond to the CoA about the site visit report. Based on the self-study, the site visit report, and the program's response to the site visit report, the CoA determines further action regarding accreditation status. The site team has no more contact with the program regarding the accreditation process.

### **Criteria of Accreditation**

The accreditation process was established to protect the rights of students, universities, consumers of psychological services, and community citizens. There are a number of requirements that need to be met before a program becomes accredited. The applicant program must provide evidence that it can and will ethically and effectively prepare students or trainees to provide psychological services to the public. The CoA recognizes that there are a variety of reliable and valid ways to effectively prepare students to serve the public. In reviewing the initial application of a program, the CoA will help the applying program formulate specific goals, encourage experimentation in achieving these goals, and suggest ways of constructing flexibility and reasonable freedom within these goals. Once the applicant program has set forth a model of training that has been approved by the CoA, site visitors will visit the program and review eight different domains in order for the CoA to determine whether the program should be accredited or not. The CoA and the site visitors will review the following: eligibility; program philosophy, objectives, and curriculum plan; program resources; cultural and individual differences and diversity; student-faculty relations; program self-assessment and quality enhancement; public disclosure; and relationships with accrediting body.

### ***Eligibility***

Site visitors assess whether the program is housed in an environment that is conducive to the appropriate



training of doctoral level students or trainees in professional psychology. To be eligible, the program needs to be sponsored by a regionally accredited higher education institution. The program also needs to have a mission statement congruent with the goals of the academic department in which it is housed; require each student to complete at least three years of academic coursework and one year of internship training before granting a doctoral degree; advocate for the development of students' understanding of cultural and individual diversity; and produce a viable means in which information regarding their program is shared with all interested parties.

### ***Program Philosophy, Objectives, and Curriculum Plan***

Site visitors look for evidence of congruence of the philosophy and plans of the program with the mission statement of the sponsoring institution, and they determine whether the institution is appropriate for training in the science and practice of professional psychology. The match between the program and the sponsoring institution is considered vital for students to receive an education that is comprehensive, complex, sequential, and cumulative. The team also reviews whether program training objectives prepare students to serve the general public. They review student records and materials such as syllabi, dissertations, and comprehensive examinations and conduct interviews with students, faculty, supervisors, administrators, and support staff to determine the consistency and quality of the program's philosophy and model of training, the substantive areas of professional psychology in which the students are trained, and the ability of the program to foster a high level of understanding of ethical, legal, and quality assurance issues related to the practice of psychology.

The site team also examines program curriculum to determine if all the major requirements are being met. The CoA expects that students have a comprehensive conceptualization of scientific psychology, theoretical foundations of psychology, diagnosis of difficulties through psychological assessment, cultural and individual diversity, and attitudes conducive to lifelong learning.

Last, site visitors assess whether each program has adequate and appropriate practicum experiences. Practicum sites should clearly commit to training, integrate practice with education, ensure that appropriate

experiences are consistent with the program's training model, and justify the sufficiency of the practicum experience in order for the student to be prepared for internship. Site visitors assess appropriate material and practices in internship and postdoctoral residency programs.

### ***Program Resources***

In regards to the program resources domain, the CoA is concerned with the ability of the program to successfully implement methods to achieve the stated mission, objectives, or goals. Site visitors assess whether or not the program has an identified core faculty (or supervisors) who are responsible for training, education, and supervision; has identified a sufficient number of quality students who have the necessary skills and abilities to effectively practice psychology; is housed in a stable learning environment; and effectively utilizes resources that enhance the level of preparation of the students or trainees.

### ***Cultural and Individual Differences and Diversity***

Site visitors use their "eyes and ears" for the CoA to assess whether and how the program recognizes the importance of cultural and individual diversity in professional psychology. They look at whether the program has and continues to make systematic, coherent, and long-term commitments to recruit and retain diverse students and faculty or supervisors into the program. They also look at the extent to which the program takes steps to ensure an encouraging, supportive environment appropriate to the education and training of individuals from diverse backgrounds. The team further assesses the program's incorporation of relevant knowledge and experience with culturally diverse individuals and issues into the science and practice of psychology.

### ***Student-Faculty Relations***

Site visitors assess whether the program is conducive to the formation of ethically appropriate relationships between the student body or trainees and the faculty or supervisors that enhance the quality of learning experiences. The team attempts to determine whether the faculty or supervisors are accessible to provide appropriate guidance and supervision to the students and if the program acknowledges students'



rights, advocates for the cultural and individual diversity among the students, provides students with written policies and procedures upon entering into the program, and documents all complaints and grievances filed against the program.

### ***Program Self-Assessment and Quality Enhancement***

Site visitors attempt to determine if the program is committed to excellence and enhancement of the quality in its training and supervision. The program should engage in continual self-study to assess the effectiveness of meeting its philosophical goals and objectives. The program should frequently review its goals and objectives in order to be congruent with an evolving body of scientific and practical knowledge that serves as the basis of psychology practice.

### ***Public Disclosure***

The program must publicly disclose information regarding the procedures and policies that underlie its training and education. The program should make available to the general public accurate and complete documents relative to its goals, mission statement, faculty, students, admission criteria, administration policies, research and practicum experiences, education and training outcomes, and accreditation status. As of January 1, 2007, for doctoral graduate programs, this information needs to include time to degree completion, program costs, success in obtaining internships, and attrition.

### ***Relationships With Accrediting Body***

The program is expected to demonstrate its commitment to the accreditation process by fulfilling responsibilities outlined in the *Guidelines and Principles for Accreditation of Programs in Professional Psychology*. It is expected to follow APA's published principles and policies, to inform the CoA of relevant changes to the program's philosophy or model of training, and to be in good standing with the CoA and APA in terms of financial and accreditation status.

### **Importance of Accreditation**

For students, faculty members, supervisors, university officials, administrators, state licensing boards, and

community members, the process of accreditation engenders a sense of assurance that the accredited program reflects a high level of quality in its philosophy, goals, implementation of its policies and procedures, and training and education. During their graduate training or education and required internships and optional postdoctoral residencies programs and specialization, professional psychology students and trainees invest a significant amount of money and time in obtaining their degrees and completing the required supervised experiences necessary for psychology licensure. It is important for them to choose a program that fosters a high standard of learning that will adequately prepare them to face the challenges of an entry level psychologist in the job market. By choosing an accredited program, students and trainees can be assured that their rights will be respected, they will receive a significant amount of guidance and supervision from faculty members and supervisors, and the program will continually review policies and curriculum so that it meets the demands of evolving scientific and practical knowledge.

An accredited program provides benefits to university officials and faculty members and to internship and postdoctoral supervisors and administrators. The accreditation process provides guidelines that, if followed, will help protect them from ethical violations and enhance the quality of their relationships with students and trainees.

The accreditation process engenders a sense of security, credibility, and trustworthiness in the community. Accreditation indicates that a program reflects a high standard of quality in the preparation of its psychology trainees to effectively meet the needs of the public. State psychology licensing boards look for licensure applicants to come from APA-accredited programs or to document an equivalent training and supervised experience.

Overall, accreditation reflects a standard of quality and accountability that protects the interests of students, faculty and university officials, internship and postdoctoral training institutions, psychology licensing boards, and the community.

*Sue C. Jacobs and Jeffrey J. Klibert*

**See also** Accreditation by the Council for Accreditation of Counseling and Related Educational Programs (v1); Credentialing Individuals (v1); Postdegree/Prelicensure Supervision (v1); Predoctoral Internships (v1); Professional Degrees (v1)



### Further Readings

- American Psychological Association. (2006). *Frequently asked questions about accreditation in psychology*. Retrieved August 31, 2006, from <http://www.apa.org/ed/accreditation/accrfaq.html>
- Committee on Accreditation. (2000). *Guidelines and principles for accreditation of programs in professional psychology*. Retrieved August 26, 2006, from <http://www.apa.org/ed/gp2000.html>
- Committee on Accreditation. (2005). *Accreditation operating procedures of the Committee on Accreditation*. Retrieved August 26, 2006, from <http://www.apa.org/ed/oprtgpred.pdf>
- Committee on Accreditation. (2005). *Guidelines and principles for accreditation of programs in professional psychology*. Retrieved August 31, 2006, from <http://www.apa.org/ed/G&P052.pdf>
- Council of Counseling Psychology Training Programs. (1987). *Director of training manual*. Retrieved August 28, 2006, from <http://www.cccptp.org/TDManual.html>
- Office of Program Consultation and Accreditation. (2006). *Site visitors and the accreditation process*. Retrieved August 31, 2006, from <http://www.apa.org/ed/accreditation/sitevisitprcs.html>
- Smith-Bailey, D. (2004). Why accreditation matters: Accreditation guidelines set the standard for your education—and can ease your way to licensure. *DEGREE In Sight*, 2(2). Retrieved August 31, 2006, from <http://gradpsych.apags.org/apr04/accreditation.cfm>

---

## ACCREDITATION BY THE COUNCIL FOR ACCREDITATION OF COUNSELING AND RELATED EDUCATIONAL PROGRAMS

---

Accreditation of an academic program reflects the initiative of faculty, administration, and even students at an institution. Accreditation provides multiple benefits for these constituency groups, as well as for consumers, by establishing a professional curriculum and by attending to specific aspects of quality assurance and gatekeeping. Though no panacea, accreditation offers one means by which an institution, an academic program, and its graduates can verify to both public consumers and professional peers that a contemporary and quality program of study has been embraced and promoted.

Accreditation of most graduate-level academic programs is advanced through one of two routes, these

being (a) institutional accreditation or (b) specialty accreditation. The former is quite common for academic settings, because it fosters a measure of uniformity and standardization among otherwise disparate academic programs. Institutional accreditation has a rather lengthy history of implementation and is well known to citizens as well as educators. Institutional accreditation is frequently awarded by one of the six regional accrediting bodies recognized by the United States Department of Education (e.g., Southern Accreditation for Colleges and Schools, North Central Accreditation for Colleges and Schools).

By contrast, specialized accreditation has a somewhat less established history than institutional accreditation. Specialized accreditation involves review of a smaller unit than an institution by professional peers advancing a curriculum peculiar to that discipline. Examples of specialized accreditation are noted in the accreditation practices of the American Medical Association, the American Bar Association, and the American Psychological Association (APA). A significant aspect of specialized accreditation is its oversight by a voluntary rather than governmental body. Currently, such oversight is by the Council for Higher Education Accreditation (CHEA). Recognition by and affiliation with CHEA is an endorsement of the specific nature of the educational process for a profession. Thus, CHEA recognition of the Council for Accreditation of Counseling and Related Educational Programs (CACREP) represents both rigor and uniqueness for the specialized accreditation of counselor training programs.

### History of Counselor Accreditation

The establishment of CACREP in 1981 was primarily related to efforts from the Association for Counselor Education and Supervision (ACES) and the American School Counselor Association (ASCA), both divisions of the American Personnel and Guidance Association (APGA), the forerunner of the current American Counseling Association (ACA). This initiative from ACES was logical, because its membership was largely representative of counselor educators and supervisors involved in the development of new counselor practitioners in public school, higher education, and mental health sectors of the field. The 1973 document that propelled the accreditation movement was titled "Standards for Entry Preparation of Counselor and Other Personnel Services Specialists." This effort



reflected a consensus of opinion concerning both classroom and applied academic experiences necessary for the minimally prepared graduate of a counselor education program.

In its initial 1981 standards, CACREP established the three practice environments of School Counseling, College Student Personnel Counseling, and Community and Other Settings. Beginning in 1988, CACREP embarked on a different route of accreditation with the adoption of standards for the accreditation of graduate programs in mental health counseling. Subsequently, various other specialty tracks of accreditation were instituted, including college counseling; gerontological counseling; career counseling; marriage, couple, and family counseling and therapy; and student affairs.

Since its inception, CACREP has functioned as an agency apart from ACA control. The CACREP board has traditionally been composed of members affiliated with various divisions of the ACA. A notable exception in this regard has been the accredited track in community counseling, for which no divisional status has ever been established by the ACA or its predecessors. This situation is historically remarkable, because the majority of non-school accredited programs have been in community counseling, but no ACA or professional affiliate group representing this track has ever been among the composition of the board. Additionally, some professional identity and turf related difficulties emerged in the 1980s for the CACREP track in marriage, couple, and family counseling and therapy when compared with the specialty accreditation for graduate study in marriage and family therapy advanced by the Commission on Accreditation of Marriage and Family Therapy Education (COAMFTE), a CHEA peer of CACREP. Still, amid a history of evolution and refinement, the CACREP, according to Schmidt, steadily developed as the primary agency for the recognition of counseling as a distinct and viable discipline.

### **Curricular Requirements for Entry and Doctoral Programs**

One significant aspect of accreditation has always been the establishment of a minimum curricular experience for graduate study in professional counseling. The academic requirements for accreditation have historically been fashioned to reflect national standards for the field. Accreditation by CACREP is founded on

adherence to curricular requirements at both entry and doctoral levels of graduate study. With few exceptions, the master's degree reflects the minimal graduate degree level for accredited entry programs, though some programs feature the educational specialist as the entry-level degree. Such degrees are intended to prepare graduates for postgraduate supervision in their pursuit of independent licensure. Such preparation is typical for licensure in social work and in marriage and family therapy, unlike psychology, which traditionally relies on completion of the doctorate for independent licensure. Currently, the CACREP curricular requirements for entry-level programs include eight content areas, these being (a) professional orientation, (b) human growth and development, (c) social and cultural diversity, (d) career development, (e) helping relationships, (f) group work, (g) assessment, and (h) research and evaluation. Additional clinical requirements reflective of the national standards involve a practicum (minimum of 100 hours, 40 hours of which are to be in direct client service) and an internship (minimum of 600 hours, 240 of which are to be in direct client service). Both of these clinical experiences are to include regular weekly individual supervision as well as group supervision.

Accreditation of doctoral programs by CACREP reflects continuing but advanced preparation beyond the foundational curricular requirements in entry-level study. However, accredited doctoral programs feature unique elements of preparation such as (a) advanced supervised clinical practice (often in teaching roles), (b) formal training in supervision (c) quantitative and qualitative methodologies for conducting original research, (d) pedagogical practices related to counselor education, and (e) advanced course work in supplemental areas, often as doctoral minors.

The minimal curricular requirement for the various entry-level degree tracks ranges from 48 to 60 semester hours. The minimal curricular requirement for the doctorate is a total of 96 semester hours (including master's study). A significant aspect of doctoral work is the equivalent of the accredited master's degree as prerequisite to pursuit of the terminal degree. Just as with most other professions, a master's degree in a related peer discipline (e.g., social work, psychology) is not typically considered to be the equivalent to the accredited master's degree in counseling, meaning that in many cases, those wishing to pursue the doctoral degree in a CACREP-accredited program may



have to complete additional course work before beginning their pursuit of the doctorate.

### **The Accreditation Process**

Accreditation represents both a condition and a process of professional review. As with any form of review, accreditation by CACREP involves multiple layers of scrutiny, both internal and external. As an initial step, the faculty in a program conducts an internal review of their status relative to the requirements in the CACREP standards. In this process of internal auditing, a program often devotes years of review and revision to align its policies, practices, and procedures with the standards. The cumulative product in this initial step is the preparation and submission of a self-study for accreditation. The self-study is designed to provide summary evidence for the scrutiny of external review relative to the program's compliance with CACREP standards. Once they have been submitted, self-studies are reviewed by multiple CACREP board members. If the self-review passes these initial evaluations successfully, the next phase of accreditation review begins: This is an on-site team review.

Drawing from their familiarity with both the specialty tracks for which the program is seeking accreditation and the CACREP standards, an on-site visiting team comprising volunteer professionals arranges for travel to the institution. The charge of the team is to verify the statements from the self-study and to address any questions identified by the board members who completed the review of the self-study. During a visit that is typically 3 days in length, the on-site team interviews both institutional and community stakeholders as well as program graduates, field supervisors, and others. The exit report from the team features summary findings concerning standards the team believes to be met or not met, which will be reported to the CACREP board. The institution receives a copy of the team report and has the opportunity to submit a rejoinder for clarification or dispute concerning the report.

Board decisions typically involve review of the self-study, the team report, and the institutional rejoinder as the basis for an accreditation decision. If the decision is unfavorable, a program may request an appeal at the next board meeting. If the decision is favorable, a program may receive either 2-year accreditation (with a required interim report that

addresses progress in improvement on standards identified as deficient) or 8-year accreditation from CACREP. Maintaining accreditation requires an annual fee and an annual report concerning vital statistics and related information.

### **Accreditation and Counselor Credentials**

The CACREP curricular requirements serve as the foundation for certification by at least two professional bodies. The National Board for Certified Counselors (NBCC) is an independent organization that certifies counselors on the basis of their completed graduate study. Significant in this process is that the academic requirements for certification by NBCC mirror those of CACREP. Similarly, the National Credentialing Academy (NCA), established by the International Association for Marriage and Family Counselors, offers a national certification in family therapy based on a variety of academic options. Specifically, a graduate degree from the marriage, couple, and family counseling and therapy specialty track accredited by CACREP is one of these options available for national certification by the NCA.

As of May 2006, 48 state legislatures (and the District of Columbia) had established licensure for the practice of professional counseling. In all but a few of these states, the National Counselor Examination (NCE), developed by the NBCC, is a part of the formal examination process for licensure. Additionally, the majority of licensure states have adopted CACREP curricular content areas as the minimal academic requirements for licensure. In this respect, relocation to a new state and subsequent licensure as a professional counselor can be assisted when licensure bodies rely on a common curriculum of graduate study for their licensees.

An obvious benefit in completing an accredited entry-level program is a seamless transition into doctoral study. Additionally, doctoral graduates are prepared specifically to function as advanced practitioners, researchers, or educators in the field of counseling.

### **A View to the Horizon**

As of May 2006, CACREP had accredited 202 institutions. Of these, one was Canadian (University of



British Columbia) and one offered a totally online training program (University of Phoenix—Phoenix and Tucson campuses). Each of these 202 institutions had at least one accredited entry-level track and 49 had accredited doctoral programs. According to CACREP, the prominence and professional viability of accreditation of counselor training programs has been steady and impressive during its initial 25 years of existence.

In its draft documents for the 2008 standards, CACREP's Standards Revision Committee has considered a variety of pending changes, including (a) merging community counseling and mental health counseling into a single entry-level track, (b) deleting the specialty track in gerontological counseling, (c) merging the college-oriented specializations, (d) requiring program faculty hired after 2008 to be from counselor education programs (a requirement similar to that of the APA for faculty composition in an accredited program), and (e) adopting a competency-based orientation for accredited programs. In this respect, revision efforts for CACREP standards reflect a continuation of the contemporary issues affecting the professional practice of counseling.

CACREP has also begun the revision process for organizational aspects other than accreditation standards. Specific changes discussed in the spring 2006 newsletter (*The CACREP Connection*) by then-Chair John Culbreath were (a) an application process to select an independent board composed of persons unaffiliated with an ACA divisional interest, (b) an expanded vision of international accreditation of counselor preparation programs, and (c) a reexamination of the organizational name, particularly related to "other educational programs." Additionally, sustained and successful discussions have begun between CACREP and the Commission on Rehabilitation Education (CORE) on unifying these counselor accrediting bodies. These and other evidences indicate that the horizon looks quite promising for a 21st-century version of CACREP to be focused on curricular advancement and refinement as well as organizational vitality and relevance.

McGlothlin and Davis note that the benefits of accreditation to the student are demonstrated in terms of acquired knowledge for formal credentialing (e.g., certification, licensure), demonstrated competency for practice, and participation in professional acculturation for identity. As a form of specialized

accreditation, CACREP offers a formal means of assuring quality preparation for the practice of professional counseling.

*S. Allen Wilcoxon*

**See also** Accreditation by the American Psychological Association (v1); Credentialing Individuals (v1); Postdegree/Prelicensure Supervision (v1); Predoctoral Internships (v1); Professional Degrees (v1)

### Further Readings

- McGlothlin, J. M., & Davis, T. E. (2004). Perceived benefit of CACREP (2001) core curriculum standards. *Counselor Education and Supervision, 43*, 274–285.
- Schmidt, J. J. (1999). Two decades of CACREP and what do we know? *Counselor Education and Supervision, 39*, 34–45.

### Web Sites

Council for Accreditation of Counseling and Related Educational Programs: <http://www.cacrep.org>

---

## ADULT DEVELOPMENT

---

Along with aging, human development occurs. Contemporary definitions characterize development as systematic changes and continuities in the individual that occur between conception and death. Development is implied to be predictable and continuous with pattern and order. Counseling is developmental and strength-based, and the counselor aids an individual, couple, or family through normative developmental adjustments and transitions. Because counseling is concerned with normative stresses, adjustments, and life transitions, rather than pathologies of the individual, knowledge of development is essential.

### The Nature of Development

The developmental process occurs at psychological, biological, and social levels. In psychological development, the perceptions of a person change, as do other mental processes. Biologically, a person's body and organs tend to decline in efficacy while aging.



The social aspect of development includes interpersonal relationships and skills and roles played in the larger society. A developmental approach examines the interplay of environmental and individual factors on a person. Developmentally, a person is always in the process of change, influenced by the interplay of outside influences on his or her life.

Maturation and learning are the two processes that underlie developmental change. *Maturation* is the biological unfolding of the individual according to the heredity of his or her parents and the passing on of genes. *Learning* is the process through which experience brings about changes in a person's thoughts, feelings, and behavior. Development occurs in historical and cultural context that influences the rate and intensity of how an individual's development occurs. A broader context for discussing adult development follows; it examines some early influences on the developmental perspective.

### Historical Synopsis

According to some, developmental psychology began nearly 4 centuries ago, as evidenced in the works of literary artists, like Shakespeare, who viewed development as extending beyond adolescence, well into adulthood. In the 20th century, others began to think of development as continuing throughout a person's life. The objectives were to measure changes over a person's life span rather than to focus on the process of change itself.

Developmental systems encompass the entire life span of the individual and offer evidence that development in a person proceeds by stages. While there are several theories of human development that agree on some points and disagree on others, development is not so much a single theory as it is a way of looking at a person's life, in which theories can be integrated within a framework. The shift to a life-span view of the developing individual was solidified with the developmental perspective of Erikson, who sought to understand the psychosocial challenges confronting the individual at each stage of life. Building on Freud's ideas, Erikson and others broadened the developmental perspective by including psychosocial trends evidenced by a crisis or turning point in each stage of human development. This shift resulted in a renewed focus on issues related to the "whole" individual, including such factors as spirituality, family

environment, socioeconomic considerations, and the impact of groups on the individual's developmental process.

### Theories of Adult Development

The primary tension in theories of adult development is between the *ontogenetic* perspective, which posited that developmental forces are internal and biologically based, and the *sociogenic* perspective, which argued that change in adulthood is due primarily to social influences. Ontogenetic proponents were mostly from Germany, while the sociogenic proponents were influenced by French sociologists, such as Durkheim. One person who may be classified as part of the ontogenetic school of thought was Freud. Freud published a number of works emphasizing the role of sexuality in human life. Influenced by the philosophers of his era (i.e., Schopenhauer and Nietzsche), Freud saw human beings as guided by passion as well as reason. Freud went beyond the traditional Victorian views of sexuality by identifying such theories as the Oedipus complex (named for the legendary king of Thebes who killed his father and married his mother) and the Electra complex (named for the mythological Greek who avenged her father's murder by killing her mother). Freud disclosed in conceptual terms what literary poets had espoused all along and stated those themes in mythopoetic terms. Even the naming of the two aforementioned theories was indicative of how Freud's character was influenced by the passionate figures in mythology as well as of his own passion to become an intellectual force in his own right.

### Ontogenetic Models

Ontogenetic models posited that development consisted of stages that are universal, sequential, and irreversible. Ontogenetic theorists, such as Buhler, Jung, Levinson, and Maslow modified Freud's psychosexual theory to a psychosocial model. Neo-Freudians, such as Adler, suggested that siblings are significant in development. Jung claimed that adults experienced a midlife crisis, which could lead to a liberating effect on an individual's personality in adulthood. Horney challenged Freud's ideas about gender differences, and Sullivan demonstrated how early relationships in life could set the stage for styles of relating in adulthood. Perhaps the person who most influenced life-span



development was Erikson. Erikson concerned himself with the inner dynamics of personality and proposed that an individual's personality evolved through systematic changes. His *epigenetic* approach to human development assumed that development was the result of interacting genetic and environmental elements.

Piaget believed that individuals' innate intellectual development helped them adapt to their environment. He posited the concept of *constructivism*, claiming that individuals actively construct new understandings of the world based on their experiences in development. As an individual developed, he or she constructed a more accurate understanding of the world.

### **Sociogenic Models**

Sociogenic models of adult development sought to balance a completely innate, and thus predetermined, perspective of human development with a perspective that individuals have an influence over their own development and are not completely subject to events out of their control. One sociogenic model is the *disengagement theory*, which posits a mutual withdrawal between the individual and society as one ages. This was countered by the *activity theory*, which posited that the more active a person is as he or she ages, the better quality of life experienced. These theories were integrated by Havighurst, Neugarten, and Tobin, who sought to demonstrate that the factor that determined the level of activity among individuals as they age was personal desire.

Watson believed that learned associations between external stimuli and observable responses were the building blocks of human development. A basic tenet of Watson's behaviorism theory was that observations of behavior, rather than speculations about unconscious motives, should be the foundation of theory. Watson stressed the importance of learning in human development to the point that nurture was dominant and nature counted for little.

A proponent of the sociogenic model was Bandura, who posited a social learning theory of development. His theory suggested that humans were cognitive beings whose processing of information from the environment had a major influence on their human development. *Observational learning* from other people, or models, was the primary way in which a person changed his or her behavior. Aldwin and Gilmer sum it up this way: "According to these

theories, change in adulthood is characterized by a succession of role transitions that are shaped by the immediate social context and larger social structure rather than by internal psychological processes alone" (p. 58).

### **Multidimensional Models**

Many theories attempted to provide middle ground between the ontogenetic and sociogenic perspectives by integrating biological, psychological, and spiritual influences on development. One such theorist was Bronfenbrenner, who felt that many developmentalists assessed human development out of context. To counter this thought, he formulated the *bioecological* approach, which took into account biological and psychological changes of the individual interacting with the environment. From this perspective, people were not just passively subjected to outside influences; they shaped their physical and social environments while also being shaped by the cultural environment they helped create. Development was something that individuals *do* rather than something that simply *happens* to them. These theories proposed an increasing liberation from social and biological conditioning of adult development.

### **Holistic Models**

More recently, the counseling field has devoted increased attention to *wellness* as a theoretical approach to human development. Wellness includes physical, intellectual, social, psychological, emotional, and environmental factors and is a way of life oriented toward optimal health and well-being, in which body, mind, and spirit are integrated by the individual to live life more fully within the community. The Wheel of Wellness model was based on Adlerian theory, and incorporates aspects of gender and cultural identity.

Systems theory was based on the work of biologist von Bertalanffy. He saw the essential phenomena of life as individual entities called organisms. An organism was defined as "a form of life composed of mutually dependent parts and processes standing in mutual interaction" (Bertalanffy, 1968, p. 33). All living systems operate on a similar set of principles, which means they are internally interdependent. Proponents of systems theory conceptualized a system (e.g., an individual, a couple, or a family) as a whole consisting of interrelated



parts, each of which affects and is affected by every other part, and each of which contributes to the functioning of the whole. Development takes place simultaneously and interdependently amongst each member of the system, and each person's development affects the development of the other members.

### **Transpersonal Models**

A *fourth force* (a term originally coined by Maslow) emerged in counseling to capture a more complete perspective of the individual in development. Recently this approach has been receiving more attention; its central theme is inclusive, but it still values diversity and unity. Early theories focused on the individual's problem behaviors and cognitions. Wellness models attempted to embrace a person's differences while facilitating a balanced way of life for an individual. More recently, developmentalists have been examining a broader perspective of development. This view of transcending (*trans* meaning in this case *beyond*) human differences was an attempt at revealing what unites all persons, from the subatomic level to the physical level to the spiritual level to stages of consciousness and beyond. Transpersonalism is concerned with the study of humanity's highest potential and with an individual's essential nature of being. This is an attempt to focus on what unifies individuals as spiritual beings while respecting a person's biological, ethnic, religious, and other differences.

The fourth force, which also emerged from mainstream psychology, is concerned with states of consciousness, identity, spiritual growth, and levels of human functioning *beyond* those commonly accepted as healthy and normal. It integrates Eastern perspectives on human development with Western psychological perspectives. Such influential views of the stages of consciousness were proposed by Aurobindo and Maharshi, both Indian sage-philosophers who proposed developmental views of human consciousness and enlightenment.

Perhaps the seminal effort in the study of consciousness in Western psychology was provided by James, who is arguably the father of transpersonal psychology. His interest in spiritualism and introspective studies of consciousness set him apart from his colleagues who were in favor of the prevailing positivistic view of his time, that knowledge was limited to observable facts. James identified mind with consciousness and called it a *stream of consciousness*.

A more current model was proposed by Wilber, who posited an integrative and developmental model of human development and consciousness. Wilber asserted that different developmental schools have often clung to one school's logic while ignoring the validity of other perspectives. Consciousness poses a challenge to some developmentalists because of the difficulty in reducing and measuring a person's consciousness in a traditional observable method. Wilber argued that consciousness has been reduced to personal structures, and that its study has focused merely on altered states of consciousness, while no coherent theory of the development of consciousness has emerged. What Wilber calls *integral psychology* is the goal to honor and embrace "every legitimate aspect of human consciousness" by using a logic of inclusion, networking, and what he calls *wide-net casting*.

### **Future Directions**

Counseling's view of development continues to expand as more information becomes available concerning the complexity of human life and the urgency to meet the changing needs of society. While transpersonal counseling means to go "beyond the personal" or beyond a person's conditioned personality, it seeks to reveal and develop a person's identity in a broader, more unified whole. The parallels between modern physics and transpersonal philosophies have been noted for many years. For instance, there is a connection between Western science and what has been described for thousands of years by the philosophical traditions of the Far East.

Quantum theory has eradicated the idea that objects are fundamentally separated and views the entire universe as an interconnected web. Another principle of quantum physics is the *observer effect*. Simply put, there is a dynamic interaction between the observer and what he or she is observing, to the point that the observer influences change in that which is being observed. From a developmental perspective, this confirms the Eastern view that people are participants in creating their world. A transpersonal counselor would have the view that a person's attitudes, expectations, and beliefs create the reality that he or she experiences. As the field of counseling continues to mature and our knowledge of human beings expands beyond the physical realm, counselors also must explore and examine their own development in



order to continue to accommodate the needs of a diverse world.

*Miles Matise*

*See also* Adults in Transition (v4); Aging (v1); Counseling the Elderly (v1); Developmental Counseling and Therapy (v2); Gerontology (v1); Identity Development (v3); Life Transitions (v2); Parenting (v1); Retirement, Implications of (v1)

### Further Readings

- Adler, A. (1927). *Understanding human nature*. New York: Greenberg.
- Aldwin, C., & Gilmer, D. (2004). *Health, illness, and optimal aging: Biological and psychosocial perspectives*. Thousand Oaks, CA: Sage.
- Bandura, A. (1986). *Social foundations of thought and action: A social cognitive theory*. Englewood Cliffs, NJ: Prentice Hall.
- Bertalanffy, L. von. (1934). *Modern theories of development: An introduction to theoretical biology*. London: Oxford University Press.
- Bronfenbrenner, U. (1979). *The ecology of human development: Experiments by nature and design*. Cambridge, MA: Harvard University Press.
- Erikson, E. (1963). *Childhood and society* (2nd ed.). New York: Norton.
- Freud, S. (1910). *The origin and development of psychoanalysis*. Washington, DC: Regnery Gateway.
- Havighurst, R. (1961). Successful aging. *The Gerontologist*, 1, 8–13.
- Horney, K. (1945). *Our inner conflicts: A constructive theory of neurosis*. New York: Norton.
- James, W. (1902). *The varieties of religious experience: A study in human nature*. New York: Longmans, Green.
- Jung, C. (1933). *Modern man in search of a soul*. New York: Harcourt Press.
- Levinson, D. (1978). *The seasons of a man's life*. New York: Knopf.
- Maslow, A. (1968). *Toward a psychology of being*. New York: D. Van Nostrand.
- Piaget, J. (1950). *The psychology of intelligence*. New York: Harcourt, Brace & World.
- Watson, J. (1913). Psychology as the behaviorist views it. *Psychological Review*, 20, 158–177.

---

## ADVENTURE THERAPY

---

Adventure therapy is an active and creative form of group psychotherapy that employs experiential

activities designed to promote desired therapeutic outcomes for clients. Adventure therapy is a broad rubric that subsumes a variety of experiential approaches to group therapy that utilize challenging, cooperative tasks to foster healthy change in clients. Examples include experiential outdoor counseling, adventure-based counseling, wilderness therapy, and residential camping. It is often, though not always, conducted in outdoor or wilderness settings, and it is closely related to the fields of therapeutic recreation and outdoor education. While careful assessment of the problems that clients bring to therapy will inform the specific interventions that skilled therapists choose to employ, adventure therapy is a solution-focused approach that emphasizes group members' individual and collective strengths and resources.

### History

The use of group activities as the primary agent of psychological change emerged with J. L. Moreno's psychodrama innovations in the 1920s, and several modern experiential approaches to psychotherapy emphasize the use of an activity base, including art, music, and play therapies. The therapeutic effects of natural settings were evident in the camping programs developed for troubled youths in the 1930s. Outward Bound, the experiential learning program developed by Kurt Hahn in the 1940s and brought to the United States in the 1960s, effectively inspired self-discipline and self-confidence through physically and mentally challenging experiences in wilderness settings. The principles of experiential learning developed in the Outward Bound schools were later adopted and further developed by organizations such as Project Adventure and the Association of Experiential Education. These and similar organizations adapted the survival challenges of the Outward Bound protocols to nonwilderness settings in schools, recreation centers, and physical and mental health treatment centers by developing challenge courses, high and low ropes courses, cooperative games, and initiatives designed to elicit learning through experience. Today, the principles of adventure therapy are evident across a wide range of programs, including personal growth and enrichment curricula, corporate training and teambuilding efforts, antirecidivism programs for adjudicated youth, substance abuse treatment, and both outpatient and inpatient mental health counseling for families, couples, and individuals.



## Nature of Adventure Therapy

The fundamental proposition of adventure therapy involves exposing a group of individuals to a novel setting in which they strive to negotiate a variety of challenging tasks that involve real or perceived risk and where the outcome of their efforts is directly affected by the choices that they make, both individually and in concert with other group members. The settings of adventure therapy often involve the natural surroundings of the outdoor environment and usually entail adventurous activities inspired by such outdoor pursuits as rock climbing or wilderness survival. Confronted by the real or perceived risks—both physical and psychological—inherent in the challenges posed by these activities, clients experience reactions consistent with their preferred or characteristic affective, cognitive, and behavioral responses when confronted by difficult situations in their everyday lives. Thus, they have an opportunity to “catch themselves being themselves.” As clients process their experiences with the group by sharing their experiences and receiving feedback from the other members, they have an opportunity to gain insight about their choices and about the consequences of their behavior. As the activities of the group proceed, they may choose to enact new behaviors that they believe will be more likely to produce the outcomes they desire and thereby they gain an experience of positive behavioral change. The goal of adventure therapy is to assist clients to transfer what they learn from the novel experiences of these adventurous initiatives to the more significant domain of their daily lives.

The challenges that confront group members in therapy serve as metaphors for the challenges they must negotiate in everyday living. The metaphoric content of the cooperative games, outdoor pursuits, and challenge initiatives employed in adventure therapy may be implicit or explicit. Implicit metaphors may vary among individuals in a therapy group and emerge when the group therapist or facilitator elects to allow an experience to speak for itself.

However, group leaders will often choose to explicitly frame the metaphoric content of an activity using a procedure known as *frontloading*. Frontloading involves introducing an activity or initiative to the group using a metaphoric theme related to the treatment issues of the members. Clients then draw parallels between the completed activity and challenging experiences in their lives; this process allows them to more readily transfer the learning they gained from

the experience to their lives outside of therapy. Such a transfer of learning gained from a specific experience to more general life experiences is known as an *isomorphic connection*.

The process of forming isomorphic connections is furthered by the structure of the adventure therapy experience. In addition to frontloading the metaphoric content of activities, adventure therapists also carefully choose the *sequence* of challenge initiatives they present to the group in order to encourage a sense of commonality or cohesiveness within the group, to foster trust among the members, and to build upon the successful experiential learning of earlier activities. In addition, adventure therapists also assist members to *debrief* or process their experiences after the group has completed an activity or whenever an opportunity arises to gain from something experienced by the group. Frontloading, sequencing, and debriefing are processes that shape the fundamental structure of adventure therapy, intended to enhance the transfer of positive behavioral change gained through therapeutic experience in order to help clients achieve the treatment goals established at the outset of therapy.

## Effectiveness and Efficacy

While a wealth of anecdotal evidence would support the treatment effectiveness of adventure therapy, very little empirical research exists in the professional literature concerning the efficacy of this experiential approach to group psychotherapy, and few conclusions can be drawn from the studies that do exist. Support for modest positive treatment effects across a range of adventure programs can be found in peer-reviewed journals; however, few studies examine therapeutic techniques, and well-controlled outcome research for various forms of psychopathology do not exist. There is no well-defined or broadly accepted treatment methodology for conducting therapy using adventure-based activities; therefore practitioners and researchers have little guidance as to which activities or settings might effectively treat particular client concerns.

Despite the absence of substantial research support, many programs exist that offer adventure therapy to clients with a broad range of problems and concerns. The ethical constraints of professional group practice demand that practitioners be competent to provide the interventions they offer to their clients, and individuals interested in adventure therapy can obtain training in numerous programs of study in the



fields of counseling, psychology, and social work as well as supervised practical experience in a variety of therapeutic settings. Experienced practitioners currently enjoy numerous resources to assist them in providing adventure-based initiatives to their clients. Adventure therapy is a creative and attractive alternative to traditional talk therapies for both clients and therapists alike. The competent application of this experiential approach appears to have the potential to enhance a client's experience of the therapeutic process and to promote lasting, positive change.

*James L. Martin and Jeffrey S. Ashby*

**See also** Empowerment (v3); Group Therapy (v2); Metaphors, Use of (v2); Play Therapy (v1); Psychoanalysis and Psychodynamic Approaches to Therapy (v2); Self-Help Groups (v2)

### Further Readings

- Davis-Berman, J., & Berman, D. (1994). *Wilderness therapy*. Dubuque, IA: Kendall/Hunt.
- Fletcher, T. B., & Hinkle, J. S. (2002). Adventure based counseling: An innovation in counseling. *Journal of Counseling & Development, 80*, 277–285.
- Gillis, H. L., & Gass, M. A. (1993). Bringing adventure into marriage and family therapy: An innovative experiential approach. *Journal of Marital & Family Therapy, 19*, 273–286.
- Gillis, H. L., & Gass, M. A. (2003). Adventure therapy with groups. In J. L. DeLucia-Waack, D. A. Gerrity, C. R. Kalodner, & M. Riva (Eds.), *Handbook of Group Counseling and Psychotherapy*. Thousand Oaks, CA: Sage.
- Glass, J. S., & Shoffner, M. F. (2001). Adventure-based counseling in schools. *Professional School Counseling, 5*, 42–48.
- Hans, T. (2000). A meta-analysis of the effects of adventure programming on locus of control. *Journal of Contemporary Psychotherapy, 30*, 33–60.
- Hattie, J., Marsh, H. W., Neill, J. T., & Richards, G. E. (1997). Adventure education and Outward Bound: Out-of-class experiences that make a lasting difference. *Review of Educational Research, 67*, 43–87.
- Herbert, J. T. (1996). Use of adventure based counseling programs for persons with disabilities. *Journal of Rehabilitation, 62*(4), 3–9.
- Kottman, T., Ashby, J. S., & DeGraaf, D. (2001). *Adventures in guidance*. Washington, DC: American Counseling Association.
- Neill, J. T. (2003). Reviewing and benchmarking adventure therapy outcomes: Applications of meta-analysis. *Journal of Experiential Education, 25*, 316–321.
- Schoel, J., & Maizell, R. (2002). *Exploring islands of healing: New perspectives on adventure-based counseling*. Beverly, MA: Project Adventure.

---

## AGING

---

Although aging is a topic that applies to everyone, it tends to be a mysterious process, often leading to more questions than answers upon thoughtful reflection. It may be that we know it when we see it, but little agreement exists in terms of definition, explanation, understanding, or relevancy to oneself.

Old age is typically defined as any age over 65 years, although this number is an arbitrary cutoff. With the increasing life span, additional terminology or definitions have appeared. Gerontologists, professionals who study aging, refer to adults over 65 but under age 75 as the “young-old,” those age 75 to 85 as the “old-old,” and those over age 85 as the “oldest old.” However, aging may be best understood when placed within a cultural context, as life expectancy varies greatly around the world. Today, the life expectancy in most industrialized countries is well over 70 years of age and increasing. Seven percent of the world's population is currently over the age of 65; by the year 2030, this figure is likely to more than double.

Life expectancy in the United States has increased dramatically over the past two centuries with advances in medicine and public health. Today the average life expectancy at birth is approximately 74 years for men and 80 for women. The “graying of America” has become a popular phrase in reference to the drastic changes occurring in the U.S. population demographics. Although one out of every eight Americans is currently over age 65, with the baby boom cohorts aging, the elderly population is projected to reach 70.3 million in the next decade, making up 20% of the population. Estimates indicate that by 2030, one out of every five Americans will be over age 65, with racial and ethnic diversity continuing to increase with the population expansion.

Historically, the aged or oldest members of a community were held in high esteem and valued for their wisdom and knowledge. However, in modern society, there are many myths and stigmas attached to



growing older, leading to what gerontologists identify as ageism. The term *ageism* refers to prejudice or discrimination against an individual because of age, and it tends to be facilitated through the use of stereotypes to categorize the elderly. Older people are often thought of as weak, fragile, senile, asexual, and incompetent. Research suggests that some stereotypes are so prevalent that they affect older adults' performance on memory and performance tasks as well as reports of self-esteem.

Regardless of myths, aging is an ongoing process affecting those fortunate enough to avoid the alternative and experience the full life cycle. With people living longer and healthier lives, more focus is being given to the topic of aging than ever before.

### **Psychosocial Theories of Late Adulthood**

Many theories have emerged to explain the psychosocial development of late stages of life. Although there are multiple theories available, the majority fall under one of three categories, depending on the general aspects of adult development focus.

#### ***Core Self Theories***

Identity theories stem from the concept that adults strive to achieve their full potentials, and that each person must depend on him- or herself to achieve that goal. Much work in this area comes from Erikson's stages of development; this concept posits that in times of transition, individuals struggle with issues of identity and role confusion. Erikson postulated that in the final stage of life, people work toward integrating their own life experiences with their vision of society and the future.

Core self theories hinge on the idea of optimization of goals through compensation, meaning that individuals both assess their goals and identify how to achieve their goals despite personal difficulties. These theories tend to be supported by behavioral genetics, suggesting that some inherited traits are more apparent later in life. An example would be temperament, which remains constant across the life span.

#### ***Stratification Theories***

Stratification theories purport that how people are divided into social strata (e.g., age, gender, ethnicity,

sexual orientation) influence their access to various options, which can then have an impact throughout the life span. Some theories focus explicitly on the impact that age plays in shrinking an individual's social sphere, thus leading to social withdrawal. Another theory states that the elderly remain socially active but are forced into withdrawal due to ageism. However, the stratification theories are best viewed through a lens of multiculturalism. Given that cultural values and social categorization are present from birth throughout the life span, they presumably affect life paths.

#### ***Dynamic Theories***

In contrast, dynamic theorists focus on individuals and the world they inhabit, suggesting there are daily changes in late adulthood. A life of adaptive changes is assumed as people strive to maintain their core selves within the context of a changing body and world. These theories are based on the position of ongoing, nonstop changes in the self and the world, but it is assumed that people will adapt to changes in a way that maintains the core of who they are.

### **Physical Changes in Aging**

The most overt changes of aging may be those that are physical in nature. Much like psychosocial development, physical aging has been explained by various theories, with two basic postulates emerging. Although both focus on the adaptations of the human body, one defines aging as a predetermined, natural part of a fixed genetic plan, with the other examining aging on a cellular level and identifying the cause of aging through interactions with the environment.

#### ***Genetic Aging***

The genetic theory of aging is based in information about life expectancy, noting that every species seems to have a maximum life span, with this being approximately 120 years for humans. According to genetic explanations of aging, all people inherit genes that allow for survival until middle age or through the reproductive years. Genes causing aging are then activated, with illness and death each occurring in a specific genetic way. Even without the genes for various diseases that occur later in life, there may be several genes that cause aging directly. Some theorize that death could be an adaptive way to make room for a new generation.



### **Cellular Aging**

Theories that emphasize aging at the cellular level state that cell duplication allows for aging as minor errors accumulate over time. Often referred to as damage-based theories, aging is thought to be caused by mutation caused by stresses or toxins or occurring in the processes of cellular repair. Other possible causes of errors on the cellular level may be the presence of oxygen free radicals, deficiencies of the immune system, or telomere shortening when cells no longer reproduce. These cases of imprecise replication, and the cells' decreased ability to detect and correct them, can result in harmless changes, minor reductions in function, or fatal damage. The processes by which cells are able to repair and replicate themselves are believed to become less successful with age.

### **Appearance**

Physical appearance may be the most concrete indication of aging. The first outward signs of aging are typically seen in the skin, as aging skin becomes drier, thinner, and less elastic. There may also be an appearance of age spots, blood vessels, and wrinkles in the skin. A change in hair color and texture is a common sign of aging, with hair tending to thin and turn gray and then eventually white.

Changes in body shape and musculature also occur with age as people become shorter in late life due to settling of the vertebrae. Body shape also changes as body fat redistributes and collects in the torso, abdomen, and lower face. Regardless of the fat redistributed, there can be an overall weight loss occurring with age due to loss of muscle and even bone, leaving older people at risk for falls. Remaining as physically active as possible helps aging adults to protect themselves from serious losses of muscle or bone.

### **Dulling of the Senses**

Because our senses allow us to connect with other people and the world around us, these changes can be devastating if the losses are not compensated for. Sensory deficits can limit an older adult's ability to interact socially and perhaps cause an accelerated process of withdrawal and isolation. Only 10% of the elderly have adequate vision. Although some aging individuals can correct their vision with glasses, a substantial portion suffers serious vision problems

due to cataracts, glaucoma, or macular degeneration. Another sensory deficit common in older age is that of hearing loss. One-third of individuals over 60 have hearing loss, with one out of two adults over the age of 80 suffering from poor hearing. For many people this can be helped with the use of hearing aids, but it may be difficult to compensate for if loss is severe.

### **Sexual Response**

Changes in physical appearance and sensory acuity may feed the stereotype of the elderly as asexual. However, research indicates that intimacy and sexuality are an important part of healthy relationships throughout the life span. One age-related physiological change is that of the slowing of the sex response cycle. It may take a man longer to attain an erection, and it may take longer for a woman to attain sufficient vaginal lubrication for intercourse. An erection may not be as firm as it was at a younger age, nor will the vagina have as much elasticity. It may also become more difficult for both men and women to achieve orgasm. However, contrary to popular belief, these changes do not signal the end of a satisfying sex life, and many older adults enjoy intimacy and physical contact throughout the life span.

### **Common Health Problems Associated With Aging**

Poor physical health is not an inevitable consequence of aging. Unfortunately, many illnesses go undetected and untreated because older adults mistakenly blame symptoms on the aging process. Through prevention, early detection, and treatment, many health problems can be avoided during later years of life.

Arthritis, a painful, chronic stiffening of joints, is common in the United States, with over one half of adults over the age of 65 suffering from this disease. Diabetes, caused by blood levels of glucose being too high, can lead to dangerous health problems in older adults, including kidney failure, vision loss, and neuropathy. Although cancer can develop at any age, older adults are also more likely to experience this disease.

Osteoporosis, often considered a "silent" disease because symptoms may not be initially noticed, weakens the bones, increasing risks for a fracture or break. Although osteoporosis is more common in women, many men also encounter weakening bones. In addition, men over the age of 50 may be at risk for prostate



problems. Not caused by aging in itself, urinary incontinence, or the loss of bladder control, can range from mild to uncontrollable in older adults.

High blood pressure, or hypertension, is often referred to as the “silent killer” of the elderly due to the lack of identifiable symptoms. However, left unidentified or treated, high blood pressure can lead to stroke, heart disease, and kidney failure. Strokes, the third leading cause of death after heart disease and cancer in the general population, occur when blood is unable to flow to a part of the brain; this causes cells to be damaged or die. In an aging individual, strokes are a leading cause of physical and mental disabilities.

### Cognitive Decline

Research consistently supports observations of decrease of memory and speed of thought processing with age. However, there appears to be little agreement on the specific domains or timing of cognitive decline. Although few 80-year-olds would deny change in their cognitive functioning compared to when they were 40, cognitive change is characterized by individual differences. For some people, decline occurs rapidly and appears extreme. For others, decline may be a slow and gradual process or may not appear to occur at all until late life. The dulling of the senses that occurs with aging may have an impact on cognitive processes as the brain may receive distorted sensory input. However, if input reaches the brain, memory can be quite good, although speed of retrieval may be slower due to decreased processing speeds. It seems that cognitive decline in late life is not as extensive or as devastating as was once thought.

### Dementia

Dementia is defined as a chronic decrease in memory in addition to impairment in at least one other area of thought process, including impaired judgment, problem-solving ability, emotional regulation, or language ability. There are more than 70 diseases or circumstances that can cause various forms of dementia, all characterized by forgetfulness and confusion. In general, dementia is a product of damage to the brain and can be reversed less than 5% of the time, depending on the circumstances (e.g., brain tumor or injury, stroke, incorrect medication, or other head injury). Dementia should not be confused with delirium, which is a rapid onset of decreased cognitive ability

such as altered consciousness or impaired memory, but which abates with treatment of underlying cause.

The most common form of dementia is due to Alzheimer’s disease. This cognitive decline is not part of the normal aging process but is defined as a gradual loss of memory and personality. Vascular dementia is the next most common type of dementia, leading to cognitive decline through one or a series of strokes. This dementia causes sporadic and progressive loss of cognitive functioning. Some dementias, such as Parkinson’s disease or Huntington’s disease, tend to begin with motor deficits and produce cognitive deficits only in the later stages of the disease process.

An important aspect of the dementia literature addresses the challenges faced by those caring for individuals suffering from dementia. Caregivers are encouraged to seek information and support, given the taxing nature of caregiving for a person with dementia.

### Future Directions

Although there is no denying that change occurs over the life span, aging is not synonymous with disease, frailty, decline, or unhappiness. Many older adults would say that they continue to thrive and find meaning in their lives well beyond the age of 65; some would say life didn’t start until they turned 70.

More than ever before, focus is on the process of healthy aging. Contemporary approaches to aging highlight the optimal physical, mental, and social well-being or functioning of older adults, with clear intentions for the quality, and not simply the length, of life continuing to improve. One thing is certain—as long as it continues to occur, aging will be a journey of continued interest and exploration.

*Tammi Vacha-Haase and Kate L. Martin*

*See also* Adults in Transition (v4); Counseling the Elderly (v1); Developmental Counseling and Therapy (v2); Gerontology (v1); Identity Development (v3); Life Transitions (v2); Retirement, Implications of (v1)

### Further Readings

AARP, Office of Policy Integration. (2006). *Policy book: AARP public policies 2006*. Washington, DC: AARP.  
Aldwin, C. M., & Gilmer, D. F. (2004). *Health, illness, and optimal aging: Biological and psychosocial perspectives*. Thousand Oaks, CA: Sage.



- Caputo, R. K. (Ed.). (2005). *Challenges of aging on U.S. families: Policy and practice implications*. Binghamton, NY: Haworth Press.
- Cox, H. (Ed.). (2006). *Aging*. Dubuque, IA: McGraw-Hill.
- Erber, J. T. (2005). *Aging and older adulthood*. Belmont, CA: Thomson Wadsworth.
- Roszak, T. (2001). *Longevity revolution: As boomers become elders*. Berkeley, CA: Berkeley Hills Books.
- Wahl, H., Scheidt, R. J., & Windley, P. G. (Eds.). (2003). *Focus on aging in context: Socio-physical environments*. New York: Springer.

---

## ALCOHOLICS ANONYMOUS

---

Alcoholics Anonymous (A.A.) is an organization created in 1935 by two men who had a desire to stop drinking and become sober. Today, this group offers friendship, understanding, and hope to other people struggling to recover from alcoholism. The A.A. organization is based on the Twelve Steps. The only requirement to join is a desire to stop drinking. Alcoholism has long been the common denominator for many social ills, affecting areas of personal finance, legal status, personal and business relationships, and long-term health. Unlike programs in the self-help movement, A.A. is focused on mutual help.

### The A.A. Philosophy

A key to their philosophy is that A.A. views alcoholics as lacking the ability to control their drinking once they begin and that help outside the self is needed to gain and maintain sobriety. Although A.A. and its members do not seek out alcoholics who would benefit from A.A., they espouse the notion that those who seek help must be taught that alcoholism cannot be cured, but it can be treated via total abstinence. The typical path of A.A. participants is to first hit rock bottom because of their drinking habits, then to attend A.A. to become sober, and then to continue in a state of recovery by attending A.A. meetings.

### A.A. Meetings

It is in the A.A. meetings where the therapeutic value of talking comes into play; talking topics are limited to those relating only to alcohol. Meetings generally include a recitation of the Twelve Steps, a motivational

speaker (usually a member), and the Serenity Prayer. Outside of these core elements, the meetings are quite autonomous in that they are member driven, and each group creates its own culture and traditions.

The meetings are designed to offer each member an outlet to talk about personal alcohol-related experiences and to hear the stories of others; the therapeutic value of such talk has been the core of the program. The interpersonal climate of the A.A. meeting is one that typically encourages relationships based on the common goal of abstinence. In addition, the meetings offer members a place to meet new friends, hear inspirational speakers, and socialize in an alcohol-free environment.

The open meetings allow for anyone to attend with the pledge to not reveal the names of the participants. The closed meetings are only for A.A. members so they can discuss problems and situations that are specific to alcohol; closed meetings also give the newcomers opportunities to ask questions of veteran A.A. members. A.A. meetings are available in most towns and cities all across the United States and in 150 countries.

A.A. meetings in an online environment are the most recent advancement and source for support. Online meetings exist for convenience and for those who are unable to attend meetings due to geographic locale, or physical inability to attend due to lack of mobility.

Eighty-six percent of A.A. members belong to a home group, which is the meeting group they primarily attend; this group is where the member volunteers time, gives support, makes friends, and receives support from other members. In addition to attending meetings with the home group, A.A. members often seek out and attend meetings when they are away from home. Listings of A.A. meetings are found in newspapers, A.A. booklets, and through word of mouth. Often groups are formed based on demographics or particular needs; these include meetings for beginners, women only, men only, gay or lesbian individuals, nonsmokers, and Spanish speakers, to name a few.

Medical and mental health professionals, the courts, and clergy often recommend A.A. to problem drinkers. However, A.A. is not affiliated with any church, prison, or institution.

### Sponsorship

A.A. advocates and encourages new members to seek out the guidance of a sponsor, someone who has been



in the program and worked through the steps. Seventy-eight percent of A.A. members have a sponsor, and the majority of those sought out sponsors within the first 90 days of joining A.A. Sponsor relationships can be long- or short-term and may change over time depending on the needs of the member. These volunteer sponsors are not counselors but rather mentors or coaches; they are supportive by responding when requested, but they do not give advice. The sponsor-based relationship can become very personal and for many is the key to staying sober and continuing to attend meetings. Sponsorship helps not only the A.A. member in need but also the sponsor, who finds it therapeutic to help someone else through a difficult time.

### **Al-Anon and Alateen**

Separate organizations exist for those people touched by alcoholism in one form or another. These groups comprise parents, spouses, children, friends, or anyone who has a connection with a problem drinker. Members attend sessions similar to A.A. meetings, where they share their experiences in a safe and healing environment, and they can join in discussions or be silent depending on their needs. Whether or not the person with the drinking problem attends A. A., these meetings are a place to go for help and hope. Concerns about drinking, relapse, deception, money problems, self-esteem, threats, public embarrassment, abuse, anger, and many other topics are shared by people who have first-hand experience dealing with alcoholic significant others. Like A.A. meetings, Al-Anon and Alateen meetings are free and their locations can be found in the phone book, through A.A., or online.

### **Downside to A.A.**

As is the case with any organization, not everyone finds the good experienced by those who succeed in and continue to stay with A.A. A 1998 federal study found that just 26% of clients seeking treatment for addiction had problems only with alcohol, so many A.A. members may be faced with dual addictions (e.g., to cocaine, heroine, marijuana, or methamphetamine as well as to alcohol). These members may be particularly vulnerable to relapse and are encouraged to seek out other 12-step programs.

Some A.A. members are coerced to attend meetings; according to A.A.'s *2004 Membership Survey*, 11% of their clientele attend meetings because of a

court order. Coercion to attend meetings goes against the premise and criterion that to belong to A.A. one must have the desire to stop drinking alcohol. Other forms of coercion come from family members and employers. There are no statistics to determine the continued success of those who were introduced to A.A. under coercion.

The core A.A. requirement of total abstinence comes from the belief that one drink inevitably leads to another and another. The debate between models of total abstinence and controlled drinking has raged for decades; the opinion of A.A. leaders and counselors is unyielding. Younger people and those with a shorter history of problem drinking are more apt to strive for controlled drinking instead of total abstinence.

The implied belief in God, a higher power, or some notion of spirituality (step 3 in the 12-step plan) is another reason some resist A.A. However, A.A. proclaims that there is no requirement to believe in any spiritual entity to be successful in A.A. but rather to know that success cannot be achieved on one's own. Other elements of receiving help outside of the self include sponsors, therapists, medical assistance, role models, and nondrinking friendships.

Another criticism of A.A. is that it does not address the medical side of alcoholism. The *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV)* states that alcohol withdrawal occurs with the termination of heavy and prolonged alcohol use; such use is typical of a new A.A. member. Although A.A. acknowledges that alcoholism is a disease and that medical problems stem from withdrawal, it does not employ professionals to assist with alleviating the physical pain associated with the cessation of alcohol.

### **A.A. as a Counseling Strategy**

Knowledge of A.A. and what it has to offer may be a therapeutic bridge for clients who have questions and concerns about this path. Counselors' familiarity with A.A.'s Twelve Steps and the core beliefs and expectations of members may serve well the alcoholic or problem drinker who is searching for the strategy that works best for him or her.

Knowing where a client is in the alcoholism treatment process and what A.A. has to offer provides another option to improve the client's life situation. Counselors may attend open meetings to get a sense of the diversity, problems, and life issues discussed in



local groups and how they might meet the client's needs. Familiarity with the tools offered and the benefits of Al-Anon and Alateen groups may also be helpful when referrals are requested.

Encouraging clients to attend meetings where they can openly discuss their feelings with others in similar situations may lead to their empowerment and increased self-esteem. Healing properties that exist in groups include members who admit defeat while they still attend meetings and offer hope to newcomers. Positive and uplifting communication behaviors are evident as members allow hidden feelings and emotions to be shown to others where they can be worked through in a safe environment. Stories are shared without shame, and members learn from each other as all the stories blend together. A sense of understanding, friendship, and care evolves as members tell their truths and share their wisdom with each other.

Group counseling is a powerful tool for clients who are struggling to face each day without alcohol in their lives. Knowing they have a circle of people, including their sponsors who understand their dependency and despair and other members who have been in that situation before, allows them to become and remain sober. Being part of an empathic group where members all share the same goals of fighting alcoholism may instill a sense of harmony in a previously chaotic world.

### A.A. Twelve Steps

1. We admitted we were powerless over alcohol—that our lives had become unmanageable.
2. Came to believe that a Power greater than ourselves could restore us to sanity.
3. Made a decision to turn our will and our lives over to the care of God as we understood Him.
4. Made a searching and fearless moral inventory of ourselves.
5. Admitted to God, to ourselves and to another human being the exact nature of our wrongs.
6. Were entirely ready to have God remove all these defects of character.
7. Humbly asked Him to remove our shortcomings.
8. Made a list of all persons we had harmed, and became willing to make amends to them all.
9. Made direct amends to such people wherever possible, except when to do so would injure them or others.
10. Continued to take personal inventory and when we were wrong promptly admitted it.
11. Sought through prayer and meditation to improve our conscious contact with God, as we understood Him, praying only for knowledge of His will for us and the power to carry that out.
12. Having had a spiritual awakening as the result of these Steps, we tried to carry this message to alcoholics, and to practice these principles in all our affairs.

*Source:* Alcoholics Anonymous. *This is AA . . . an introduction to the AA recovery program* [Brochure]. (1984). Alcoholics Anonymous World Services, Inc. (conference approved literature), page 20. The Twelve Steps and excerpts from the pamphlet “2004 Membership Survey” are reprinted with permission of Alcoholics Anonymous World Services, Inc. (AAWS). Permission to reprint excerpts from the pamphlet “2004 Membership Survey” and the Twelve Steps does not mean that AAWS has reviewed or approved the contents of this publication, or that AAWS necessarily agrees with the views expressed herein. A.A. is a program of recovery from alcoholism *only*—use of the Twelve Steps in connection with programs and activities which are patterned after A.A., but which address other problems, or in any other non-A.A. context, does not imply otherwise.

*Marge Katherine Mercurio and S. Bennett Mercurio*

**See also** Family Counseling (v1); Cigarette Smoking (v1); Gambling (v1); Group Therapy (v2); Self-Help Groups (v2); Stress-Related Disorders (v1); Substance Abuse and Dependence (v2); Suicide Postvention (v1)

### Further Readings

- Alcoholics Anonymous. (1983). *Questions and Answers on Sponsorship* [Brochure]. Conference approved literature. New York: A. A. World Services.
- Alcoholics Anonymous. (1984). *This is AA . . . an introduction to the AA recovery program* [Brochure]. Conference approved literature. New York: A. A. World Services.
- Alcoholics Anonymous. (1990). *The AA Group . . . Where it all begins* [Brochure]. Conference approved literature. New York: A. A. World Services.
- Alcoholics Anonymous. (2005). *2004 Membership Survey* [Brochure]. Conference approved literature. New York: A. A. World Services.
- American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed.). Washington, DC: Author.
- Coldwell, B. (2005). Abstinence and controlled drinking: Success under any name remains a triumph. *Drugs and Alcohol Today*, 5(1), 23–26.



- Cunningham, J. A., & Breslin, F. C. (2001). Exploring patterns of remission from alcohol dependence with and without Alcoholics Anonymous in a population sample. *Contemporary Drug Problems*, 28(4), 559–566.
- Le, C., Ingvarson, E. P., & Page, R. C. (1995). Alcoholics Anonymous and the Counseling Profession: Philosophies in conflict. *Journal of Counseling & Development*, 73(6), 603–609.
- M. T. (2001). AA Unmasked. *The Village Voice*, 46(19), n.p.
- Perkinson, R. R. (2004). *Treating alcoholism: Helping your clients find the road to recovery*. Hoboken, NJ: Wiley.
- Selle, R. R. (2000). Leo Hennigan: Alcoholism's nemesis. *The World and I*, 15(6), n.p.
- VanLear, C. A., Sheehan, M., Withers, L. S., & Walker, R. A. (2005). AA Online: The enactment of supportive computer mediated communication. *Western Journal of Communication*, 69(1), 5–26.
- Velleman, R. (2001). *Counselling for alcohol problems*. (2nd ed.). London: Sage.
- White, W. L., & Edwards, T. (2000). [Review of the book *Resisting 12-step coercion: How to fight forced participation in AA, NA, or 12-step treatment*]. *Contemporary Drug Problems*, 27(3), 669–675.
- Zweben, J. E. (1995). The therapist's role in early and ongoing recovery. In S. Brown (Ed.), *Treating alcoholism* (pp. 197–230). San Francisco: Jossey-Bass.

---

## ALTMAIER, ELIZABETH M. (1952– )

---

Elizabeth Mitchell Altmaier, a native New Yorker, was born in 1952 to a father who was an engineer and a mother who was a homemaker. Unlike her brothers, for whom working careers were simply an expected eventuality, Altmaier was encouraged by the urgings she received during her educational experiences to explore her potential as a student and professional and to do so beyond the limited traditional venues open to women at that time—teaching and nursing.

Ironically, Altmaier came, quite literally, by way of chance to a career in psychology, selecting this area of study at random from a list of possible majors she found interesting. During her collegiate years, she found a fine match with the faculty in the psychology department at Wheaton College, and her mentor there persuaded her to pursue graduate studies in psychology. After collecting her B.A. in 1973 with honors from Wheaton College, she went on to earn a Ph.D. in 1977 in counseling psychology from Ohio State University.

It was at OSU that Altmaier found her feet as a scholar and developed her preference to view her research and professional efforts in an unfettered manner, away from what would be considered by others as “traditional” areas for interest and work in counseling psychology. This willingness to venture off the beaten path proved to be an important doorway for her in eventually pursuing her now well-established interest in health psychology (again, broadly defined). Following her clinical internship at the OSU Counseling and Consultation Service, she accepted her first academic post at the University of Florida in 1977. From there she moved, in 1980, to the University of Iowa where she is today.

Altmaier is truly a pioneer in counseling psychology; she was among the first to fully explore the potential avenues for research and applied education and training efforts in various areas of health psychology and its interface with medicine. Her initial, highly successful work in anxiety management for oncology patients receiving chemotherapy blossomed and extended over the years into National Institutes of Health (NIH)–funded research on coping strategies for stress and pain management with various oncology patient populations. Altmaier also made significant contributions to the research literature and medical care practices concerning patients who suffer from chronic low back pain. Finally, she has made a highly successful foray into helping medical school admission committees and training sites assess the suitability and potential success of applicants to their programs and has helped to improve the quality of physician–patient interactions in medical practice. In total, Altmaier has participated in more than \$1.5 million worth of grant-funded research efforts in these areas as well as in the general area of education and training in psychology. For this body of work, she received the 2003 Dorothy Booz Black Award for Outstanding Achievement in Health Psychology from Division 17 (Society of Counseling Psychology) of the American Psychological Association (APA).

For over 25 years, Altmaier has been a core faculty member in the APA-accredited program in counseling psychology at the University of Iowa. She also holds a secondary faculty appointment in the College of Public Health. She has enjoyed great favor and appreciation as a doctoral advisor to those fortunate students who have earned their doctoral degrees under her tutelage. Altmaier has held numerous administrative positions within the university, including department



chairperson, associate dean, and associate provost for faculty personnel and development. Illustrating her penchant for unique foci in her work, Altmaier has also been involved with the National Collegiate Athletic Association (NCAA), serving at the national level as a member of the Academics, Eligibility and Compliance Cabinet and the Study Group for the Use of Athletes' Names and Likenesses and at the local level on the University of Iowa's NCAA Certification Committee. Altmaier also serves on several other committees at the University of Iowa; she is its Big 10 and NCAA faculty athletics representative and is a member of its Board of Control of Athletics, its Presidential Committee on Athletics, and its Athletics Advisory Council. Finally, she has served on the search committees for several key sports administration positions at the University of Iowa, including the director of athletics, head coach for men's basketball, and head coach for football. In 2005, Altmaier was awarded the Michael J. Brody Award by the Faculty Senate at Iowa for her tireless contributions and service to the university.

Altmaier has also served the general psychology community in many capacities. For the APA, she chaired the Committee on Accreditation (ushering in the fully reformed accreditation standards and procedures in use today), was a member of the Commission for the Recognition of Specialties and Proficiencies in Professional Psychology, and served as a panel consultant for the Initiative on Women in Science and Technology. She has also served in governance roles for the Society of Counseling Psychology and the Council of Counseling Psychology Training Programs (CCPTP). Locally, she is a licensed psychologist in the state of Iowa and has served as chair of the Iowa Psychological Association's Ethics Board.

As a scholar, Altmaier's productivity is impressive; she has produced over 200 works to date, including 6 books, 14 book chapters, over 90 refereed articles, and over 80 research presentations. She has served in several editorial roles, including tours as editor of APA's *Clinician's Research Digest* and as associate editor of *The Counseling Psychologist*, *Journal of Counseling Psychology*, and *Contemporary Psychology*. Altmaier's efforts and accomplishments as a scientist have been nationally recognized. She is a fellow of the American Psychological Association and a charter fellow of the American Psychological Society (now the Association of Psychological Science), and she was the 1994 recipient of the American Psychological Association's prestigious Award for Distinguished Contribution to Education and Training in Psychology.

Most important and admirable given all she has accomplished, Altmaier has always been, and remains, very dedicated to her family—her husband Michael, her daughter Kathryn, and her son Greg. Those who have the good fortune to know Altmaier personally are aware of how much she enjoys her family and the experiences they share.

In reviewing her own career, Altmaier wrote, "In reflecting on the roads taken to date, and considering roads ahead . . . for me, uncommon choices . . . had in common a sense of excitement and the opportunity to work with others in a collaborative way. I look forward to more of these roads ahead" (1998, p. 103). Those who have had the good fortune to work with Altmaier have greatly appreciated her excitement, her willingness to collaborate, and the opportunity to share the road with her.

Loreto Prieto

*See also* Cancer Management (v1); Chronic Pain (v1); Coping (v2); Panic Disorders (v2); Physical Health (v2)

### Further Readings

- Altmaier, E. M. (1998). Reflections on choices: The road not taken. In L. T. Hoshmand (Ed.), *Creativity and moral vision in psychology: Narratives on identity and commitment in a postmodern age* (pp. 91–105). Thousand Oaks, CA: Sage.
- Altmaier, E. M. (Ed.). (2003). *Setting standards in graduate education: Psychology's commitment to excellence in accreditation*. Washington, DC: American Psychological Association.
- Altmaier, E. M., Ewell, M., McQuellon, R., Geller, N., Carter, S., Henslee-Downey, J., et al. (2006). The effect of unrelated-donor marrow transplantation on health-related quality of life: A report of the unrelated donor marrow transplantation trial (T Cell Depletion Trial). *Biology of Blood and Marrow Transplantation*, 12, 648–655.
- Altmaier, E. M., Fraley, S. S., Homaifar, B. Y., Maloney, R., Rippentrop, E. A. B., & Rasheed, S. (2003). Health counseling: Assessment and intervention. In M. Kopala & M. Keitel (Eds.), *Handbook for counseling women* (pp. 323–344). Thousand Oaks, CA: Sage.

---

## AMERICANS WITH DISABILITIES ACT

---

The Americans with Disabilities Act (ADA), a landmark piece of civil rights legislation, is a product of



bipartisan support. Signed into law on July 26, 1990, the ADA “signals the end to the unjustified segregation and exclusion of persons with disabilities from the mainstream of American life,” declared President George H. W. Bush. Although the passage of the ADA was challenged by some legislators who considered its supporters a “sodomy lobby,” the legislation’s history demonstrates an unwavering commitment of the Congress to the more than 43 million people with disabilities in the United States. The ADA protects those who encounter various forms of discrimination, exclusion, and segregation because of their disabilities and gives them “the right to participate in the cultural, economic, educational, political and social mainstream,” said Senators Bob Dole and Tom Harkin in celebration of the ADA’s tenth anniversary.

The language in the ADA and in subsequent judicial decisions defines what the law covers and to whom the law applies. As psychologists increasingly are called upon to conduct disability evaluations for insurance compensation, academic accommodations, work modifications, and federal income subsidies, it has become critical for psychologists to understand how and the extent to which the ADA applies to specific service populations. Key language and concepts in the ADA are fundamental to standards and requirements for many disability evaluations. This entry provides an overview of the ADA and its legislative background along with a discussion of the statutory definition of the term *disability* and the reasonable accommodations and modifications mandated by the ADA.

### **Overview of the ADA and Legislative Background**

The ADA came from the civil rights movement of the 1960s and 1970s. It was modeled after the Civil Rights Act of 1964, which prohibits racial discrimination for employment and in public accommodations (e.g., hotels or restaurants). Different from the Civil Rights Act of 1964, where protection applies to people of all races, the ADA provides protection against discrimination only for those whose limitations meet the statutory definition of disability. The ADA also borrows several key definitions from an early disability rights statute, the Rehabilitation Act of 1973. These include definitions for *disability*, *reasonable accommodation*, and *undue hardship*.

In spite of their similarities, there are major differences between the Rehabilitation Act of 1973 and the ADA. Although both statutes are disability rights

laws, the Rehabilitation Act of 1973 applies only to programs or activities receiving federal financial assistance (e.g., education, courthouses, and transportation). The ADA, on the other hand, covers public or private employment, transportation, accommodations, and telecommunications regardless of whether federal funding is involved. Also, housing, education, and air transportation are issues included in the Rehabilitation Act of 1973 that were not covered by the ADA. It is clear from the legislative history that Congress made a great effort to make the ADA consistent with the Rehabilitation Act and did not intend it to supersede its statutory predecessor.

The ADA includes five separate titles. Title I involves employment issues. It prohibits discrimination with regard to job application procedures, hiring, advancement, discharge of employees, compensation, job training, and employment privileges. Title II involves public services. Any state or local government instrumentalities, the National Railroad Passenger Corporation, and commuter authorities cannot deny people with disabilities services or participation in programs or activities available to those without disabilities. Title III concerns public accommodations (e.g., roads and sidewalks) and services operated by private entities (e.g., movie theaters and amusement parks). All such accommodations that are newly constructed must be accessible to people with disabilities. For existing facilities, architectural barriers to services must be removed if modifications are readily achievable. Title IV concerns telecommunications. Telephone relay services must be provided by telecommunication companies for people who use telecommunication devices for the deaf or other similar devices. Title V involves miscellaneous provisions that prohibit coercing, threatening, or retaliating against individuals with disabilities or those attempting to assist individuals with disabilities to assert their rights.

### **Definition of a Disability**

One key issue that raised a substantial amount of discussion during the legislative history and after the passage of the ADA concerned the definition of disability. The definition in the ADA is similar to that of the Rehabilitation Act of 1973; *disability* means (a) a physical or mental impairment that substantially limits one or more of the major life activities of such individual, (b) a record of such an impairment, or (c) being regarded as having such an impairment.



The ADA expanded its protection not only to those currently with a disability or those with a documented record of one but also to those who are perceived falsely as having a disability. For example, a person with epilepsy might be treated adversely by his employer, because his employer believes his condition could limit his ability to perform his job. Although his condition is well managed and does not affect his job functions, this person still would be covered by the ADA.

### **Physical and Mental Impairment**

A physical or mental impairment means (a) any physiological disorder or condition, cosmetic disfigurement, or anatomical loss affecting one or more of the following body systems: neurological, musculoskeletal, special sense organs, respiratory (including speech organs), cardiovascular, reproductive, digestive, genitourinary, hemic and lymphatic, skin, and endocrine; or (b) any mental or psychological disorder, such as mental retardation, organic brain syndrome, emotional or mental illness, and specific learning disabilities.

While ADA covers a broad range of disabilities, including psychiatric conditions, health conditions, sensory impairments, orthopedic impairments, and learning disabilities, there are certain conditions to which ADA does not apply. Transvestites, transsexuals, bisexuals, gay identified individuals, and individuals with pedophilia, exhibitionism, voyeurism, gender identity disorders not resulting from physical impairment, other sexual behavior disorders, pyromania, compulsive gambling, kleptomania, and alcohol or drug addiction do not qualify individuals for ADA protection if they are treated adversely solely on the basis of these conditions.

In *Shafer v. Preston Memorial Hospital Co.*, Deborah Shafer, a nurse anesthetist, sued Preston Memorial Hospital under the ADA, claiming that Preston Memorial Hospital discriminated against her on the basis of her drug addiction. Shafer was addicted to fentanyl, a Schedule II narcotic analgesic, and had diverted postoperative fentanyl for her personal use. On the day of her completion of inpatient rehabilitation treatment, Shafer was notified by the hospital that her employment was terminated. Shafer sued Preston Memorial Hospital for employment discrimination and appealed the district court's order, which granted

summary judgment for Preston Memorial Hospital. The circuit court concluded that Shafer was a current user of an illegal drug and was therefore not considered disabled under the ADA. Because of her addiction, she was not considered "otherwise qualified" under the ADA, and therefore the hospital was not held liable for discharging her from her employment.

### **Otherwise Qualified**

The ADA protects the rights of those who are able to demonstrate that they are qualified individuals with disabilities. A "qualified individual with a disability" as applied to employment under the ADA is a person "who, with or without reasonable accommodation, can perform the essential functions of the employment position that such individual holds or desires." Essential job functions may be determined by the employer's judgment, written job descriptions, the amount of time the person has spent performing those functions, terms of collective bargaining agreements, work experiences of previous incumbents, and experiences of current incumbents in similar positions. For example, an employer may require all secretaries to have the ability to type 75 words per minute. A person with paraplegia who applies to be a secretary but fails to meet the typing requirement is not be considered a qualified individual with a disability as long as this employer can demonstrate that this particular requirement is an essential job function and that no reasonable accommodation can be provided to modify this requirement.

In education settings, a person with a disability must be able to fulfill the essential requirements of the program, with or without the provision of reasonable accommodations. Sherrie Lynn Zukle was a medical student at Davis School of Medicine at the University of California. After receiving unsatisfactory performance reports for several semesters, Zukle was placed on academic probation and referred for an evaluation, through which Zukle was found to suffer a learning disability. She consequently received academic accommodations, including extra time on exams and note-taking assistance. Zukle's subsequent academic and clinical performances remained poor in spite of her academic accommodations. She failed a clinical clerkship when she was placed on academic probation the second time and later was dismissed from the medical school. Zukle brought suit against the Regents of the University of



California, claiming that she experienced educational discrimination because of her learning disability. In *Zukle v. Regents of the University of California*, the circuit court argued that Zukle continued to demonstrate unsatisfactory performance after she was granted academic accommodations. The court ruled that Zukle failed to meet the school's academic standards, and her dismissal was justified. This case clarifies that accommodations do not give students with disabilities a competitive advantage over other students. Students with disabilities have to meet the same academic standards and requirements as students without disabilities.

### **Major Life Activities**

The ADA defines major life activities as including, but not limited to, caring for oneself, performing manual tasks, seeing, hearing, speaking, breathing, learning, walking, working, standing, sitting, and reading. A person who suffers traumatic brain injury and has difficulty with walking, memory, attention, or caring for his or her basic needs as a result would be considered a person with disability under the ADA. For example, in *Pacourek v. Inland Steel Co.*, the plaintiff was terminated from her job because of her absences on several occasions for infertility treatment. The court determined that reproduction was a major life activity and the plaintiff was therefore covered by the ADA.

### **Substantial Limitations**

A person is substantially limited when this person is "unable to perform a major life activity that an average person in the general population can perform" or is "significantly restricted as to the condition, manner or duration under which an individual can perform a particular major life activity" as compared to the average person in the general population. For example, Casey Martin, a professional golfer, suffered a rare circulatory disorder that resulted in the malformation of his right leg and blockage of his blood flow back to his heart. His illness made walking difficult and had the potential to lead to amputation of his leg. The Professional Golf Association (PGA) insisted that walking was part of the competition on its tour, and it refused to allow Martin to use a golf cart at certain tournaments. In *PGA Tour, Inc. v. Martin*, Martin

successfully invoked the protection of the ADA, arguing that he had a life-threatening health condition that prevented him from walking, and that the PGA should permit him to use a golf cart in order for him to compete professionally.

### **Mitigating Measures**

Reviewing court cases involving the ADA, judicial decisions have restricted the definition of disability when considering the impact of mitigating measures on a person's disability. For example, in *Sutton v. United Air Lines, Inc.*, twin sisters sued United Air Lines for failure to consider them for employment as airline pilots. Both of them suffered poor vision and could not pass the required vision test without glasses. They brought suit under the ADA, claiming that their poor vision had resulted in the refusal of employment. The Supreme Court ruled that the plaintiffs should be considered when their vision was in the corrected state. Because the plaintiffs' corrected vision was 20/20, the plaintiffs were not considered disabled, and therefore excluded from coverage under the ADA. In *Murphy v. United Parcel Service, Inc.*, the Supreme Court also ruled that mitigating measures should be taken into consideration in determining a person's disability. Vaughn Murphy had a blood pressure of 186/124, but, when he was properly medicated, Murphy's blood pressure was within healthy limits. Murphy was fired from his job because he failed to satisfy the health requirement of the Department of Transportation. The Supreme Court ruled that Murphy's hypertension was not a disability, because, according to the testimony of his physician, Murphy, when under medication, could function normally. In both cases, mitigating measures were used to determine whether a person is disabled or not. Because the plaintiffs were ruled not disabled, they were excluded from ADA coverage.

Although a person may not be considered disabled when mitigating measures are considered, some mitigating measures could be disabling and could contribute to a person's disability. For example, negative side effects of psychiatric medication could generate adverse symptoms that may cause additional impairments. Whereas the existence of a disability does not warrant ADA protection unless it causes substantial limits to major life activities, the use of mitigating measures does not automatically exclude a person



from coverage under the ADA. Substantial limits to major life activities have to be analyzed on a case-by-case basis.

### Reasonable Accommodations and Modifications

The ADA includes reasonable accommodations or modifications as part of the nondiscrimination mandate. Reasonable accommodations are changes in the work or education environment or in the way things are customarily done that would enable a qualified individual with a disability to enjoy educational and employment opportunities equal to those of individuals without disabilities. Reasonable accommodations should be provided without altering the essential components of the academic or job requirements. In classroom settings, reasonable accommodations may include modifications to the delivery methods of instruction (e.g., captioning of a class lecture vs. oral presentation), modifications to examinations (e.g., extended testing time), or flexibility in attendance policies. In cases of employment, reasonable accommodations may include, for example, modifications to a work schedule, changes in ways work is performed, use of communicative devices (e.g., teletypewriters), or modifications to the work environment.

Concerning modifications to the work environment, both Title I and Title III of the ADA include statutory language that prohibits discrimination resulting from structural barriers. Title I of the ADA prohibits discrimination at the employment facility, whereas Title III of the ADA applies to public accommodations and services. The ADA requires that facilities built after January 26, 1993, be accessible and that modifications to existing public accommodations made after that date also be accessible. Alternative methods of providing services to the public are to be implemented where structural removal of barriers is not “easily achievable” because of difficulty or expense.

Accessibility requirements for public accommodations are outlined in the ADA Accessibility Guidelines for Buildings and Facilities (ADAAG). The ADAAG is issued by the United States Architectural and Transportation Barriers Compliance Board (or Access Board), which was formed to help to establish accessibility standards for new and existing facilities. The guidelines were revised in July 2004 to maintain consistency with technology and national standards, and they are used routinely by architects. Examples of

ADAAG guidelines include the number of locations for wheelchairs at any given seating capacity, height and clearance of lavatories, signage, and visual alarms.

There are other disability rights statutes that interrelate, to various degrees, with the ADA. In addition to the Rehabilitation Act of 1973, there are, for example, the Individuals with Disabilities Education Improvement Act of 2004 (IDEIA), which applies to education rights of individuals with disabilities at elementary and secondary levels; the Family and Medical Leave Act (FMLA), which applies to employees’ rights to care for family members’ medical conditions; and the Fair Housing Act, which prohibits discrimination by the direct providers of housing against individuals because of their race, disability, religion, sex, national origin, or familial status.

Dau-shen Ju

**See also** Civil Rights (v3); Discrimination (v3); Individuals with Disabilities Education Act (v1); Low-Incidence Disabilities (v1); Mental Health Issues in the Schools (v1); Mental Retardation and Developmental Disabilities (v1)

### Further Readings

- Americans with Disabilities Act of 1990, 42 U.S.C. § 12101 et seq. (West 1993).
- Americans with Disabilities Act Accessibility Guidelines for Buildings and Facilities, 28 C.F.R., Part 1191, app A. (2004).
- Colker, R. (2005). *The disability pendulum: The first decade of the Americans with Disabilities Act*. New York: New York University Press.
- Colker, R., & Tucker, B. P. (2000). *The law of disability discrimination* (3rd ed.). Cincinnati, OH: Anderson.
- Equal Employment Opportunity Commission Regulations to Implement the Equal Employment Provisions of the Americans with Disabilities Act, 29 C.F.R. § 1630 et seq. (2002).
- Murphy v. United Parcel Service, Inc., PGA Tour, Inc. v. Martin, 532 U.S. 661 (2001).
- Pacourek v. Inland Steel Co., 858 F. Supp. 1393 (N.D. Ill. 1994).
- Rothstein, L. F. (1997). *Disabilities and the law* (2nd ed.). Danvers, MA: West Group.
- Shafer v. Preston Memorial Hospital Co. 107 F.3d 274 (4th Cir. 1996).
- Sutton v. United Air Lines, Inc. 527 U.S. 471 (1999).
- Zukle v. Regents of the University of California 166 F.3d 1041 (9th Cir. 1999).



---

## ART THERAPY

---

Art therapy combines the process of art making (drawing, painting, sculpture, and other art media) with methods of psychotherapy to improve and enhance the psychological well-being of individuals of all ages. It is based on the belief that the creative process involved in artistic self-expression helps people to resolve psychological problems, develop interpersonal skills, manage behavior, reduce stress, increase self-esteem and self-awareness, and achieve insight. Individuals who are referred for art therapy need not have previous experience or skill in art, because art therapy is not primarily concerned with formulating an aesthetic or diagnostic assessment of the people's images. The overall goal of art therapy is to enable clients to achieve emotional, interpersonal, or cognitive growth through specific art-making experiences.

While visual expression has been used for healing throughout history, it was not until the early 20th century that psychiatrists became interested in the artwork created by their patients with mental illness and in how these patients used art expression as a form of communication. At around the same time, educators discovered that children's drawings and paintings reflected developmental, emotional, and cognitive growth and that children's art and play provided a means of evaluating psychological disorders. By the 1940s, art therapy emerged as a distinct discipline, and hospitals, clinics, and rehabilitation centers increasingly began to include art therapy programs along with traditional talk therapies or as "milieu therapies." Subsequently, the profession of art therapy grew into an effective and important method of assessment and treatment with children, adults, and families as recognition increased that the creative process of art making enhanced recovery, health, and wellness.

As with other forms of psychotherapy, the relationship between the art therapist and the client is a key component of treatment. However, art therapy differs from other forms of psychotherapies because, in addition to talking, art is also used as a form of communication; art also serves as an intervention. In essence, there are several aspects of art therapy that set it apart from other forms of psychotherapy: (1) It helps individuals to externalize feelings and thoughts in a unique and tangible way; (2) it helps individuals to convey feelings or thoughts that may be difficult to verbalize; and (3) it is usually perceived as

nonthreatening, neutral, or even as "play," reducing resistance to treatment.

Art therapy is used to assess and treat anxiety, depression, and other mental and emotional problems and disorders; substance abuse and other addictions; family and relationship issues; abuse and domestic violence; social and emotional difficulties related to disability and illness; trauma and loss; physical, cognitive, and neurological problems; and psychosocial difficulties related to medical illness. Art therapy programs are found in a number of settings, including hospitals, clinics, public and community agencies, wellness centers, educational institutions, businesses, and private practices. Methods of art therapy are often combined with other forms of creative arts therapies or expressive therapies such as music, dance and movement, drama, or play therapies as well as numerous forms of psychotherapy such as psychoanalytic, person-centered, humanistic, cognitive-behavioral, narrative, and solution-focused approaches.

Cathy Malchiodi

*See also* Humanistic Approaches (v2); Metaphors, Use of (v2); Play Therapy (v1); Psychoanalysis and Psychodynamic Approaches to Therapy (v2); Psychological Well-Being, Dimensions of (v2)

### Further Readings

- Malchiodi, C. (1997). *Breaking the silence: Art therapy with children from violent homes* (2nd ed). New York: Brunner-Routledge.
- Rubin, J.A. (2001). *Approaches to art therapy: Theory and technique* (2nd ed). New York: Brunner-Routledge.

---

## ASPERGER'S SYNDROME

---

*See* AUTISM/ASPERGER'S SYNDROME

---

## ATTENTION DEFICIT/ HYPERACTIVITY DISORDER

---

Attention deficit/hyperactivity disorder (AD/HD) is the most common childhood behavior disorder. It is characterized by developmentally elevated levels of



inattention, impulsivity, and hyperactivity. These three symptoms are so imperative that they have been referred to as the “holy trinity” of AD/HD. Over the years, the disorder has gone by a number of different names, including minimal brain dysfunction (MBD), hyperkinesis, hyperkinetic reaction of childhood, and attention deficit disorder (ADD). Regardless of the name, some variation of those three symptoms has been included as a part of the diagnosis. Concerns related to symptoms of AD/HD represent 30% to 40% of all psychologically based referrals made to primary care medical practices.

In the past, it was widely assumed that children outgrew AD/HD during their adolescent or early adult years. While some individuals do appear to no longer be affected by the disorder once they reach their early 20s, there is increasing evidence that 40% to 60% of children will continue to experience debilitating symptoms of AD/HD well into adulthood.

Attention deficit/hyperactivity disorder negatively affects not only the affected individual, but also those around him or her. Consequently the assessment and treatment of AD/HD needs to be comprehensive and systemic. Research suggests that pharmacological and behavioral treatments are quite effective in reducing the severity of the symptoms and resulting negative effects. In addition, individuals receiving treatment are less likely to develop additional psychiatric disorders as they get older.

## Prevalence

While there is variability in the estimated prevalence of the disorder, most researchers agree that AD/HD affects between 3% and 7% of the school-age population. The reported prevalence differences likely reflect variations in assessment methodologies, such as sampling procedures, assessment instruments, and diagnostic criteria. For example, the estimates of affected children tend to be inflated when sampling procedures do not assess for the degree of functional impairment. There is currently limited information regarding the prevalence of AD/HD in adults, but based upon extrapolations from childhood estimates, some researchers have suggested that AD/HD affects between 2% and 6% of the adult population.

Prevalence variation also appears to be related to gender. There is a large body of empirical evidence to suggest that males are much more likely to be diagnosed with AD/HD than females. Estimated male-to-female ratios for the disorder range from 2:1 to 9:1

depending upon the setting (community sample vs. clinic referred sample). It also appears that the gender discrepancy is lower for individuals with the predominantly inattentive subtype of AD/HD.

## Diagnostic Criteria

The *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR)* specifies 18 symptoms that compose the disorder. Nine of the criteria are related to symptoms of inattention, and nine are related to symptoms of hyperactivity/impulsivity. Symptoms of inattention include failure to pay attention, having difficulty with sustained attention, not listening, not following through on instructions, poor organization skills, avoiding tasks requiring sustained mental effort, often losing things, being easily distracted, and being forgetful. Symptoms of hyperactivity include fidgeting often, getting out of one's seat at inappropriate times, behaving or feeling restless, not being able to play quietly, being compelled to be active, and talking excessively. Symptoms of impulsivity include blurting out answers, having difficulty awaiting one's turn, and interrupting others.

Based upon this cluster of symptoms, three primary subtypes of AD/HD can be diagnosed. If an individual exhibits six of the nine inattention symptoms for a period of at least 6 months, and if these exhibitions are both maladaptive and inconsistent with the individual's developmental level, the diagnosis of *attention deficit/hyperactivity disorder, predominately inattentive type* can be made. If an individual exhibits six of the nine hyperactivity/impulsivity symptoms for at least 6 months and to a maladaptive degree given the individual's developmental level, the diagnosis of *attention deficit/hyperactivity disorder, predominately hyperactive-impulsive type* can be made. If an individual exhibits significant elevations on six of the inattention symptoms and six of the hyperactive-impulsive symptoms, he or she could be diagnosed with *attention deficit/hyperactivity disorder, combined type*. In all of the subtypes of AD/HD listed above, some symptoms causing impairment must have been present before the age of 7, some impairment from symptoms needs to be present in two or more settings, and there needs to be clear evidence of significant impairment in social, academic, or occupational functioning. In cases where it is unclear if these criteria have been met, a diagnosis of *attention-deficit/hyperactivity disorder, not otherwise specified* could be made.



The final criterion to consider is that the symptoms could not be better accounted for by another mental disorder. This is a very important criterion to consider. Symptoms characterized by inattention, impulsivity, and hyperactivity can occur in numerous other mental disorders. The clinician needs to consider not only that the individual has some disorder *other than* AD/HD, but that the individual has another disorder *in addition to* AD/HD.

### Making the Diagnosis

When making the diagnosis of AD/HD, the clinician has a number of different tools to choose from. First are the *DSM-IV* AD/HD rating scales. These scales take the *DSM-IV* criteria and have parents or teachers rate a child's behavior on a Likert-type scale. These specific scales tend to be relatively brief and easy to administer and have adequate psychometric properties.

The second type of assessment instrument is the broad-band rating. These instruments assess for a broader array of behaviors than just those associated with AD/HD. Examples of commercially available instruments that would fall into this category include the Child Behavior Checklist (CBCL) and the Behavior Assessment System for Children–2nd Edition (BASC-2). Both of these instruments assess for a broader range of symptoms, including depression, aggression, and somatic complaints. These instruments are well normed, have acceptable psychometric properties, and are available in parent, teacher, and self-report versions. Research suggests that youth self-report versions are rather poor at differentiating between children with AD/HD and controls, suggesting that children may not be accurate informants of their behavior problems. In addition studies suggest that when there are discrepancies between parents' and teachers' perceptions on such instruments, teachers tend to be the more accurate informants. The reason for this is that teachers usually have a better understanding of child development and age-appropriate behavior than many parents do.

Structured and semistructured interviews are a third type of assessment tool that can be employed when making a diagnosis for AD/HD. These instruments have advantages over rating scales in that the clinician can follow up on parent ratings and ensure that the parent understands the intent of the question. However, interviews are time intensive for both the examiner and the informant (usually the parent). The Diagnostic

Interview for Children and Adolescents–Revised (DICA–R) and the Diagnostic Interview Schedule for Children–Version IV (DISC–IV) are two of the more widely used diagnostic interviews that have adequate psychometric properties.

Impairment rating scales are a fourth category of assessment for AD/HD. Some measures provide documentation for global or overall impaired psychosocial functioning (e.g., the Children's Global Assessment of Functioning), whereas others provide a multidimensional rating of impairment (e.g., the Child and Adolescent Functional Assessment Scale). Some of the more widely used impairment rating scales show good temporal stability and interrater reliability. In addition they also have evidence for convergent and concurrent validity.

A fifth category of assessment is observational measures. There is a long tradition of conducting observations for children with behavior disorders. Observations can occur in analogue or naturalistic settings. Observation measures can be very complex and assess multiple behaviors across multiple settings or can be relatively simple and involve the assessment of only a couple of behaviors (e.g., verbal intrusions and out-of-seat activity in the classroom). Studies have shown that when the behaviors for observation are carefully chosen, observation measures that involve relatively few behaviors can be as effective as the more comprehensive systems.

Physiological or laboratory measures form a final category of assessment. While no such measures can diagnose AD/HD, some are widely used to aid in making the diagnosis. One group of such measures is the continuous performance tests (CPTs). There are many different types of CPTs available; some of the more common commercially available ones include the Test of Variables of Attention (TOVA), Conner's CPT, and the Individual Variables of Attention (IVA). All CPTs attempt to provide a computerized assessment of inattention, response inhibition (hyperactivity), and reaction time (impulsivity). While studies have shown that individuals with AD/HD do perform more poorly on these tests than do controls, individuals in other clinical groups (e.g., learning disabilities, depressed) also perform more poorly than controls.

Some researchers have argued that when assessing for AD/HD, less emphasis should be placed on identifying symptoms that confirm the diagnosis and more emphasis should be placed on evaluating the function of the behavior that is causing the problems. Through



functional behavioral analysis, clinicians are better equipped not only to recognize the maladaptive behaviors but also to implement a strategy to treat them.

### **Associated Features**

When compared to children of similar age and gender, children with AD/HD experience functional and adaptive impairment academically, behaviorally, and socially. The core symptoms of inattention, impulsivity, and hyperactivity can manifest in various ways. Attention is frequently defined by a set of observable behavioral characteristics. For example, children with AD/HD may find it difficult to remain focused on an assignment with ongoing distractions. Each passing moment may present a challenge for them to focus on a particular stimulus. Furthermore, once distracted, these children are often slower to return to task. Factors such as background noises, their own thoughts, and activity of any kind present potential distractions, which may preclude the child from staying on task. Adults working with these children frequently report that the children appear to be daydreaming, lethargic, or prone to not listening to instructions.

Impulsivity represents the inhibitory deficits an individual exhibits. These problems are associated with the tendency to interrupt others, to call out answers before the speaker can finish a question, and to have trouble waiting one's turn. Frequently, children with AD/HD report acting without considering the consequences for their behavior. Problems with low frustration tolerance and temper outbursts may be related to impulsivity. Some researchers, such as Russell Barkley, consider impaired inhibition to be the paramount symptom associated with AD/HD.

Hyperactivity is the third component of the AD/HD triad. When compared to normal controls, children with AD/HD are significantly more active. Often this activity appears aimless, as if the child is compelled to be doing something. This tendency may also result in the child engaging in more high-risk behaviors, such as running into the street without looking or jumping from a fast-moving object. These risk-taking behaviors appear to persist in adulthood. Adults with AD/HD have been found to be more prone than controls to substance abuse, traffic accidents, and legal problems.

Frequently, a child with AD/HD will first exhibit problematic behavior at school. Teacher-student relationships are often marked by strain and significant

discord. Children with AD/HD frequently engage in disruptive behavior, refuse to follow directions, and fail to complete assignments. Observers often misinterpret such a child's dislike for tasks that require sustained attention as an indication that the child is lazy or immature. Additionally, when compared to peers, children with AD/HD tend to lose necessary materials and have more organizational difficulties. Consequently parents and teacher may view them as being oppositional and defiant. These behaviors often result in increased disciplinary referrals, lower academic achievement, and more school failure.

Parents of children with AD/HD frequently experience problems relative to parenting practices, parent-child interactions, and parenting stress. They frequently exhibit higher levels of stress than parents of controls. In addition, there is a greater chance of disagreement between parents relative to child-rearing practices. Mothers of children with AD/HD are more likely to be depressed, and fathers are more likely to have substance abuse problems, than parents of controls.

Parent-child interactions are frequently marked by conflict. Research suggests that these parents are more likely to engage in punitive parenting practices. Perhaps in response to these conflicted interactions, children with AD/HD become even more overactive, defiant, uncooperative, and impulsive. This further exacerbates the parent-child conflicts. There is some research to suggest that the use of harsh physical discipline is associated with the development of oppositional defiant disorder or a conduct disorder in children with AD/HD. Older adolescents and young adults who received harsh physical punishment as children appear to be more impaired than their AD/HD peers whose parents did not use such practices.

In addition to negative family interactions, peer relationships also tend to suffer. Children with AD/HD interact less with playmates during conversation, tend to be more bossy, exhibit a diminished receptivity to social cues, and appear less likely to engage in close friendships. The aforementioned problems are exacerbated when there is a comorbid oppositional defiant or conduct disorder.

Low self-esteem has been observed more frequently in children with AD/HD than in controls. In an effort to preserve their self-esteem, children with AD/HD may overestimate their performance in the domains with greatest deficits. So, a child with AD/HD who is



struggling in school may exaggerate his or her academic achievement for the purpose of self-protection.

### Comorbid Disorders

When a child has AD/HD, he or she is more likely than not to have a comorbid disorder. Recent research suggests that up to 87% of children with AD/HD have at least one comorbid condition and up to 67% have at least two. Approximately half of children with AD/HD will go on to develop another behavior disorder such as oppositional defiant disorder or conduct disorder. Other common comorbid conditions include the following: learning disability (40% to 60%), depressive disorder (17% to 30%), anxiety disorder (20% to 43%) and substance abuse disorder (18% to 36%). There is some evidence to suggest children with AD/HD may be more likely to develop juvenile-onset bipolar affective disorder. While half of the individuals with Tourette's syndrome have AD/HD, children with AD/HD do not appear to be more likely to develop Tourette's.

### Etiology

There are numerous hypotheses relative to the etiology of AD/HD. However, few are supported with empirical research. One of the theories that has some support surmises a strong biological component. The evidence for a genetic influence in AD/HD has been gathered from family studies, twin studies, and molecular genetics studies. From the research relative to families, there are data that suggest that parents with an AD/HD diagnosis are more likely than non-AD/HD parents to have children with the same disorder. In fact, some researchers assert that there is a 57% chance that parents with AD/HD will have children with the same diagnosis.

Researchers have also looked at the prevalence of the disorder in parents of children who have been diagnosed with AD/HD. These studies found that 15% to 20% of the mothers and 20% to 30% of the fathers of an affected child also have AD/HD. There is also a 1 in 3 chance that a child with AD/HD will have a sibling who also has the disorder. Identical twins also appear to have increased risk for AD/HD. However, with these studies it is difficult to tease out environmental contributions to the expression of the disorder. Gonzales-Limas suggested that 70% to 95% of the trait variability among individuals with AD/HD can

be accounted for with genetic heritability. Researchers involved in molecular genetics research believe that several genes are related to risk for AD/HD. These genes include DAT1, DRD4, and DHB.

Some studies have found that birth complications may increase the likelihood that a child will develop AD/HD. In addition, several studies suggest a link between premature birth or low birth weight and AD/HD. In fact, it has been estimated that low birth weight is associated with 14% of all AD/HD diagnoses. Maternal behaviors such as smoking and using drugs or alcohol during pregnancy have also been linked to low birth weight and increased risk for AD/HD.

Several environmental variables have been consistently implicated in the expression of AD/HD. Correlations between exposure to environmental toxins, such as lead, and hyperactive behaviors have been reported in numerous studies. Other environmental variables may include malnutrition, disease, and trauma. Several large, well-controlled studies that systematically evaluated the diets of children for the effects of additives such as processed sugar, wheat germ, and food dyes on the development and expression of AD/HD have failed to find significant differences between groups of children who were exposed to the additives and those who were not.

### Psychopharmacological Treatments

Stimulant medications are one of the most widely used and oldest treatments for AD/HD. In fact, stimulants have been used to treat AD/HD since the mid-1930s. The therapeutic mechanism of action relative to stimulant medications is not precisely understood. Data generated from a large body of research suggest that stimulants increase neural activity in some parts of the brain; in others areas stimulants actually inhibit neural activity. Stimulant medications have been shown to be effective at increasing an individual's ability to focus attention and to inhibit impulsivity. It has been estimated that up to 82% of children over the age of 5 with AD/HD have a positive response to stimulant medication. However, a growing body of research suggests that persons who do not respond to standard stimulant medication may respond positively to low doses of amphetamines.

The use of stimulant medications does come with negative side effects, including loss of appetite and difficulty sleeping. In addition, the benefits from stimulants



may be relatively short-term. Some have estimated that stimulants lose their effectiveness within 5 years. Given the potential contraindications and limited longevity of psychotropic interventions, prescriptions must be issued judiciously. Physicians can usually adjust the doses of the medications to alleviate most side effects, and children frequently take “drug holidays” during the summer months to decrease the likelihood that a child will develop a tolerance to the medication. While stimulant medications have been shown to be effective in treating AD/HD, multiple studies have shown that optimal treatment effects result when individuals receive pharmacological intervention paired with behavioral interventions.

### Behavioral Interventions

Behaviorally based treatment plans are commonly used in clinics, schools, and day treatment centers to treat children with AD/HD. Numerous behavioral interventions exist; however only parent-training programs and classroom-based treatments have been supported by evidence-based research. Many behavioral interventions are based upon an antecedent, behavior, and consequence (A-B-C) paradigm. According to this theory, all behaviors (B) are preceded by environmental variables (A), and the positive or negative reactions children receive from that behavior (C) will determine whether a given behavior will increase, decrease, or remain unchanged. Behavior management programs that identify target behaviors and provide for the contingent application of positive or negative consequences is the most common manifestation of behavioral interventions. For adults with AD/HD, self-management procedures that involve self-monitoring, stimulus control, and self-reward are often used.

### Parent Training

Parent-training programs are a common, well-researched, and efficacious treatment for AD/HD. Some examples include Cunningham’s Community Parent Education (COPE), Eyberg’s Parent–Child Interaction Therapy (PCIT), and Barkley’s Parent Training Program. These parent-training programs have all been subject to research and are widely used. The methods and rationales associated with parent training programs are usually very similar: they endeavor to teach parents how to shape their child’s

behavior with appropriate behavioral management techniques.

The majority of parent-training programs include psychoeducational sessions. In these sessions, parents are provided with information about AD/HD (e.g., prognosis, course, and etiology). These sessions may be supplemented with handouts, books, or videotapes. Providing parents with information about AD/HD improves their perceptions of their children and may improve treatment outcomes.

In addition to the general overview of AD/HD, parents are also taught the basic principles of behavioral modification. Attending skills are also a critically important component of these programs. *Attending skills* refer to a process in which the parent listens, provides positive attention, and ignores mild undesirable behaviors exhibited by the child. Frequently these attending skills are practiced in a low-stress, play-based setting. Attending skills represent the cornerstone of behavioral modification; however, by themselves these skills will not effectively shape the target behaviors. Therefore, parent training focuses on several other aspects of parenting. Often parents are required to completely change the manner by which they interact with their children. This is because many parents appear to overfocus on undesirable behaviors and neglect to acknowledge when desirable behaviors occur. Parent training teaches parents to listen more effectively, shift the focus of attention from undesirable to desirable behavior, consider developmental variables, and issue frequent positive reinforcement.

The success or lack thereof associated with any parenting intervention is predicated upon the quality of the parent–child relationship. Parents are often encouraged to examine the quality of the relationship they have with their children and to identify conditions that negatively impact their relationship. Parents begin to explore the relationship between their children’s behavior problems and their own reactions when the children misbehave. For example, a parent may unintentionally reinforce an undesirable behavior; this often occurs when parents attend primarily to undesirable behavior and overutilize punishment. During this critically important phase, ineffective parenting practices are identified and replaced with more efficacious methods.

Skilled use of reinforcement is quintessential to successful behavioral change. There are several prerequisites to the implementation of a reinforcement system. First, the parent must identify, define, and



communicate behaviors in clear, specific, and measurable terms. Furthermore, whenever possible, the goals should be articulated with positive language and focus on the behavior that the child will exhibit, rather than what the child will cease to exhibit. A special type of reinforcement is praise. Parents learn that if they want to modify their child's behavior through praise, they should use *specific-labeled praise*. This means the parent makes sure that the child knows exactly why he or she is being praised. So instead of saying "You're a big boy," the parent learns to say, "You got up and got dressed all by yourself. Thank you for helping. You are such a big boy."

The second technique, punishment, must be implemented judiciously, and parents should always remember that reinforcement results in more enduring behavior change. In parent training (and behavior modification programs), a specific form of punishment called *response cost* is also used to shape behavior. Response cost refers to the removal of some privilege when the child exhibits an unwanted behavior. So, a child may lose his or her video game privileges for the evening if he or she chooses to neglect the dishes. Again, it is critically important that parents implement punishment strategies with caution. Unfortunately if parents want to stop a behavior quickly, the use of punishment is the fastest way to do so, but that change tends to be short-lived. Long-term behavior change occurs best with reinforcement.

Another effective behavioral intervention, *time-out*, is conceptually similar to response cost. While response cost results in the removal of a privilege, time-out results in the removal of positive reinforcement. Like response cost, time-outs should be utilized sparingly. Some researchers suggest that time-outs be limited to as few as two predetermined noncompliance behaviors. Similarly, the location and amount of time spent in time-out for a given offense should be predetermined. Children should be required to correct the behavior that actuated the time-out; in addition, the child should be rewarded for positive behavior. While a common rule of thumb for the length of time to keep a child in time-out is 1 minute for each year of age, research suggests that time-out achieves maximal impact for children in 3 to 5 minutes, regardless of their age.

The *token economy* represents another popular technique, which utilizes both reinforcement and response cost. As with the other techniques, the focus of the token economy should be on positive behavior.

A complete explanation of the token economy would exceed the scope of this entry, so only basic principles will be addressed.

Token economies are often used when the child requires frequent reinforcement. A list of target behaviors—following the guidelines relative to positive reinforcement—is generated. These behaviors should be clear, concrete, and measurable. Next, parents, teachers, or helping professionals issue tokens (usually plastic chips) or points (recorded in a notebook or calendar) when the child exhibits desirable behavior. The tokens or points are taken away when the child engages in undesirable behaviors. After a predetermined period of time, the child is allowed to exchange tokens or points for a privilege (e.g., extra time playing video games) or some other reinforcing product (e.g., comic book, candy bar).

Brian D. Johnson and Richard Bunce

*See also* Behavioral Therapy (v2); Conduct Disorder (v1); Conners' Rating Scales—Revised (v1); Learning Disorders (v1); Mental Health Issues in the Schools (v1); Oppositional Defiant Disorder (v1); Parent–Adolescent Relations (v1); Psychopharmacology, Human Behavioral (v2)

## Further Readings

- American Academy of Child and Adolescent Psychiatry. (1997). Practice parameters for the assessment and treatment of children, adolescents, and adults with attention-deficit hyperactivity disorder. *Journal of the American Academy of Child and Adolescent Psychiatry*, 36(suppl), 82–121.
- American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed., Text rev.). Washington, DC: Author.
- Anastopoulos, A. D., Barkley, R. A., & Shelton, T. L. (1997). Family based treatment: Psychosocial intervention for children and adolescents with attention deficit hyperactivity disorder. In E. D. Hibbs & P. S. Jensen (Eds.), *Psychosocial treatment research of child and adolescent disorders* (pp. 267–284). Washington, DC: American Psychological Association.
- Barkley, R. A. (2004). Adolescents with ADHD: An overview of empirically based treatments. *Journal of Psychiatric Practice*, 10, 39–56.
- Barkley, R. A. (2006). *Attention deficit hyperactivity disorder: A handbook for diagnosis and treatment* (3rd ed.). New York: Guilford Press.



- Brinkmeyer, M. Y., & Eyberg, S. M. (2003). Parent-child interaction therapy for oppositional children. In A. E. Kazdin & J. R. Weisz (Eds.), *Evidence-based psychotherapies for children and adolescents* (pp. 204–223). New York: Guilford Press.
- DuPaul, G. J., & Stoner, G. (2003). *ADHD in the schools: Assessment and intervention strategies*. New York: Guilford Press.
- Frick, P. J., Lahey, B. B., Applegate, B., Kerdyck, L., Ollendick, T., Hynd, G. W., et al. (1994). DSM-IV field trials for the disruptive behavior disorders. Symptom utility estimates. *Journal of the American Academy of Child & Adolescent Psychiatry* 33, 529–539.
- Johnston, C., & Mash, E. J. (2001). Families of children with attention-deficit/hyperactivity disorder: Review and recommendations for future research. *Clinical Child and Family Psychology Review*, 4, 183–207.
- Johnston, C., & Murray, C. (2003). Incremental validity in the psychological assessment of children and adolescents. *Psychological Assessment*, 15, 496–507.
- Pelham, W. E., Fabiano, G. A. & Massetti, G. M. (2005). Evidence-based assessment of attention deficit hyperactivity disorder in children and adolescents. *Journal of Clinical Child and Adolescent Psychology*, 34, 449–476.
- Pelham, W. E., Wheeler, T., & Chronis, A. (1998). Empirically supported psychosocial treatments for attention deficit hyperactivity disorder. *Journal of Clinical Child Psychology*, 27, 190–205.
- Weiss, G., & Hechtman, L. T. (1993). *Hyperactive children grown up* (2nd ed.). New York: Guilford Press.
- Wender, P. H. (1995). *Attention-deficit hyperactivity disorder in adults*. New York: Oxford University Press.

---

## AUTISM/ASPERGER'S SYNDROME

---

According to the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR)*, the formal diagnostic category for autism and Asperger's syndrome is pervasive developmental disorder, or PDD. Pervasive developmental disorders include autistic disorder, Rett's disorder, Asperger's disorder (syndrome), childhood disintegrative disorder, and pervasive developmental disorder—not otherwise specified (PDD-NOS). Mental health professionals, however, often refer to each of these disorders as autism spectrum disorders (ASD), which better conveys the continuum of

types and severity of symptoms delineated by this diagnostic label.

## The Autism Spectrum

The first accurate description of autistic symptoms appeared in 1943, when Leo Kanner published "Autistic Disturbances of Affective Contact." The term *autism*, a derivative of the Greek word *autos* or *self*, highlighted the primary symptom exhibited by the 11 children in Kanner's study. Kanner noted that these children presented with marked deficits in their ability to relate to other people.

Over time, the conceptualization of autism has evolved into the current view of a spectrum of psychological disorders identified by a fundamental deficit in one's ability to navigate the social world. Autistic disorder and Asperger's disorder, for example, share a common symptom in a significant impairment in social functioning relative to the individual's chronological age and measured intelligence.

The key distinguishing criteria for autistic disorder is a marked impairment in language, cognitive, or adaptive development before age 3. While some persons with autistic disorder are "high-functioning" (HFA), it is not uncommon for someone with autism to have severe language, emotional, and cognitive delays—including mental retardation. A classically autistic individual presents with early communication and language delays, cognitive deficits, stereotyped and restricted interests and behaviors, and a profound lack of social awareness. Stereotyped and restricted interests may include a specialized interest in a certain area or subject such as electrical wiring or computers. Stereotyped behaviors are often exhibited as repetitive hand, finger, or whole-body movements aimed at providing increased self-stimulation. These are referred to as self-stimulatory behaviors or "stimming" and should be distinguished from the motor tics that are typically observed in anxiety disorders.

A year after Kanner published his findings on autism, Hans Asperger, an Austrian pediatrician, published a paper discussing four boys who presented with symptoms similar to those described by Kanner. Asperger, however, described children that were higher-functioning in terms of developmental history than those described by Kanner.

Similar to autistic disorder, persons with Asperger's disorder present with social difficulties that pervade



their ability to establish and maintain peer relationships. Moreover, they exhibit highly specialized areas of interests and are often referred to as being “experts” on that subject. A person with Asperger’s disorder, however, is differentiated from a person with autism in that the individual does not have a history of significant cognitive, adaptive, or language delays.

While individuals with Asperger’s disorder do not have a history of communication delays, they, like persons with autistic disorder, present with peculiar linguistic tendencies, including a pedantic style, awkward tone and rate (often referred to as “robotic”), and difficulties maintaining reciprocal, give-and-take conversations. Moreover, they often avoid using idioms and figures of speech because they struggle to separate the literal meaning of these expressions from the underlying expressive connotation.

### **Etiology**

Researchers continue to struggle to identify specific causes of autism. Research strongly suggests, however, that autism may be a heritable disorder. With increased funding and support for autism research, scientists can continue to explore the genetic epidemiology of the disorder and other possible causes.

### **Diagnosis**

Autism spectrum disorders are formally diagnosed through a comprehensive psychological evaluation of the individual conducted by a qualified professional, such as a licensed psychologist. A thorough assessment should begin with a clinical interview that explores developmental history and current social, emotional, behavioral, and cognitive functioning. The clinician then administers standardized global assessment questionnaires that measure social, emotional, and cognitive functioning. Other standardized questionnaires and assessment tools that are specific to ASD are also administered, such as the *Autism Diagnostic Observation Schedule*. It is important to include a behavioral observation of the individual in an unstructured social setting.

### **Treatment**

Once a diagnosis is made, treatment recommendations can then be individualized to the individual’s

specific diagnosis and needs. Researchers agree, however, that early intervention for persons with ASD is essential and can significantly improve an individual’s level of functioning.

Current research indicates that lower-functioning individuals with autistic disorder benefit from intense behavioral therapy, such as applied behavioral analysis (ABA) and verbal behavior analysis (VB), to improve functional communication skills, adaptive skills, and behavior. ABA utilizes the principles of behavioral psychology and pairs repeated trials with a positive reinforcer to modify inappropriate behaviors by improving receptive language skills. VB also uses behavior modification techniques but emphasizes the functionality of expressive language skills. Another effective program, treatment, and education of autistic and communication handicapped children (TEACCH), uses an amalgamation of therapeutic techniques and methods to address the specific needs of each individual.

Persons with ASD often report significant problems relating to others and establishing peer relationships; thus a key component of treatment is an intensive focus aimed at improving the individual’s social skills. It is common for persons with ASD to present with social skills deficits, including difficulties establishing and maintaining reciprocal conversations, an inability to understand nonverbal social cues (e.g., facial expressions), problems communicating to others through nonverbal language (e.g., using appropriate eye contact to modulate a social interaction), and inadequately processing or a complete lack of awareness of others’ emotions. Thus, social skills training for AS focuses on topics ranging from conversational skills to personal space.

Although there are many techniques and programs designed for persons with ASD, there is no one-size-fits-all approach to treatment. Given the variability of symptoms and the frequency of comorbid disorders, it is common for clinicians to take a multidisciplinary approach in treating the disorder. Treatment teams might include licensed psychologists, occupational therapists, speech and language pathologists, medical professionals, teachers, and physical therapists.

### **Changes and Challenges**

The autism spectrum disorders continue to be a mental health issue of intense interest for clinicians, researchers, and politicians. Increased federal funds



for further research on autism and Asperger's disorder have led to an expansion of information and resources available to both parents and clinicians. Given the heterogeneity of ASD symptoms, a large portion of these funds are allocated to improving diagnostic procedures, such as refining current assessment tools and their ability to identify persons with ASD. Moreover, the importance of early and intensive intervention as well as effective treatment across the life span have continued to be the foci of research.

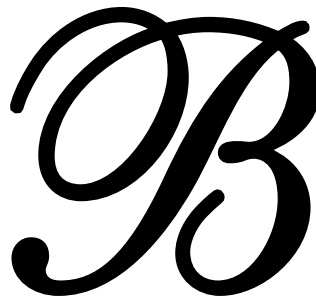
*Brandi L. Chew and Lee A. Rosén*

**See also** Behavioral Therapy (v2); Developmental Disorders (v1); Language Difficulties, Clinical Assessment of (v4); Mental Retardation and Developmental Disabilities (v1)

### Further Readings

- American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed., Text rev.). Washington, DC: Author.
- Asperger, H. (1944). Die "Autistischen Psychopathen" im Kindesalter. *Archiv für Psychiatrie und Nervenkrankheiten*, 117, 76–136.
- Attwood, T. (2000). Strategies for improving the social integration of children with Asperger syndrome. *Autism*, 4, 85–100.
- Green, G. (1996). Early behavioral interventions for autism: What does the research tell us? In C. Maurice, G. Green, & S. C. Luce (Eds.), *Behavioral intervention for young children with autism: A manual for parents and professionals* (pp. 29–43). Austin: Pro-Ed.
- Kanner, L. (1943). Autistic disturbances of affective contact. *Nervous Child*, 2, 217–250.
- Kanner, L. (1971). Follow-up study of eleven autistic children originally reported in 1943. *Journal of Autism and Developmental Disorders*, 1, 119–145.
- Krasny, L., Williams, B., Provencal, S., & Ozonoff, S. (2003). Social skills interventions for the autism spectrum: Essential ingredients and model curriculum. *Child and Adolescent Psychiatric Clinics of North America*, 12, 107–122.
- Lovaas, O. I. (1981). *Teaching developmentally disabled children: The ME book*. Austin: Pro-Ed.
- Lovaas, O. I. (1987). Behavioral treatment and normal educational and intellectual functioning in young autistic children. *Journal of Consulting and Clinical Psychology*, 55, 3–9.
- Mesibov, G. B. Shea, V., & Schopler, E. (2005). *The TEACCH approach to Autism spectrum disorders*. New York: Springer.
- Painter, K. K. (2006). *Social skills groups for children and adolescents with Asperger's Syndrome*. London: Jessica Kingsley.
- Sundberg, M. L., & Michael, J. (2001). The benefits of Skinner's analysis of verbal behavior for children with autism. *Behavior Modification*, 25, 698–724.
- Sundberg, M. L., Michael, J., & Partington, J. W. (1998). *Teaching language to children with autism or other developmental disabilities*. Pleasant Hill, CA: Behavior Analysts, Inc.
- Sundberg, M. L., Michael, J., Partington, J. W., & Sundberg, C. A. (1996). The role of automatic reinforcement in early language acquisition. *The Analysis of Verbal Behavior*, 13, 21–37.
- Szatmari, P., Jones, M. B., Zwaigenbaum, L., & MacLean, J. E. (1998). Genetics of autism: Overview and new directions. *Journal of Autism and Developmental Disorders*, 28, 351–368.





---

## BEHAVIORAL OBSERVATION METHODS, ASSESSMENT

---

Behavioral observation is a widely used method of behavioral assessment. Unlike other methods of behavioral assessment, most of which rely on people's perceptions of behavior, behavioral observation involves watching and recording the behavior of a person in typical environments (e.g., classrooms). The assumption is therefore that data collected are more objective than are perceptions. Most methods of behavioral observation provide quantitative and objective data that can be used to determine current levels of behavior, to set goals for behavioral improvement, and to measure change following intervention plans.

Depending on the nature of the behaviors of concern, observers may be interested in any one or a combination of several characteristics related to the behavior. The most common characteristic observed is frequency, or how often a behavior occurs. Other characteristics include magnitude (how intense a behavior is) and duration (how long a behavior lasts). A behavior change agent might be interested in reducing the frequency of a problem behavior, reducing its intensity, or reducing its duration. Regardless of which characteristic is observed, it is important to measure that characteristic consistently throughout the behavior intervention process.

### **Anecdotal (ABC) Recording**

One exception to the suggestion that behavioral observation methods produce objective and quantifiable information about behaviors is anecdotal recording. Anecdotal

recording involves recording and interpreting a narrative of behavior during an observation period using an antecedent-behavior-consequence (ABC) format for interpreting behavior. To conduct an anecdotal observation, an observer records all behaviors observed, along with what was observed to occur before and after the behaviors. For this type of observation, it is important that only observable behaviors are recorded. No inferences about behaviors should be made. For example, if a student is observed to slam her book closed, the observer should record "slammed book closed," rather than "student frustrated." Either during or after the observation period, it is helpful to arrange observations into a chart that specifies behaviors, antecedents (what happened prior to the behavior), or consequences (what happened as a result of the behavior). It is also helpful to keep track of the time at which behaviors were observed to occur.

Anecdotal recording is a method of choice when behaviors of concern are unclear. In other words, if one is unsure about the exact nature of a behavioral concern, anecdotal recording allows the observer to include observations of all behaviors. This is often a necessary first step in targeting particular behaviors for more focused or structured observation. Once behaviors of concern are pinpointed, however, the subjective and effuse nature of anecdotal recording makes it unsuited for continued use. At that point, the methods of choice are those that provide more quantitative and objective data. These methods are discussed below.

### **Interval Recording Methods**

Interval recording methods produce a record of the number of intervals during which a behavior is



observed to occur. There are three basic variations on interval recording—partial-interval recording, whole-interval recording, and momentary time sampling—but all focus on observing the frequency of the behavior, and all use simple *yes* or *no* counts of whether a behavior was observed to occur during each interval.

### ***Partial-Interval Recording***

Partial-interval recording begins with the observer determining the size of the interval needed. The size of the interval depends on the nature of the behavior, but 30 seconds is a common choice. Next, the observer creates a grid of boxes on a sheet of paper, with each box representing one interval. If the observation is conducted without the assistance of a computer program, a stopwatch is typically used to time the intervals. The observer begins observing the student or client for the presence of the target behavior. After the interval has passed, the observer records whether the behavior occurred during the interval. If observations are being recorded on paper, an X would be marked in the appropriate box if the behavior occurred. The observer then observes for the remaining intervals until the observation period is over.

Observers may choose one of two options for actually recording whether the behavior occurred during the interval. One option is to set aside a prespecified amount of time for the actual recording of the behavior. For example, if an interval is 30 seconds in length, the last 5 seconds of that interval might be devoted to recording. During those 5 seconds, no behavior that occurs is recorded. The second option is to observe and record simultaneously. In this option, behavior would be observed for the entire 30 seconds, and the observer records while continuing to observe. The advantage of the first option is that no behaviors are missed while recording. This is especially important if more than one behavior is being observed at the same time. The disadvantage, however, is that 5 seconds of each interval are unavailable for data collection. If only one behavior is being observed, if maximum observation time is desired, and if the observer is skilled in behavioral observation, the observe-and-record-simultaneously option may be preferred.

### ***Whole-Interval Recording***

Whole-interval recording is similar to partial-interval recording in all aspects but one. In partial-interval

recording, the behavior is recorded as having occurred (i.e., an X is placed in the box) if it was observed to occur at any point during the interval. For example, if head banging is the behavior of interest, it would be recorded as having occurred even if it lasted only 3 seconds. In whole interval recording, the behavior has to have occurred throughout the entire interval in order to be recorded as having occurred. Head banging in the previous example would only be marked as having occurred if it lasted for the entire 30-second interval.

Data interpretation is the same, regardless of whether one is using partial- or whole-interval recording. Once the observation period is over, the data collected are aggregated so they are easily understandable. This involves adding the number of intervals during which the behavior occurred, dividing the sum by the number of intervals observed, and multiplying by 100. The resulting product indicates the percentage of intervals during which the behavior was observed to occur. Converting to a percentage allows for comparisons across intervals of varying lengths.

Interval recording is a preferred method when the target behavior occurs at a moderate but steady rate. It should be noted that interval recording tends to over- or underestimate the actual frequency of behaviors, depending on whether partial- or whole- interval recording is used. With partial-interval recording, behavior frequency tends to be overestimated. For example, if the target behavior occurs once every 30 seconds during a 5-minute observation, but each instance lasts only 2 seconds, the observer would record an X in each box. The resulting percentage is 100, which is interpreted to mean that the behavior occurred during 100% of the intervals observed. Although this is true, “100%” overestimates the actual time the person spent engaged in the behavior (which in this case is only 20 seconds out of a 5-minute observation). With whole-interval recording, underestimations are possible. For example, using the same data presented above, no Xs would be placed in any boxes, because the behavior never lasted an entire 30-second interval. The observer would interpret these data as indicating that the behavior occurred during 0% of the intervals observed. Although this is true, it underestimates the actual frequency. Typically, whole-interval recording is used only when the duration of the behavior is of concern.

One significant advantage of using interval recording is that it is easier than some other methods. Specifically, because behaviors are not being counted per se, the observer only needs to note whether or not



the behavior occurred during the interval. Regardless of the number of times the behavior occurs during an interval, only one X is marked in the box.

### **Momentary Time Sampling**

The second major type of interval recording is momentary time sampling. Like interval recording, time sampling begins with the observer determining the size of the interval desired. Intervals typically are shorter in time sampling than in partial- or whole-interval recording.

A grid is constructed, with each box representing one interval. The observer begins the observation by starting the timer, and then momentarily observes the student or client at the end of the interval. If the behavior was observed to be occurring at the moment observed, an X is placed in the box. The next interval immediately follows. The major difference between interval recording and time sampling is that in interval recording, all behaviors that are observed during the interval are recorded. In time sampling, only behaviors that are occurring at the end of the intervals are recorded. It is entirely possible that a behavior might occur during every interval but never be recorded as having occurred if the behavior does not happen to be occurring at the end of the interval. For this reason, time sampling is not a preferred method for behaviors that occur only briefly (e.g., hitting). It is relatively easy, like interval recording, because the observer needs to note only if the behavior was occurring at the end of the interval. To interpret time sampling data, the observer adds the number of times sampled during which the behavior was observed to occur (i.e., the number of Xs), divides the sum by the number of intervals observed, and then multiplies that number by 100. The resulting figure represents the percentage of times sampled during which the behavior was observed to occur.

The advantages of time sampling are its relative ease (as noted above), and the fact that between sampling points, the observer can perform other tasks (such as observing others in the vicinity). The major disadvantage of time sampling is that very little of the total observation time is spent actually observing the student or client. For example, assuming “momentary” means 1 second, a 5-minute observation divided into 10-second intervals would mean the observer would observe 30 times (i.e., 6 times per minute for 5 minutes) or for 30 seconds out of 5 minutes. Many behaviors that could be recorded during that time are

not recorded unless they happen to be occurring at the end of the interval.

### **Event or Frequency Recording**

Event or frequency recording involves recording the number of times a behavior is observed to occur during an observation period. This type of recording involves a count of the number of separate instances of the behavior. An observer using event recording records the time at which the observation starts. The observer then notes each time the behavior either begins or ends, usually by using tally marks on a piece of paper (if a computer is not being used). At the end of the observation period, the observer adds the number of tally marks. The data can be interpreted as the number of times the behavior occurred. If comparisons across observations of different lengths are desired, the data can be recorded as a rate. For example, if 10 behaviors occurred during a 10-minute observation, the rate would be 1 behavior per minute.

Although event or frequency recording sounds simple, it is actually more difficult than either interval recording or time sampling. In the latter two methods, the observer needs to note only whether the behavior was occurring at the time of the observation. With event recording, the observer needs to know when a behavior either starts or stops. Therefore, it is imperative that behavioral definitions are written comprehensively enough to make this determination. For example, if a person engages in a self-injurious behavior for 3 seconds, pauses for 1 second, and then resumes the behavior, is this counted as one event or two events? The answer needs to be available in the definition of the behavior being used for the purpose of the observation.

Sometimes event recording can be used without the need for an observer actually seeing the behavior occur. Many behaviors produce *permanent products* that can be counted. Examples include the number of math worksheet problems completed and the number of days a student is tardy for school (using attendance records). The use of permanent products is desired over live observation because of its efficiency and verifiability. This is especially true for behaviors that occur very infrequently. Infrequent behaviors are very difficult to “catch” during an observation. With permanent products, behaviors can be “observed” after the fact.

Event recording is easily understandable to those not trained in behavioral observation, as it involves



counting behaviors. Assuming behavioral definitions are written to discriminate between instances of a behavior, event recording is a good choice for recording the frequency of a behavior. Its disadvantages include, as mentioned above, the requirement of very precise behavioral definitions and the fact that it lacks utility for behaviors that are not easy to count (e.g., inattention) as well as for behaviors that occur very infrequently (if no permanent products result from the behavior).

### **Duration Recording**

Duration recording produces an estimate of the amount of time a person spends engaged in a particular behavior. This is the only method discussed thus far that allows one to make statements related to percentage of time spent engaged in a behavior (although interval recording and time sampling data are often misinterpreted as meaning this). Duration recording is a difficult recording method to use, because the observer needs to note when the behavior both begins and ends. As such, behavioral definition specificity is imperative with this method.

Duration recording begins with the observer watching for the target behavior to begin. A stopwatch is started at that time, and then stopped when the behavior ends. The intervening time is recorded and the stopwatch is reset. This procedure is continued for the rest of the observation period. Subsequent to the observation, the total amount of time spent engaged in the behavior is computed by adding each of the amounts of time for individual instances of the behavior. Typically, that sum is divided by the number of instances of the behavior to obtain an average duration of each behavior. Because each recorded amount of time also corresponds to one behavior, duration recording also provides event or frequency recording data.

Duration recording provides very useful information, but it is difficult to use. Furthermore, it is only recommended if the duration of the behavior is a concern. For example, behaviors such as smoking or hitting are not particularly amenable to duration recording, because what is of most concern is the frequency of smoking or hitting (not how long they last). However, for behaviors such as tantrums or daydreaming, the goal may be to decrease their duration.

### **Latency Recording**

Latency recording is a very specific observation method that provides information about the amount of

time that elapses between an environmental event and the commencement or completion of a target behavior. Most typically, this method is used to determine the amount of time it takes for a person to comply with a command. In this case, the environmental event is the command, and the target behavior is compliance with that command. This method is very difficult to use, because not only does “compliance” need to be very solidly defined, but the event (i.e., command) also needs to be identifiable.

With latency recording, the observer starts the stopwatch when a command is given, and stops it when the client either begins to comply or has complied completely with the command. It is the observer’s choice whether to measure the time to beginning compliance or completing the task, but whatever method is chosen needs to be used consistently. The decision is likely to be based on the commands themselves (i.e., the behavior being requested), and characteristics of the client. For example, if the client typically begins to comply immediately when asked to brush his or her teeth, but then becomes distracted and never finishes the task, the observer would likely record time to completion of the task.

Regardless of method, once the client has satisfied the condition, the observer notes the time that elapsed, and he or she resets the stopwatch until the next command is given. This procedure is repeated for the duration of the observation period. Afterwards, the observer adds the elapsed time for each command and divides by the number of commands. This produces an average amount of time to compliance. It should be noted that compliance might not occur with some commands. In those cases, the observer would note that there was no compliance and restart the stopwatch when the next command is given. When interpreting results, it is important to note how many instances of noncompliance were observed.

### **Other Methods of Observation**

With the exception of duration and latency recording, each of the methods discussed above addresses behavioral frequency. As discussed earlier, observations may be made of frequency, magnitude/intensity, and duration. Duration recording and latency recording are both examples of methods for measuring duration of behaviors. Typically, behavioral magnitude/intensity is assessed by assigning a rating to the magnitude of a behavior (sometimes referred to as *performance-based behavioral recording*). Rating



scales may be developed to measure behavioral magnitude during a particular observation.

The validity of this method may be unknown, because validity is typically not determined for measures created for use with a single client. Some published procedures are available for particular behaviors (e.g., self-injurious behavior), but most often scales are created for use with particular clients. Measuring behavioral magnitude/intensity can be difficult, because different levels of magnitude need to be defined. For example, if the magnitude/intensity of social withdrawal is being measured using a scale of 1 to 4, definitions of what specific behaviors or characteristics constitute each of those ratings need to be written.

In addition to serving as a measure of behavior frequency, permanent products can also be used as a measure of behavior intensity. For example, the magnitude or intensity of trichotillomania (i.e., compulsive hair pulling) can be assessed by measuring the size of patches of pulled out or thin hair. The amount of bedwetting can be observed by measuring the size of wet spots on a bed. These behaviors leave permanent products that make actual observation of the behaviors unnecessary.

### Observation With Published Instruments

Several commercially available behavior-rating scales include forms for behavioral observation. Two of the more widely used include the Behavior Assessment System for Children—2nd Edition (BASC-2) and the Achenbach System of Empirically Based Assessment (ASEBA). The BASC-2's Student Observation System uses a momentary time sampling format for rating a variety of maladaptive and adaptive behaviors that are also included in other BASC-2 components (e.g., parent and teacher rating forms). The ASEBA includes a Direct Observation Form that includes 96 problem behaviors that are also represented on other ASEBA forms. Unlike the BASC-2 Student Observation System, the Direct Observation Form involves observing the student and recording behavior for a 10-minute period, then rating on problem behaviors observed during that time.

### Technology and Behavioral Observation

Increasingly, behavioral observations are being conducted using various computer-based tools and programs. Software for personal computers and hand-held

devices is often used for observations. These programs decrease observer error (e.g., observers are prompted to record behavior, eliminating the requirement for observers to keep track of time while observing), compile data collected in a format easily interpretable by the professionals involved, and allow for more sophisticated observational strategies. For example, some programs allow for the assessment of sequential conditions for behaviors. This possibility allows the observer to measure the likelihood of a particular behavior occurring, given the behavior that occurred before it. In other words, it allows predictions of behavioral probabilities.

## Issues in Behavioral Observations

### *Assessment Reactivity*

Because observers are in the physical presence of the client while collecting behavioral observation data, there is the potential for the procedure itself to change the client's behavior. This is referred to as *assessment reactivity*. Assessment reactivity can significantly affect the validity of observation data, so steps need to be taken to minimize its effects. The most common step addressed in the literature is to allow the client time to habituate to the observer's presence and activities. Habituation refers to a process whereby a person, upon prolonged exposure to a stimulus, stops responding to that stimulus. In the case of behavioral observation, the stimulus is the observer and the response is the change in typical behavior. Habituation can be achieved by allowing the client to get used to the observer's presence before any data are collected. Habituation is easier to achieve if the observer is as unobtrusive as possible. Sitting slightly behind but to the side of the person being observed is sometimes helpful.

### *Reliability*

Reliability refers to the consistency of results obtained from an assessment procedure, and it is important for the purposes of behavioral observation. There are several types of reliability, including internal consistency, test-retest, and inter-rater reliability. The first two are less applicable than the third for behavioral observation. With regard to test-retest reliability, for example, behaviors are not expected to remain stable over time, so low retest reliability is less a function of the instrumentation being used than the characteristics being assessed. Inter-rater reliability is



an important concept in behavioral assessment, however. It is important that two observers agree on whether targeted behaviors are occurring. Strong inter-rater reliability depends heavily upon solid behavioral definitions and comprehensive training for behavioral observers.

### Defining Behaviors

Behavioral definitions should have several characteristics. They should be objective, clear, and complete. Objective means the definition should include only observable aspects of the behavior. No inferences or judgments should be necessary when using the definition. The definition should be clear, meaning that it is understandable to any person who would want to conduct observations using the definition. Finally, the definition should be complete. It should delineate the bounds of the behavior, so that decisions can be made about whether a particular behavior represents an instance of the target behavior being observed.

### Using Behavioral Observation Results

Results of behavioral observations are typically used for three purposes related to intervention planning. First, they are used as a baseline of current levels of behavior. A baseline tells the professionals involved what to expect in the future if no intervention is to occur with an individual. Baseline data are also used for the second purpose—namely, the formulation of goals. Goals should be based on current levels of behavior. To not use baseline data in formulating goals is to risk setting goals that are unrealistic or too lenient. The third purpose for which results of behavioral observation are used is to measure outcomes. If initial observation data are used to determine baseline levels of behavior and for goal setting, later data can be used as a measure of whether interventions are successful. If data are being collected on a problem behavior, the behavior should decrease in frequency, magnitude, or duration if an intervention is successful. Conversely, if data are collected on an appropriate behavior, occurrences of the behavior should increase.

Behavioral observations are also conducted for research purposes. The data may be used to describe the behavior of an individual or group, or they may be used to measure change in behavior contingent upon some environmental manipulation or individual treatment. Sometimes in research, sophisticated coding

schemes are used to categorize or describe the behaviors observed, but they typically involve the use of one or more of the methods described above.

*Michelle S. Athanasiou*

*See also* Behavior Rating Scales (v1); Functional Behavioral Assessment (v1); Qualitative Methodologies (v1); Quantitative Methodologies (v1); School Psychology (v1)

### Further Readings

- Cooper, J. O., Heron, T. E., & Heward, W. L. (2007). *Applied behavior analysis* (2nd ed.). Upper Saddle River, NJ: Pearson.
- O'Neill, R. E., Horner, R. H., Albin, R. W., Sprague, J. R., Storey, K., & Newton, J. S. (1997). *Functional assessment and program development for problem behavior: A practical handbook* (2nd ed.). Pacific Grove, CA: Brooks/Cole.
- Thompson, T., Felce, D., & Symons, F. J. (Eds.). (2000). *Behavioral observation: Technology and applications in developmental disabilities*. Baltimore, MD: Paul H. Brookes.
- Watson, T. S., & Steege, M. W. (2003). *Conducting school-based functional behavioral assessments: A practitioner's guide*. New York: Guilford Press.

---

## BEHAVIOR ASSESSMENT SYSTEM FOR CHILDREN, SECOND EDITION

---

The Behavior Assessment System for Children, Second Edition (BASC-2) is used to facilitate differential diagnosis in individuals ages 2 to 25 years old. The BASC-2 comprises three forms: the Teacher Rating Scale (TRS), the Parent Rating Scale (PRS), and the Self-Report of Personality (SRP). The Teacher Rating Scale and the Parent Rating Scale have three versions delineated by age: preschool (2 through 5), child (6 through 11), and adolescent (12 through 21). Likewise, the SRP includes three forms differentiated by age: 8 through 11, 12 through 21, and 18 through 25. Both the PRS and SRP are available in Spanish for individuals living in the United States.

Informants—parents and teachers completing the relevant forms—provide ratings based on a 4-point response scale, ranging from *never* to *almost always*. The SRP includes items rated on a 2-point response



scale—*true* or *false*—while other items use a 4-point response scale. The BASC can be scored by hand or with computer software, which provides percentile ranks and *T* scores ( $M = 50$ ,  $SD = 10$ ). Interpretive information is provided by composite, primary, and (optional) content scales. In addition, the BASC-2 includes a Behavioral Symptoms Index and four composite scores, which offer broad estimates of behavioral problems and individual strengths.

The general norm sample included approximately 13,000 individuals. Data were collected from 375 sites, located in 257 cities, in 40 states across the country. Data collection sites included schools, mental health clinics, and day care facilities. General norm samples—collected from general-education classrooms—were similar to U.S. population estimates on specific variables: socioeconomic status, race/ethnicity, gender, and geographic region. Clinical norm samples did not reflect U.S. census estimates.

Coefficient alpha reliabilities for the Behavioral Symptom Index and composite scores range from .94 to .97 on Externalizing Problems, .87 to .92 on Internalizing Problems, .91 to .97 on Adaptive Skills, .92 to .94 on School Problems, and .95 to .97 on the Behavioral Symptoms Index. Clinical norm samples produced similar correlations on parallel composites. Test-retest reliability coefficients are based on individuals—including persons from general and clinical samples—rated by the same teacher. The stability of the BASC-2, measured with a retest interval of 8 to 65 days, is adequate, with coefficients ranging from .78 to .91. Inter-rater reliability estimates were based on responses of two raters. The rating intervals range from 0 to 62 days. Correlations for composite scores range from .53 to .65.

Construct validity, evidenced by factor analysis, supports four factors for the Teacher Rating Scale and Self-Report of Personality: Externalizing Problems, Internalizing Problems, Adaptability, and School Problems. Factor analysis for the PRS evidences identical factors, excluding School Problems. Criterion related validity, as shown by correlations between similar composite scores, was acceptable. For example, correlations between Externalizing Problems scores range from .73 to .84; between Internalizing Problems scores, the range is from .65 to .75.

The BASC-2 provides practitioners with a multi-method and multidimensional assessment of behavioral, social, and emotional competencies. It is an attractive measure for several reasons. Data are gathered from a

variety of sources, in multiple settings, that represent pertinent diagnostic information. Additionally, the BASC-2 provides estimates of problematic behavior and positive attributes; therefore, desirable qualities can be incorporated into treatment planning. For the purposes of classification and diagnosis, comprehensive assessment—including a functional behavior analysis—is quintessential. Therefore, the BASC-2 is one of the many sources of a thorough assessment.

*Richard Bunce*

*See also* Adaptive Behavior Testing (v2); Affect (Mood States), Assessment of (v2); Assessment (v3); Behavioral Observation Methods, Assessment (v1); Behavior Rating Scales (v1); Psychometric Properties (v2)

### Further Readings

- Reynolds, C. R., & Kamphaus, R. W. (2004). *Behavior Assessment for Children—Second Edition*. Circle Pines, MN: American Guidance Services.
- Sattler, J. M., & Hodge, R. D. (2006). *Assessment of children: Behavioral, social, and clinical foundations* (5th ed., pp. 278–280). La Mesa, CA: Sattler.

---

## BEHAVIOR RATING SCALES

---

Behavior rating scales are one of the oldest assessment tools used in mental health, education, and research. These scales typically assess problem behaviors, social skills, and emotional functioning; are widely employed in the assessment of personality development, adaptive behavior, and social-emotional functioning; and aid in diagnostic decision making and in planning treatment and education. These well-proven scales are easy to administer, score, and interpret and have become an integral part of the clinical and school assessment of children and adolescents.

A variety of behavior rating scales are available for use in clinical practice and research. The majority of behavior rating scales are intended for use with children, though a handful can be used with adults. The use of behavior rating scales in the evaluation of adult clients is gaining popularity. There are a number of advantages of using behavior rating scales: They quantify and systematically organize client information, administration and scoring is generally quick and easy, most allow for



comparison of ratings across respondents and/or settings, and because these are norm-referenced instruments, the client's symptoms and behaviors can be compared with those of his or her peers.

Behavior rating scales help clinicians obtain information from parents, teachers, and others about a client's symptoms and functioning in various settings, which is necessary for an appropriate assessment for a number of disorders as well as for treatment monitoring. Such instruments are generally only one component of a comprehensive evaluation, which commonly includes direct observation of the client, objective and projective measures, and interviews. Most behavior rating scales are normed using nationally representative samples, but they also often include clinical norms as well, which allows for a variety of behavior comparisons. Ideally, the rating scale used should be normed to similar client populations, so results indicate if a client's skill, behavior, or emotional status is typical or significantly different from that of peer groups.

### Uses of Behavior Rating Scales

The most common use of behavior rating scales is in the diagnosis of mental and behavioral disorders. The content of behavior rating scales often conforms to *Diagnostic and Statistical Manual of Mental Disorders (DSM)* diagnostic criteria, though it often differs in the way the symptoms are quantified as well as in the way the symptoms are combined. In the educational setting, these scales are also used to help determine eligibility for special education and other programs. In addition, they are used to plan interventions and to monitor symptoms and behavior during and following treatment.

There is ample empirical support for the validity of using behavior rating scales for diagnostic and placement decision making. However, the use of these scales in planning interventions and monitoring client progress has not yet been adequately validated. Because of this, behavior rating scales should never be the sole method used to monitor response to treatment, though behavior rating scales do have a place as one piece of a multimodal method. For example, direct observations and rating scales are considered the best methods to evaluate the effects of medication trials on a child's behavior. When used in conjunction with direct observations, behavior rating scales may give an indication of differences in behavior across settings or differences in the perception of the client's behavior by significant others in his or her life. It is

always important to ensure that the scale is appropriate for this use. If a behavior rating scale is used to monitor a behavioral intervention, care should be taken to make sure the scale aligns with this goal. Many scales monitor reductions in negative behaviors, but most lack items that measure positive replacement behaviors.

Behavior rating scales typically quantify the severity of the behaviors or symptoms on Likert scales (e.g., 0—*not present* to 4—*severe*) or the frequency that the behavior or symptom is observed (e.g., 0—*never* to 4—*almost always*). Scores on the scale or subscales are then summed and converted to a standard score such as a *T* score, which allows for comparison of the frequency of a variety of behaviors to norms for a client's gender and/or age group. These data are critical for determining the clinical significance of the client's symptoms and behaviors.

### Types of Behavior Rating Scales

Many of the newer behavior rating scales use a comprehensive, multidimensional approach to the assessment of behavior. For example, many scales include observer/informant and self-report forms. In addition, clinicians can choose from global scales that assess multiple domains of functioning or scales that focus on a specific dimension of behavior.

#### Observer/Informant Scales

Significant others, such as parents and teachers, can provide valuable information about a client's behavior that would otherwise be unavailable to the clinician. This information can be extremely helpful as part of case conceptualization, especially with child clients. Informant scales assess the degree or frequency of certain behaviors or skills based on the respondent's perceptions. The rater must be very familiar with the client to provide useful information, and using multiple raters helps reduce biased perceptions. The psychologist's report should note who provided the ratings and describe his or her relationship to the client.

#### Self-Report Scales

Older child clients and adults are often asked to provide ratings of their own behavior, feelings, and skills. These measures are similar, or even identical, to other rating scales and are often used in conjunction



with teacher or parent ratings. It can be helpful to compare how clients perceive themselves relative to how others perceive them. However, it is important to note that in psychiatric disorders where either the client's verbal capacity (e.g., autism, dementia) or insight (e.g., psychotic conditions) is compromised, self-rating scales have very little value.

### ***Single Domain Scales***

Scales that assess one specific area allow for focused, in-depth evaluation of a behavior or particular area of functioning. Focusing on a single dimension of behavior may be warranted when the referral question is limited to a specific concern. Most of these scales are intended to assess attention deficit hyperactivity disorder (AD/HD), social skills, or conduct problems. These measures are often used subsequent to the use of multidomain scales that have identified one or more areas of concern.

### ***Multidomain Scales***

Multidomain behavior rating scales assess a broad array of social, emotional, and behavioral functioning. The use of these scales has increased dramatically in popularity due to research findings that many individuals, particularly children, tend to have difficulties in multiple areas. For example, research in developmental psychopathology suggests a high degree of comorbidity among the social, emotional, and behavioral domains. Thus, multidomain behavior rating scales allow the clinician to obtain information about a variety of areas of functioning with one tool.

## **Widely Used Behavior Rating Scales**

There are many different behavior rating scales available to clinicians. The most commonly used scales are the Achenbach Scales, the Behavior Assessment System for Children (BASC-2), the Connors instruments, the Attention Deficit Disorders Evaluation Scale (ADDES), the ADD-H Comprehensive Teacher Rating Scale (ACTeRS), the ADHD Rating Scale-IV, the Behavior Rating Profile (BRP-2), the Burk's Behavior Rating Scales (BBRS), and the Social-Emotional Dimension Scale (SEDS-2). One other behavior rating scale that is quickly gaining popularity is the Behavior Rating Scale of Executive Function (BRIEF). Although this list does not cover the full range of available

behavior rating scales, it is a good representation of scales that are widely or typically used, as determined by surveys of practitioners.

### ***Achenbach Scales***

The Achenbach System of Empirically Based Assessment (ASEBA) offers a comprehensive approach to assessing adaptive and maladaptive functioning. These multidomain instruments allow for multi-informant assessment across the age span (1.5 to 90 years). ASEBA instruments allow for documentation of clients' functioning in terms of both quantitative scores and individualized descriptions in respondents' own words. Descriptions include what concerns respondents most about the client, the best things about the client, and details of competencies and problems that are not captured by quantitative scores alone. Evidence of adequate psychometrics of the Achenbach scales is provided in the test manual. In addition, numerous studies have demonstrated significant associations between ASEBA scores and both diagnostic and special education categories.

ASEBA behavior rating scales include the Child Behavior Checklist (CBCL), the Caregiver-Teacher Report Form (C-TRF), the Teacher Report Form (TRF), the Youth Self-Report (YSR), the Adult Behavior Checklist (ABCL), the Adult Self-Report (ASR), the Older Adult Behavior Checklist (OABCL), and the Older Adult Self-Report (OASR). The ASEBA informant scales generally take 15 to 20 minutes to complete, while the self-report scales take 20 to 30 minutes. Forms can be hand- or computer-scored.

#### **CBCL**

The CBCL/6–18 obtains reports from parents, other close relatives, and/or guardians regarding children's competencies and behavioral or emotional difficulties. The CBCL/6–18 has 112 items that describe specific behavioral and emotional problems, plus two open-ended items for reporting additional problems. Parents rate their child for how true each item is using a 3-point scale from 0 (*not true*) to 2 (*very true or often true*). Parents also provide information for 20 competence items covering their child's activities, social relations, and school performance.

The CBCL/6–18 scoring profile provides *T* scores and percentiles for three competence scales (Activities, Social, and School), Total Competence, eight



syndromes, six *DSM*-oriented scales, and Internalizing, Externalizing, and Total Problems. The syndrome scales include Aggressive Behavior, Anxious/Depressed, Attention Problems, Rule-Breaking Behavior, Social Problems, Somatic Complaints, Thought Problems, and Withdrawn/Depressed. The six *DSM*-oriented scales are Affective Problems, Anxiety Problems, Somatic Problems, Attention Deficit/Hyperactivity Problems, Oppositional Defiant Problems, and Conduct Problems.

The CBCL for preschool-age children (CBCL/1½–5) is used to obtain parents' reports of their 1½- to 5-year-old child's competencies and problems. It obtains ratings of 99 problem items, plus descriptions of problems, disabilities, what concerns parents most about their child, and the best things about the child. Items combine to form the following scales: Emotionally Reactive, Anxious/Depressed, Somatic Complaints, Withdrawn, Attention Problems, Aggressive Behavior, and Sleep Problems. Scores on Internalizing, Externalizing, and Total Problems composite scales are also provided.

Like the CBCL/6–18, the preschool profile features *DSM*-oriented scales in addition to the empirically based scales. Scales were constructed for the following five *DSM*-oriented categories: Affective Problems, Anxiety Problems, Attention Deficit/Hyperactivity Problems, Oppositional Defiant Problems, and Pervasive Developmental Problems. The CBCL/1½–5 also includes the Language Development Survey (LDS), which uses parents' reports to assess children's expressive vocabularies and word combinations as well as risk factors for language delays. The LDS indicates whether a child's vocabulary and word combinations are delayed relative to norms for children ages 18 to 35 months. The LDS can also be completed for language-delayed older children.

#### TRF and C-TRF/1½–5

The TRF is designed to obtain teachers' reports of children's academic performance, adaptive functioning, and behavioral or emotional problems. The scale has 118 problem items, of which 93 have counterparts on the CBCL/6–18. The remaining items concern school behaviors that parents would not observe, such as difficulty following directions and or disturbance of other pupils. Teachers rate the child for how true each item is using the same 3-point response scale used on the CBCL/6–18.

Scores for Academic Performance, Total Adaptive Functioning, the eight cross-informant syndrome

scales, and the six *DSM*-oriented scales can be obtained. Like the CBCL, the TRF also provides Internalizing, Externalizing, and Total Problems composite scores.

For 1½- to 5-year-olds, preschool teachers and day care providers can complete the Caregiver-Teacher Report Form for Ages 1½–5 (C-TRF/1½–5). The C-TRF consists of 99 items, plus descriptions of problems, disabilities, what concerns the respondent most about the child, and the best things about the child.

#### YSR

The YSR is a self-report scale that can be completed by youths who have fifth grade reading skills, or it can be administered orally. Its competence and problem items generally parallel those of the CBCL/6–18; plus it contains items covering physical problems, concerns, and strengths that require open-ended responses. In addition, the YSR has 14 socially desirable items that most youths endorse about themselves. The YSR scoring profile includes two competence scales (Activities and Social), Total Competence, the eight cross-informant syndrome scales, and the six *DSM*-oriented scales that are also scored on the CBCL and TRF, and Internalizing, Externalizing, and Total Problems scales.

#### ABCL

The ASEBA is one of the few assessment systems with a behavior rating scale intended for use with adults. The ABCL is for clients ages 18 to 59. The client's spouse or partner typically serves as the respondent, but any adult who is close to the client can complete the ABCL. The profiles of the ABCL include scales for Adaptive Functioning, Empirically Based Syndromes, Substance Use, Internalizing, Externalizing, and Total Problems. The ABCL profiles also feature new *DSM*-oriented scales and a Critical Items scale consisting of items of particular concern to clinicians.

The following cross-informant syndromes were derived for the ABCL: Anxious/Depressed, Withdrawn, Somatic Complaints, Thought Problems, Attention Problems, Aggressive Behavior, Rule-Breaking Behavior, and Intrusive. The ABCL and ASR have parallel Substance Use, Critical Items, Internalizing, Externalizing, and Total Problems scales. The *DSM*-oriented scales are Depressive Problems, Anxiety Problems, Somatic Problems, Avoidant Personality



Problems, Attention Deficit/Hyperactivity Problems, and Antisocial Personality Problems. For older clients (ages 60–90+), clinicians can use the OABCL.

### ASR

The Adult Self-Report (ASR) is normed for clients 18 to 59 years. Like the YSR, the ASR profiles include scores for Adaptive Functioning, cross-informant empirically based syndromes, Substance Use, Internalizing, Externalizing, and Total Problems. In addition, the ASR profiles feature the *DSM*-oriented scales that are scored on the ABCL and a Critical Items scale. Older clients (60–90+ years) can complete the OASR.

### BASC-2

The BASC-2 system is a set of tools that assess the behaviors and emotions of preschool- through college-age individuals and is respected for its developmental sensitivity. The scales of the BASC-2 were first defined conceptually and then confirmed via factor analysis. In addition to evaluating personality and behavioral problems and emotional disturbances, the instruments identify positive attributes that can be capitalized on in the treatment process.

The BASC-2 system enables assessment from three vantage points: self, teacher, and parent or caregiver. Thus, information from multiple sources can be compared using instruments with overlapping norms to help achieve reliable and accurate diagnoses. The system provides an extensive view of adaptive and maladaptive behavior and measures areas important for both Individuals with Disabilities Education Act and *DSM-IV* classifications. Various types of validity checks are incorporated into the BASC-2 to help the clinician detect careless or untruthful responding, misunderstanding, or other threats to validity.

The BASC-2 Parent Rating Scales (PRS) and Teacher Rating Scales (TRS) are normed for individuals ages 2 years to 21 years, 11 months. These scales can typically be completed in 10 to 20 minutes. The Self-Report Scale (SRP) can be completed by individuals 8 years through college-age and takes about 30 minutes to complete.

*T* scores and percentiles for both general population and clinical norms can be obtained for all measures, and computer scoring and interpretation programs are

available. Reliability and validity evidence is supportive of this measure.

### PRS

The PRS assesses numerous aspects of behavior, including both adaptive (healthy) and clinical (problem) behaviors in the community and home settings. Parents or caregivers can complete forms for one of three age levels—preschool (ages 2 to 5), child (ages 6 to 11), and adolescent (ages 12 to 21)—in 10 to 20 minutes. The PRS contains 134 to 160 items that describe specific behaviors that are rated on a 4-point scale of frequency, ranging from *never* to *almost always*. The PRS clinical scales include Hyperactivity, Attention Problems, Aggression, Conduct Problems, Atypicality, Anxiety, Somatization, Withdrawal, and Depression. The adaptive scales are Activities of Daily Living, Adaptability, Social Skills, Functional Communication, and Leadership.

The clinical scales on the PRS combine to form three composite scales: Internalizing Problems, Externalizing Problems, and a Behavioral Symptoms Index. An Adaptive Skills Composite score is formed from scores on the adaptive scales. Validity and response set indexes used to help judge the quality of completed forms are also available. One additional tool is a list of Critical Items that may have clinical importance of their own. Some of these items are included solely for this singular attention and are not part of any scale (e.g., “Has a hearing problem”) while others have special significance such as “Says, ‘I wish I were dead.’”

### TRS

Like the PRS, the TRS includes forms for three age levels and uses a four-choice response format for the 100+ items. Teachers or other qualified observers provide information about adaptive and problem behaviors in the preschool or school setting. Clinical scales on the TRS parallel those on the PRS but also include a Learning Problems scale for those between 6 and 21 years of age. The TRS adaptive scales are also identical to those on the PRS except for a Study Skills scale that is substituted for the Activities of Daily Living scale. The following composite scores are reported on the TRS profile: Internalizing Problems, Externalizing Problems, School Problems, Behavioral Symptoms Index, and Adaptive Skills.



### SRP

The SRP helps provide insight into an individual's thoughts and feelings. It contains 139 to 185 true/false and multiple choice (*never* to *always*) items and measures the following clinical areas: Attitude to School, Attitude to Teachers, Sensation Seeking (ages 12 to 21 only), Atypicality, Locus of Control, Social Stress, Anxiety, Depression, Sense of Inadequacy, Somatization, Attention Problems, and Hyperactivity. Positive psychological adjustment is measured via the adaptive scales (Relations with Parents, Interpersonal Relations, Self-Esteem, and Self-Reliance). Four composite scores are provided on the profile: School Problems, Internalizing Problems, Externalizing Problems, and Personal Adjustment.

### Conners Scales

First published in 1989, the Conners Rating Scales (CRS) is one of the most popular tools for assessing ADHD and other disruptive disorders in children and adolescents. The 1997 revised edition, the CRS-R, is linked to the *DSM-IV* and allows for multimodal evaluation of problem behaviors. There are long and short versions of each type of scale (parent, teacher, and self-report) that use a 4-point scale: *not at all* to *very much*. The short scales take 5 to 10 minutes to administer and the long scales take 15 to 20 minutes. Both the parent and teacher rating scales are used to characterize the behaviors of children and adolescents ages 3 to 17, while the self-report scales can be completed by 12- to 17-year-olds. The Conners manuals provide evidence of adequate psychometric properties of these measures.

The 10 scales scored on the long parent and teacher forms are Oppositional, Cognitive Problems/Inattention, Hyperactivity, Anxious-Shy, Perfectionism, Social Problems, Psychosomatic, *DSM-IV* Symptom Subscales, Global Index (formerly the Hyperactivity Index), and AD/HD Index. The short forms offer scores on four scales: Oppositional, Cognitive Problems/Inattention, Hyperactivity, and AD/HD Index.

The Adolescent Self Report long form has 87 items and 8 scales: Family, Emotional, Conduct, Cognitive, Anger Control Problems, Hyperactivity, AD/HD Index, and *DSM-IV* Symptoms Subscales, while the short self-report form has four scales: Conduct Problems, Cognitive Problems, Hyperactivity/Impulsive, and AD/HD Index.

The Conners Adult AD/HD Rating Scales (CAARS) is used to assess AD/HD in adults. It can be used with individuals 18 years and older and includes both observer and self-report forms. The CAARS quantitatively measures AD/HD symptoms across clinically significant domains while examining the manifestations of AD/HD in adults based on scientific literature and the authors' clinical experience.

The self-report (CAARS-S) and observer forms (CAARS-O) address the same behaviors and contain identical scales, subscales, and indexes. *T* scores are produced for each scale, subscale, and index. Separate norms are available by gender and age-group intervals (18–29, 30–39, 40–49, and 50+ years).

Like the CRS, the CAARS has both long and short versions. The long versions comprise 66 items that assess a broad range of problem behaviors. They include a variety of factor-derived and *DSM*-derived subscales as well as three *DSM-IV* symptom measures (Inattentive, Hyperactive-Impulsive, and Total ADHD Symptoms), a 12-item AD/HD Index, and an Inconsistency Index for identifying random or careless responding. The short self-report (CAARS-S: S) and observer (CAARS-O: S) forms contain 26 items that are abbreviated versions of the factor-derived subscales that appear in the long versions. The AD/HD Index and the Inconsistency Index are also incorporated.

### BRP-2, BBRS, and SEDS-2

Although the BRP-2, the BBRS, and the SEDS-2 still rank among the most frequently used behavior rating scales, they are being used with much less regularity than in the past. These scales are all multidimensional scales designed to be used with children. The BRP-2 has parent, teacher, and self-report forms; the BBRS has a single form that can be administered to parents and teachers, and the SEDS uses a teacher form only.

Although each of these scales can provide some helpful information, they all have limitations that the Achenbach, BASC-2, and Conners scales do not. For example, the BBRS has fairly weak psychometric properties, and the authors used a rather narrow standardization sample when norming the instrument. The BRP-2's item content is limited, and the items lack behavioral specificity. Finally, the *T* scores on the SEDS-2 cannot be compared across scales, limiting the scale's usefulness.



## Measures for Assessment of ADHD

The most widely used measures of symptoms of AD/HD—the ADDES, ACTeRS and ADHD Rating Scale-IV—all use parent and teacher forms. The respondents rate the child client on characteristics typically associated with attention deficit disorders: inattention, impulsivity, and hyperactivity. All of these scales are generally easy to administer and score and provide helpful information that can contribute to the diagnostic process. However, considering the complexity of AD/HD, as well as the literature on comorbidity, it is wise to consider using a multidimensional instrument such as the CBCL or the BASC, either of which is more likely to detect evidence of commonly comorbid conditions such as a learning disability, oppositional defiant disorder, conduct disorder, obsessive-compulsive disorder, or depression.

## BRIEF

Unlike other behavior rating scales, the BRIEF is designed specifically to assess impairment of executive function. According to the user manual, executive functions are those processes responsible for purposeful, goal-directed, and problem-solving behavior. The BRIEF uses parent and teacher forms that can be used with children ages 5 to 18. Both forms have 86 items and take 10 to 15 minutes to administer. Scoring by hand takes 15 to 20 minutes, and computer scoring software is available.

The BRIEF comprises two validity scales (Negativity and Inconsistency of Responses) and eight nonoverlapping theoretically and empirically derived clinical scales that measure various aspects of executive functioning. The clinical scales include Inhibit (control impulses, stop behavior), Shift (move freely from one activity or situation to another; problem-solve flexibly), Emotional Control (modulate emotional responses appropriately), Initiate (begin activity, generate ideas), Working Memory (hold information in mind to complete a task), Plan/Organize (anticipate future events, set goals, develop steps), and Monitor (check work, assess own performance). These scales form two broader indexes, Behavioral Regulation and Metacognition, as well as a Global Executive Composite score.

The family of BRIEF rating scales includes a preschool version for ages 3 to 5 years (BRIEF-P), a self-report form for adolescents ages 13 to 18 years (BRIEF-SR), and adult observer and self-report forms

for individuals 18 to 90 years of age (BRIEF-A). Each of these scales parallels the original BRIEF in terms of format and conceptual framework. The BRIEF is useful in evaluating individuals with a wide spectrum of developmental and acquired neurological conditions and psychiatric disorders such as learning disabilities, AD/HD, Tourette's disorder, traumatic brain injury, pervasive developmental disorders or autism, lead exposure, multiple sclerosis, dementias, and schizophrenia.

*Franci Crepeau-Hobson*

**See also** Behavioral Observation Methods, Assessment (v1); Behavior Assessment System for Children, Second Edition (v1); Conners' Rating Scales—Revised (v1); Qualitative Methodologies (v1); Quantitative Methodologies (v1)

## Future Readings

- Achenbach, T. (2005). *Mental health practitioner's guide to the ASEBA*. Burlington, VT: Author.
- Angello, L., Volpe, R., & DiPerna, J. (2003). Assessment of attention-deficit/hyperactivity disorder: An evaluation of six published rating scales. *School Psychology Review*, 32(2), 241–262.
- Buros Institute of Mental Measurements. (2006). *The Mental Measurements Yearbook*. Retrieved from <http://www.unl.edu/buros>
- Conners, C. K. (1997). *Conners' Rating Scales: Revised user's manual*. North Tonawanda, NY: Multi-Health Systems.
- Conners, C. K., Erhardt, D., & Epstein, J. (1999). Self-ratings of ADHD symptoms in adults: I. Factor structure and normative data. *Journal of Attention Disorders*, 3(3), 141–151.
- Hosp, J., Howell, K., & Hosp, M. (2003). Characteristics of behavior rating scales. *Journal of Positive Behavioral Interventions*, 5(4), 201–208.
- Jarratt, K., Riccio, C., & Siekierski, B. (2005). Assessment of Attention Deficit Hyperactivity Disorder (ADHD) Using the BASC and BRIEF. *Applied Neuropsychology*, 12(2), 83–93.
- Krol, N., De Bruyn, E., & Coolen, J. (2006). From CBCL to DSM: A comparison of two methods to screen for DSM-IV diagnoses using CBCL data. *Journal of Clinical Child and Adolescent Psychology*, 35(1), 127–135.
- Reynolds, C., & Kamphaus, R. (2002). *Behavior Assessment System for Children, 2nd edition manual*. Circle Pines, MN: American Guidance Services.
- Shapiro, E., & Heick, P. (2004). School psychologist assessment practices in the evaluation of students referred for social/behavioral/emotional problems. *Psychology in the Schools*, 41(5), 551–561.



## BEREAVEMENT

Bereavement refers to the experience of loss of a person through death. Grief is the most typical response of survivors to bereavement, while mourning is the expression by the bereaved of thoughts and feelings in culturally patterned ways. In our society, typical responses include confusion, despair, forgetfulness, sleep disturbances, extended periods of crying, and a variety of physical symptoms.

### The Contexts of Bereavement, Grief, and Mourning

The range and intensity of grief reactions vary as a function of the family position and life stages of the people involved, the nature of their relationships, and the manner in which the death occurred. (See *Death and Dying* for a discussion of the latter.)

#### *Loss of a Child*

When a child dies, parents generally are stunned by the violation of their presumption that children don't die, that they should bury their parents. Lost as well are parental hopes and dreams for the dead child along with belief systems about what was assumed to be a more orderly and just universe. Parents tend to have a strong need to tell their story and often search for reassurance that the child who died is all right.

The impact of miscarriage or early neonatal death often is unrecognized, and the parents' grief is minimized or overlooked. Parents who have lost a child under such circumstances also may fear becoming pregnant again or feel guilty about being happy if and when they do.

Parents' ability to care for surviving children is likely to be compromised. They may become either overprotective or withdraw in the face of their own confusion as they seek to make sense out of what has occurred. Additionally, the relationship between grieving parents may experience challenges. Parental conflict may occur given different mourning styles, an inability to meet each other's needs, miscommunication, differences in readiness to return to sexual intimacy or social activities, and disagreement about religious beliefs. Parents also may differ regarding the handling of the dead child's clothing, room, and possessions.

#### *Loss of a Sibling*

Loss of both an important relationship and of appropriate parental support may occur with sibling loss. Children's sense of security may be threatened as parents behave differently, are inconsistent, appear vulnerable, refuse to reminisce about the dead sibling, and are unable to support their grieving processes. Insensitive behavior on the part of others may include failure to understand sibling grief and inquiries about their parents without first or ever asking how they are doing.

Sibling loss may increase children's perceptions of vulnerability to death and may be a confusing and lonely experience. Younger children may feel the burden of being a "replacement" for the dead child, and older children may experience survivor guilt. Adolescents must face death in addition to such developmental tasks as contemplating the meaning of life. Reactions include excessive guilt, distorted concepts of death, death phobia, religious confusion, and disruptions in behavior and cognitive functioning.

Sibling loss in adulthood may heighten awareness of one's own mortality. Loneliness and emptiness accompany the loss of an expected lifelong companion, or source of current and future support. Reactions due to a residue of pain from other losses likely to occur late in life are likely to resurface for older adults.

#### *Loss of a Parent*

The impact of parental death on children tends to have the greatest variation. It is an unthinkable and life-changing loss for young children; for older adults it is highly predictable and often assumed to be less disturbing. The level of cognitive and emotional maturation affects survivors' ability to understand the meaning of a parent's death.

Very young children may grieve, may continually request that the lost parent return, and may reject anyone who attempts to act as a substitute. Children between the ages of 2 and 5 may be helped to understand the meaning of death, can be dealt with in an honest, direct manner, and may regress in their behavior (e.g., bedwetting). Between ages 5 and 8, children may experience guilt about their parent's death or may deny that it is permanent. Between ages 8 and 12, children's reactions tend to mimic those of adults, including increased fears about both their own mortality and that of their surviving parent. For many



adults, the loss of a parent may be followed by an extended, often unanticipated, period of anguish and bereavement.

Daughters may feel more depressed than sons as they tend to remain more closely tied to their parents, even as adults. For adult daughters, mother loss may mean the loss of a friend and companion. For adult sons, grief at the death of a mother may be intense because, of the two parents, she was the one with whom they were able to be more open and expressive. Father loss is significant for both men and women, who tend to measure their sense of personal success against the standard set by their fathers, turn to them for advice and guidance regarding finances and careers, and seek their sanction for life choices.

### **Loss of a Spouse**

Spousal loss may shatter the survivor's sense of security. For both widows and widowers, the most severe reactions tend to occur when the death was unanticipated. Women often report that they feel abandoned, while husbands tend to describe a sense of dismemberment. Women generally cry more freely than men, who are more likely to behave according to societal constraints against emotional expression. Both men and women may feel angry, with women tending to describe a sense of injustice and men tending to experience guilt.

The death of a spouse for both young and middle-age couples is an occurrence out of time. Surviving spouses suddenly may find themselves single parents of school age or teenage children. Having launched children, they may have anticipated greater freedom and more opportunities to spend time together. While more expected, spousal loss late in life ends a relationship of great length and may be painful for different reasons. The challenges of loneliness and of making it alone are very real as remarriage becomes less likely the older the surviving spouse is; this is even more typical for women than for men.

Partnerships created in committed relationships often are comparable to marriages in terms of depth of emotion and shared hopes, expectations, and dreams. However, there generally are few legal and societal supports for surviving partners. *Lack of permission* to express grief appropriately or participate in funeral and burial arrangements and ceremonies is likely. In the case of an AIDS-related death, stigma may further complicate grief reactions.

### **Loss of an Extended Family Member or a Friend**

The role played by the person who died and the degree of emotional dependence between that person and the survivors affect the impact of losing a friend or extended family member. If similar the two are in age, the death may represent a reminder of one's own mortality. Grief may be unrecognized or unsupported, because others tend to judge significance based on the degree of kin-relationship. Absence from work to attend funerals may not be permissible, the deceased's close family members may not acknowledge or even be aware of the person's depth of grief, and external expressions of grief may be curtailed for fear of intruding on the immediate family. Loss of a coworker may be confusing, with colleagues unsure of how to behave with each other, unable to attend funerals or other rituals, wary of speaking about the dead person, and unsupported relative to their grief. The parents of children who lose a classmate may not understand the impact of this loss or take appropriate steps to deal with its ramifications. When a pet dies, others are unlikely to understand the depth of grief that may be felt.

## **Understanding Bereavement, Grief, and Mourning**

The responses of professionals to bereaved clients generally have been guided by two different models, with the degree of intensity and length of time in which reactions are considered appropriate much debated.

### **Classical Models of Grieving**

Based on the psychoanalytic perspectives of Sigmund Freud and Erich Lindemann and the attachment theory of John Bowlby, classical approaches describe grieving as a time-limited process characterized by 2 weeks of shock and intense grief, 2 months of strong grieving, and 2 years during which the grief decreases and bereaved individuals recover and return to full, normal functioning. The ultimate goal is detaching from emotional ties to the deceased and regaining the ability to form new relationships with the living. Grief is considered maladaptive when not resolved within the designated appropriate amount of time. The basic assumptions underlying this approach are that bereaved people go through predictable stages of grief, depression following loss is inevitable,



people who do not experience severe distress over the loss eventually will show some sign of psychopathology, and working through the loss is essential to recovery.

### ***Revised Model of Grieving***

Research conducted in the 1980s led to recognition of the importance of understanding grief in context and considering the bereaved person's belief systems and coping skills. Newer conclusions include that the grieving process may have no fixed endpoint and may last a lifetime; complete detachment from the deceased is neither desirable nor possible; bereaved persons may remain involved and connected to the deceased, often constructing inner representations of them; bereavement may take many forms; and the degree to which grief is adaptive or maladaptive must be determined on an individual basis. Coming to terms with the loss may be particularly difficult when the circumstances of the death represent a threat to one's worldview or when little social support is forthcoming. Those whose coping styles involve either avoidance or excessive rumination may have more difficulty dealing with bereavement. People who tend to be dependent or pessimistic, who lack self-control, or who are emotionally less stable also are likely to experience greater difficulty making the adjustments required.

### **Counseling the Bereaved**

Professionals are advised to just be "with" the bereaved, to allow them to cry, to rage, to despair, to express all of their feelings. Understanding anger as an essential component of grief is essential, as is sensitivity to irrationality in thoughts, feelings, and behaviors, with both acceptance and a focus on transforming guilt becoming important. Survivors may benefit from engaging in a process of forgiveness. Working to achieve justice for an act of wrongdoing may provide a useful outlet for frustration and impotence felt following a violent death. Helping survivors replace painful images with those more consistent with how the person looked when alive may be helpful. Giving time and attention to perceived loose ends may facilitate a sense of completion.

Funerals acknowledge survivors' loss and pain, allow for open expressions of grief, and offer opportunities for public recognition of the death and affirmation of the life of the person who died. They also

provide a setting in which to consider and speak about the meaning of both death and life while serving the public purpose of disposing appropriately of the body. In some religious traditions, funerals support the transition for the deceased while providing comfort for the bereaved. They also create a context that facilitates connection with a community of support.

Survivors may need help deciding what type of arrangements they desire and how they would like things to be handled. They also may need support as they meet with funeral directors and clergy persons. Helpers may provide information about options for caring for the body and preparing for burial or cremation. They may listen sensitively, explore possibilities, encourage survivors to trust their intuition about what seems right, and make suggestions and offer ideas based on experiences with others.

Ceremonies may be small or large, public or private, and may be planned to achieve many goals. They may fill a void, providing closure if no service was held at the time of the death, or they may supplement, satisfying a perceived need for something additional. Professionals may assist survivors in considering their goals and maintaining an emphasis on the strengths of everyone involved. They may suggest the inclusion or exclusion of others as appropriate. They also may emphasize the importance of affirmation for the survivors as well as for the deceased, remembering that their primary role is that of consultant rather than creator.

Daily life involves a series of rituals, including the ways we get up in the morning, fix and eat meals, prepare for bed, etc. All rituals and regular routines are likely to be disturbed by the death of a loved one, thereby increasing the sense of dislocation experienced by the bereaved. Recognition of their importance and a focus on adaptation of rituals may be important. Meaningful healing rituals also may be encouraged, including maintaining or transforming rooms; journaling; meditating or praying; designating time to grieve; wearing an article of clothing or jewelry that belonged to the person who died; dealing with holidays, birthdays, and anniversaries; lighting candles; creating scrapbooks, albums, or videotapes; writing letters; and volunteering or supporting a cause.

Making sense of loss is the last and most difficult step in the search for resolution. Assisting the bereaved in this regard may include assessing the role of religion or spirituality as resource or disappointment, listening carefully and offering questions or



reflections that test the logic of various lines of reasoning, recommending books, validating nontraditional explorations, suggesting explorations of death in other cultures, and confirming the possibility of reclaiming joy. Rather than getting over the loss, resolving grief may be understood as a process of acknowledgment, of learning to accept and to live with grief while at the same time being successful in reclaiming joy as an equally valid part of life.

Dorothy S. Becvar

*See also* Coping (v2); Crisis Counseling (v2); Death and Dying; Disasters, Impact on Children

### Further Readings

- Becvar, D. S. (2001). *In the presence of grief: Helping family members successfully resolve death, dying, bereavement and related end of life issues*. New York: Guilford Press.
- Boss, P. (1999). *Ambiguous loss: Learning to live with unresolved grief*. Cambridge, MA: Harvard University Press.
- Kastenbaum, R. J. (1986). *Death, society, and human experience* (3rd ed.). Columbus, OH: Charles E. Merrill.
- Kennedy, A. (1991). *Losing a parent: Passage to a new way of living*. New York: HarperCollins.
- Klass, D. (1988). *Parental grief: Solace and resolution*. New York: Springer.
- Nolen-Hoeksema, S., & Larson, J. (1999). *Coping with loss*. Mahwah, NJ: Lawrence Erlbaum.
- Rando, T. (1991). *How to go on living when someone you love dies*. New York: Bantam Books.
- Rosen, H. (1986). *Unspoken grief: Coping with childhood sibling loss*. Lexington, MA: Lexington Books.
- Smith, H. I. (1996). *Grieving the death of a friend*. Minneapolis, MN: Augsburg Fortress.
- Zonnebelt-Smeenge, S. J., & De Vries, R. C. (1998). *Getting to the other side of grief: Overcoming the loss of a spouse*. Grand Rapids, MI: Baker Books.

---

## BINGHAM, ROSIE PHILLIPS (1949– )

---

Rosie Phillips Bingham has always been determined as well as a person of vision. It appears that these are values she learned from her parents growing up in poverty on a plantation in Mississippi with 11 siblings. During her childhood, she and one of her brothers contracted typhoid fever and spent nearly a month

in the hospital, where her mother stayed with them day and night despite having no accommodations (e.g., bed, chair, cot). Determination propelled her mother to sleep standing up or sitting on one of her children's beds, and undoubtedly Bingham carries the memory of this determination and tenacity with her.

At the age of 4, Bingham and her family moved from Mississippi to Memphis, Tennessee, where her father became a sanitation worker. He was involved in the 1968 sanitation strike that promoted equal wages and benefits for African American sanitation workers and sparked the attention of Dr. Martin Luther King, Jr., who visited the city to support these workers and was later assassinated there. Bingham must have also been influenced by her father's determination in seeking racial and economic equality as well as encouraged by her father's optimism that this type of equality was attainable.

Bingham was described as a "smart girl" growing up, and she immensely enjoyed reading books as a child, because books allowed her to escape her poverty. Her vision and imagination allowed her to take herself into another world. Because Bingham's family was poor, it was only through her intelligence and determination that she was able to attend Elmhurst College in Elmhurst, Illinois, and receive a bachelor of science degree in sociology and education. Bingham then went on to receive her master of arts degree in counseling and guidance and her doctorate in counseling psychology from Ohio State University.

In 1972, Bingham began her career as a psychologist and relied on the same determination and vision from her parents and from the civil rights movement in order to accomplish her goals and aspirations. First, Bingham became an assistant professor of psychology at Ohio Dominican College in Columbus, Ohio. She worked there for 6 years, focusing on college students' scholastic efficacy, before moving to the University of Florida in 1978. There, Bingham became a staff psychologist, adjunct professor, and finally associate director of the University of Florida Counseling Center. Her peers considered her determined, hard-working, and someone who could always recognize the big picture while also attending to the details. In addition, Bingham was described as always having a vision of how she and the center would accomplish their established goals and as an individual who would somehow find a way to bring this vision to fruition. While maintaining professional boundaries at the University of Florida, Bingham also established



lifelong friendships because of her good-natured humor and her ability to balance work with play.

In 1985, Bingham moved to the place she considered home and accepted a position as the director for the Center for Student Development/Counseling Center at the University of Memphis. During this same time, she accepted an appointment as adjunct professor in the Department of Counseling, Educational Psychology, and Research at the University of Memphis; this later turned into a full professorship. As the director of the counseling center, she had the vision to establish an internship at the university, and due to her determination and diligence as well as the commitment of others, this internship has been accredited by the Office of Program Consultation and Accreditation (OPCA) of the American Psychological Association since 1988.

During her tenure at the University of Florida and at the University of Memphis, Bingham worked with a variety of students, and she has been amazed by the impact of career counseling on these students' well-being and academic performance. Because of this, she has sustained an interest in vocational counseling and has written many journal articles and book chapters and coedited one book on the subject, particularly as it relates to multicultural career counseling. Also, several of the counseling models she codeveloped with Connie Ward (e.g., Steps to Career Counseling and Multicultural Career Counseling Checklist for Counselors) have become staples for researchers and practitioners alike when addressing career counseling issues with a wide range of individuals.

In 1993, Bingham became assistant vice president for student affairs/student development, because she wanted to continue to make a difference in the lives of University of Memphis students and to facilitate change in her community and beyond. She worked earnestly on improving the retention of undergraduate students, particularly those at risk, meaning they had either low ACT scores or low grade point averages upon entering the university. Student retention was an area that Bingham invested much time and effort in, and she established procedures to learn more about at-risk students and how to maintain their level of engagement. For instance, she developed a retention committee, she sent quarterly retention newsletters to alert faculty and administration about the concern, and she conducted studies to determine the predominant reasons for academic withdrawal and the ways in which the students felt that the administration could support them.

In 2003, after a national search, Bingham was selected as vice president for student affairs at the

University of Memphis. It was once again because of her determination and her penchant for viewing things outside the box that she was able to become the first female vice president in the history of the University of Memphis. This is not to mention that she is also the first African American female vice president in the school's history, which is quite an accomplishment given that years earlier Martin Luther King, Jr., was assassinated in the very same city because of his vision and his beliefs on equality and justice. Her mission as vice president focuses on "Students Learning through Engagement and Involvement." Her staff describes her as disciplined, excellent to work with, fair, inclusive of everyone, and having a great sense of humor.

Bingham is nationally renowned as a contributor to the discipline of psychology in numerous roles as academician, scholar, scientist, licensed practitioner, leader, and policymaker. Her vision allows her to lead effectively, and she has done so on more than one occasion as president of the Association of University and College Counseling Center Directors, president of the International Association of Counseling Services, and president of the American Psychology Association's (APA's) Society of Counseling Psychology (Division 17). As an active leader in APA, she has also chaired the Board for Professional Affairs and participated on the Ethics Committee, the task force for APA's annual convention, and the transition team for a past APA president. She is also a Council of Representatives member for Division 17, has served in various caucus capacities (e.g., Utilization of New Talent, Women's Caucus), and has been involved in bringing issues, particularly of science, into APA governance. One peer has described her as a "wonderful woman who says what she believes and has an uncanny knack for saying the difficult things that must be said but making them palatable for others to digest."

With some of the leading psychologists in the nation, Bingham cofounded and organized, in 1999, the first National Multicultural Conference and Summit, which focused on ground-breaking multicultural psychology, science, research, and practice. Because of its success, she and the other cofounders were asked to coordinate follow-up summits in 2001 and 2007. Bingham has also served on the editorial boards of *The Counseling Psychologist*, *Journal of Counseling Psychology*, *Journal of College Student Development*, and *Journal of Counseling and Development*, *In Session* for the *Journal of Clinical Psychology*, and the *Journal of Career Assessment*.



Bingham has given numerous presentations at national conventions and conferences and has been recognized in several ways as a woman with determination and vision. For instance, she was acknowledged as Woman of the Year by the Section for the Advancement of Women of the Society of Counseling Psychology and has been selected as 1 of 15 women from around the world to participate in the Women of Color Development Incubator Project funded by the Kellogg Foundation. In June 2004, Bingham also became chair of the board of the Women's Foundation for a Greater Memphis, a philanthropic organization that focuses on women's economic independence.

Rosie Phillips Bingham's life and work continue to be inspired by determination and vision. She will assuredly continue to answer the call, which she labels in her life as her response to a higher power compelling her to care and to do.

*Melissa McGhee Butler*

*See also* Career Counseling, African Americans (v4);  
Multicultural Career Assessment Models (v4);  
Multicultural Career Counseling Checklist (v4)

### Further Readings

- American Psychological Association. (2006). APA Presidential Election: Dr. Rosie Phillips Bingham. *Monitor on Psychology*, 37(5), 81–84.
- Bingham, R. P. (2005, August). The balancing act: The role of determination and guilt. Presentation at the annual convention of the American Psychological Association, Washington, DC.
- University of Memphis. (2006). *Rosie Phillips Bingham* [biography]. Retrieved from <http://saweb.memphis.edu/vpoffice/binghambio.htm>
- Ward, C. M., & Bingham, R. P. (1993). Career assessment of ethnic minority women. *Journal of Career Assessment*, 1, 246–257.
- Ward, C. M., & Bingham, R. P. (1997). Theory into assessment: A model for women of color. *Journal of Career Assessment*, 5, 403–418.

linked to bullying. Bullying has been defined in many ways, and there is some disagreement about what behaviors constitute bullying. The most widely used definition, provided by Olweus, a leading researcher, states that people are bullied when they are repeatedly exposed to negative actions from others. Olweus proposed three key components of bullying: intent to harm another person, behavior repeated over time, and imbalance in power between the bully and victim. This definition includes behaviors as diverse as physical abuse, threats of harm, teasing, social exclusion, spreading rumors, damage of property, and theft. Some believe that an imbalance of power need not be present. However, others suggest physical, psychological, or social power differences must exist to constitute bullying. Other definitions state that bullying may be conducted for the purpose of displaying dominance.

Historically, most attention has been focused on direct forms of bullying, including overt physical and verbal aggression. Direct physical bullying includes behaviors like hitting, kicking, and pushing and sexual aggression such as touching, pinching, and groping. Direct verbal bullying includes behaviors such as name calling, teasing, and threats of harm. Additional forms of bullying have been identified, including the use of intimidation; bullying based on one's race, ethnicity, culture, appearance, or ability; and sexual harassment or using sexual references to make someone uncomfortable. Often, children are both victims and perpetrators of bullying.

Recently, much attention has been given to indirect forms of bullying, which are sometimes referred to as social or relational bullying. This type of bullying is more covert in nature and often has the goal of damaging the victim's social relationships or reputation. Relational bullying includes behaviors such as spreading rumors, social exclusion, friendship manipulation, and gossiping.

### Gender Differences

Differences have been found between the ways boys and girls use and respond to bullying. Traditionally, bullying was thought to be more of a male phenomenon and that bullying was more prevalent among males. This bullying was direct in nature; it included physical assault or threat of assault. More recently, researchers have found girls to be equally involved in bullying, but they have the tendency to use more indirect means of aggression such as relational bullying. This has led to the terms *boy bullying* (referring to

---

## BULLYING

---

Bullying is a problem that threatens the well-being of children and adolescents across the world; estimates are that up to 50% of children are perpetrators or victims. Numerous school shootings recently have been



direct aggression) and *girl bullying* (indirect aggression). However, it appears that the distinction between gendered forms of bullying is more complex than previously thought. While research supports the concept that boys are involved in more direct forms of bullying than girls, recent research has found that boys and girls show equal involvement in indirect bullying, but they respond to it differently. More specifically, some researchers believe that indirect forms of bullying appear more harmful to girls than to boys.

### **Prevalence**

There appears to be a high prevalence of bullying worldwide, with general prevalence rates ranging from 11% to 50% of school children. Bullying has been assessed in numerous countries in North America, Europe, and Asia. Most countries report prevalence estimates of 10% to 20% of students being involved with bullying. The prevalence of bullying in the United States is one of the highest in the world; most estimates are that between 20% and 30% of all U.S. school children are involved. However, these rates are likely underestimates of the actual prevalence of bullying due to underreporting by students, exclusion of relational bullying, and unawareness of the extent of bullying in schools by teachers and parents. There may be prevalence differences between urban and rural areas. Recent research on bullying in small or rural schools reported much higher rates of bullying, with upwards of 80% of students reporting involvement in bullying. Bullying has been shown to begin as early as the toddler years, and it increases through middle school. Bullying behavior tends to peak during junior high and then slowly decline throughout high school.

### **Outcomes**

Bullying has been associated with a number of adverse outcomes for both the bully and the victim. More specifically, bullying has been shown to affect psychosocial well-being, academic achievement, and physical health. Some long-term outcomes have also been associated with bullying.

#### ***Victims***

Victims experience problems with depression, anxiety, low self-esteem, aggression, relationship problems, social isolation, loneliness, substance abuse, psychosomatic

symptoms, and even suicide. In terms of academics, victims of bullying exhibit school refusal behavior (contributing to frequent school absences), dislike of school, reduced participation in school activities, and lower academic achievement than nonbullied peers. Children who are frequent victims of bullying may also report more headaches, stomachaches, and other somatic complaints, which could lead to greater health-care utilization and costs. Long-term outcomes of being victimized include continued depression and anxiety as well as relationship problems.

#### ***Bullies***

Bullies exhibit many externalizing problems, including aggression, antisocial behavior, conduct problems, delinquency, substance use, and early sexual experiences. They have also been shown to experience internalizing problems, such as anxiety and depression. Some bullies experience victimization, negative reputations, and difficulties with peer relationships. Academic outcomes associated with bullies include truancy, low academic achievement, and dropping out of school. Long-term consequences of bullying may include sustained antisocial behavior, abuse, domestic violence, substance abuse, and trouble with authorities.

### **Treatment and Prevention Programs**

Numerous prevention and treatment programs have been developed to address school bullying. Overall, research has shown modest but consistently positive effects of such programs.

#### ***The Olweus Bully Program***

The Olweus Bully Program is a comprehensive, schoolwide program designed to reduce and prevent bullying problems among school children. A secondary aim of this program is to improve peer relations at school. This program can be used with children in elementary school, middle school, or junior high school. The Olweus program has been shown to be effective in reducing bullying, improving the social climate within schools, and reducing antisocial behaviors. This program has been successfully implemented in several countries around the world.

The Olweus Bully Program seeks to reduce bullying through restructuring the school environment and



intervening at three levels: the school, the classroom, and the individual. This program strives to make the school a safe learning environment for all students and to reduce the negative effects associated with being a victim and a bully. Some of the key aspects of the program include identifying bullies and victims through administration of the Olweus Bully/Victim Questionnaire, formation of a bullying prevention coordinating committee, staff training, development of schoolwide rules against bullying, supervision during break periods, regular classroom meetings about bullying and peer relations, class parent meetings, and individual work with those identified as bullies or victims and their parents. Educators are trained to work with individuals to reduce certain behaviors known to be risk factors for bullying. These risk factors include impulsivity, dominant personality, lack of empathy, difficulty following rules, low frustration tolerance, positive attitudes toward violence, and decreased interest in school. The Olweus Bully Program also seeks to intervene with students who have known risk factors, such as having friends with positive attitudes toward violence, lack of parental warmth and involvement, overly permissive parenting, harsh discipline, lack of parental supervision, and school attitudes that are indifferent to or accepting of bullying behavior. Outcome studies on this program have shown it to reduce bullying behaviors by 33% to 64%.

### ***The Steps to Respect Program***

The Steps to Respect Program is a bullying prevention program for elementary students that seeks to create a safe and respectful school climate through bullying prevention. Educators, students, and families are encouraged to reduce the problem of bullying at the schoolwide level. The main objectives of this program are to increase prosocial beliefs and behaviors, to increase personal responsibility for bullying (including the responsibility of bystanders to intervene), to understand that aggression is an unacceptable route to power, and to increase access to peers and adults for functional and emotional support.

There are three phases to this program. The first phase involves getting the school to commit to the program through developing a bullying prevention

steering team to create bullying policies and consequences for bullying behavior. The second phase involves training the staff to recognize bullying and effectively deal with its occurrence. Families are also educated about the program at this time. The third phase involves implementing the program by having educators deliver skill lessons to children, helping children learn and practice bullying prevention skills, and teaching prosocial skills. Throughout this instruction, children should learn how to recognize, refuse, and report bullying.

*Alissa F. Doobay and Daniel L. Clay*

**See also** Child Maltreatment (v1); Conduct Disorder (v1); Externalizing Problems of Childhood (v1); Mental Health Issues in the Schools (v1); School Counseling (v1); School Psychology (v1); School Refusal Behavior (v1)

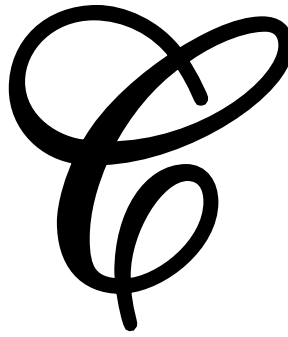
### **Further Readings**

- American Psychological Association. (2006). *Bullying*. Retrieved from <http://www.apa.org/ppo/issues/bullying.html>
- Committee for Children. (2006). *The Steps to Respect Program*. Retrieved from <http://www.cfchildren.org/cfc/str/str/strindex/>
- Institute on Family & Neighborhood Life. (2003). *Olweus Bullying Prevention Program*. Retrieved from <http://www.clemson.edu/olweus/>
- Olweus, D. (1978). *Aggression in the schools: Bullies and whipping boys*. Washington, DC: Hemisphere Press.
- Olweus, D. (1991). Bully/victim problems among school children: Basic facts and effects of a school based intervention program. In D. Pepler & K. Rubin (Eds.), *The development and treatment of childhood aggression* (pp. 411–448). Hillsdale, NJ: Lawrence Erlbaum.
- Olweus, D. (1993). *Bullying at school: What we know and what we can do*. Oxford, UK: Blackwell.
- Olweus, D., & Limber, S. (1999). *Blueprints for violence prevention: Bullying prevention program*. Boulder: Institute of Behavioral Science, University of Colorado, Boulder.
- Prinstein, M. J., Boergers, J., & Vernberg, E. M. (2001). Overt and relational aggression in adolescents: Social-psychological adjustment of aggressors and victims. *Journal of Clinical Child Psychology*, 30, 479–491.









---

## CANCER MANAGEMENT

---

Managing one's experience with cancer requires coping with diagnostic procedures, treatment protocols, uncertainty in prognosis and recurrence, and often a reduced capacity to engage in normal, daily activities. These external and internal demands may seem overwhelming at times and challenge an individual's ability to cope. The term *coping* has been defined by Richard Lazarus and Susan Folkman as a person's changing cognitive and behavioral efforts to manage psychological stress resulting from a situation or event appraised as harmful in some way. This widely accepted definition emphasizes a fluid process in which coping responses change depending on one's subjective evaluation or appraisal of his or her circumstances. Individuals diagnosed with cancer commonly appraise their situation as threatening, harmful, or personally challenging, and they often experience a sense of loss and control. They and their families face practical concerns in terms of paying for medical care, time lost from work or school, and a limited ability to fulfill normal role expectations. Therefore, the goals of adaptive coping with a cancer diagnosis and treatment are most appropriately defined by the quality of life one is able to maintain on a daily basis rather than by the ultimate resolution of the cancer experience.

### Common Coping Strategies

Coping strategies are commonly categorized as either approach versus avoidance strategies or problem-focused versus emotion-focused strategies. The coping

literature indicates that in the context of an uncontrollable situation such as cancer, approach-oriented strategies such as cognitive restructuring, seeking social support, and information seeking tend to be more adaptive ways of managing one's disease than avoidant strategies like denial and disengagement. That said, because of each person's unique personal and situational attributes and the multidimensional nature of the cancer experience, researchers also conclude that there is no one right way to cope. Two seemingly similar coping responses may produce very different results or a strategy that is helpful in one context may not be helpful in another.

For example, two common, approach-oriented, emotion-focused strategies are *positive reinterpretation and growth* and *focusing on and venting of emotions*. Both involve the acknowledgment, processing, and expression of emotions. Positive reinterpretation and growth is related to adaptive outcomes and involves cognitively reprocessing distressing emotions resulting from a stressful event into a new framework that incorporates positive aspects as well; it is an individual's deliberate effort to take knowledge gained from a negative experience and use it to move forward in a positive direction. Focusing on and venting of emotions is a process of attending to and expressing typically distressing feelings. Research indicates that engaging in emotional expression may only contribute to positive adaptation when one is able to express him- or herself in the context of a receptive, supportive network of others who are willing and able to listen. In the absence of a supportive environment, this strategy may lead one to ruminate excessively, thereby compounding the stress already being experienced.



The stress and coping literature suggests that problem-focused coping strategies typically associated with managing external demands may not be effective in reducing the emotional distress generated by uncontrollable factors in situations such as facing cancer. Resolving the ambiguity inherent in living with an uncertain prognosis as well as some limitations resulting from treatment side effects are beyond one's ability to control. Taking action to resolve these types of problems is not possible, and attempting to do so may further emphasize the uncontrollable aspects of the situation and lead to more anxiety and worry. An important distinction here is the recognition that problem-focused coping doesn't necessarily imply taking action directed at the broad scope of the problem itself; it may also involve passive, approach-oriented strategies directed at consequences.

For example, managing the daily uncertainty imposed by a cancer diagnosis and treatment requires willingness to approach external demands, like complying with treatment, with a certain amount of deliberate acceptance aimed at increasing one's ability to tolerate unavoidable physical and psychological distress. Acceptance of one's situation can be the first step in taking a more active role in understanding the nature of the cancer experience. Cancer patients often report an increased sense of control and well-being when they accept responsibility and become stronger advocates for their own medical care via seeking information and instrumental support. Among men with prostate cancer, approach-oriented coping strategies were related to decreased levels of depression and anxiety, better self-esteem, and more positive mood. Conversely, prostate cancer patients who tended to manage distress through avoidance reported both poorer physical and poorer psychological health.

### **Individual Differences in the Coping Process**

While coping is generally thought of as a transactional process between an individual and the environment rather than as a stable, person-centered trait, individual differences such as personality and dispositional characteristics influence the coping strategies one tends to engage in when attempting to regulate physical, emotional, and behavioral distress. In the area of breast cancer, which has been particularly well researched, women in advanced stages of cancer who were more optimistic exhibited an ability to approach

their prognosis with a combination of realism and fighting spirit that was related to significantly lower levels of anxiety and depression than were seen in less optimistic women. Similar findings in other areas of the adult cancer literature indicate that overall, more optimistic cancer patients tend to use more approach-oriented, active, and accepting coping strategies and report less distress during each phase of cancer treatment than patients who are less optimistic.

### **The Role of Social Support**

Social support, broadly defined as having one's need to feel a sense of belonging, care, affection, and esteem met by others such as spouses, parents, friends, coworkers, and classmates, can be a valuable resource for both adult and pediatric cancer patients and their families. While differences among the types of support offered—that is, how it is offered, when, and by whom—relate to one's perception of how helpful it is, social support is generally related to better physical and psychological adjustment.

### **Coping and Positive Emotions**

The literature on adaptation to chronic illnesses, including cancer, has shifted away from measuring coping outcomes solely by an absence of distress toward also determining whether positive mental and emotional states are present. The experience of positive emotions is considered an adaptive response that may help to sustain an individual's inner resources during lengthy periods of stress, to maintain much needed social support networks, and to contribute to more optimal use of adaptive coping strategies. Research indicates that it is not at all uncommon to experience positive moods and emotions, such as benefit-finding, in the midst of simultaneous feelings of psychological distress produced by ongoing stressors. In Shelley Taylor's theory of cognitive adaptation to trauma, benefit-finding is a subjective evaluation that operates as a way to enhance and maintain one's self-esteem in a threatening, aversive situation such as cancer. Cancer patients frequently identify benefits resulting from their cancer experience, such as closer family relationships, deepening of values, and a reordering of life's priorities. Benefit-finding among cancer patients and survivors has been positively linked to better mood, stronger self-efficacy, and better social support. Increased levels of benefit-finding



have been documented in people with more advanced cancers compared to those with earlier-stage diagnoses and may help these patients maintain a balance between the positive, soothing aspects of their lives and the threatening reality of their cancer.

### **Coping With Cancer in Childhood and Adolescence**

Family, caregiver, and environmental factors, as well as a child's age and developmental stage at diagnosis and throughout treatment, play a significant role in shaping an experience very different from that of an adult cancer patient. How pediatric cancer patients and their families cope varies greatly depending on a host of situational factors. Because children may look to their families and other adults around them for cues to help them understand and manage their cancer experience, the responses of parents, caregivers, and others in their immediate environment impact their adjustment. In general, children who perceive less cancer-related stress in their environment exhibit better adjustment than those who experience more stress. Children are better able to adjust when their families are supportive, adapt positively to changing circumstances, and are able to work together. Furthermore, an open style of communication among family members seems to foster a child's ability to communicate more openly about his or her experience and is positively related to more optimal outcomes. When a child is undergoing a diagnostic or treatment procedure, parents or other caregivers are usually present. Adults' responses, including to pain, are significantly related to a child's subjective experience of these events. Children whose parents and caregivers support them with expressions of warmth, concern, and empathy during these procedures perceive significantly less pain and distress and exhibit better adaptive outcomes than children whose fears and concerns are not validated or soothed by their adult caregivers.

### **Developmental Factors**

Because of the normal growth and maturational processes simultaneously occurring in childhood and adolescence, the physical and psychosocial late effects of cancer have the potential to be more detrimental for pediatric cancer patients than for adults. Advances in neuroscience have increased our ability to understand cognitive and affective developmental

trajectories across the life span. Overall, children with higher levels of cognitive abilities typically exhibit better adjustment than children with developmentally less advanced cognitive abilities. Higher-order cognitive processes such as the ability to plan and think abstractly, to regulate emotion, and to coordinate one's cognitions and emotions do not begin to fully develop and mature until adolescence. These maturational growth processes proceed independently and at different rates for each individual.

In terms of coping with a cancer diagnosis, this means that an adolescent cancer patient may have developed the ability to perceive the serious long-term implications of his or her diagnosis but still not have the emotional maturity to cope with the ensuing distress. The interaction of these varying developmental stages has the potential to heighten an adolescent's perception of threat over and above what may be perceived by an adult with a better ability to gauge risk and cope with intense thoughts and emotions. Because cognitive and emotional processes continually factor into their ongoing appraisals of the events composing their cancer experience, their developmental stage significantly influences their coping abilities as well as strategies used. Therefore, children and adolescents face unique challenges coping with the negative emotions produced by their experience with cancer.

### ***Pediatric Physical and Psychosocial Late Effects***

Physical late effects following pediatric cancer treatment may include compromised sensory functioning; neurocognitive impairment; problems with endocrine function; damage to the kidneys, liver, and heart; and infertility. Some physical late effects, such as infertility, vary according to age and gender and may not be fully appreciated until adult roles are being assumed. As pediatric cancer patients mature, deficits in specific areas of functioning can arise, including decreased academic achievement, employment difficulties, fewer social relationships, a poorer sense of self and identity, and symptoms of posttraumatic stress.

Despite well-documented evidence of physical and psychosocial impairments, research shows that most pediatric cancer patients adapt and cope very well, and there is very little evidence of overall maladjustment. Adolescent cancer survivors typically rate



themselves significantly higher than their noncancer peers in terms of physical and emotional functioning, academic functioning, overall quality of life, and frequency of positive mental states, and they rate themselves as having fewer experiences of emotional distress. The contradictions between these objective and subjective indicators of adjustment suggest that coping strategies used by adolescent cancer survivors enable them to effectively suppress distress and view themselves in a positive light.

### Repressive Coping Style

In the larger body of psychological literature, individuals who avoid distress by blocking out or repressing negative stimuli are termed *repressors*. Repressors report a pattern of low levels of anxiety combined with high levels of defensiveness even under difficult circumstances. Adult repressors who have never experienced a cancer diagnosis often exhibit increased levels of stress-related health problems, including high blood pressure, ulcers, migraines, and irritable bowel syndrome. Some children with cancer may adopt a *repressive adaptive coping strategy* whereby they minimize the distressing aspects of their disease.

Research shows that repressive coping among both adult and pediatric cancer patients arises as an adaptive response to a seriously threatening event. It has been related to significantly decreased levels of depression in pediatric patients, especially among adolescents in the active treatment phase. As an adaptive strategy, it is sustained across time as children struggle to cope with and manage levels of distress for which they are developmentally ill prepared. However, extant research on adolescent patients with cancer shows increased rates of repressive coping persisting as long as 12 months after diagnosis compared to just 12 weeks in adults with cancer. Repressive coping strategies that become habitual and long-term in pediatric cancer patients raise additional concerns regarding their future well-being in light of the poor health outcomes seen among adult repressors. When, how, and if repressive coping strategies subside among pediatric cancer patients as the length of their cancer survival time increases are questions that remain unanswered.

*Monica M. Durette and Marilyn Stern*

**See also** Children with Chronic Illness (v1); Chronic Illness (v1); Chronic Pain (v1); Coping (v2); Death and Dying

(v1); Disasters, Impact on Children (v1); Optimism and Pessimism (v2); Physical Health (v2); Positive Psychology (v2); Social Support (v2)

### Further Readings

- Bader, L., Cooper, C. L., & De-Nour, A. K. (Eds.). (1996). *Cancer and the family*. New York: Wiley.
- Canning, E. H., Canning, R. D., & Boyce, W. T. (1992). Depressive symptoms and adaptive style in children with cancer. *Journal of the American Academy of Child & Adolescent Psychiatry*, 31(6), 1120–1124.
- Eiser, C. (2004). *Children with cancer: the quality of life*. London: Lawrence Erlbaum.
- Franks, H. M., & Roesch, S. C. (2006). Appraisals and coping in people living with cancer: A meta-analysis. *Psycho-oncology*, 15(12), 1027–1037.
- Lazarus, R., & Folkman, S. (1984). *Stress, appraisal, and coping*. New York: Springer.
- Northouse, L., Kershaw, T., Mood, D., & Schafenacker, A. (2005). Effects of a family intervention on the quality of life of women with recurrent breast cancer and their family caregivers. *Psycho-oncology*, 14, 478–491.
- Patenaude, A. F., & Kupst, M. J. (2005). Psychosocial functioning in pediatric cancer. *Journal of Pediatric Psychology*, 30(1), 9–27.
- Penner, L. A., Cline, R. W., Jones, E. M., Taub, J. W., Ruckdeschel, J. C., & Albrecht, T. L. (2006). Dispositional and affective correlates of treatment-related pain among pediatric cancer patients. *Annals of Behavioral Medicine*, 31, 7–8.
- Phipps, S., Steele, R. G., Hall, K., & Leigh, L. (2001). Repressive adaptation in children with cancer: A replication and extension. *Health Psychology*, 20(6), 445–451.
- Roesch, S. C., Adams, L., Hines, A., Palmores, A., Vyas, P., Tran, C., et al. (2005). Coping with prostate cancer: A meta-analytic review. *Journal of Behavioral Medicine*, 28(3), 281–293.
- Steinberg, L. (2005). Cognitive and affective development in adolescence. *Trends in cognitive science*, 9(2), 69–74.
- Taylor, S. E. (1983, November). Adjustment to threatening events: A theory of cognitive adaptation. *American Psychologist*, 38, 1161–1173.
- Walco, G. A., Conte, P. M., Labay, L. E., Engel, R., & Zeltzer, L. K. (2005). Procedural distress in children with cancer: Self-report, behavioral observations, and physiological parameters. *Clinical Journal of Pain*, 21(6), 484–490.
- Zachariae, R., Jensen, A. B., Pedersen, C., Jorgensen, M. M., Christensen, S., Lassen, B., et al. (2004). Repressive coping before and after diagnosis of breast cancer. *Psycho-Oncology*, 13, 547–561.



Zaza, C., & Baine, N. (2002). Cancer pain and psychosocial factors: A critical review of the literature. *Journal of Pain & Symptom Management*, 24(5), 526–542.

---

## CAREGIVER BURDEN

---

*Caregiver burden* is a term used to describe the physical, mental, social, and financial impact of caring for someone who is ill or who has functional impairments. Although the term can be applied to all caregivers (paid and unpaid), in most circumstances the term is applied to unpaid caregivers (called *informal caregivers*) who are usually family members of the ill or impaired care receiver.

### Description of the Caregivers and Care Receivers

A large national study of informal (unpaid) caregivers and care receivers in the United States (conducted in 1999) found that two fifths of caregivers fall between the ages of 45 and 64, one fifth are aged 65 to 74, and another one fifth are over the age of 75. Thus, a significant number of caregivers are older adults, themselves at risk for health problems due to advanced age. The same study found that two thirds of all caregivers are female, and most informal caregivers are immediate family members of the person needing care. Around 40% are spouses, another 40% are adult children, and the remaining 20% are categorized as “other” and can include friends, neighbors, siblings, grandchildren, or other relations. Although the number of hours spent providing care can vary from person to person depending on the level of dependency of the care receiver, the National Alliance for Caregiving reports that 17% of caregivers provide care for more than 40 hours per week. Therefore a significant number of caregivers are providing care full time for their relatives. In addition, many are providing care on their own, without the help of secondary caregivers. In 1989, about one third of caregivers reported being the only caregiver for their relative. Over the next ten years, however, this number rose dramatically. In 1999, around half of all caregivers reported providing care on their own, without the assistance of others.

Care receivers can vary significantly in their ages, their level of impairment, and their reasons for needing care. Most research on caregiver burden evaluates

caregivers of people over the age of 65 who are living in the community (not in nursing homes or other care facilities), but of course people can need care at any age. Care receivers typically need assistance from caregivers in instrumental activities of daily living (IADL), which include assistance with activities such as shopping, transportation, and household chores. Sometimes care receivers are impaired even further, needing assistance in personal activities of daily living (PADL), which include needing help with bathing, eating, dressing, or other personal care needs.

Much of the research on caregiver burden studies caregivers of people with dementia, particularly those with Alzheimer’s disease. For these caregivers, in addition to providing assistance with daily needs and activities, the caregiver also must manage the care receiver’s behavioral symptoms, such as wandering, aggression, anxiety, and depression. Research on caregiver burden is not limited to caregivers of people with dementia, however, and significant attention has been paid to caregivers of people with Parkinson’s disease, cancer, mental illness, intellectual disabilities, severe arthritis, or amyotrophic lateral sclerosis (ALS, or Lou Gehrig’s disease) and to caregivers of people who have had a stroke or who have suffered from posttraumatic stress disorder or head injury. Depending on the disease or condition, care receivers may need extended periods of time for their care. Cancer, for example, may require shorter periods of care (months), but even individuals who develop Alzheimer’s disease late in life may require 3 to 15 years of care. Caregiver burden is usually studied within the context of caregivers providing care for long periods of time, such as over months or years. Although caring for a person during an acute illness (perhaps caring for someone for days or a few weeks) may lead to feelings of caregiver burden, caregivers of this sort are usually not the focus of research on caregiver burden.

### Burden as a Predictor or as an Outcome

Caregiver burden is considered to be an outcome of caregiving, in itself, and it is also used to predict other outcomes. For example, as an outcome of caregiving, some studies have shown that increasing levels of necessary assistance (in their daily activities) for care receivers predict higher levels of caregiver burden. Caring for someone with lower cognitive functioning and caring for someone with increased behavioral



problems (for example, wandering and aggression in patients with Alzheimer's disease) has also predicted higher levels of burden. Contextual variables, such as caregivers' gender, age, and employment status, have been tested, and although findings are sometimes mixed for these variables, there is evidence that female caregivers report more burden, older caregivers report more burden, and employed caregivers report more burden.

In addition, in studies where burden is considered an outcome, certain mediator variables have been identified. For example, higher levels of quality social support from family and friends seem to buffer the negative impact of some of the above mentioned predictor variables on caregivers' levels of burden, as does getting a break from their role of caregiving. Using in-home respite services and having the care receiver attend adult day care services, for example, both seem to buffer caregivers' levels of reported burden.

As stated previously, caregiver burden is not always considered to be an outcome to be studied. It is also often used to predict other caregiver outcomes. Higher levels of caregiver burden predict a higher likelihood of placing the care receiver in an adult day care facility, and also predict higher likelihood of placing the care receiver in a residential care facility, such as a nursing home. Higher levels of burden have also been linked to higher levels of physical and mental health outcomes in caregivers; for example, higher burden has been found to predict more depressive symptoms and poorer self-rated health in caregivers.

### Objective Versus Subjective Caregiver Burden

Research on caregiver burden has differentiated between two main types of burden: objective burden and subjective burden. Objective burden refers to the physical, psychological, social, and financial impact on the caregiver caused by tangible caregiver-related disruptions to his or her life. Examples of such disruptions may include the increased amount of time the caregiver takes from his or her own life to care for the care receiver, or it may be the amount of money spent giving care. The accumulation of objective stressors, such as lack of time and lack of money, produces objective burden on a caregiver. Subjective burden, on the other hand, refers to the physical, psychological, social, and financial impact on the caregiver caused by feelings and appraisals of the caregiving role.

Some caregivers may perceive the objective tasks of caregiving as being rewarding, while others may perceive them to be quite stressful and negative. The accumulation of subjective stressors, such as negative feelings toward their role or feelings of guilt about not meeting the needs of their care receiver, produces subjective burden on the caregiver.

Although objective and subjective burdens are related to each other, many studies have found evidence that the hours spent caregiving or progression of memory loss in the care receiver (both measures of objective burden) are not related to how burdened the caregivers perceive themselves to be (subjective burden). For example, two caregivers may both be caring for a person with dementia full time (40 hours a week), and both may be exposed to similar behavioral problems and may need to perform similar kinds of care for their relative, yet one caregiver may perceive himself as very burdened by the caregiving role, while the other perceives little burden. It is thought that there is much variability in how caregivers process the stress faced from their caregiving role, and how they cope with it, which leads to such variability in the outcome of burden.

### How Is Caregiver Burden Measured?

Caregiver burden is most commonly measured by asking caregivers to fill out or respond to a multi-item scale. Several analyses have been performed to assess the number and quality of measures of burden. One such study conducted in 2004 identified 16 different measures of burden. The most widely cited measure is the Zarit Burden Interview (sometimes also called the Burden Scale, the Burden Index, or the Caregiver Burden Index). The scale, developed in 1980, was intended for use with caregivers of persons with dementia, but it has also been used with success in other contexts. Although it originally had 29 items, the 22-item shorter version is more commonly used. This scale lists symptoms or feelings related to caregiver burden, and it asks caregivers to respond with how often they feel that way, using *never* (0), *rarely* (1), *sometimes* (2), *quite frequently* (3), or *nearly always* (4). Sample items include the following: "Do you feel that because of the time you spend with your relative you don't have enough time for yourself?" "Do you feel your social life has suffered because you are caring for your relative?" and "Do you wish you could leave the care of your relative to someone else?" Caregivers' scores are added up for all 22 items, thus



the scale ranges from 0 to 88, with higher scores indicating that the caregiver feels more burden.

The second most commonly cited measure of burden is the Caregiver Strain Index, or CSI. It was first published in 1983, and it was intended for caregivers of patients who were recently hospitalized for hip fracture or heart disease. This scale has also been used with success in other contexts. The CSI is a 13-item scale with questions requiring a *yes* (1), or *no* (0) response. The responses are added for a total range of 0 to 13, with higher scores indicating higher levels of burden. In the CSI, caregivers are given a list of things that they may find difficult, and they are asked if the items apply to their caregiving experience. Sample items include the following: “There have been work adjustments,” “There have been family adjustments,” and “Some behavior is upsetting.” In addition, there has been a modified version of the scale (called the Modified Caregiver Strain Index, or MCSI) which asks similar versions of the same 13 items, but asks caregivers to respond *no* (0), *yes, sometimes* (1), and *yes, on a regular basis* (2), instead of using the original dichotomous response choice (no vs. yes). In the modified version of the scale, the responses are also summed, such that higher scores still indicate higher levels of burden.

Both the Zarit Burden Interview and the Caregiver Strain Index have demonstrated acceptable psychometric properties, with both having satisfactory levels of reliability and validity across multiple studies. Reviews of the other measures of caregiver burden have found that in general, the other scales are also acceptable, and no one scale can be deemed superior over all others. The main disadvantage of having so many measures of caregiver burden is the difficulty of making comparisons across studies that use differing measures of the construct.

### **Is Caregiver Burden a Distinct Concept?**

There is some debate over whether caregiver burden and caregiver well-being are “opposite sides of the same coin,” or whether they should be treated as distinct concepts and measured separately. Those that do not favor separating the constructs suggest that caregiver burden is merely a dimension of well-being, with both constructs measured by assessing physical, mental, social, and financial problems (or lack of problems, as is the case when measuring well-being). These researchers propose that studying well-being in

caregivers instead of studying burden offers researchers the ability to compare caregiver and non-caregiver populations. Many other researchers, however, interpret caregiver burden as a concept that is distinct from caregiver well-being (although they recognize that the two are often related to each other). Researchers from this orientation state that although caregivers high on burden are often low on well-being, there are also caregivers who have high levels of burden, but who also have adequate or high levels of well-being. Thus, it is possible for the two constructs to operate independently.

### **Interventions to Reduce Caregiver Burden**

Reducing the negative effects of stress for caregivers has often been the target of caregiver interventions. The outcome variables of interest in these studies may differ, but the studies usually aim to increase positive affect, quality of life, or health and well-being; or to reduce stress, depression, or caregiver burden. Thus, reducing burden, itself, is not always the main or only goal of caregiver interventions, but burden is often an important component included in evaluations of caregiver programs. Caregivers who are the most at risk for adverse outcomes, and who are thereby most in need of intervention, tend to be older females with little income or education who provide high levels of care, have low levels of social support, and feel they have no choice in taking on their role as a caregiver.

Interventions that aim to reduce burden in caregivers often include one or more of the following components. They may seek to reduce the needs or the behavior problems in the care receiver, or they may introduce respite care for the care receiver, thereby reducing the objective stress on the caregiver. They also may seek to target the caregivers themselves. Some interventions aim to increase caregivers’ knowledge of resources and appropriate care techniques (for example, by providing education about the availability of local services to education on how to bathe an uncooperative care receiver). Other caregiver-targeted interventions aim to provide individual (or group) support or therapy.

While providing caregivers emotional support (listening, giving advice, and reassuring them) in an individual or group counseling session may be helpful, the most beneficial aspects of counseling seem to be when there is a focus on increasing problem-solving strategies and support-seeking behaviors for the caregiver.



In general, individual treatment seems to be more beneficial for caregivers than group sessions; however, group sessions have the advantage of being less expensive (often free) for caregivers. It is important to note that referrals to psychiatrists are recommended for any caregivers displaying evidence of psychopathology, such as significant depressive symptoms.

In general, interventions that include more than one component, for example, targeting the behaviors of the care receiver as well as providing education and support for the caregiver, have more positive results. In addition, it is not surprising that higher-intensity interventions have more of an impact on caregivers than low-intensity programs. Overall, however, findings on the effectiveness of all types of caregiver interventions in reducing caregiver burden have been mixed. Some researchers speculate that this variability in the interventions' effectiveness stems from the fact that caregivers' situations, needs, and appraisals of stress vary significantly themselves. A one-intervention-fits-all approach does not seem promising in reducing caregiver burden. Although they may be more difficult to evaluate, interventions that place an emphasis on the individual needs of the caregivers may have the most effect in ultimately reducing their objective and subjective burden. It is suggested that an evaluation of caregivers' needs should include an assessment of their safety and that of their care receivers as well as an assessment of the care receivers' physical health, depression, and anxiety. Appropriate ways to intervene for the individual can then be dictated by their needs in these areas.

*Elizabeth Fauth*

**See also** Adult Development (v1); Aging (v1); Caregiving (v1); Coping (v2); Counseling the Elderly (v1); Dementia (v2); Depression (v2); Psychological Well-Being, Dimensions of (v2); Quality of Life (v2); Secondary Trauma (v2); Stress (v2); Stress Management (v2); Stress-Related Disorders (v1)

### Further Readings

- Chappell, N. L., & Reid, R. C. (2002). Burden and well-being among caregivers: Examining the distinction. *The Gerontologist*, 42(6), 772–780.
- Dinkin, J. J., & Anderson-Hanley, C. (1998). Dementia caregiver burden: A review of the literature and guidelines for assessment and intervention. *Neurology*, 51(1), S53–S60.
- Schulz, R., Martire, L. M., & Klinger, J. N. (2005). Evidence-based caregiver interventions in geriatric psychiatry. *Psychiatric Clinics of North America*, 28, 1007–1038.
- Stull, D. E., Kosloski, K., & Kercher, K. (1994). Caregiver burden and generic well-being: Opposite sides of the same coin? *The Gerontologist*, 34(1), 88–94.
- Visser-Meily, J. M. A., Post, M. W. M., Riphagen, I. I., & Lindeman, E. (2004). Measures used to assess burden among caregivers of stroke patients: A review. *Clinical Rehabilitation*, 18, 601–623.
- Visser-Meily, A., van Heugten, C., Post, M., Schepers, V., & Lindeman, E. (2004). Intervention studies for caregivers of stroke survivors: A critical review. *Patient Education and Counseling*, 56, 257–267.
- Wolff, J. L., & Kasper, J. D. (2006). Caregivers of frail elders: Updating a national profile. *The Gerontologist*, 46(3), 344–356.

---

## CAREGIVING

---

It has been estimated that nearly 50 million people in the United States are acknowledged caregivers and that as many as one in four individuals will be involved in caregiving duties at some point in their adult lives. Given the often cited “Graying of America” phenomenon, the number of caregivers will likely increase during the coming decades.

Of significance for counseling psychologists is the fact that caregiving has been found to be associated with substantial stress and mental health problems, both of which are significant public health concerns that are amenable to counseling interventions. This entry elucidates the following: (a) a definition of caregiving, (b) its association with mental health problems, (c) strategies for coping, and (d) an approach to caregiving that emphasizes positive functioning and possibilities for skill-based strategies to assist caregivers.

### Defining Caregiving

Informal caregiving in its most elemental form characterizes a family member, loved one, neighbor, or significant other who provides direct assistance to a person (a care recipient) who, due to disability, is unable to be functionally independent without such assistance. Although the preceding definition is broad, a truly generalized characterization of caregiving is



challenging in our multicultural society. This is due primarily to the fact that the manifestations of caregiving differ across cultures and cohort groups. For instance, in some traditional cultures (Asian, Hispanic, New Zealand Maori) it is expected and even common to provide care for family members by taking them into one's home and providing the necessary instrumental and emotional support to help them maintain functional independence. In contemporary American society (particularly among the White affluent majority culture in the United States), it is less expected that a family member will serve as the sole full-time caregiver, perhaps due to current mobility trends and an increased focus on individual goals and attainments. There are also numerous ways with which people from different contexts provide care. For instance, research has demonstrated that African Americans are more likely to provide care to friends and extended family members, in contrast to White Americans who are more likely to care for a member of their immediate family. These findings suggest that like many social phenomena, defining the nature of caregiving depends to a large extent on contextual factors.

There are, however, some common elements of the caregiver experience that can help to portray, in general, the caretaker role. Caregiving is most often an activity that focuses on providing needed support to another individual who is disabled to the extent that he or she is not capable of independent functioning. Caregiving also includes providing a variety of different types of support, but more often than not includes providing direct care in the service of everyday needs that the care recipient is not capable of performing due to a disease process, an injury, or a life-long disability. With regard to the elderly, the most common problems that result in the need for caregiving stem from senile dementia (Alzheimer's disease and vascular dementia), stroke, and disorders such as severe arthritis or osteoporosis that markedly limit functional independence. Among children, pervasive developmental disorders such as autism or Rett's disorder and forms of severe intellectual disability such as Down's syndrome or fetal alcohol syndrome frequently require a family member to engage in caretaking.

### **Coping With Caregiving**

Caregiving for a significantly disabled individual is arguably one of the more difficult activities that a person undertakes during his or her life span, and it has

been shown to have a number of adverse outcomes, including depression, anxiety, and chronic physical health problems. It is likely that the distressing correlates of caregiving, known in the literature as caregiver burden, stem from a number of factors. These might include an often unexpected life change; financial difficulties; a limited amount of time for personal activities such as recreation, exercise, and intimate relationships; and, in some cases, the necessity of ceasing career pursuits due to the competing demands of the caregiver role. In the case of disorders that result in personality change of the care recipient or a progressive loss of cognitive functioning, there is often a corresponding sense of interpersonal loss on the part of the caregiver. Research has identified a number of caregiving variables that are reliably associated with negative outcomes, including problematic behavior of the care recipient and caregiver overload.

Research during the past decade has expanded the knowledge base of caregiver well-being by examining variables that are predictive of mental health outcomes. Most of this research has focused on ways of coping with the stressors of the caregiver role and has identified ways of coping that are reliably associated with negative outcomes. In particular, "emotion-focused" coping strategies, such as escape or avoidance, wishful thinking, and fantasizing have been shown to be associated with high levels of anxiety and depression. These studies have underscored the notion that coping strategies that are based on denial or avoidance tend to result in poor psychological outcomes for caregivers. It's likely that this type of coping inhibits the caregiver from facing stressors, which reduces the chance of working through the difficult issues the caregiving situation creates. Avoidant coping may also result in reduced health functioning for the care recipient, as this form of coping likely renders the caregiver less psychologically available to the care recipient.

Fortunately, current research not only has examined factors associated with negative mental health outcomes among caregivers but also has widened its lens to examine factors related to positive outcomes. This trend has been influenced by dissatisfaction of professionals in the field with the search for cures to negative mental health outcomes. There is also a growing body of literature that indicates that positive mood can serve to protect individuals from the effects of stressful experiences. Not surprisingly, research has indicated that approach-related coping strategies, such as having a problem-solving orientation, using positive appraisal,



and having a high degree of perceived control, are related to enhanced levels of positive mood among caregivers. These results indicate that strategies that enable the caregiver to approach and productively engage in active solution-focused behaviors tend to report better subjective well-being, both during the caregiving experience and after it has ended.

### A Positive Approach to Counseling Caregivers

The future trend in research appears to be moving away from strategies designed to ameliorate negative effects and consequences of caregiving in favor of a viewpoint that focuses on building a positive schema for caregiving. For instance, research with caregivers of dementia patients has indicated that providing care for a loved one can result in a sense of being personally fulfilled and a sense that one is engaged in a meaningful duty. Recent studies have also documented that certain personal characteristics such as an orientation to helping others is related to enhanced well-being among caregivers, even with the influence of other coping strategies controlled.

Robert Hill describes a “positive aging” approach to caregiving that construes the provision of care as a life skill not unlike those associated with parenting very young children. Specifically, these skills include (1) *control*, which involves the degree to which the caregiver feels able to manage the task, (2) *competence*, which relates to the caregiver’s perceived self-efficacy to perform caregiving tasks, (3) *flexibility*, which involves the ability to take a larger perspective outside of one’s immediate world purview, (4) *a positive orientation*, which involves finding meaning in the caregiver role, (5) *self-care*, or the ability of the caregiver to attend to her or his personal needs, and (6) *resource utilization*, or the extent to which the caregiver can access external sources of support to deal with issues of caregiving. When the focus of caregiving emphasizes these component skills, then the ability of caregivers to provide not only the assistance needed by care recipients but also to generate their own positive source of meaning is amplified. As a direct outcome of skill mastery, caregivers who can sustain relationship continuity through the provision of caring tend to have better long-term adjustment.

Recent research in informal caregiving has focused on finding ways to identify the benefits or positive outcomes of caring for a disabled loved one.

A contemporary instrument in the scientific literature that emphasizes this approach is the Positive Aspects of Caregiving Scale. This instrument gauges the extent to which a person finds meaning in caregiving along a number of positive dimensions, including sense of usefulness, self-esteem, relationship enhancement, meaning through service to a loved one in need, and a positive attitude toward life even in the presence of caregiving. This scale, as well as other assessment tools and intervention strategies, are the basis of the positive aging approach to caregiving. Such an approach is consistent with the long-standing traditions in counseling and counseling psychology that have emphasized individual strengths and positive coping as variables that facilitate adaptation to challenging life contexts such as caregiving. It is anticipated that a positive aging approach to caregiving will embody the design of therapeutic interventions to improve quality of life among caregivers.

*Patrick Dulin and Robert D. Hill*

**See also** Adult Development (v1); Aging (v1); Caregiver Burden (v1); Coping (v2); Counseling the Elderly (v1); Life Transitions (v2); Persons with Disabilities (v4); Positive Psychology (v2); Positivist Paradigm (v2); Psychological Well-Being, Dimensions of (v2); Quality of Life (v2); Retirement, Implications of (v1); Secondary Trauma (v2); Stress (v2); Stress Management (v2); Stress-Related Disorders (v1); Work–Family Balance (v4)

### Further Readings

- Billings, D. W., Folkman, S., Acree, M., & Moskowitz, J. T. (2000). Coping and physical health during caregiving: The roles of positive and negative affect. *Journal of Personality and Social Psychology*, 79, 131–142.
- Boerner, K., Schultz, R., & Horowitz, A. (2004). Positive aspects of caregiving and adaptation to bereavement. *Psychology and Aging*, 19, 668–675.
- Bowman, G. D., & Stern, M. (1995). Adjustment to occupational stress: The relationship of perceived control to effectiveness of coping strategies. *Journal of Counseling Psychology*, 42(3), 294–303.
- Cohen, C., Colantonio, A., & Vernich, L. (2002). *International Journal of Geriatric Psychiatry*, 17, 184–188.
- Connell, C., & Gibson, G. (1997). Racial, ethnic and cultural differences in dementia caregiving: Review and analysis. *Gerontologist*, 37, 355–364.
- Crespo, M., Lopez, J., & Zarit, S. H. (2005). Depression and anxiety in primary caregivers: A comparative study of



- caregivers of demented and nondemented older persons. *International Journal of Geriatric Psychiatry*, 20, 591–592.
- Dilworth-Anderson, P., Williams, I., & Gibson, B. (2002). Issues of race, ethnicity and culture in caregiving research: A 20-year review (1980–2000). *Gerontologist*, 42, 237–242.
- Dulin, P., & Dominy, J. (2005, June). *Coping strategies and helping attitudes as predictors of emotional functioning among elderly caregivers in New Zealand*. Paper presented at the Ninth European Congress on Psychology, Granada, Spain.
- Frederickson, B. L. (2001). The role of positive emotions in positive psychology: The broaden-and-build theory of positive emotions. *American Psychologist*, 56(3), 218–226.
- Gaugler, J. E., Davery, A., Pearlin, L. I., & Zarit, S. H. (2000). Modeling caregiver adaptation over time: The longitudinal impact of behaviour problems. *Psychology and Aging*, 15, 437–450.
- Hill, R. D. (2005). *Positive aging: A guide for mental health professionals and consumers*. New York: W. W. Norton.
- Hill, R. D., Thorn, B. L., & Packard, T. (2000). Counseling older adults. Theoretical and empirical issues in prevention and intervention. In S. D. Brown & R. W. Lent (Eds.), *Handbook of counseling psychology* (3rd ed., pp. 499–531). New York: Wiley.
- Rapp, S. R., & Chao, D. (2000). Appraisals of strain and gain: Effects on psychological wellbeing of caregivers of dementia patients. *Aging and Mental Health*, 4, 142–147.
- Sanders-Dewey, N. J., Mullins, L. L., & Chaney, J. M. (2001). Coping style, perceived uncertainty in illness, and distress in individuals with Parkinson's and their caregivers. *Rehabilitation Psychology*, 46, 363–381.
- Wijngaarden, B., Schene, A., & Koeter, M. (2004). Family caregiving in depression: Impact on caregivers' daily life, distress, and help seeking. *Journal of Affective Disorders*, 81, 211–222.

---

## CHILD MALTREATMENT

---

*Child maltreatment* is a broad term encompassing child neglect and abuse. It has been identified at the national and international levels as a tragedy of drastic proportions, drastic in the number of people it affects and drastic in the costs it exacts from the individual, the family, and society. Concern about the problem of child abuse in the past century has grown out of two important social phenomena: the development of a specialized group of medical and mental health care professionals, educational specialists, and

legal professionals concerned with children and families, and the women's rights movement. Together, both have contributed to a social and political environment that has changed our view of children and how to work on their behalf.

## Incidence

In 2004, child protective agencies investigated approximately 3,503,000 children for maltreatment. Nearly 872,000 of these reports were substantiated. The majority of these children experienced neglect (62.4%), followed by physical abuse (17.5%), sexual abuse (9.7%), psychological abuse (7%), and medical neglect (2.1%). There is often overlap in these cases: For example, most children who are physically abused also experience neglect. In addition, 14.5% of victims experienced abandonment, threats of harm, or congenital drug addiction. Children under the age of 4 were most vulnerable for severe injury or death: 81% of the 1,490 children who died of maltreatment in 2004 were in this age group.

Approximately 54% of all victims in 2004 were Caucasian, followed by African American (25.2%) and Hispanic children (17%). African American, Pacific Islander, and American Indian or Alaska Native children had the highest rates of victimization at 19.9, 17.6, and 15.5, respectively, per 1,000 children of their own race. Caucasian, Hispanic, and Asian children had rates of approximately 10.7, 10.4, and 2.9, respectively, per 1,000 children of their own race.

## Definitions

Generally, child maltreatment is differentiated into acts of omission and acts of commission, with the former describing neglect and the latter abuse. *Neglect* is the failure to provide for a child's basic needs and includes physical, emotional, medical, mental health, and educational neglect. Examples include parents or caretakers failing to provide adequate food, clothing, shelter, or supervision; refusal to seek or delay in seeking medical or mental health care that has been prescribed or highly recommended; abandonment; permission to engage in chronic truancy; inattention to special educational needs; domestic abuse in the child's presence; or permission for the child to abuse drugs or alcohol. It is important to distinguish between willful neglect and failure to provide caused by poverty. It is also critical to consider cultural norms



and for professionals to develop cultural competence when working with families.

*Abuse* includes an injury done to a child or acts that could cause physical injury. Abuse can be psychological, physical, and sexual, although these commonly overlap: A child who is sexually abused is often physically and psychologically abused as well.

The term *psychological maltreatment* is a broader term than *emotional abuse*. It includes behaviors that could cause serious behavioral, cognitive, and emotional disorders. Examples include spurning, terrorizing, isolating, exploiting, and denying emotional responsiveness to a child. Behaviors might include constant belittling and rejecting of a child, or bizarre forms of punishment, such as locking a child in a closet.

Physical abuse consists of nonaccidental injury that is often characterized by punching, beating, kicking, biting, burning, or otherwise physically harming a child. Injury may result from discipline that is inappropriate to the child's age, but it is abuse, nonetheless.

Sexual abuse, or the more broadly encompassing term *sexual exploitation*, includes molestation, fondling a child's genitals, intercourse, sodomy, exhibitionism, incest, prostitution, and exposure to or involvement in the production of pornography.

## Signs and Symptoms

It is difficult to identify specific symptoms for specific types of abuse, as many children experience multiple types of abuse. Age, severity, and duration of abuse are also factors in how symptoms are manifested. For example, babies who are shaken (shaken baby syndrome) may experience vomiting, respiratory distress, seizures, concussion, and death. However, general indicators of child maltreatment include a sudden change in behavior or school performance, untreated medical problems, learning problems or difficulty concentrating that cannot be attributed to specific psychological or physical problems, hypervigilance, lack of adult supervision, or overly compliant or withdrawn behaviors. These children may come to school activities early or stay late and sometimes do not want to go home.

In terms of symptoms specific to abuse type, indicators of neglect may include small physical size for age, dirty or inadequate clothing, poor hygiene, malnutrition, begging, lack of medical care, failure to thrive, poor school attendance and academic functioning, and disruptive behavior. In contrast, children who are physically abused often have unexplained burns, bruises,

broken bones, or black eyes. These frequently appear after an absence from school or day care. The child may express fear at the approach of adults or may appear frightened of the parents or caregivers. Children who are sexually abused may experience nightmares or bed-wetting, show a sudden change in appetite, express bizarre or unusual sexual knowledge for the child's age, have difficulty with walking or sitting, may run away, and may refuse to participate in physical activities.

## Historical Perspective

Recent statistics may give the appearance that child abuse is increasing. However, gathering statistics on child maltreatment is a recent practice, so it is difficult to be certain if there is more abuse now than in ancient times or earlier in the last century. It is important to think about how children are viewed as we try to understand abuse through history. In modern times, children are often seen as having inherent worth and deserving of protection, but it has not always been this way. There is evidence of child welfare from ancient Mesopotamia, 6000 years ago, when orphans had their own patron goddess. According to the *Regveda*, one of the oldest sacred Hindu texts, a deity among the ancient Hindus looked after abandoned children. More than 4,000 years ago, there were laws pertaining to child abuse from the Code of Hammurabi, king of Babylon. However, in ancient times and in some cultures, until the right to life was bestowed, the infant was a nonentity who could be disposed of. A father had to acknowledge a child and he had ultimate authority over the child and over the mother.

In 17th- and 18th-century Europe, children might be seen as property belonging to the father, as low-wage workers, or as "blank slates," or innocents, worthy of care. Children are often depicted as miniature adults in artwork from this time. European writers wrote treatises urging parents to adopt nonviolent childrearing methods, as children were commonly beaten and sometimes killed. The character Cosette in Victor Hugo's *Les Misérables* was used as a metaphor to admonish French society for its severe punishment of children and its lack of concern for abandoned children. Johann Peter Frank, the founder of the public health field, advocated for child labor laws in the 18th century, but it took 100 years before such laws were developed and enacted.

Developments in the 19th century include the first commissioned study on abuse, in 1860, from France, to determine why some parents kill their children. In



1866, the Society for the Prevention of Cruelty to Animals was established. The case of “Mary Ellen” is well known in the child maltreatment field. Mary Ellen was a severely abused little girl, and there were no laws to protect her. Her protection was ultimately undertaken through the New York Society for the Prevention of Cruelty to Animals, which was established prior to the Society for the Prevention of Cruelty to Children. In 1876 these two organizations joined together to form the American Humane Association.

In the 20th century many changes were designed to benefit children. One of these changes was compulsory school for both genders. Prior to the 20th century, girls often stayed home, where there was more opportunity for abuse as they had little exposure to the public. Child labor laws were enacted during the industrial revolution, and laws were developed against harsh physical punishment. Very important, the development of child welfare agencies spread. In 1961, Henry Kempe, a Denver pediatrician, and his colleagues developed the model for child abuse law that has since been adopted throughout the United States.

In 1974, the Child Abuse Prevention and Treatment Act (CAPTA) was passed, and the National Clearinghouse on Child Abuse and Neglect (NCCAN) was established. In 1978, child sexual abuse was incorporated into the federal law, expanding the scope of mandatory reporting requirements. In 1978, the Indian Child Welfare Act became law. This law was designed to keep Indian children more closely connected to their families, or to other tribal members in the cases of necessary adoptions. The 1984 publication of the American Humane Association’s book *Making an Issue of Child Abuse: Political Agenda Setting for Social Problems* was influential in making child abuse an important political agenda item. In 1993 the United Nations adopted the resolution on the Rights of Children.

Clearly there have been improvements over time as views of children have changed and laws have been enacted for their protection. Organizations abound to provide education to parents and caregivers. Nevertheless the problem of child maltreatment persists, and it is important to have some understanding of the circumstances and dynamics that lead to it.

## Causes

There is a considerable body of research examining why maltreatment occurs in the most vulnerable of

our population: children. Most recent research suggests that models studying interactive processes taking multiple variables into account will be the most fruitful for understanding the causes of child maltreatment. Although models vary, all consider at least three common dynamics that interact together: the parent (or caretaker), the child, and the environment.

## Parents

The vast majority of child maltreatment occurs within the family. Certain parental factors are significant predictors of maltreatment. These may include depression, lack of impulse control (especially when stressed), excessively high and developmentally inappropriate expectations of the child, lack of empathy, or an impaired attachment with the child. Parents may themselves have a history of victimization as a child, but most abused children do not become abusive parents. Those who do become abusive often have unresolved issues regarding intimacy, trust, autonomy, and dependency. Other risk factors for parents include young age, being a single or nonbiological parent, lack of knowledge about childrearing, a chaotic lifestyle, and low frustration tolerance. Lack of social support is a very significant finding in research examining child maltreatment potential. Parents’ reluctance to admit they need help, and their lack of knowledge about how to ask for or access help, is also critical. We live in a culture that emphasizes independence and autonomy. Asking for help may be perceived as a weakness. If a parent at risk is not part of a cohesive community, his or her increased isolation contributes to a sense of estrangement that further exacerbates stress.

## The Child

It is important to understand the bidirectionality of the parent–child relationship, as each party fundamentally influences the behavior of the other. The following types of children are overrepresented in maltreatment situations: normal infants who were unwanted or are the product of an untimely pregnancy, children with disabilities, “difficult” children (that is, those who are difficult to soothe, feed, or take care of in other ways), and adopted or foster children. Certain child characteristics (e.g., behavior problems such as hyperactivity, irritability) may also increase the risk of maltreatment.



## The Environment

This term refers to the immediate and personal environment as well as the broader cultural environment. Stressors associated with the more immediate environment include economic problems, unemployment, chaos, violence between parents, overcrowding, and isolation. Within the broader cultural environment, certain attitudes, beliefs, and practices of the culture can contribute to an environment ignorant or tolerant of maltreatment. These include an emphasis on individual rights, male supremacy or aggression, tolerance for abuse, and isolation from family and community.

## Consequences

Not all children who suffer maltreatment exhibit significant effects as a result of their maltreatment. Personal characteristics such as optimism, high cognitive ability, high self-esteem, or a sense of hopefulness in spite of the circumstances may function as a buffer to the potentially damaging effects. Other children experience a wide range of cognitive, emotional, psychological, behavioral, and relational consequences of child maltreatment. These effects are determined by factors such as age, type, severity, and chronicity of abuse.

Maltreatment during infancy and early childhood may restrict healthy brain development. For example, insufficient nutrition and emotional stimulation can have an impact on the release of important growth-regulating hormones. This affects the physical development of both the body and the brain, which can lead to severe and irreversible damage. Without remedial interventions, developmental damage in these early stages may result in deficits that follow the child into later developmental stages, producing a variety of problems. Long-term consequences of shaken baby syndrome can include blindness, mental retardation, learning disabilities, paralysis, and cerebral palsy.

In general, child maltreatment has been linked to the development of internalizing disorders such as depression, anxiety, somatic complaints, suicidal intention, and posttraumatic stress. It is also linked to externalizing disorders such as acting out, aggression, eating disorders, impulsivity, anger, delinquency, hyperactivity, attachment disorder, sexual acting out, and cognitive impairments or delays. Physically abused children tend to be aggressive toward peers and adults and to have difficulty with empathy and

establishing relationships with others. Neglected toddlers may have difficulty trusting others. This may lead them to feel unloved and unwanted and may inhibit their ability to learn the social skills they need to develop lasting and meaningful relationships, thus becoming a lifelong problem. Adult survivors of childhood maltreatment are 3 times more likely than other adults to suffer mood disorders and 2 to 4 times more likely to suffer from an anxiety disorder.

Like physical abuse, the consequences specific to sexual abuse vary by age, severity, and chronicity of abuse and number and relationship of perpetrator(s). Research indicates that symptoms vary over time, and some symptoms may be more transient than others. Not all sexually abused children experience these adverse effects. Approximately one third of victims show no clinical symptoms. The most common symptoms identified in preschoolers are anxiety, nightmares, posttraumatic stress disorder, inappropriate sexual behavior, and internalizing and externalizing behaviors. Somatic problems include enuresis, stomachaches, headaches, and developmental delays.

School-age children may display fear, aggression, nightmares, school problems, hyperactivity, and regressive behavior. Like the preschoolers, they may exhibit inappropriate sexual behaviors. They may also experience dissociation and difficulties with peer relationships. In the academic domain, they may receive poor performance ratings from teachers and have low achievement test scores, and they frequently receive diagnoses of attention deficit hyperactivity disorder (AD/HD). Adolescents may exhibit depression, withdrawal, somatic complaints, running away, eating disorders, substance abuse, suicidal or self-injurious behaviors, and delinquent behaviors. In adulthood, survivors may abuse alcohol or drugs and may experience externalizing problems such as diagnoses of antisocial personality disorder. They also may experience depression and anxiety, greater revictimization rates, and problems with child rearing.

In addition to individual effects, child maltreatment affects families and society. A 2001 report by Prevent Child Abuse America estimates the cost of health system, judicial, and law enforcement responses at \$24 billion a year. In addition, there are also indirect costs associated with maltreatment, such as the cost of providing special education services for affected children and providing treatment for mental illness, substance abuse, domestic violence, and juvenile and



adult criminal activity. These indirect costs may cost more than \$69 billion per year.

## Cultural Considerations

Lisa Aronson Fontes, an expert on multicultural counseling and child abuse, emphasizes the importance of taking an ecosystemic perspective for understanding child maltreatment. This includes examining all relevant social worlds the child inhabits. Professionals need to consider the individual—including the child's genetic makeup, developmental status, and home and family situation; the ethnic culture—including gender roles, religion, and worldview; the proximal social system—including school, neighborhood, and peer group; and the wider social system—state and national policies that impact all other systems. If counseling professionals are too close to the individual perspective, they may miss contextual variables that could assist them in helping a person. Conversely, if they have too wide a lens, they may miss important cultural variables, such as native child-rearing practices important for appreciating the child in his or her context.

This ecological model is useful in three ways: (1) It deemphasizes the individual, who is otherwise the focus in much of Western culture, (2) it indicates various levels where professionals can intervene for the child, and (3) it shows professionals where they fit in the child's ecosystem. If they are not from the same culture, they are one step further away; they need to have culture-specific knowledge to get closer. Professionals can also see how they are influenced by the proximal and wider social systems. It is critical to be aware of their own professional ethnocentrism, that is, to understand how the culture of their profession influences how they see the world. This requires them to be conscious of their own biases, to confront stereotypes, and to have culturally relevant information. This information should include knowledge of how child maltreatment is defined and of traditional help-seeking behaviors, including unfamiliar disciplinary methods and medical interventions. They must also consider issues of language and the appropriate use of interpreters. With low-income clients, professionals need to be aware of the influence of poverty in their clients' lives and recognize that what may look like neglect may be related to poverty.

Writers in the child advocacy and multicultural counseling fields emphasize that professionals need to

work within a systems framework. For example, they need to ask how nonabusive family members can help. Fontes notes that the main predictor of success for recovery from incest is the mother believing the disclosure. A few guidelines for working with families include knowing who is considered "family"; it may include godparents and close friends who are not related by blood. Professionals should understand family structure, gender roles, and respectful ways of addressing clients. Families often appreciate mental health professionals who help them access community and social resources other than counseling.

## Counseling Interventions

Early interventions are necessary to reduce the severity and chronicity of abuse symptoms and alter family and environmental factors contributing to maltreatment. Services and interventions for maltreatment should be multidimensional, including individual, family, and societal interventions. Research studies on intervention effectiveness indicated that individual, group, family, milieu, or multilevel forms of treatment are equally effective. Surprisingly, treatment effects did not vary based on voluntary versus mandated treatment.

Individual interventions may include providing appropriate medical care, helping the child express his or her emotional experiences (verbally or through drawing or play), processing trauma or neglect, reducing or overcoming general feelings of shame resulting from maltreatment, finding educational services to improve cognitive ability and academic performance, and teaching personal safety skills, empathy, assertiveness, and relationship-building skills appropriate to the child's age.

Since nearly 84% of victims of maltreatment are abused by a parent, family interventions should address issues such as improving parenting skills. This can include education on nonviolent discipline strategies, child developmental stages, effects of maltreatment, anger management, and communication skills. Interventions should also assess and address family mental health or substance abuse issues contributing to family dysfunction and explore gender roles that may contribute to abuse.

In a broad general sense, the treatment process consists of three phases: (1) acknowledgment of the abuse and its subsequent effects, (2) development of parenting competencies and sensitivity to the child, and



(3) resolution either through reunification of the child with the family or relinquishment of parental rights.

Individuals involved in providing support and assistance to children and families involved in maltreatment often include nurses, doctors, teachers, school counselors, social services staff, therapists, foster care providers, law enforcement officers, and individuals in the judicial system. However, while these services focus on the protection of children and punishment of abusers, they rarely provide assistance in addressing the unemployment, poverty, and substance abuse that frequently play a role in child maltreatment. These issues need to be addressed at the societal level to effectively combat child maltreatment. Similarly, non-English-speaking minority families may feel isolated from community services that could help them cope with financial, cultural, and familial stressors. Federal and local governments and communities need to provide services for these families to prevent them from having to enter the child protection and legal systems.

Finally, a significant and badly needed intervention in maltreatment is developing effective prevention programs. Primary prevention interventions begin with raising the awareness of the public and decision makers about maltreatment. These include public service announcements regarding available programs and services, school safety programs, free parent education programs, and information on how and when to report abuse.

Mary Sean O'Halloran and Arlene K. Weimer

*See also* Abuse (v2); Disasters, Impact on Children (v1); Family Counseling (v1); Legal Issues in Parenting (v1); Parenting (v1); Quality of Life (v2); Sexual Violence and Coercion (v1); Stress-Related Disorders (v1)

### Further Readings

- Ammerman, R. T., & Patz, R. J. (1996). Determinants of child abuse potential: Contribution of parent and child factors. *Journal of Clinical Child Psychology*, 25, 300.
- Bal, S., de Bourdeaudhuij, I., Crombez, G., & van Oost, P. (2004). Differences in trauma symptoms and family functioning in intra- and extrafamilial sexually abused adolescents. *Journal of Interpersonal Violence*, 19, 108–123.
- Browne, A., & Finkelhor, D. (1986). Impact of child sexual abuse: A review of the research. *Psychological Bulletin*, 99, 66–77.
- Deblinger, E., & Runyon, M. K. (2005). Understanding and treating feelings of shame in children who have experienced maltreatment. *Child Maltreatment*, 4, 364–376.
- English, D. J. (1998). The extent and consequences of child maltreatment. *The Future of Children: Protecting Children from Abuse and Neglect*, 8(1), 39–53.
- English, D. J., Upadhyaya, M. P., Litrownik, A. J., Marshall, J. M., Runyan, D. K., Graham, J. C., et al. (2005). Maltreatment's wake: The relationship of maltreatment dimensions to child outcomes. *Child Abuse and Neglect*, 29, 597–619.
- Fink, P. (2005). The problem of child sexual abuse. *Science*, 309(5378), 1182.
- Finkelhor, D. (1990). Early and long-term effects of child sexual abuse: An update. *Professional Psychology: Research and Practice*, 21, 325–330.
- Jones, D. P. (1997). Treatment of the child and family where child abuse or neglect has occurred. In M. E. Helfer, R. S. Kempe, & R. D. Krugman (Eds.), *The battered child* (5th ed., pp. 521–542). Chicago: University of Chicago Press.
- Kendall-Tackett, K., Williams, L., & Finkelhor, D. (1993). Impact of sexual abuse on children: A review and synthesis of recent empirical studies. *Psychological Bulletin*, 113, 164–180.
- Lutzker, J., & Bigelow, K. (2002). *Reducing child maltreatment: A guidebook for parent services*. New York: Guilford Press.
- National Clearinghouse on Child Abuse and Neglect (DHHS). (2003). *Recognizing child abuse and neglect: Signs and symptoms*. Retrieved June 3, 2006, from <http://nccanch.acf.hhs.gov/pubs/factsheets/signs.cfm>
- National Clearinghouse on Child Abuse and Neglect (DHHS). (2005). *Long-term consequences of child abuse and neglect*. Retrieved June 3, 2006, from [http://www.nccanch.acf.hhs.gov/pubs/factsheets/long\\_term\\_consequences.cfm](http://www.nccanch.acf.hhs.gov/pubs/factsheets/long_term_consequences.cfm)
- Perry, B. (2001). The neuroarcheology of child maltreatment. In K. Franey, R. Geffner, & R. Falconer (Eds.), *The cost of maltreatment: Who pays? We all do* (pp. 15–37). San Diego, CA: Hawthorne Press.
- Perry, B. D., Colwell, K., & Schick, S. (2002). Neglect in childhood. In D. Levinson, (Ed.), *Encyclopedia of crime and punishment* (Vol. 1, pp. 192–196). Thousand Oaks, CA: Sage.
- Sheinberg, M., & Fraenkel, P. (2001). *The relational trauma of incest: A family-based approach to treatment*. New York: Guilford Press.
- Skowron, E., & Reinemann, D. H. S. (2005). Effectiveness of psychological interventions for child maltreatment: A meta-analysis. *Psychotherapy: Theory, Research, Practice, Training*, 42, 52–71.
- U.S. Department of Health and Human Services, Administration on Children, Youth, and Families. (2006).



*Child maltreatment 2004*. Retrieved June 3, 2006, from <http://www.acf.hhs.gov/programs/cb/pubs/cm04/chapterthree.htm#race>

Whitaker, D. J., Lutzker, J. R., & Shelley, G. A. (2005). Child maltreatment prevention priorities at the Centers for Disease Control and Prevention. *Child Maltreatment, 10*, 245–259.

---

## CHILDREN WITH CHRONIC ILLNESS

---

Approximately 20% of school-age children have a chronic illness, making counseling increasingly important due to the impact on the child's family relationships, school functioning, and peer interactions. Certain chronic illnesses have a greater effect than others on the psychosocial and educational aspects of a child's life, depending on symptom severity and the nature of the treatment. Numerous counseling interventions address the unique needs of these children, particularly regarding school reintegration. This entry provides an overview of common childhood chronic illnesses, discusses psychosocial and educational implications, and describes effective counseling interventions used with this population.

### Common Childhood Chronic Illnesses

#### ***Asthma***

Asthma is currently the most common childhood illness, affecting approximately 5 million children under the age of 18 in the United States. Asthma is a respiratory condition characterized by an obstruction of the airway; it can result in wheezing, coughing, shortness of breath, chest tightness, and fatigue. Attacks may be triggered by allergens, environmental conditions, exercise, or stress. The severity and timing of asthma attacks vary. They can result in limitations on physical activity and increased frequency of medical visits. Treatment varies depending on severity and may consist of self-administered inhalers, nebulizer treatments, or hospitalization. Side effects of these medications can include hyperactivity, anxiety and depression, drowsiness, and impairment in memory and attention.

#### ***Diabetes***

Diabetes mellitus (DM) is an autoimmune disease affecting metabolism. There are two different

types—type 1, which is insulin-dependent or juvenile diabetes, and type 2. Type 1 DM affects approximately 1 in 400 to 600 children and results in permanent insulin deficiency. Treatment for type 1 DM involves regular blood glucose monitoring and daily self-administered insulin injections or the use of an insulin pump.

Type 2 DM is found in 10% to 20% of newly diagnosed cases of juvenile DM. The recent increase in the incidence of childhood obesity is likely responsible for recent increases in type 2 diagnoses. Type 2 DM is characterized by insulin resistance, resulting in chronically high levels of insulin in the body. Treatment of type 2 DM involves strict management of diet and exercise and the administration of oral medication or insulin injections. Based on the nature of the disease and required treatments, diabetes has been found to affect the learning process, mood and attention, and social interactions.

#### ***Juvenile Rheumatoid Arthritis***

Juvenile rheumatoid arthritis (JRA) is an autoimmune condition affecting approximately 200,000 children in the United States under the age of 18. There are three subtypes of JRA: pauciarticular (least severe), polyarticular, and systemic (most severe). Symptoms include stiff and swollen joints, limited mobility, pain, and occasional fevers and rash. Severe JRA can impact bodily organs as well. Treatment for JRA includes medication, limiting activity, and participating in therapeutic exercise programs. Pain and stiffness associated with JRA can affect writing, physical activity, and school attendance.

#### ***Cancer***

Cancer is the uncontrolled spreading of abnormal cells that can affect various parts of the body. The most common childhood cancers are leukemia (blood cancer), lymphomas (cancers of the lymphatic system), and brain tumors. Because cancer treatments are very intense, both the disease and treatment can have severe impacts. Treatments for cancer often include some combination of surgery, chemotherapy, radiation, bone marrow transplants, and immunosuppressants. Symptoms of the disease and treatment may include nausea and vomiting, fatigue, muscle weakness, and significant changes in appearance (e.g., facial swelling, hair loss, temporary weight gain or



loss). Particular attention should be paid to social adjustment, peer relationships, and the emotional well-being of the child.

### ***Low-Incidence Conditions***

Several less common conditions also affect children in their family, social, and educational environments. Low-incidence conditions include cystic fibrosis, epilepsy/seizures, stress-related conditions (headaches, stomach pain), enuresis, encopresis, gastrointestinal disorders, blood disorders (e.g., hemophilia), migraines, heart conditions, and infectious diseases.

## **Psychosocial and Educational Implications**

### ***Family Implications***

Caring for and raising a child with a chronic illness can lead to innumerable burdens on the parent or primary caregiver. Parents must become knowledgeable about the condition, serve as the principal informant to medical professionals, and deal with the financial consequences of the illness. Compared to parents without an ill child, these parents report higher levels of role strain, or stressors associated with the parenting role, as well as frustration and conflict about division of labor and expectations. Parents may also demonstrate increased levels of anxiety and over protectiveness, they may have lowered expectations for their ill child, and they may fail to provide boundaries or consistent discipline for the child.

Caring for a chronically ill child may also result in work-related and marital stress as well as compromised personal self-care. Such stressors can often lead to marital separation and divorce. Gender differences have been noted in how coping relates to marital adjustment. Women demonstrate a negative association between marital adjustment and the tendency to use avoidance strategies to deal with their child's illness, while men indicate that marital satisfaction is associated with positive interpretation and growth. Women, who have a tendency to use avoidance strategies, often experience a strain on their marriages, while for men, interpreting the situation as positively as possible leads to greater marital satisfaction.

Childhood chronic illnesses can also affect siblings. Research suggests that siblings experience increased psychological distress, most frequently

internalizing disorders. Siblings may feel neglected due to increased attention toward the ill child, thereby leading to feelings of distress and isolation. Adaptive functioning of siblings has been linked to family cohesion, social support, and maternal mood or psychological distress. Furthermore, sibling adjustment is influenced by individual factors such as age at diagnosis, gender, birth order, and illness characteristics.

Overall, the most prevalent predictors of well-being in families with a chronically ill child include flexibility, integration into a supportive social network, balancing the demands of the illness and family needs, clear boundaries, effective communication, active coping, and the encouragement of development and growth within the family.

### ***Social Implications***

Several characteristics of diseases and their treatments have been shown to affect children's relationships with peers. Peers are a critical component of the socialization process and heavily influence the behavior of children. Limitations on physical activity resulting from pain, fatigue, or other physical restrictions can limit participation in peer-oriented activities, thus resulting in fewer opportunities to socialize. For instance, a child with asthma may not take part in sports or games that are physically intense. Likewise, changes in physical appearance from the illness can result in negative self-perceptions and negative reactions from peers. A child who has lost his or her hair from chemotherapy may be teased or ostracized by other children. Children with cognitive impairments (e.g., problems with intelligence, memory, or attention) also may be more prone to peer difficulties, which may be attributed to their inability to both understand social information and express social behavior. Likewise, visible differences resulting from illness may lead to increased levels of teasing and bullying.

### ***Educational Implications***

Making school accommodations for a chronically ill child is necessary to prevent social, emotional, and academic problems. Many illnesses result in increased absences from school, thereby causing a child to fall behind in schoolwork. Certain illnesses may result in prolonged periods of school absence or hospitalization. Reintegration into the school system may result in additional concerns such as the fear of falling



behind academically (e.g., having to repeat a grade), worrying about what others may think or say, and concern over having missed important school activities.

Some illnesses require a child to make several daily visits to the school nurse to monitor or administer medication or address symptoms associated with the illness. More nurse visits can lead to feelings of being different, more responsibility for the child, and potentially negative attention from peers.

## **Effective Counseling Interventions**

### ***Family-Based Interventions***

Several pediatric family interventions focus primarily on psychoeducation for parents. More specifically, some of these interventions for children with chronic illness involve working with the family to increase treatment adherence or to address family trauma. Because adherence regimens can create additional conflict within the family system, interventions addressing family conflict are also beneficial.

### ***Social and Behavioral Interventions***

Cognitive-behavioral therapy (CBT) has been found to be effective for helping children cope with the additional stressors of having a chronic illness. CBT addresses maladaptive thinking patterns and behaviors and aims to replace them with healthier coping strategies. Primary goals with this technique include changing thinking and behavior patterns to reflect a more effective approach to managing stress and solving problems.

Stress management involves learning to relax in order to decrease tension and changing the way the child thinks about the illness. Various methods of relaxation include progressive muscle relaxation, passive relaxation, and guided imagery. The aim of relaxation training is to create a physiological state that is incompatible with the anxious physical and emotional reactions. Relaxation, along with distraction, is often used to manage the stress of painful medical procedures such as shots or blood draws.

Because children may be teased by peers as a result of the illness, it is important to help the ill child enhance social skills. Teaching children strategies and behaviors to manage teasing or bullying is critical. Because illnesses can have such a profound impact on the child's social development and relationship with

peers, it is essential to address peer relationships, especially at school.

Another CBT method involves increasing approach coping skills. Approach coping has been shown to be more effective than other methods, such as avoidant coping. While at times avoidance coping might be desirable to the child, CBT interventions designed to help the child learn to actively approach stressors and actively solve problems have been shown by research to be more effective. Approach strategies include the use of problem-solving techniques to gain mastery over coping. For example, a child with diabetes is taught to actively manage dietary intake and insulin treatments in the school environment instead of avoiding these undesirable activities. This method also includes encouraging the child to identify and discuss emotional stressors associated with the illness.

### ***Educational Interventions (Systems Approach)***

Because children spend a majority of their time in school, accommodations within this setting are necessary. Schools address the unique needs of children by developing a 504 plan or an Individualized Education Plan (IEP). A child with a chronic illness qualifies for a 504 plan when the illness interferes with daily functioning in the educational environment but the child has not been formally identified for special education services. An IEP is developed for children diagnosed with a learning disability, communication impairment, or emotional disturbance when the child's needs warrant special education services. Both plans outline specific objectives and modifications to implement in the schools to best meet the educational needs of the child. It is necessary to become familiar with the specific goals and objectives of both IEPs and 504 plans to advocate for the child within the school setting.

### ***Integration/Reintegration***

There are many challenges facing a child returning to school. For example, children may have to cope with changes in physical appearance, daily administration of medication, physical effects of the illness (e.g., fatigue), social isolation following prolonged school absences, and making up missed work. Accommodations can be made to decrease the stress of returning to school. Some examples include shortening the school day initially, helping with note taking,



using a tutor, or using special equipment to assist with learning. Returning to a routine quickly and helping the child maintain normal activities is very important. Facilitating good communication among the school, healthcare professionals, student, and family is critical.

*Jessica A. Lohnberg, Robyn A. Howarth,  
and Daniel L. Clay*

**See also** Cancer Management (v1); Caregiver Burden (v1); Chronic Illness (v1); Chronic Pain (v1); Cognitive-Behavioral Therapy and Techniques (v2); Death and Dying (v1); Family Counseling (v1); Low-Incidence Disabilities (v1); Medication Adherence (v1); Mental Health Issues in the Schools (v1); School Counseling (v1); Secondary Trauma (v2); Stress Management (v2); Treatment Compliance (v1); Work–Family Balance (v4)

### Further Readings

- Clay, D. L. (2004). *Helping schoolchildren with chronic health conditions: A practical guide*. New York: Guilford Press.
- Roberts, M. C. (Ed.). (2003). *Handbook of pediatric psychology*. New York: Guilford Press.
- Spirito, A., & Kazak, A. E. (Eds.). (2006). *Effective and emerging treatments in pediatric psychology*. New York: Oxford University Press.

---

## CHRONIC ILLNESS

---

Chronic illnesses are those incurable conditions that are not contagious, but have multiple risk factors and often involve extended periods of decline resulting in increasing functional impairment. Examples of chronic illnesses include hypertension, asthma, diabetes, and multiple sclerosis. Living with a chronic illness presents many challenges, not only for the person with the illness, but also for family members who must adapt to the changing life circumstances that often accompany ongoing health concerns. Evidence suggests that the quality of life of persons living with chronic conditions is mediated by behavioral and social mechanisms. Beginning with diagnosis, counselors can play a very important role in assisting patients and families with adjustment to chronic illness, assessing quality-of-life issues related to the

illness, and developing interventions to help clients learn new skills and ways of coping with challenging situations. Counselors can also help physicians and the healthcare team to understand the multidimensional psychosocial needs of patients and families.

### Diagnosis

The diagnosis of a chronic illness can result in both immediate and long-term psychological challenges. Diagnostic tests and ongoing treatments can be physically painful and emotionally stressful for both patients and families. Disbelief, denial, anger, and depression are common reactions to a diagnosis of chronic illness. In many cases these are understandable responses to the situation. However, patients and families may need assistance to look beyond these responses in order to adopt new ways of coping and more realistic goals regarding their lives and the future. For example, denial may be helpful in assisting patients and families to get past the initial crisis point of diagnosis. However, denial has sometimes been associated with an individual's resistance to following a medical regimen or medical advice, which can lead to negative health consequences. In general, in order to provide the most effective services, it is important for counselors to have a basic understanding of the nature of the illness, the multiple demands of the procedures involved in diagnosing and treating the illness, the potentially ongoing aspects of medical care, and the prognosis of the illness.

### Chronic Illness in Adults

Once diagnosed, adults are confronted with the process of adjustment to living with a chronic illness. This process is often ongoing, depending on the nature and course of the specific illness. Adjustment is complex, often involving emotional, cognitive, behavioral, physical, and social components. Emotional adjustment can include dealing with feelings of helplessness, being overwhelmed, and fear of the future. Cognitive components may include difficulty with concentration, hypervigilant appraisals of the illness and one's condition, and decline in short-term memory functioning. Behavioral concerns include role fulfillment and role change in an individual's life and meeting the demands of the illness (e.g., doctor visits, taking medications as prescribed). Physical components of illness may include loss of mobility, physical adaptations needed



at home or work, or not being able to drive. Finally, social concerns often focus on personal relationships, social support, the stigma of chronic illness, and social comparisons with others. The combined effects of these adjustments and changes brought on by chronic illness represent an enormous challenge to the patient at a time when most personal resources are very low. Therefore, assistance from a counselor is extremely important in order to support the individual in this process of adjustment.

### **Chronic Illness in Children and Adolescents**

Many children and adolescents experience chronic health conditions. While all children have times of sickness and health in their young lives, children with chronic illnesses have ongoing conditions that affect their normal activities and that may require extensive medical care, including hospitalizations or home health care. Examples of chronic illnesses include asthma (the most common condition), diabetes, cerebral palsy, cancer, epilepsy, spina bifida, AIDS, congenital heart problems, and sickle cell anemia.

Young people with chronic health conditions often face a wide range of problems related to their disease. These can include feeling “different” from other children, frequent doctor and hospital visits, having to endure painful or difficult medical treatments, and hospital stays that can be frightening or lonely. A young person’s reaction to both the diagnosis and the disease will be heavily affected by his or her personality, the specific illness, his or her developmental stage, and perceived support from family and medical personnel. Counselors can help children and their families cope with illness using behavioral techniques such as relaxation, biofeedback, and positive practice and by modeling healthy behaviors for children. Counselors can also help children cope with their illnesses by providing them with a forum in which they can speak openly about their disease and their experiences. Due to the chronic nature of these childhood diseases, depression is often a side effect in children, who may feel that they will never be “normal,” or like other children. Counselors should be aware of the signs of depression in children and should assess for these regularly. Play therapy and expressive therapies, such as art, music, and drama therapy, can be helpful in allowing children to

explore their emotions and process experiences related to their condition.

### **Family Issues**

Patients do not experience chronic illnesses alone. Families and significant others typically go through a number of life-altering new challenges and stressors related to the illness over time. For example, the presence of chronic illness often results in increasing financial, time, and emotional burdens on patients and their families. Many individuals who experience chronic illness have a loss of income due to a decrease in days at work or the loss of a job, and at the same time they have an increase in expenses related to medical bills, therapies, and medications. The primary caregiver (typically the spouse, parent, or adult child) of the ill person may need to decide whether to give up working in order to care for the patient. Balancing the new role of caregiver with possible concurrent roles of parent, breadwinner, head of household, etc., is a daunting challenge for many individuals.

Family relationships and perceived social support can be important contributors to the effective management of chronic illness, reducing some of the stressful impacts of the disease. Significant positive relationships may also affect the ability of the patient to develop and implement coping skills, follow medical instructions, recover from surgery or other procedures, and perform in-home tasks and adapted vocational roles. Some patients with chronic illnesses report closer relationships with family and friends as a result of their diagnosis and illness. Patients who perceive more social support are typically better able to cope with the effects of their illnesses than patients who report less perceived support.

On the other hand, the effect that chronic illness can have on interpersonal relationships can be very difficult for some patients and families. For example, families often struggle to understand what the patient is experiencing and whether he or she is doing too much or too little to cope with the situation. Unrealistic expectations related to how the patient “should” cope with the illness can cause a number of difficulties. Families often report a sense of helplessness and fatigue, especially when trying to adapt to new roles necessitated by changes related to the chronic condition. In an effort to provide support, families may offer advice that is not always helpful or welcomed by the



patient. These interactions related to changes accompanying the chronic illness often result in stress and frustration, which may lead to increased depression and anxiety. The counselor can help patients and families learn to listen and communicate more effectively with one another. These skills, in turn, may strengthen bonds of social support, which contribute to better adjustment and quality of life.

### **Diversity Considerations**

Awareness of special characteristics of patients' backgrounds and environments is important in understanding individual and family responses to illness and treatment. Counselors may want to explore the cultural heritage and religious values of clients in order to respect and incorporate some of these key strengths and resources in their work with patients. For example, we all have health schemas related to the cause or reason for illness (e.g., we may believe the cause is natural or supernatural or that the illness is a punishment for wrongdoing). Exploration of these beliefs can provide valuable information about patients' views of themselves, the world, and potential healthcare interventions. Some cultures are more interdependent than others and value a different style of decision making than other cultures that value independence. Different groups may view medical treatments or death in very different ways, and understanding these differences can be extremely helpful in dealing with patients and families who are facing life crises or decisions with long-term consequences (e.g., having a feeding tube inserted that extends the patient's life but does not lead to better quality of life over time). Some cultures clearly value extensive familial-social support networks, which can be a great asset to individuals or families facing chronic illness. Other cultural groups, because of language and background, may lack competence in verbal expression or use cultural idioms of distress unfamiliar to the counselor. In many cultures, there is a stigma related to seeking help outside the family. As in other areas of counseling, it is critical to examine one's cultural competence when working with clients and to be aware of one's own limitations of background and experience. Consultation with colleagues is often helpful.

### **Assessment**

Performing assessments can be useful when working with individuals who are chronically ill and their

families. For example, assessments can be used to gain information related to patients' cognitive ability to adhere to medication and treatment requirements, their competency to make medical decisions, and their overall psychological capacity to handle new challenges. Assessments can also be performed to help with treatment planning.

There are a variety of ways to perform assessments, including clinical interviews, formal paper-and-pencil measures, and basic neuropsychological screening. Relevant areas to address in the clinical interview include personal and environmental strengths, perceived barriers to adjustment, and personal meaning-making regarding the illness. Family members, especially the primary caregiver, should also be interviewed and included in the assessment. Interviews may be conducted separately for caregivers depending on the type of information that is needed. Formal assessment instruments may cover areas such as depression, anxiety, quality of life, and caregiver burden. Neuropsychological screening can be suggested if there is a question of diminished cognitive ability. One caution relative to assessment is that a variety of symptoms overlap the domains of physical illness and emotional distress. For example, aspects of some illnesses include change in appetite or sleep patterns, loss of energy, or difficulty in concentration, which are also symptoms of depression. It is important to remember that the purpose of all assessment is to inform the counselor about how best to support and promote the adjustment and care of patients and families.

### ***Interviews: Personal Meaning of Illness***

Research has shown that patients' ascribed meanings can be used to screen for maladaptive coping and to predict health outcomes and quality of life. For example, developing a chronic illness may cause a shift in personal life goals or worldview. After an illness diagnosis, patients' perceived meanings of their own lives can be drastically altered. For example, many individuals pay more attention to issues of spirituality and faith than they did prior to diagnosis. Patients may also become more introspective and reflective.

With chronic illness, major transformations sometimes occur in patients' lives as they struggle to make sense of the diagnosis. Meaning-making is an ongoing process of evaluation, exploration, and weighing of values that takes place when people are faced with life circumstances that in many ways are beyond their



control. The search for meaning is not only an intensely personal response to chronic illness, but it can also be viewed as an interactional process involving family or significant others. Existential questions such as “Who am I now in relation to my family or to this person I love so much?” or “What will my identity be now that I can no longer work and provide for my family?” may arise. It is important for the counselor to attempt to understand the meaning of illness for both the patient and the family, because the very process of trying to understand itself helps to foster cooperation, coping, adjustment, adherence, and empowerment.

### ***Interviews: Family Members and Caregivers***

Because of the challenges that family members experience as a result of chronic illness, it is important to consider the strengths and resources available to family members and more specifically to the primary caregiver. Learning about the needs and potential range of difficulties associated with the illness from each person’s perspective also helps the counselor assist family members in finding positive ways to cope with the situation.

### ***Formal Measures: Emotional Changes***

It is often helpful to have a baseline measure of the patient’s emotional functioning. There are a number of standard paper-and-pencil measures that can provide information about a variety of mood states, including depression, anxiety, stress, intrusiveness of illness, hope, and loneliness. This information can assist the counselor in setting priorities for treatment planning. It is important to remember that changes in mood may be a normal reactive response to the diagnosis and circumstances of illness. However, mood change can also be a manifestation of some aspect of the disease itself. It is also possible that some of these symptoms may have been present before the diagnosis of chronic illness and can represent comorbid conditions. The counselor will want to consider these alternative explanations and to explore the source of the mood disturbance with the patient and the family or significant others. Depending on the severity of the condition, this discussion may be followed by a suggestion that the patient or family consider seeking consultation with the primary care physician regarding these concerns.

### ***Formal Measures: Quality of Life***

Quality of life (QOL) is often defined as an overall state of physical, emotional, and social well-being. The literature in this area often includes other facets of quality of life such as role functioning. Physical functioning may be assessed by using a checklist of activities of daily living (ADLs) or by determining the patient’s ability to perform everyday tasks. Emotional functioning includes assessment of variables such as those described in the previous section. Social functioning is often assessed by measuring actual or perceived social support. Role functioning is assessed in terms of the patient’s ability to perform functions related to work, parenting, or maintaining a career.

Assessment tools have been developed that attempt to assess the physical, psychological, and social changes that occur as a result of chronic illness. These instruments have also been created in order to determine if specific interventions or treatments improve not only physical symptoms as assessed by medical staff but QOL as reported by the patient. Quality of life is based on the patient’s perception of how the illness affects his or her day-to-day life. Thus, these tools are typically self-report instruments that provide the counselor with an understanding of how the patient views his or her life and functioning in various areas.

There are two primary approaches to measuring quality of life. First, global questionnaires provide a broad, overall view of the patient’s functioning. Such questionnaires often generate useful health profiles. The second approach consists of instruments that are more disease-specific and that focus on problems associated with single disease states, patient groups, or areas of function. These approaches are not mutually exclusive and each has specific advantages.

## **Counseling Interventions**

In order to help individuals with chronic conditions deal effectively with adjustment to illness, counselors often employ a variety of interventions that have been shown to be useful in decreasing anxiety, fostering social support, and reducing symptom severity. Behavioral and cognitive-behavioral techniques are the primary interventions used in health psychology and medical settings. These approaches are often focused on symptoms, identify factors related to a particular problem, and attempt to modify the factors that cause or maintain the problem. These strategies have



been found to be effective in enhancing an individual's compliance with medication and other health routines, helping with symptom control (e.g., pain management), and increasing a sense of self-efficacy, or an individual's sense of control over his or her own life and disease. Some of the specific techniques used in these approaches include relaxation training, biofeedback, differential attention, goal setting, and positive practice. Because stress, anxiety, and pain are often associated with illness and medical interventions such as surgery or chemotherapy, the use of relaxation techniques that include deep breathing and decrease arousal are often helpful to the patient. Cue-controlled and differential relaxation are useful in the generalization of the relaxation response to settings outside of treatment. These techniques are often combined with other interventions, such as distraction, comforting self-talk, imagery, and systematic desensitization to provide the patient with a repertoire of helpful skills.

### ***Stress Management***

Stress management is an intervention of particular importance, as it can help patients deal with chronic, ongoing conditions as well as crisis situations. Knowing how to manage stress can also help prevent the onset of headaches, muscle tension, and the development of other chronic diseases such as diabetes, pulmonary dysfunction, and rheumatoid arthritis. Many stress management programs are disease-specific and present a series of patient education modules offered over a period of weeks in a group format. Typical modules include an explanation of how stress affects the body, challenges patients face, problem solving related to those challenges, presentation and practice of relaxation techniques, and possible treatment options. Homework assignments, involvement of family members, and discussion of misconceptions about the illness are often incorporated.

### ***Self-Efficacy Enhancement***

Two standardized courses have been developed to help patients manage the symptoms and complications of their conditions. The Arthritis Self-Help Course and the Chronic Disease Self-Management Course (both conceived by Kate Lorig at Stanford University) are 7-week courses that are offered to groups of eight to ten patients. A variety of topics are addressed, including goal setting, problem solving,

and exercise. Participants are paired with one another and asked to check in with their partners on at least a weekly basis. Reports of the extremely positive and long-lasting outcomes of these courses have noted that the greatest predictor of improvement is increased self-efficacy. Altruism, or the opportunity to help others in the group with ideas, suggestions, or support, has also been noted as important to participants. Training is available for counselors to become certified to offer these courses.

### ***Support Groups***

Support groups can help patients deal with aspects of the disease, the trauma it has caused, and its future implications in a way that promotes a sense of personal coherence, coping, and adaptation. Support groups may also help chronic illness patients engage in a reappraisal of their experience, focus on meaning-making, and integrate their experience into their personal narrative. By joining a support group, individuals often establish new connections with others who may be having similar experiences. Group participants typically give and receive social support, which appears to buffer stress and to benefit persons with chronic illness.

Support groups for family members and caregivers can also be very beneficial. Such groups allow individuals a safe place to express the concerns and frustrations inherent in their position. Others who care for persons with chronic illnesses can commiserate with the difficulties that are faced and offer suggestions about how to approach specific problems. Laughter over some of the humorous circumstances that occur that “outsiders” wouldn't understand can be very therapeutic.

### ***Additional Roles of the Counselor***

In addition to assisting the patient and family through emotional aspects of adjustment to chronic illness, the counselor may be called upon to help clients advocate for themselves with physicians, the medical system, insurance companies, or others involved in the patient's care and treatment. It is helpful to know enough about the healthcare system to support clients as they seek answers to the myriad questions that arise as they face new dilemmas and work toward managing challenging life circumstances. The counselor may also work as a liaison between medical personnel and the patient and family, supporting and interpreting the communication so that everyone clearly understands



explanations, instructions, and the implications of treatment choices and decisions.

## Future Directions

In the future, there will be increased need for counselors who specialize in areas such as genetic counseling. With the completion of the Human Genome Project, there is expanding development of genetic testing for a variety of inherited diseases and conditions. Undoubtedly, with more advances in research, there will be broader uses of genetic testing for growing segments of the population.

The future will most likely bring the expansion of health promotion programs. In order to contain health-care costs, prevention programs targeting health behaviors such as weight loss, exercise, and smoking cessation will become more widespread. Counselors with special expertise in psychoeducational presentations and group work will be needed to deliver these interventions.

Finally, increasing access to computers and familiarity with technology will provide patients and families with new avenues of information and support. Counselors will want to be aware of resources that are available online to clients in rural areas or those who are not able to physically access other opportunities or interventions.

*Cynthia McRae, Eileen Chaves,  
and Erin A. Sullivan*

**See also** Acculturation (v3); Bereavement (v1); Cancer Management (v1); Caregiver Burden (v1); Caregiving (v1); Chronic Pain (v1); Cognitive-Behavioral Therapy and Techniques (v2); Coping (v2); Death and Dying (v1); Family Counseling (v1); Low-Incidence Disabilities (v1); Medication Adherence (v1); Quality of Life (v2); Secondary Trauma (v2); Self-Efficacy/Perceived Competence (v2); Stress Management (v2); Treatment Compliance (v1); Work-Family Balance (v4)

## Further Readings

- Collie, K., & Long, B. C. (2005). Considering "meaning" in the context of breast cancer. *Journal of Health Psychology, 10*(6), 843–853.
- Frank, R. G. (Ed.). (2004). *Primary care psychology*. Washington, DC: American Psychological Association.
- Frank, R. G., & Elliott, T. R. (Eds.). (2000). *Handbook of rehabilitation psychology*. Washington, DC: American Psychological Association.
- Lorig, K., & Fries, J. F. (2006). *The arthritis helpbook: A tested self-management program for coping with your arthritis and fibromyalgia* (6th ed.). Jackson, TN: Da Capo.
- Lorig, K., Holman, H., Sobel, D., Laurent, D., Gonzalez, V., & Minor, M. (2000). *Living a healthy life with chronic conditions* (Rev. ed.). Emeryville, CA: Publishers Group West.
- Nicassio, P. M., & Smith, T. W. (1995). *Managing chronic illness*. Washington, DC: American Psychological Association.
- Petersen, C., Schmidt, S., Bullinger, M., & the DISABKIDS Group. (2006). Coping with a chronic pediatric health condition and health-related quality of life. *European Psychologist, 11*(1), 50–56.
- Power, P. W., & Dell Orto, A. E. (Eds.). (2004). *Families living with chronic illness and disease: Interventions, challenges and options*. New York: Springer.
- Sanderson, C. A. (2004). *Health psychology*. New York: Wiley.
- Schulz, M. S., & Masek, B. J. (1996). Medical crisis intervention with children and adolescents with chronic pain. *Professional Psychology: Research and Practice, 27*(2), 121–129.
- Stanton, A. L., Collins, C. A., & Sworowski, L. (2001). Adjustment to chronic illness: Theory and research. In A. Baum, T. Revenson, & J. E. Singer (Eds.), *Handbook of health psychology* (pp. 387–403). Mahwah, NJ: Lawrence Erlbaum.
- Suls, J., & Wallston, K. A. (Eds.). (2003). *Social psychological foundations of health and illness*. Malden, MA: Blackwell.

---

## CHRONIC PAIN

---

The classical model of pain, first articulated by the philosopher Descartes in the 17th century, regarded pain as a sensory experience triggered by tissue damage. Despite the fact that this model is unsupported by empirical research, it continues to be a common misconception. Research on pain has demonstrated that it is a complex biopsychosocial phenomenon, with sensory, affective, cognitive, and social components. The International Association for the Study of Pain defines pain as being both a sensory and emotional experience. It goes on to state that pain is always a subjective experience, and its presence cannot be verified by any kind of objective test. Consequently, the only way of knowing if an individual has pain is through the verbal report or other communication of that individual. Chronic



pain can sometimes persist in the absence of any identifiable physical cause.

In the acute phase following the onset of disease or injury, pain is often more closely associated with nociception. Nociception is a sensory system that alerts the brain to actual or potential tissue damage and initiates self-protective behaviors. Nociception, however, cannot be equated with pain, as nociception can occur without pain, and pain can occur without nociception. In contrast, as pain becomes chronic, its cognitive, affective, and social components tend to play a progressively larger role. Research studies using functional magnetic resonance imaging (f-MRI) have shown that the brain activity observed while experiencing physical pain is similar to brain activity observed while experiencing social pain or “hurt feelings.” This blurs the distinction between physical and social pain. Similar f-MRI studies have also found that physical pain and imagined pain also produce similar brain activity.

The complex nature of pain has led some to classify pain as being either “real” or “not real,” but this is a false dichotomy. Consider the example of someone whose foot is traumatically amputated in an accident. Many who experience this type of injury will experience “phantom pain,” or pain in the missing foot. Where is this pain? Is this pain “real” and “in the foot”? Or is this pain “not real” and “in the head”? Pain is an inherently subjective experience, and subjectively, this pain is clearly in the foot. Objectively though, there is no foot there to hurt. Consequently, it could be argued that the pain is actually in the stump, where the severed, damaged nerve ending is transmitting the wrong signal to the brain. However, the patient could counter that the pain cannot be in the stump, because the stump itself does not hurt. It could also be argued that the pain is in the brain, because the brain is involved in all subjective experience. The fact that all three of these explanations are correct in their own way illustrates the complex nature of pain. Because all pain is a subjective experience, the individual’s report of pain should be accepted. At the same time, knowing that chronic pain is a complex and multidimensional phenomenon, the various factors influencing pain need to be explored.

### Pain and Development

Developmentally, pain is one of the first experiences communicated, when the infant cries in response to

painful sensations and draws the attention of caregivers. Thus, from the earliest times of life, pain is experienced in association with emotional distress and is expressed within a social context. It is through these experiences that the child comes to understand the meaning of the word *pain*, associates sensory and emotional experiences with it, and begins to develop expectancies about what other people will do if pain is experienced.

Within the first few years of life, pain develops into a complex experience. For example, a child who is knocked down by a playful dog and sustains a bruise may cry and complain of pain. Upon closer inspection, however, this child’s report of pain may include unpleasant physical sensations and also a cognitive appraisal of danger, fear of harm, and anger at the dog as well as a desire for the comfort and protection of the parent. If this child’s complaints of pain can be alleviated by a hug and cookie, though, it affirms that this particular experience of pain was not purely sensory information related to tissue damage but was rather an undifferentiated amalgam of unpleasant physical sensations, cognitions, and emotions that was accompanied by a desire for the support of others. In this manner, the perception of pain and its meaning evolves over the course of life.

Most commonly, emotional distress acts to magnify the level of pain caused by organic pain generators. However, a construct that has been used to explain some types of chronic pain is alexithymia (meaning “without words for feelings”). Alexithymia may occur when a person is raised in an emotionally impoverished environment and as a result is unable to express or even recognize emotional states. Such a person, being unable to recognize emotional pain, may be unable to differentiate it from physical pain and may report experiences of both types simply as “pain.” Because medical treatment for physical pain generally does not reduce emotional pain, this can complicate treatment, as it may not be clear what kind of pain is being reported.

### Theories of Pain

Modern theories of pain were influenced greatly by Melzack’s gate control theory, which postulated that emotional arousal could alter pain perception by opening and closing perceptual “gates.” Nociceptive information pertaining to pain travels through spinal pathways that take it through areas of the brain known to be associated with affect; limbic structures, the



medial thalamic nuclei, and the anterior cingulate play especially important roles. This has led to the use of the phrase *limbically augmented pain syndrome* to refer to states where chronic pain seems to be closely intertwined with vegetative depressive signs.

One recent theory proposed by Melzack, neuromatrix theory, attempts to explain a variety of pain-related phenomena. The neuromatrix is conceptualized as being a widely distributed neural network in the brain that is in part genetically determined but is also affected by sensory experiences, emotional arousal, chronic stress, and other factors. According to this theory, the neuromatrix interprets nociceptive information and in so doing produces the experience of pain.

Research on stress and the endocrine system by Heim, Bremner, and others helps to shed light on the relationship between chronic pain and chronic stress proposed by neuromatrix theory. For example, patients who report a history of emotionally traumatic events have been found to exhibit increased pituitary-adrenal and autonomic responses to stress compared with controls. This increased reactivity under stress may explain the increased vulnerability to chronic pain that has been observed in those who have suffered emotional traumas.

### Pain in the Medical Setting

Research suggests that pain may be the most common single symptom seen by primary care physicians. The National Center for Health Statistics has estimated that up to 80% of office visits to primary care providers involve some complaint of pain, and this accounts for over 35 million new office visits a year. One large study on medical expenditures in managed care found that the medical treatment costs associated with chronic pain exceeded the costs attributable to the treatment of other disorders, such as heart disease, respiratory disease, or cancer. However, unlike these other diseases, which can be diagnosed by objective medical findings, pain is a subjective experience. As a result, the goal of medical treatment for pain is usually to change the verbal report of pain.

Chronic pain can affect any part of the body. However, certain types are more common. In particular, low back pain and headaches are commonly reported. For some types of chronic pain, there is an obvious organic pain generator. However, chronic pain sometimes exceeds what can be explained by objective medical findings and can

occur in patterns that cannot be explained on a purely anatomical basis.

### The Assessment of Pain

In addition to heart rate, respiration rate, blood pressure, and body temperature, the presence or absence of pain is regarded as one of the five vital signs in medicine. While the other vital signs can be objectively assessed, though, pain cannot. Typically, patients are asked to rate their pain in one of two ways, the first of which involves using a visual analog scale or VAS. On the VAS, pain is assessed by having the patient make a mark on a 10-centimeter long line, where one endpoint is labeled “no pain” and the other endpoint is labeled with some description of extreme pain. Alternately, patients are asked to rate their pain from 0 to 10 using a numerical rating scale or NRS.

The assessment of pain using either the VAS or the NRS is complicated by the fact that these tools are hampered by lack of standardization, which greatly impairs their value. First of all, extreme pain is defined in a variety of ways on these tools. For example, on these measures extreme pain is alternately defined as “the worst pain you can imagine,” “pain so bad you want to die,” or in any number of other ways. However, each of these definitions influences the rating, and a person with moderate pain who was also suicidal might rate pain differently using the two definitions above. Secondly, there are no standardized instructions. For example, these tests have no instruction regarding bodily location of pain, nor do they address the issue of multiple pain sites. Thus, if a patient has a headache of 5 on a 10-point scale and a back ache of 3, it is not clear what number will be reported if the patient is asked simply to “rate your pain level.” When patients have two or more pain complaints, they may alternately pick the highest number, try to average them, or sometimes add them together. Because of this lack of standardization, the numerous variations of the NRS and VAS are not equivalent, and this may influence the results in a variety of ways. As a result, while the other vital signs all have agreed-upon means of assessment and cutoffs for what is high, pain has neither.

More recently, new assessment tools have been developed that have attempted to address this problem. In particular, the Battery for Health Improvement 2 (BHI 2) is the first test to offer a multidimensional assessment of chronic pain with standardized instructions and established validity and reliability. The BHI



2 assesses pain in multiple locations, overall pain, pain variability over time, pain tolerability, and pain-related cognitions. These pain reports can be compared to national norms for both community members and medical patients and also to patients in the same diagnostic category. Further, this instrument also includes a variety of other scales that assess the biopsychosocial context in which the pain occurs.

## Pain Management

Because chronic pain is a biopsychosocial phenomenon, treatment for pain optimally involves a multidisciplinary team that addresses pain's biological, psychological, and social components. The biological aspects of chronic pain are addressed by physicians whose task is to evaluate the patient and identify any injury or disease that may be contributing to the pain experience. Treatment may involve a variety of medications, including medications for pain or inflammation as well as medications specific to any disease that may be present. Antidepressant medication may be prescribed to help with associated affective distress. Additionally, though, as pain and affect are closely related, some antidepressant medications also have an analgesic effect. Medications may be prescribed for insomnia, which is frequently seen in patients with chronic pain. Medical treatment can also involve surgery, injections, and other invasive procedures. Lastly, the physician may refer the patient for physical therapy as well.

The psychosocial aspects of chronic pain are usually treated by mental health professionals who can help patients with chronic pain in several different ways. First of all, psychological treatment has commonly been used to help patients manage their pain. However, more recent research has shown that psychological treatment can significantly reduce pain as well. Counseling the individual with chronic pain may involve helping this person to develop better techniques for pain management. Individuals with chronic pain sometimes "catastrophize" and view their situation as being worse than objectively is the case. Individuals with chronic pain can also become somatically preoccupied. This preoccupation with pain may heighten the pain experience and increase the level of affective distress and suffering. Catastrophizing and somatic preoccupation can lead an individual with chronic pain to feel extremely fragile, and this can lead to excessive self-limiting behaviors out of an

irrational fear of self-harm. This self-limiting behavior can in turn lead to a progressive physical deconditioning and to further disability. Helpful techniques involve teaching the patient to shift attention away from the pain, to develop a more realistic appraisal of the pain and any associated disability, and to identify desirable activities that the individual should continue to engage in.

The onset of chronic pain may require the patient to make a multitude of lifestyle changes. Patients with chronic pain can often benefit from the opportunity to discuss all of these new life challenges with a mental health professional and from using a problem-solving approach to address whatever changes are necessary in work, home responsibilities, hobbies, and other activities.

Because chronic pain and any associated disability can be stressful, offering the patient stress management techniques is often helpful. This may include relaxation training or biofeedback. Stress management is important, because stress tends to increase physiological arousal levels. As noted above in gate control theory, physiological arousal tends to increase the experienced intensity of pain. This can lead to an ever-worsening syndrome, where pain leads to stress, and the stress heightens the pain experience, which then in turn worsens the stress. It should also be noted that some types of chronic pain, such as chronic tension headaches, can be produced entirely by stress.

Chronic pain is also commonly associated with depression, anxiety, and anger. Individuals with chronic pain may feel despondent or angry about having to constantly cope with pain and may be fearful about the future. As with stress, strong emotions also tend to increase the level of experienced pain. The term *suffering* is sometimes used to refer to the combination of pain and emotional distress that is felt. Helping the individual with chronic pain to reduce the level of emotional distress will reduce the level of suffering and may reduce the level of pain as well.

Chronic pain is often associated with insomnia, as the patient cannot get comfortable and also may be too distressed to sleep. In addition to stress management training, there are specific techniques for insomnia control that are sometimes referred to as sleep hygiene training. Research has shown that these techniques are about as effective as medication for treating insomnia. Additionally, unlike medications, these techniques have no side effects.



When an individual suffers from chronic pain, it may have an impact on the entire family. The individual with chronic pain may no longer be able to take care of his or her usual household responsibilities, and this may be very disruptive. While a healthy family will tend to rally behind the individual with chronic pain, the dysfunctional, unsupportive family may refuse to adjust to the chronic pain condition. This may increase the emotional distress of the individual with chronic pain and force the individual to perform activities that worsen the pain. On the other hand, overly supportive families may encourage the individual with pain to adopt a passive role, which in turn may only increase disability. The quality of life of the individual with chronic pain can improve considerably if the family can learn to provide the optimal level of support.

*Daniel Bruns*

**See also** Cancer Management (v1); Caregiver Burden (v1); Caregiving (v1); Chronic Illness (v1); Coping (v2); Depression (v2); Low-Incidence Disabilities (v1); Medication Adherence (v1); Panic Disorders (v2); Quality of Life (v2); Secondary Trauma (v2); Sleep Disorders (v1); Stress Management (v2); Treatment Compliance (v1)

### Further Readings

- Bruns, D., & Disorbio, J. M. (2005). Chronic pain and biopsychosocial disorders. *Practical Pain Management*, 5(7), 52–61.
- Caudill, M. (2002). *Managing pain before it manages you* (Rev. ed.). New York: Guilford Press.
- Gatchel, R. J. (2004). Comorbidity of chronic pain and mental health disorders: The biopsychosocial perspective. *American Psychologist*, 59, 795–805.
- Melzack, R. (2001). Pain and the neuromatrix in the brain. *Journal of Dental Education*, 65, 1378–1382.
- Merskey, H., & Bogduk, N. (1994). *Classification of chronic pain* (2nd ed.). Seattle, WA: IASP Press.
- Turk, D. C., & Gatchel, R. J. (2002). *Psychological approaches to pain management: A practitioner's handbook* (2nd ed.). New York: Guilford Press.

---

## CIGARETTE SMOKING

---

Cigarette smoking is a behavioral risk factor for disease and one that is amenable to intervention by counseling psychologists. Clients who seek help for emotional and

behavioral problems are more likely than others to be cigarette smokers, and counseling psychologists should become familiar with treatment guidelines that exist. All smokers should be encouraged to quit, and brief interventions are effective for motivating smokers to consider quitting. More intensive treatment has been shown to be effective, but such intervention may require specialized training. Smoking is a chronic condition, and relapse is common. This entry provides statistics and information about smoking as well as guidelines for counseling the smoker.

### Statistics

Cigarette smoking increases risk for disease, and cessation can reverse this risk. It is estimated that male smokers lose an average of 13.2 years of life and female smokers lose 14.5 years due to smoking. However, cessation can minimize these health risks. Individuals who stop smoking before age 35 avoid 90% of the risks associated with cigarette smoking.

The percentage of people who smoke cigarettes in the United States has declined from highs in the mid-1970s of 42% to approximately 28% today. Trends suggest that there is a deceleration in this decline. There are also some indications that there may be a slight increase in tobacco use among teens and college students. Data from the Monitoring the Future Study conducted at the University of Michigan suggest that in 2005, 1 in 11 eighth graders and 1 in 4 twelfth graders had smoked in the past 30 days. While these rates are lower than in the past, they remain at an unacceptably high level.

### Hazards

The harmful effects of cigarette smoking are well documented, and today there is a growing understanding of the harmful effects of involuntary exposure to tobacco smoke in the environment. In June of 2006, the surgeon general issued a report documenting the harmful health effects of exposure to tobacco smoke and urged greater attention to this problem. Data from this report indicate that approximately 60% of non-smokers in the United States show biological markers indicative of environmental exposure to tobacco smoke. It is likely that there will be even greater attention given to this aspect of cigarette smoking in the coming years, and there will be policy changes such as the implementation of smoke-free workplaces.



Similar policies are currently being implemented in many healthcare facilities.

### Etiology of Tobacco Dependence

Cigarette smoking typically results in nicotine dependence and nicotine withdrawal, two Axis I disorders classified by the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition*. Compared to other drugs of abuse, such as marijuana, cocaine, or alcohol, tobacco is more likely to cause dependence. Recent studies have documented that more than 80% of individuals who report regular smoking meet criteria for nicotine dependence. Likewise, 32% of all individuals who have ever tried any tobacco products progress to nicotine dependence. Comparable statistics for heroin, cocaine, and alcohol are 23%, 17%, and 15%, respectively. Tobacco has a high risk for dependency.

Cigarette smoking is commonplace among psychiatric patients. There are differing perspectives as to why psychiatric patients smoke. Some have suggested that smoking is an attempt to self-medicate emotional symptoms. Research indicates that stress exacerbates urges or cravings to smoke and is associated with relapse. In addition to an association with emotional problems, cigarette smoking is clearly associated with other substance use problems, including use of alcohol, caffeine, and illegal drugs. The more severe the emotional disorder, the more likely that smoking will be present and the greater likelihood of dependence. Additionally, cessation is likely to be more difficult with severe emotional disorders.

### Smoking Cessation

Clinical practice guidelines for working with smokers were developed by the United States Public Health Service in 1996 and revised in 2000. The goal of these guidelines is to provide health care providers with evidence-based recommendations regarding methods for increasing the likelihood of successful smoking cessation. Counseling psychologists, as healthcare professionals, should consider adopting these guidelines with all clients regardless of presenting problems. The guidelines allow for client autonomy while maximizing effectiveness for clients who desire help.

### Assessment of Tobacco Use

For clients who do not want to quit smoking, it is suggested that a brief intervention be provided to help

increase motivation to quit. Clients who want to quit should be provided with assistance using effective strategies. Details can be found in the monograph *Treating Tobacco Use and Dependence* (Fiore et al., 2000), which can be downloaded from the Web.

Healthcare providers should assess the smoking status of every client at every visit. For individuals who smoke, it is recommended that one assess the client's interest in stopping. Depending on the answer to questions regarding desire to quit, a brief motivational intervention is recommended that can enhance motivation to quit for individuals who are not ready to quit and can be the first step in cessation for individuals ready for cessation.

### Role for Counseling Psychology in Smoking Cessation

While the clinical practice guidelines have been in place since the mid 1990s, most studies suggest that healthcare providers do not use the guidelines. For example, physicians frequently fail to counsel clients to quit smoking, although there is some evidence that rates of physician assistance are increasing, and one study showed that over 50% of physicians advised smokers to quit. Most other healthcare professionals (pharmacists, public health nurses, chiropractors, and dentists) use these guidelines less often than physicians. A recent survey of licensed psychologists indicated that psychologists often provide assistance and intervention for clients who want to quit smoking, but like other healthcare providers, they rarely inquire about a client's tobacco use.

Given that psychologists are often in a position to provide effective intensive clinical interventions for smoking cessation or at least to provide brief interventions, it is disappointing that as a health care profession, psychologists are not leading the way. This is particularly important given the high comorbidity seen for cigarette smoking and other mental health problems. As noted earlier, smoking rates are substantially higher for individuals with psychiatric mood, anxiety, and psychotic problems, and these individuals have more difficulty with cessation than individuals without comorbid psychological problems.

Recently, Miles McFall and his colleagues at the Seattle Veterans Administration Medical Center have initiated smoking cessation treatment for patients seeking treatment for posttraumatic stress disorder (PTSD). His data suggest that clients who



received integrative treatment (e.g., treatment for both PTSD and cigarette smoking) were 5 times more likely to abstain from smoking than those who received standard PTSD treatment. More importantly, stopping smoking was not associated with increased PTSD or depressive symptoms. These data are promising, and psychologists should not be concerned that treating nicotine dependence will be contraindicated in the treatment of clients with other emotional problems.

### Brief Clinical Interventions

All counseling psychologists should have the basic clinical skills necessary to implement brief interventions. Long-term abstinence can be greatly increased through the use of brief clinical interventions; the base rate for long-term abstinence is 7% when there is no intervention and 15% to 30% for individuals who receive brief interventions.

Effective brief interventions utilize skills and techniques often associated with motivational intervention strategies. The clinical practice guidelines recommend an approach commonly known as the “Five A’s”: *ask*, *advise*, *assess readiness*, *assist*, and *arrange*. Every client should be asked about tobacco use at every visit (*ask*), and every tobacco user should be encouraged to quit (*advise*). The client’s willingness to quit should be assessed (*assess readiness*), and appropriate assistance should be provided to the client (*assist*). For individuals who are not ready to quit, assistance could be in the form of a brief motivational intervention designed to enhance motivation to change. For those ready to quit, assistance could include providing self-help materials or a referral for a more intensive intervention. Finally, the clinician should arrange to follow up with clients who use tobacco (*arrange*). Follow-up could be as simple as a phone call to assess smoking status or a scheduled visit to discuss cessation plans. During follow-up, the clinician might congratulate success or help address problems as well as anticipate future challenges. For clients referred for intensive interventions, assessment of treatment is important.

### Intensive Clinical Interventions

While all counseling psychologists should be in a position to offer brief clinical interventions for smoking cessation, more intensive intervention will be needed for some clients. These interventions are often

provided by clinicians who specialize in treating tobacco dependence and who work in a setting where the primary focus is on smoking cessation. There is substantial evidence that intensive interventions are more effective than brief interventions with respect to cessation success rates; however, many studies have found that only a minority of smokers participate in intensive interventions.

Evidence for intensive interventions suggests several necessary components. First, assessment should ensure that smokers are willing to make an attempt to quit. A willingness to attempt cessation is critical for success. Second, use of multiple types of clinicians is effective and may be desirable. One clinician might provide counseling strategies related to health risk; another clinician might provide pharmacotherapy; and a third clinician might provide additional psychosocial or behavioral interventions.

Third, since there is evidence of a dose-response relationship, it is recommended that intensive treatment use sessions that are at least 10 minutes in duration and that treatment involve four or more sessions. Fourth, the type of intervention (group vs. individual) does not appear to be important. In fact, telephone counseling has been shown to be effective. Fifth, techniques used should be practical (problem solving or skill training), and social support should be provided within sessions and fostered in the client’s environment.

Finally, pharmacotherapy should be encouraged for all smokers, unless there are particular contraindications for the client. First-line pharmacotherapies include bupropion SR, nicotine gum, a nicotine inhaler, nicotine nasal spray, and the nicotine patch. Many of these are over-the-counter medications and do not need a prescription. Special considerations are needed for teens and pregnant individuals.

As noted earlier, intensive treatment should be used by clinicians with specialized training in working with nicotine dependence. However, all psychologists should be aware of the effectiveness of intensive interventions and should make appropriate referrals for their clients who smoke.

### Relapse Prevention

The vast majority of cessation attempts result in some type of relapse. It is useful to consider the difference between a brief lapse (an isolated event that is followed by continued abstinence) and a more extensive relapse (a period of several days or more of continued



smoking after a period of abstinence). While any form of lapse is very risky and increases the likelihood that the abstinent smoker may return to previous smoking rates, the frequency with which lapses occur suggests that some form of relapse prevention is critical to maximize the chance that a lapse can be followed by continued abstinence, instead of becoming a relapse.

Methods for reducing relapse have included booster sessions, formal relapse prevention training, and enhancing social support. The use of booster sessions alone has not been found to be very useful. Likewise, relapse prevention efforts are at best equivocal. There is some evidence that quickly recruiting individuals who have relapsed into a second course of treatment does not work. Clients who relapse and then try a new pharmacotherapy may fare better in the new attempt.

*Frank L. Collins, Jr. and Theodore L. Wagener*

**See also** Brief Therapy (v2); Chronic Illness (v1); Occupational Health Psychology (v4); Physical Health (v2); Solution-Focused Brief Therapy (v2); Substance Abuse and Dependence (v2); Technology and Treatment (v1)

### Further Readings

- Fiore, M. C., Bailey, W. C., Cohen, S. J., Dorman, S. F., Goldstein, M. G., Gritz, E. R., et al. (2000). *Treating Tobacco Use and Dependence: Clinical Practice Guideline*. Rockville, MD: U.S. Department of Health and Human Services.
- Johnston, L. D., O'Malley, P. M., Bachman, J. G., & Schulenberg, J. E. (December 19, 2005). *Decline in teen smoking appears to be nearing its end*. University of Michigan News and Information Services: Ann Arbor, MI. Retrieved July 10, 2006, from <http://www.monitoringthefuture.org>
- Leffingwell, T. R., & Babitzke, A. C. (2006). Tobacco intervention practices of licensed psychologists. *Journal of Clinical Psychology*, 62, 313–323.
- McFall, M., Saxon, A. J., Thompson, C. E., et al. (2005). Improving the rates of quitting smoking for veterans with posttraumatic stress disorder. *American Journal of Psychiatry*, 162, 1311–1319.
- Piasecki, T. M. (2006). Relapse to smoking. *Clinical Psychology Review*, 26, 196–215.
- U.S. Department of Health and Human Services. (2006). *The Health Consequences of Involuntary Exposure to Tobacco Smoke: A Report of the Surgeon General*. Atlanta, GA: Author.

## COMMUNITY-BASED ACTION RESEARCH

Community-based action research (C-BAR) is a relatively new addition to counseling and counseling psychology research. The research and interventions, or actions, occur at the community level, rather than with individuals, families, or small groups. *Community* is defined as a group linked by common interests, such as young women in a teen pregnancy program, migrant workers, or people living with AIDS.

C-BAR is distinguished from much other research in counseling in that the research is developed and conducted as a collaborative partnership between the counselor-researcher and community members. Sharing project responsibility in this way empowers the community to define its own problems and develop its own solutions. In this collaborative process, the researcher is deeply involved as a coexpert, bringing organizational and research skills to the project. Community members are the other coexperts, contributing their unique experiences, truths, and analyses of why the problem exists and how it may be solved. C-BAR projects are not value-free endeavors; they are often explicitly conceptualized as efforts to promote social justice and equality by empowering those with muted or silenced voices to speak and act on their own behalf.

### C-BAR, the Family Tree

#### *Philosophical Roots*

The emergence of C-BAR in counseling parallels the increasing influence of constructivist, feminist, multicultural, social justice, and qualitative research perspectives. Community-based action researchers believe that truth is relative. They believe that perceptions of reality are shaped by social, political, and economic factors that impact individuals and communities and that these factors determine who gets the power and authority to speak, label, and define reality.

C-BAR is part of a family of action and participatory research, including participatory action research, community participatory action research, critical action research, feminist participatory research, classroom action research, and industrial action research. Adherents of action research debate among themselves about terminology, principles, ideology, goals, and change theories. Some of the disagreements



can be traced to historical as well as philosophical differences.

### **Historical Roots**

There are a number of founders or contributors to the action and participatory research family. The majority of action researchers today stem from the following traditions: (a) social psychologist Kurt Lewin, who coined the term *action research* in the 1940s; (b) the Tavistock Institute of Human Relations in the United Kingdom, which was primarily involved in organization development; and (c) the social movements of the 1970s in the developing world, championed by individuals such as exiled Brazilian philosopher Paulo Freire, author of the banned *Pedagogy of the Oppressed* (1970).

Action researchers today have been classified in a number of ways, including along a continuum with Lewin and his followers at one end and Freire and his adherents on the other. Following the Lewin tradition, researchers engage primarily in problem-solving action research, such as in industrial psychology, and do not necessarily include the community as extensive collaborators in the research process. They also seldom conduct research with commitment to broader social change. At the other extreme of the continuum, in the Freire tradition, is research more typical of the movements of the 1970s and popular education, rooted in social justice and consciously linked to broader social change. These researchers see the community as the vanguard of social change and social justice, and they see themselves, the researchers, as catalysts and supporters of the change process.

### **Commonalities**

In spite of their differences in ideology and goals, most C-BAR researchers share certain values and principles. C-BAR involves collaboration between researchers and the community. C-BAR is a participatory, colearning process and is usually an empowering process for the community. C-BAR attempts to achieve a balance among theory, research, and action. A key commonality is an intent to change something that the participants view as worthy of change.

### **Methodological Approach**

Methods in C-BAR and other types of participatory action research have an extensive history in various

social science and social practice fields. C-BAR methods evolved from such disciplines as anthropology, sociology, psychology, education, public health, nursing, and social work. Today, C-BAR principles are often greatly influenced by feminist and multicultural ideologies. Putting these theories into practice implies that central to C-BAR methods today are issues of gender, race, class, and culture.

In practice, C-BAR uses a method of systematic inquiry that follows a series of loops that involve planning following by acting and observing followed by reflecting. This process is self-reflective in that each new loop is based on results from the preceding cycle. The number of self-reflective loops is determined by the project. The flexible and fluid design of these projects is well suited to qualitative research methods.

Beginning a C-BAR project first involves establishing a relationship with a community. Sometimes the counselor-researcher is hired as a consultant, but usually these partnerships develop from an association between the counselor-researcher and a social agency or group. For example, a counselor-researcher who has an affiliation with a domestic violence clinic, a special needs group, or a legal aid program may eventually form a C-BAR partnership. Once this relationship is forged, the problem is defined and clarified by the community; goals and methods are selected and then implemented, and the problem-solving intervention is evaluated. The end of this sequence, evaluation, simultaneously begins the next cycle, replanning.

Conceptually, this process is simplified by an action research spiral:

PLAN → ACT & OBSERVE → REFLECT

In this spiral, C-BAR researchers take on many roles, including those of observer, reporter, colearner, and collaborator in which they facilitate community empowerment. The self-reflective element is critically important, because it allows for more effective interventions at each new cycle.

To empower community voice, the project results must be disseminated. This may represent a departure from traditional research. Rather than publishing only in professional journals, the C-BAR researcher will also make results known to policymakers, the media, popular or specialty magazines, and to whoever else can best use the information.



## Counseling and Counseling Psychology

Because it is a newcomer to counseling and counseling psychology, C-BAR's use has been limited. Generally, counselors and counseling psychologists have viewed their proper role as that of being therapists or scientists, believing community-based projects and advocacy were better suited for social workers. However, some scholars maintain that a social justice agenda is simply a return to counseling's roots, beginning with Frank Parsons.

There is a growing momentum supporting C-BAR in counseling and counseling psychology. In the past decade, professional counseling journals have dedicated entire issues to exploring counselors' emerging role as advocates for social justice. In academia, a growing number of counselors and counseling psychologists are calling for social justice agendas within training programs and practice settings. Some even suggest that APA guidelines for multicultural competence mandate an ethical responsibility to practice C-BAR. Asserting that multicultural competence must entail social justice, progressive training programs are moving to expand the traditional roles of counselors and counseling psychologists. This philosophical shift may necessitate role reconciliation to bridge the gulf between the-counselor-as-healer-scientist and the-counselor-as-social-change-agent ideologies.

C-BAR projects are carried out in a variety of settings. In a Chicago-based teen smoking prevention effort, teenagers contributed information that led to legislative changes and a police crackdown on selling tobacco to minors. In another project aimed at teens, the agency itself was the primary community and collaborated with researchers to develop sex education and pregnancy prevention interventions for at-risk youth. In yet another endeavor, researchers collaborated with clergy and parishioners to facilitate the congregations' ability to absorb an influx of immigrant members. These examples illustrate the basic principles underlying C-BAR projects. The collaborative partnerships and sharing of power were evidenced by each community's input in defining their problems and implementing solutions. Community empowerment was achieved through enhanced education, opportunity, or ability to act on their behalf.

The emerging utilization of C-BAR in counseling and counseling psychology promises both challenges and opportunities. C-BAR proponents may be initially

viewed negatively by others in counseling and counseling psychology due to their philosophical and methodological shifts encouraging community involvement and empowerment. Concerns range from objections to C-BAR's social and political overtures to questions about its academic validity and scientific rigor. C-BAR researchers may also encounter difficulties with human subject protection committees; however, these obstacles may be overcome by educating those responsible for ethical review about C-BAR. A specific opportunity for C-BAR is that some funding sources want to support projects that are based on collaboration with the community. C-BAR offers counselors and counseling psychologists expanded professional opportunities to use their skills to promote problem solving and personal empowerment at the community level.

*Sue C. Jacobs, Ann Batcheler,  
and Eneclia Saucedo*

**See also** Action Theory (v4); Community-Based Health Promotion (v1); Constructivist Theory (v2); Counseling Theories and Therapies (v2); Feminist Therapy (v1); Multicultural Counseling Competence (v3); Parsons, Frank (v4); Qualitative Methodologies (v1); Social Justice (v3)

## Further Readings

- Arrendondo, P., & Perez, P. (2003). Expanding multicultural competence through social justice leadership. *The Counseling Psychologist, 31*(3), 282–289.
- Goodman, L., Liang, B., Helms, J., Latta, R., Sparks, E., & Weintraub, S. (2004). Training counseling psychologists as social change agents: Feminist and multicultural principles in action. *The Counseling Psychologist, 32*(6), 793–837.
- Israel, B. A., Eng, E., Schulz, A. J., & Parker, E. A. (Eds.). (2005). *Methods in community-based participatory research for health*. San Francisco: Jossey-Bass.
- Kemmis, S., & McTaggart, R. (2005). Participatory actions research: Communicative action and the public sphere. In N. Denzin & Y. Lincoln (Eds.), *The SAGE handbook of qualitative research* (3rd ed., pp. 559–603). Thousand Oaks, CA: Sage.
- Khanlou, N., & Peter, E. (2005). Participatory action research: considerations for ethical review. *Social Science & Medicine, 60*(10), 2333–2340.
- Kidd, S., & Kral, M. (2005). Practicing participatory action research. *Journal of Counseling Psychology, 52*(2), 187–195.



- Minkler, M., & Wallerstein, N. (Eds.). (2003). *Community-based participatory research for health*. San Francisco: Jossey-Bass.
- Prilleltensky, I., & Prilleltensky, O. (2003). Synergies for wellness and liberation in counseling psychology. *The Counseling Psychologist*, 31(3), 273–281.
- Reason, P., & Bradbury, H. (Eds.). (2001). *Handbook of action research*. London: Sage.
- Sandler, I., & Chassin, L. (2002). Training of prevention researchers: Perspectives from the Arizona State University prevention research training program. *Prevention and Treatment*, 5. Retrieved from <http://journals.apa.org/prevention/volume5/pre0050006a>
- Vera, E., & Speight, S. (2003). Multicultural competence, social justice, and counseling psychology: Expanding our roles. *The Counseling Psychologist*, 31(3), 253–272.

---

## COMMUNITY-BASED HEALTH PROMOTION

---

Health is having quality of life in the physical, emotional, social, cognitive, and spiritual realms. The diseases that pose the most threat to achieving that quality of life are cardiovascular diseases, cancer, and diabetes. The factors that contribute to these diseases are integrally intertwined with the community and deeply connected to culture. Poverty, inadequate education, crime, and unemployment weaken the community, and these factors are associated with a higher prevalence of disease and higher mortality rates from diseases. The human and economic costs affect everyone, and these costs are soaring.

Yet, the factors that exacerbate disease are preventable or modifiable. Some factors are personal habits: smoking and chewing tobacco, overeating, sedentary lifestyles, and high consumption of polyunsaturated fats and sugars. Some factors are contextual: school-based soda vending machines, limited and overpriced healthy food choices in inner-city grocery stores or the lack of grocery stores in inner-city neighborhoods, unsafe streets that make walking dangerous, lack of adequate exercise facilities in rural areas, discriminatory practices toward minorities within the medical system, and the lack of insurance coverage for early detection of disease. Others emerge from culture-bound beliefs that inhibit health behavior change: language barriers, lack of engagement in preventive health practices, fatalism, use of emergency

rooms as primary care facilities, inability to meld the medical system to the cultural beliefs of minorities, and attitudes toward certain behaviors, such as the link between smoking and status within a subculture.

Some community factors can be changed through advocacy efforts and community awareness. For example, many school systems in America are introducing higher nutrition standards for their lunch programs. The personal factors can be changed through personally engaging interventions and community support. Efforts, however, must be stepped up to develop and test culturally sensitive strategies for health promotion. Community health promotion is proceeding along two directions. One direction is toward more individualized interventions; the other toward reaching greater numbers of people, specifically, the underserved and minorities. The challenge we face today is their integration: accomplishing a wider reach while individualizing interventions to improve effectiveness.

The diseases that carry the highest costs are caused or exacerbated by poor diet, obesity, and smoking. Therefore, this entry synthesizes the research on those practices that are likely to have the greatest impact on health.

### Smoking Cessation

Although social policy changes and media campaigns have reduced the rate of smoking in subsets of the population, smoking remains the single most preventable cause of serious illness. Despite tremendous efforts to develop and test efficacious smoking cessation treatments, only 10% to 28% of smokers achieve long-term cessation. Most treatments have been aimed at higher socioeconomic levels, yet smoking is more prevalent among those with low socioeconomic status. African Americans have higher rates of smoking, experience higher rates of tobacco-related diseases and at younger ages, and are less likely to receive physician recommendations to quit, and existing cessation programs do not address the differing beliefs, motivations, and patterns of smoking in minority populations.

At this juncture, successful treatment is too costly, impractical, and ineffective for widespread application. Community-based and workplace interventions have been shown to have limited effectiveness. However, these interventions typically focused on multiple behaviors rather than smoking alone. Low-intensity interventions such as physician reminders



can affect the rate of smoking by raising awareness and educating smokers, but they have fallen short of causing successful long-term abstinence. Those treatments that have been successful combine pharmacological components, counseling, education, and follow-up contacts. Most people relapse within the first week of quitting. Therefore, counseling interventions must be front-loaded, providing numerous contacts within the first week. Individual counseling, including problem solving and skills training tailored to idiosyncratic smoking triggers, along with assistance in obtaining social support, increase sustained abstinence. Proactive follow-up by the provider also increases success rates.

Several conclusions can be drawn from the research on smoking cessation interventions. First, multicomponent treatment, including counseling, follow-up, education, and nicotine replacement therapy (NRT) is most effective. Second, NRT improves success rates when combined with other treatments; however, the reported effectiveness of NRT has diminished in studies conducted since drugs for NRT became available over the counter, from an average of 45% to 9%, which is only 2% better than self-treatment. Third, tailoring the intervention to the stage of change leads to higher abstinence rates and improves relapse prevention. Fourth, traditional counseling approaches alone, such as cognitive-behavioral mood management, do not boost the efficacy of a multicomponent treatment program. However, applications of specific counseling interventions are beginning to show promising results. These include motivational interviewing, treatment matching to degree of dependence, contingency management, and community reinforcement. Fifth, the creative use of technology is a promising method to reach more smokers and intervene in real-life situations. One example is the use of text-messaging reinforcers on cell phones and computer-tailored smoking cessation programs.

## Obesity

Over two thirds of Americans are either overweight or obese, costing \$117 billion in tax dollars and life years lost. In the United States, minorities including Hispanics, African Americans, and Native Americans are particularly affected. Obesity is a factor in diabetes, coronary artery disease, hypertension, degenerative joint disease, gallbladder disease, and certain cancers.

Weight reduction—whether pharmacologic, surgical, or behavioral—seeks to alter energy balance. Obesity treatments focusing on altering dietary intake result in 3% to 10% weight loss, but dropout rates average 58%, and fewer than 5% keep the weight off. The most promising treatments are behavioral, resulting in 5% to 20% weight loss and dropout rates of 20%; however, most people benefiting from these treatments return to baseline weight within 5 years. Not only is such nebulous success questionable, but gain-and-loss cycling is actually dangerous.

Behavioral treatments have been the most studied and provide the fewest barriers to implementation in a community setting. The goal of behavioral treatment is to help obese patients identify and modify eating, activity, and thinking habits that contribute to their excess weight and typically yield a 10% reduction in body weight during the first 6 months. Self-monitoring (i.e., keeping records of food intake) is the strongest correlate with weight loss in both short-term (12 weeks) and long-term (17 months) studies. Studies conducted over the past decade indicate that continued contact between the patient and the practitioner significantly enhances weight maintenance, and without continued contact, patients generally regain one third of this weight within 1 year.

Perhaps due to the ineffectiveness of most dieting interventions, nondieting and size acceptance build a foundation for a healthy lifestyle of exercise and healthy eating. In uncontrolled trials, the lifestyle approach has resulted in significant improvements in self-esteem, mood, and eating-related psychopathology, and these gains have been maintained for up to 2 years. Some studies show weight loss; others, weight gain.

The addition of individual behavioral counseling to the nondieting approach resulted in significant weight loss in morbidly obese women and as adjunctive therapy. In a study comparing CBT and size acceptance versus CBT and a diet-driven program, obese women in both groups demonstrated significant but modest weight loss, psychological improvement, low dropout rates, and cardiovascular improvements. Self-monitoring, stimulus control, cognitive restructuring, problem solving, goal setting, positive reinforcement, relapse prevention, nutrition education, and coping strategies for healthy eating were used in this multicomponent intervention. Promoting physical satisfaction resulted in improved weight loss maintenance. Psychological



improvement in mood and self-esteem is instrumental in maintaining weight loss, and coping distinguishes dietary temptations from dietary relapses. Strategies that result in enhancing restraint are the most effective in weight loss maintenance.

Not every person requires all the components of a multicomponent intervention, and using a stepped-up approach that matches treatment intensity to the patient's need is more cost-effective. Motivational interviewing techniques decrease dropout rates from weight loss programs.

The majority of interventions have been individual due to the fact that community interventions lack the intensity required for weight loss and maintenance, yet community efforts, such as faith-based programs, have been used most with minority populations. Tailoring interventions to the culture is essential.

### **Sedentary Lifestyle**

The lack of physical activity is implicated in the four leading causes of death in the United States: heart disease, stroke, cancer, and diabetes. While television and electronic media constantly flood the public with promotional offers of gym memberships and popular articles on the vital role exercise plays in physical health and mental well-being, according to the American Heart Association, as of 2006, more than 24% of Americans were completely sedentary. In 2004, Americans spent more time watching television and movies than on sports and any other leisure-time physical activity combined. A recent survey by the American College of Sports Medicine found that 50% of Americans who commenced exercising in the past year have discontinued exercise.

Efforts to increase physical activity levels of Americans have been moderately successful. Those demonstrated to be effective are often time- and labor-intensive and require attendance at an exercise center, expensive equipment, and competent staff supervision. Consequently, there is a need for efficient and cost-effective methods for increasing physical activity for a diverse population within the United States. The Centers for Disease Control and Prevention notes that educational efforts alone have been ineffective in changing health behavior.

Many of the exercise interventions have been conducted with community groups; however, it would be misleading to suggest that the interventions are

homogeneous. Most are tailored to different levels of motivation, physical condition, and cultural background. Tailored messages are based on the assumption that people respond differently to message presentation based on personal characteristics. Studies using tailored messages resulted in significant improvement in various health behaviors, ranging from 74% in improving health behaviors to 91% in intent to improve.

Interventions accommodating individual stages of change have resulted in increased exercise and long-term maintenance. Results of tailored-message outcome studies resulted in better health outcomes in both White and minority populations. Studies on ethnic minorities suggest that not only should material be culturally sensitive, but it should also be individually focused in order to have a greater impact. Several factors have emerged as predictors of adherence to an exercise program in ethnic minority communities; these include age, weekly caloric expenditure incurred from doing yard work, and a sense of community affiliation as well as preexisting level of fitness and concerns about health.

Behavior-based interventions in exercise adherence have produced mixed results and seem to be more efficacious when combined with financial incentives, telephone and e-mail reminders, and personal trainers. However, behavior-based interventions have been successful at isolating predictors of long-term adherence, such as higher existing fitness levels, perceived stress, lower education, life events, body mass index, exercise program format, cognitive functioning, and male gender.

Yet, change in exercise occurred in less than 20% of the participants, and the changes rarely reached significance. There is some evidence that control is an important issue in adherence to an exercise program. Researchers found that patients' attitudes and perceived behavior control provide the strongest influence on adherence when participation was more volitional, during the latter part of a cardiac rehabilitation process, as opposed to when their participation was more compulsory, during the earlier part of the rehab program. Furthermore, self-monitoring often produces dramatic results. Telephone counseling has been shown to increase adoption of physical activity, while both telephone and "snail mail" have been shown to be effective in maintaining exercise adherence in older adults, and telephone and e-mail



reminders have been shown to be effective in maintenance of physical activity. Self-efficacy has also been shown to improve exercise adherence.

Among the more promising efforts to improve exercise in the community are those that use technology. Computerized interventions are effective for increasing physical activity through self-monitoring and reporting. Using e-mail reminders increased adherence to a walking program to increase physical activity and make small, cumulative changes in food choices. At the 12-month follow-up point, Internet participants had increased daily steps by 2,021 over the baseline, while control participants had decreased steps per day by 38. In another study on rural Caucasians and inner city African Americans, those who used the system more frequently increased exercise significantly and demonstrated greater exercise capacity after 8 months. Yet another study, which examined the effects of music, television, and combined entertainment on exercise adherence, showed that a distraction through entertainment from the physical discomfort of exercise tended to foster adherence.

Whereas a sedentary lifestyle remains problematic and posits great health risks to the American population, emerging trends in behavioral medicine suggest that the utilization of individually tailored messages, communication technology such as telephones and e-mail, and cultural considerations that take into account the ethnic, religious, and racial background of the participants can contribute to the overall health and wellness of the American population. When coupled with psychoeducational interventions, community support, and behaviorally based interventions that target health beliefs and self-efficacy, these multifaceted interventions have the potential to improve health across all of its dimensions.

*Healthy People 2010* challenges Americans to reduce lifestyle-related diseases. This is a formidable task. Despite a concerted search for solutions to the problems of adherence and maintenance of exercise, weight loss, and smoking cessation, the epidemic continues. Data from numerous studies consistently indicate that efforts must be made on all fronts—individual, social group, and community—in order to reach this goal.

*Suni Petersen and Dina E. Goldstein*

**See also** Children With Chronic Illness (v1); Chronic Illness (v1); Cigarette Smoking (v1); Community-Based Action Research (v1); Exercise and Sport Psychology (v1); Occupational Health Psychology (v4); Physical Health (v2); Quality of Life (v2)

## Further Readings

- Lichtenstein, E., Glasgow, R. E., Lando, H. A., Ossip-Klein, D. J., & Boles, S. M. (1996). Telephone counseling for smoking cessation: Rationales and meta-analytic review of evidence. *Health Education Research*, 11, 243–257.
- Marcus, B. H., Nigg, C. R., Riebe, D., & Forsyth, L. H. (2000). Interactive communication strategies: Implications for population based physical activity promotion. *American Journal of Preventive Medicine*, 19, 121–126.
- Marmot, M. (2001). Inequalities in health. *New England Journal of Medicine*, 345(2), 134–136.
- Perri, M. G., & Corsica, J. A. (2002). Improving the maintenance of weight lost in behavioral treatment of obesity. In T. A. Wadden & A. J. Stunkard (Eds.), *Handbook of obesity treatment* (pp. 357–379). New York: Guilford Press.
- Revere, D., & Dunbar, P. J. (2001). Review of computer-generated outpatient health behavior interventions: Clinical encounters “in absentia.” *Journal of American Medical Information Association*, 8(1), 62–79.
- Shiffman, S., Paty, J. A., Rohay, J. M., DiMarino, M. E., & Strecher, V. (2001). The efficacy of computer-tailored smoking cessation material as a supplement to nicotine patch therapy. *Drug & Alcohol Dependence*, 64, 35–46.
- United States Department of Health and Human Services. (2003). *Comprehensive news report on smoking* [Electronic version]. Retrieved September 15, 2006, from <http://www.hhs.gov/news/press/2004pres/20040110.html>
- World Health Organization. (1998). *Obesity: Preventing and managing the global epidemic*. Report of a WHO Consultation on Obesity, Geneva, June 3–5, 1997. Geneva: Author.

---

## COMPULSIVE SEXUAL BEHAVIOR

---

Compulsive sexual behavior (CSB) is characterized by inappropriate or excessive sexual thoughts or behaviors that lead to stress, are overly time consuming, or lead to interpersonal, family, marital, financial, or legal problems. It appears to be widespread, to preferentially affect men, and to have an onset early in life. Psychiatric comorbidity is common, and while its cause remains unclear, CSB probably results from multiple factors. There is little consensus on treatment, but individual psychotherapy, cognitive-behavioral therapy, and 12-step programs may be helpful. Selective serotonin reuptake inhibitors (SSRIs) may help patients regulate their sexual impulses, while testosterone-reducing agents may help control sexual



aggressiveness. Additional studies are needed of subjects with CSB using standardized and reliable instruments as are careful treatment studies involving blinded assessments and placebo controls.

## Characteristics

Compulsive sexual behavior is not listed in the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV)*, although many of its manifestations would fit criteria for various paraphilias such as pedophilia, voyeurism, exhibitionism, or transvestic fetishism. German psychiatrist Krafft-Ebbing described “pathological sexuality” over 100 years ago and wrote of a condition not unlike today’s CSB, in which a person’s sexual drive is abnormally increased. Various terms have been used to describe this condition, most pejorative, such as *nymphomania* and *satyriasis* in women and men, respectively, while men with this condition are frequently referred to as a “Don Juan” or “Casanova.” More neutral terms include *compulsive sexual behavior*, *sexual addiction*, or *hypersexual disorder*. It is unresolved whether this condition falls within an obsessive-compulsive spectrum of disorders, is related to addictive disorders, or represents an impulse control disorder.

The prevalence of CSB in adults is estimated to range from 3% to 6% and is thought to predominately affect men. Onset appears to be in the late teens or early 20s. Gender differences include its symptom presentation: Among men, the disorder predominately involves promiscuous sexual behavior, compulsive masturbation, or a paraphilia. Among women, the disorder is thought to involve cognitive or emotional states resulting in dangerous sexual encounters or multiple unsuccessful love relationships. CSB has been described as involving nonparaphilic behaviors (i.e., conventional sexual behaviors carried to an extreme) or paraphilias (i.e., abnormal or dangerous patterns of sexual arousal or behavior); some persons with CSB have both types of behaviors.

Psychiatric comorbidity is frequent, particularly of mood and anxiety disorders, substance misuse, and the impulse control disorders, including compulsive buying, kleptomania, and pathological gambling. Axis II (personality) disorders are also frequent, and in at least one study, 83% of persons with CSB met criteria for one *DSM-IV* personality disorder. No particular personality type predominated, though it has been

observed that persons with CSB often exhibit narcissistic, borderline, dependent, or antisocial traits.

The natural history of CSB has not been well characterized, but it is likely chronic or recurrent. It has been described as beginning in adolescence with sexual preoccupations. The next stage, often referred to as ritualization, occurs when the person develops an idiosyncratic routine that prompts the sexual behavior. The third stage consists of the uncontrollable sexual behavior itself. The fourth stage is characterized by feelings of despair and hopelessness.

Persons with CSB are secretive about their disorder, which can lead to social isolation. In addition to social and interpersonal problems that develop as a result of CSB, the disorder can lead to marriage and family-related problems, work impairment, or financial and legal consequences. In some cases, CSB can lead to genital injury, sexually transmitted diseases, and unwanted pregnancies, or even the complications of abortion.

## Cause

The cause of CSB is unknown, although developmental, behavioral, neurobiologic, and sociocultural mechanisms have been proposed. Early theorists focused on intrapsychic conflicts and environmental traumas. For example, Fenichel wrote that hypersexuality was prompted by unconscious incestuous wishes that lead to a futile search for the ideal sex partner. Contemporary theories continue to be driven by psychoanalytic views regarding the effect of abusive childhood experiences that lead to low self-esteem, anxiety, and feelings of shame. In this schema, CSB develops as a means of coping with uncomfortable affects. Learning theory has been invoked by behaviorists who argue that behavioral completion mechanisms create the drive for what becomes habitual behavior.

There are no family studies of CSB, but at least one uncontrolled survey of “sex addicts” suggests that first-degree relatives often suffer from substance misuse, CSB, eating disorders, or compulsive gambling. In a small family history study of pedophilia, which may be relevant to CSB, it was reported that this disorder runs in families (19% of pedophiliacs had relatives with the same disorder vs. 3% of controls).

A monoamine theory of paraphilic disorders has been proposed invoking dysregulation of the neurotransmitters serotonin, dopamine, and norepinephrine. The theory is based on the fact that these monoamines



play a modulatory role in regulating sexual motivation and behavior, and that drugs that enhance serotonin neurotransmission seem to reduce sexual arousal and increase behavioral control. Neuropeptides (e.g., gonadotropin-releasing hormone [GRH]), and the androgenic hormones have also been suggested as having a role in CSB, because they are involved in human sexual behavior and have been successfully used to treat paraphilias.

Cultural concepts are also relevant in that sexual behavior occurs in a societal context; one must keep in mind that our notion of appropriate sexual behavior is constantly evolving. For example, pornography is widely available throughout the United States, though in the past it was considered illegal and its purveyors criminal.

### Diagnosis

The assessment of CSB begins with its recognition, although many patients may not discuss the problem unless asked; others will seek help specifically for the disorder, or at the behest of a concerned spouse, friend, or an attorney or law enforcement officer. Persons who acknowledge being sexually preoccupied or overactive should be questioned about the extent of the preoccupation and behavioral excess. Distress or impairment related to the problem should be explored. The clinician needs to distinguish normal sexual behavior from CSB, although it may sometimes be difficult to draw a clear distinction. For example, a patient may masturbate 2 or more times daily, yet report no impairment from the behavior.

Clinicians should be aware of the wide variation in sexual drive and that no specific number of orgasms can be used to describe when the behavior is “excessive” or constitutes CSB. Clinicians should also be aware of the differences in frequency of orgasms reported by men and women and understand that frequency generally declines with advancing age. Careful judgment needs to be exercised in assessing CSB so as not to mislabel a person’s behavior as pathological because it may conflict with the clinician’s view of what constitutes normal behavior. In some persons, a physical examination and neurologic examination will need to be done to rule out medical causes. Rarely, hypothalamic disturbances, brain tumors, or temporal lobe epilepsy will be the cause of inappropriate sexual behavior. Drugs of abuse, such as psychostimulants (e.g., cocaine) can cause hypersexual behavior. The

manic phase of bipolar disorder is well known to cause temporary hypersexuality, and some psychotic disorders and dementing illnesses can also cause inappropriate sexual behavior.

### Treatment

There are no standard treatments for CSB. Individual psychotherapy is often recommended, its purpose being to provide accurate information about sexual behavior and help patients understand their disorder. The goal is to assist patients in learning more appropriate ways to express their sexuality and to meet their intimacy needs. Group therapy models have also been developed that may be beneficial in confronting the patient’s defensive lies as well as in sanctioning one another’s acceptance of more appropriate sexual behavior. A 12-step program, Sex Addicts Anonymous, similar to its sister programs Alcoholics Anonymous and Gamblers Anonymous, is helpful to some persons. Self-help books are also available. Because CSB can damage marital relationships and family ties, treatment may need to include the spouse or partner and sometimes the entire family. If substance misuse appears to be promoting or fostering CSB, then that should be a focus of treatment as well. Comorbid psychiatric disorders need to be addressed.

Medications have also been used to treat CSB, including SSRIs and antiandrogenic agents. The SSRIs are well tolerated and appear to reduce sexual preoccupations and impulsivity. Case reports and open label studies of SSRIs suggest that these agents are effective, but there have been no randomized, controlled trials. Other antidepressants have also been used in small open-label studies and may be effective. In one case study, a patient with CSB was treated successfully with naltrexone, an opiate antagonist. Testosterone-reducing agents, such as medroxyprogesterone, have been used mainly to control sexually aggressive forms of CSB, though there have been no controlled trials of these agents. A controlled trial of the GRH analog triptorelin in men with severe paraphilias suggests that it is effective.

*Donald W. Black*

*See also* Alcoholics Anonymous (v1); Cognitive-Behavioral Therapy and Techniques (v2); Individual Therapy (v2); Psychoanalysis and Psychodynamic Approaches to Therapy (v2); Self-Disclosure (v2); Therapy Process, Individual (v2)



### Further Readings

- Black, D. W. (1998). Compulsive sexual behavior: A review. *Journal of Practical Psychiatry and Behavioral Health*, 4, 219–229.
- Black, D. W., Kehrberg, L. L., Flumerfeldt, L., & Schlosser, S. S. (1997). Characteristics of 36 subjects reporting compulsive sexual behavior. *American Journal of Psychiatry*, 154, 243–249.
- Gaffney, G. R., Lurie, S. F., & Berlin, F. S. (1984). Is there familial transmission of pedophilia? *Journal of Nervous and Mental Disease*, 172, 546–548.
- Kafka, M. (2000). Psychopharmacologic treatments for non-paraphilic compulsive sexual behavior. *CNS Spectrums*, 5, 49–59.
- Kafka, M. P. (2003). The monoamine hypothesis of paraphilic disorders: An update. *Annals of the New York Academy of Science*, 989, 86–94.
- Schneider, J. P., & Schneider, B. H. (1996). Couple recovery from sexual addiction/co-addictions: Results from a survey of 88 marriages. *Sexual Addiction and Compulsivity*, 3, 111–126.
- Stein, D. J., Black, D. W., Shapira, N. A., & Spitzer, R. L. (2001). Hypersexual disorder and preoccupation with the internet. *American Journal of Psychiatry*, 158, 1590–1594.

---

## CONDUCT DISORDER

---

Conduct problems in children and adolescents are among the most common referrals to mental health agencies and are a leading cause for concern among family, social, and legal systems in the United States. Conduct problems can be defined as externalizing behaviors that are oppositional, defiant, aggressive, and/or antisocial, including verbal or physical violence, threatening or bullying, destruction of property, and other delinquent acts. The *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision*, (*DSM-IV-TR*), classifies problems of conduct in the broad category of Disorders Usually First Diagnosed in Infancy, Childhood, or Adolescence. The disorders attention deficit/hyperactivity disorder (AD/HD), oppositional defiant disorder (ODD), and conduct disorder are included in the subcategory Attention-Deficit and Disruptive Behavior Disorders.

### The Nature of Conduct Disorder

Conduct disorder, as defined by the *DSM-IV-TR*, is a persistent and recurring pattern of behavior in which an

individual violates the basic rights of others or major age-appropriate societal norms or rules. It is important to note that although behaviors such as lying, aggression, and defiant behaviors occur throughout typical childhood development, the behaviors that are associated with conduct disorder significantly interfere with social, academic, or occupational functioning of the individual and are more severe than those associated with normal developmental stages. The behaviors associated with conduct disorder are categorized into four main groups: aggression toward people and animals, destruction of property, deceitfulness or theft, and serious violations of rules. In order for an individual to be diagnosed with conduct disorder, three or more of the following criteria must have been met within the past 12 months, and at least one must have been present in the past 6 months: (1) often bullies, threatens, or intimidates others; (2) often initiates physical fights; (3) has used a weapon that can cause serious physical harm to others (e.g., a bat, brick, broken bottle, knife, gun); (4) has been physically cruel to people; (5) has been physically cruel to animals; (6) has stolen while confronting a victim (e.g., mugging, purse snatching, extortion, armed robbery); (7) has forced someone into sexual activity; (8) has deliberately engaged in fire setting with the intention of causing serious damage; (9) has deliberately destroyed others' property (other than by fire setting); (10) has broken into someone else's house, building, or car; (11) has lied often to obtain goods or favors or to avoid obligations (i.e., cons others); (12) has stolen items of nontrivial value without confronting a victim (e.g., shoplifting, but without breaking and entering; forgery); (13) often stays out at night despite parental prohibitions, beginning before age 13 years; (14) has run away from home overnight at least twice while living in a parental or parental surrogate home (or once without returning for a lengthy period); and (15) is often truant from school, beginning before age 13 years.

There are generally thought to be two types of conduct disorder: childhood-onset and adolescent-onset. The childhood-onset type occurs when the characteristics of conduct disorder begin prior to age 10; in the adolescent-onset type, symptoms occur after the age of 10. (Note: An individual who is 18 years or older may be diagnosed with a conduct disorder as long as criteria for antisocial personality disorder [APD]—a pattern of disregard for and violation of the rights of others occurring since age 15—are not met.) The presentation of conduct disorder in children or



adolescents is multifaceted in terms of the number and types of symptoms, the risk factors and protective factors associated with the individual, and in the degree of severity of the behaviors.

### Prevalence and Comorbidity

The prevalence of conduct disorder ranges from 1% to 10% of the general population and about 26% in the clinical setting. More specifically, recent research has found a lifetime prevalence rate of 9.5% and a more frequent rate of occurrence in males (12%) than in females (7.1%). Conduct disorder is also more prevalent among older children and adolescents than in younger children. Conduct disorder often co-occurs with other psychological disorders, and individuals diagnosed with conduct disorder are often at risk for other problems. It remains unclear whether problems with conduct cause comorbid disorders, or whether comorbid disorders increase the risk for conduct disorder; however, links have been found between conduct disorder and many comorbid disorders. For example, children with conduct disorder often exhibit AD/HD symptoms such as impulsivity and hyperactivity; however, children diagnosed with AD/HD behaviors do not necessarily engage in severe antisocial behaviors. Often, the presence of AD/HD symptoms seems to trigger problems with conduct. Additional disorders associated with conduct disorder include internalizing disorders such as depression and anxiety, learning disabilities or academic underachievement, substance abuse, and adjustment disorders. Nearly half of individuals diagnosed with conduct disorder also meet criteria for another disorder.

### Assessment

The assessment of conduct problems is a complex process that requires a comprehensive psychological evaluation of the child in many contexts using multiple assessment tools and techniques. Evaluations typically involve diagnostic interviews with parents, teachers, family members, or other individuals working closely with the child. Clinical interviews with the child may also be incorporated, making note that youth do not always view their behavior as problematic or have insight about the impact their behavior has on others. Standardized behavior rating scales (e.g., Behavior Assessment System for Children, Child Behavior Checklist) and self-report measures of

behavior and personality (Minnesota Multiphasic Personality Inventory–Adolescent [MMPI-A]) are often utilized in order to gather reliable ratings of the child's emotional and behavioral problems as observed by the child and by others. Direct observations of a child's behavior in structured and unstructured settings are also an integral part of the assessment procedure. An extensive review of school, legal, medical, and psychological treatment records is recommended as well as complete background information and family history. An assessment should also evaluate the presence of comorbid conditions that typically occur with conduct disorder and should take into account the cultural context of an individual. It is essential to identify and evaluate contextual factors that influence the child's behavior patterns and functioning, including both internal and external factors.

### Course

Evidence suggests a developmental progression that occurs with conduct problems. In particular, the progression from ODD to conduct disorder and from conduct disorder to APD has been studied extensively. The criteria for ODD include defiant and oppositional behaviors toward authority figures, although symptoms are not as severe as the behaviors in conduct disorder. About 90% of children who are diagnosed with conduct disorder also meet criteria for ODD. Research suggest that ODD could be a precursor to conduct disorder, because most cases of conduct disorder have previously met the criteria for ODD, yet most individuals with ODD do not necessarily progress to a conduct disorder. A similar pattern is found with the progression from conduct disorder to APD (which is associated with a greater severity of sociopathy or violation of societal rules than in conduct disorder). Adults with APD have almost always previously met criteria for conduct disorder, and 25% to 40% of conduct-disordered children and adolescents will progress to APD in adulthood.

Accordingly, the prognosis for conduct disorder is not optimistic, and evidence suggests that over the course of the life span, conduct disorder is relatively stable. There is a particularly negative prognosis for childhood-onset conduct disorder; individuals who develop significant conduct problems at an early age continue to exhibit more severe aggression and delinquency in middle childhood and adolescence. High recidivism rates are also associated with conduct disorders.



## **Risk Factors**

A variety of risk factors are associated with conduct disorder, including both internal and external factors.

### ***Internal Factors***

Internal factors involve individual influences such as genetic and psychobiological influences and cognitive and social cognitive characteristics. Genetic and biological influences on conduct disorder have been shown to have an indirect influence on the development of difficulties in children. Heritability traits for aggression increase the possibility of antisocial behaviors in children as well as the possibility of neuropsychological and neurophysiological problems. Cognitive problems such as low IQ have been associated with conduct problems, as have deficits in executive functioning (such as AD/HD).

Social cognitive characteristics such as social-emotional functioning, or how individuals perceive their social world, have also been related to conduct disorders. Often, conduct-disordered individuals have problems with information processing and identifying social cues; they make hostile attributions or misinterpret the intent of others' behavior. These characteristics are associated with increased aggression and negative interactions with others such as parents and peers.

### ***External Factors***

External factors include family, parent, and community sources. Dysfunction in the family structure is key to the development of aggression and antisocial behavior among children and adolescents. Family dissolution, single parent homes, and large family size often put strains on the individual's environment, and this precipitates problem behaviors. In addition, the interaction between the child and parent, the overall functioning of the family, and parent characteristics are also associated with problems in conduct. Parental psychopathology (i.e., substance abuse and depression) and criminal behavior of parents are associated with increased aggression and antisocial behaviors in children. Inconsistent parenting techniques, inadequate supervision of children, and low parental involvement are characteristics of parents of youth with conduct disorders. Physical and sexual abuse is more common among the families of children with conduct disorder, which also contributes

to family violence and aggressive behaviors. Community factors contributing to conduct disorders include low socioeconomic status (e.g., poverty, high crime rates), disadvantaged school setting, and negative peer influences.

## **Treatment**

There are a variety of treatment approaches for conduct disorder, but only a few have been empirically supported. Treatments that are considered efficacious or promising are categorized into family-based, individual-based, community-based, and multicomponent interventions. Goals are to decrease conduct-disordered behaviors and to improve prosocial functioning of the individual as well as to improve family and parent interactions.

### ***Family-Based Interventions***

Because family dysfunction is considered to be one of the major contributors to delinquent behavior, treatment approaches have focused on family-based treatment. A specific type of family-focused intervention is functional family therapy (FFT). FFT is an integrative approach incorporating family systems; it considers the family as the system that is responsible for problematic behaviors rather than the individual alone. It also views the child as a part of multiple systems, including the community, school, and peer group. It involves family, behavioral, and cognitive approaches. FFT conceptualizes problem behavior as a function of the family system and identifies how the family system displays problematic behaviors. The goal of treatment is to improve family communication and interaction patterns; counselors using FFT teach problem-solving techniques in order to improve supportiveness in the family environment.

Parent management training (PMT) is one of the most effective and widely used treatments for conduct disorders. There are a variety of models that are behavioral in nature and focus on training parents to alter ineffective or inconsistent discipline strategies in order to change the child's behavior at home. Therapists work with parents to develop and implement behavior management techniques such as positive reinforcement and contingency management in order to decrease negative behavior and increase compliance. Therapy also teaches parents to identify behaviors and use strategic principles to manage



behaviors, and it provides an opportunity to practice using these techniques. Therapy also improves the parent–child interaction and reduces deviant and oppositional behaviors. PMT has been found effective for children from 6 to 12 years of age.

### **Individual-Based Interventions**

Pharmacological interventions have been used in treating attention deficit and disruptive behavior disorders and other mental health problems in children and adolescents. Although stimulant medication for AD/HD is widely supported and effective, research for psychopharmacological treatment for conduct disorder alone has not been established. Pharmacological treatment should be considered when there is comorbidity with conduct disorder.

Child-focused interventions include cognitive-behavioral therapy (CBT) approaches. CBT is a treatment model that considers and involves cognitions, affect, and behavior when treating childhood disorders. The goal of CBT is to teach coping skills, build upon strengths, provide opportunities for practicing new behaviors, and provide interventions. Examples of CBT interventions that have shown promising effects are anger management and emotion regulation, relaxation training, problem-solving skills, cognitive restructuring, and social skills training.

A specific CBT treatment program for conduct disorder is social problem-solving skills training (PSST). PSST teaches cognitive problem-solving skills in order to address the cognitive deficits in processing associated with conduct-disordered individuals. New ways to perceive and process situations are also developed through the use of role-plays and homework assignments. In PSST, the therapist teaches the client new interpersonal and problem-solving skills such as exploring how situations are perceived and brainstorming ideas to engage in alternative behaviors. PSST has been shown to reduce symptoms of aggressive and antisocial behaviors in older children or adolescents.

### **Community-Based Interventions**

Community programs address problems from a family systems perspective or incorporate individualized treatment with family therapy. Interventions include those that occur in the community, in places where the treatment occurs (i.e., hospital or correctional

facility), and in the school, the home, and with peers. Residential treatment, group homes, and foster care placements are community-based centers that also provide various treatments for conduct disorders.

### **Multimodal Interventions**

Multimodal interventions combine one or more of the above-mentioned interventions for the treatment of psychological disorders, including conduct disorders. Researchers have evaluated the effectiveness of the combination of PMT and PSST skills-based training, and results showed that a combined treatment led to changes in child and parent functioning up to 1 year after treatment. After 15 to 20 sessions, children between the ages of 7 and 13 were less aggressive and exhibited fewer externalizing behaviors.

Multisystemic therapy (MST) is another example of a multimodal intervention that has been empirically validated for treatment of serious conduct disorders. MST is based on family systems and community based theories and incorporates a milieu of different disciplines and systems in which the child is involved (community, peers, and school). MST views the family as the main focus of intervention, and therapists often work intensively with the family in their home environment. The goal is to provide parents with techniques to manage their children's behavior and provide the children with strategies for coping with their problems. MST has been associated with reducing an individual's re-arrest rate, criminal activity, and other serious offenses.

*Sylvia J. Acosta and Lee A. Rosén*

**See also** Attention Deficit/Hyperactivity Disorder (v1); Bullying (v1); Cognitive-Behavioral Therapy and Techniques (v2); *Diagnostic and Statistical Manual of Mental Disorders (DSM)* (v2); Externalizing Problems of Childhood (v1); Family Counseling (v1); Mental Health Issues in the Schools (v1); Oppositional Defiant Disorder (v1); Psychopharmacology, Human Behavioral (v2)

### **Further Readings**

- American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed., Text rev.). Washington, DC: Author.
- Barrett, P. M., & Ollendick, T. H. (Eds.). (2004). *Handbook of interventions that work with children and adolescents: Prevention and treatment*. Chichester, UK: Wiley.



- Essau, C. A. (Ed.). (2003). *Conduct and oppositional defiant disorders: Epidemiology, risk factors, and treatment*. Mahwah, NJ: Lawrence Erlbaum.
- Nock, M., Kazdin, A. E., Hiripi, E., & Kessler, R. C. (2006). Prevalence, subtypes, and correlates of DSM-IV conduct disorder in the National Comorbidity Survey Replication. *Psychological Medicine*, 36, 699–710.

---

## CONFERENCES, COUNSELING PSYCHOLOGY

---

Counseling psychology was initially recognized by the American Psychological Association (APA) as a distinct discipline of the Division of Counseling Psychology in 1944 (known initially as the Division of Personnel Psychologists). Division 17, now known as the Society of Counseling Psychology (SCP), has a membership of over 2500 psychologists. There have been four major conferences in counseling psychology that have served to advance discipline-specific identity and scope of practice, coalesce practitioners and academics, and address current issues and advocacy. In addition to the four major conferences, a fifth large-scale counseling psychology conference is scheduled to be held in Chicago in March 2008. This entry reviews the goals, objectives, attendance, and outcomes of the four conferences that have occurred and the anticipated focus of the 2008 conference.

While these four conferences have been critical in the developmental process of psychology, it should be pointed out that there are two annual conferences that focus on issues relevant to counseling psychology training programs (the annual conference of the Council of Counseling Psychology Training Programs) and to practice and research in counseling psychology (the Great Lakes Conference). Additionally, counseling psychologists are very visible at the annual APA convention, producing hundreds of presentations, symposia, poster sessions, and invited presentations annually.

While the aforementioned conferences serve to advance issues and training valued by counseling psychology, the objective of this contribution is to place the four critical conferences—Northwestern, Greyston, Atlanta, and Houston—in context of the ongoing development of the unique identity of counseling

psychology. The 2008 International Counseling Conference is also included in the review.

### Northwestern Conference

An early formative occurrence in the professional development of counseling psychology was the Ann Arbor conference held in 1949 and sponsored by the University of Michigan and Division 17. This conference was funded by a public health grant and had a purpose of delineating the best plan for training counselors who planned to be psychologists. A report from the conference indicated a need for clearer distinction between clinical and counseling psychology. The Ann Arbor conference was significant in this primary agenda—to articulate the distinction between these two disciplines.

While the Ann Arbor conference was critical in the formation of the discipline, the Northwestern conference is identified as the first counseling psychology conference and had a reported attendance of 34 participants. This event was held at Northwestern University in 1951, 5 years after the discipline was recognized by the APA. Nadya Fouad and colleagues delineated three themes of the Northwestern conference; these were identity, training, and political and social advocacy. However, the ambiguity of the identity of counseling psychology was central to the conference. Indeed, it was at the Northwestern conference that the term *counseling psychologist* was selected as the name of the discipline. Additionally, Donald Super is credited with articulating the focus of the discipline on hygiene, or the preservation of health, rather than on pathology. An additional theme was the recognition of the equal emphasis on science and practice rather than the prioritization of one over the other.

Training was another theme of the Northwestern conference. At the time of that conference, only a third of the members of Division 17 held doctorates. The participants formulated recommendations to increase the rigor and uniformity of the doctoral training of psychologists, including attention to curriculum needs, clinical training sequences, and admission processes.

The third theme of the Northwestern conference was political and social advocacy. While the primary allocation of time was spent on training and identity issues, there was attention given to two primary areas of advocacy—pressing APA to recognize counseling psychology as a specialty and working with the



Department of Veterans Affairs healthcare system to develop and implement internship and practicum training opportunities for counseling psychology doctoral students.

### **Greyston Conference**

The next significant counseling psychology conference is known as the Greyston conference; it was held in 1964 and organized by Donald Super and Al Thompson. Participants, approximately 60, were invited to convene and address current issues, such as the lack of empirical rigor of scholarship, low status of the specialty, program admission selection, and differential standards in colleges of education versus liberal arts schools. The conference proceedings and recommendations were published in a book by Thompson and Super in 1964.

The Greyston conference themes sorted across identity, training, and social and political advocacy. In the area of identity, what was seen in the 1960s was a lack of distinction of the specialty; there was too much overlap with clinical psychology, guidance and counseling, and vocational counseling. Preceding the conference in the early 1960s, there was great divergence on the actual identity of counseling psychologists, even to the point that Irwin Berg, Harold Pepinsky, and Edward Joseph Shoben stated in a report commissioned by the executive board of the APA that the field was declining and should fuse with clinical psychology. However, it was concluded at the conference that there was not actually an identity issue; rather, there was a lack of visibility and limited professional activity that limited the public's and universities' knowledge of the discipline.

The training issues addressed at the Greyston conference reflected concerns regarding identity. Specifically, some worried that the focus on adjustment and preservation of health precluded a necessary understanding of pathology and diagnosis. Other concerns were the relative lack of financial support of students compared to those in clinical programs and the lack of standards with regards to training program faculty. Also, there was concern about the loss of training in vocational psychology in some programs. Training recommendations emerging from Greyston included the belief that counseling psychology training programs should be led by appropriately trained counseling psychologists. There were specific recommendations made about the sequencing of clinical

training from practica through internship. Additionally, the breadth and specificity of training as reflected in the curriculum was addressed through specific recommendations.

The political and social advocacy theme of the Greyston conference was complex, focusing on the relationship between the specialty and APA as well as larger social issues of the 1960s. Specific to APA, a focus of concern was the lack of visible understanding of the discipline, which was evident in accreditation practices and documentation. Recommendations were issued that APA take a more active role in recognizing the specialty of counseling psychology as well as disseminate information about counseling psychology and evaluate internships specific to the discipline. With regard to addressing the social change and challenges of the time, one of the recommendations was for counselors to become active in the aspects of their clients' lives that related to segregation, housing, employment, and minimum wage. At the same time, there was concern that these needs might be met by master's level clinicians rather than doctoral level counseling psychologists, a concern that prevails today. The Greyston conference did not produce a specific product; rather, it is credited with a reaffirmation of the scientist-practitioner training model and that the discipline should continue to grow and prosper.

### **Atlanta Conference**

The Atlanta conference followed in 1987 with an attendance of 180 participants divided into working groups to address five issues that were then current; these were professional practice, training, research, organizational issues, and public image.

Regarding identity issues across the period since Greyston, counseling psychology continued to struggle with identity. However, this time it was due to the proliferation of clinical psychology training programs and doctoral programs in psychology as well the movement toward generic rather than discipline-specific internships. Each of these factors was seen as a potential threat to the viability of the discipline. At the same time, counseling psychology had made significant increases in the number of accredited counseling psychology programs. The primary focus at the Atlanta conference with regard to identity was on the unique aspects of the discipline. Recommendations from the conference encouraged graduate training programs to foster a sense of identity with the discipline,



to more actively regulate the designation of counseling psychology, and to have all counseling psychologists maintain membership in Division 17.

Training issues addressed at the Atlanta conference included the strong support of the scientist–practitioner training model. Participants also reviewed the need to more fully prepare students to work with a range of clients and the realities of training programs housed in colleges of education rather than arts and sciences. The primary product of the Atlanta conference was the development of the Model Training Program, which provided an agreed-upon guide for counseling psychology training programs. There were some critics of the conference, stating the conference moved from an original endorsement of health and adjustment to one of concern with pathology.

Social and political advocacy legacies of the Atlanta conference included an increase in research and training in multicultural issues, stronger advocacy in and involvement with APA governance, and the development of special interest groups within Division 17 to increase member connection to the organization by addressing their areas of interests.

### **Houston Conference**

The Houston conference followed in 2001; it was organized by Nadya Fouad, past president of Division 17 at the time, and Robert McPherson, past chair of the Council of Counseling Psychology Training Programs (CCPTP). This conference was the largest to date with over 1000 participants, including a large number of graduate students. The Houston conference was unique in that it was the joint effort of Division 17 and CCPTP. The stated goals of the conference were (1) to identify ways counseling psychologists work toward social justice by making a difference in the lives of students, clients, and communities; (2) to share scholarly and practice advances made in the field; (3) to begin to identify new pathways for counseling psychology, and (4) to become a national voice in local and global communities.

The Houston conference did not address identity for many reasons. It was believed by many that the profession had sufficiently matured and had a clearer sense of definition. Additionally, much of the work had been accomplished with regard to definition and identity in 1999, when the Commission of Recognition of Specialties and Proficiencies in Professional Psychology (CRSPP) issued, after appropriate vetting

through the relevant professional constituencies, a description and definition of counseling psychology, defining the parameters of practice: “Within the context of lifespan development, counseling psychology focuses on healthy aspects and strengths of the client (individual, couple, family, group, system, or organization), environmental/situational influences (including the context of cultural, gender, and lifestyle issues) and the role of career and vocation on individual development.”

The Houston conference did, by comparison, spend a significant amount of time addressing training issues. The program emphasized better preparing students to address the demands of clients with higher levels of distress and pathology as well as to work within managed healthcare arenas. Additionally, trainee impairment, which had recently emerged in discussion at training forums and in the literature, was also addressed in symposia. There was discussion about various training models, particularly the scientist–practitioner and practitioner–scholar models. While there was rigorous discussion across topics, clear and cogent recommendations were not a product of this conference.

Social and political advocacy was a clear strength of the Houston conference. The development and implementation of the social action groups (SAG) represents the most thoughtful, organized, large-scale effort to prioritize social advocacy in any organized effort in counseling psychology to date. The SAG coordinators for the Houston conference were David Blustein, Nancy Elman, and Larry Gerstein. There were nine SAGs developed for the conference; they focusing on the following issues—community violence, domestic violence, child abuse and neglect, homelessness and welfare, the economic boom and the poor or working class, care for the chronically or severely mentally ill, racism, social justice and ethics in counseling psychology practice, and the moral challenge of managed care. Over 400 conference participants indicated an interest in participating in one of the SAGs, although only 77 actually attended the SAG meetings. The various SAGs produced many recommendations; they suggested that a special interest group be developed in Division 17 that addressed social justice, that a listserv be set up for individuals interested in social justice and advocacy, and that attention be given to multicultural systems and social justice in APA accreditation standards as well as in graduate training programs. In addition to the SAG



activities, the Houston conference sponsored multiple auxiliary advocacy activities, including a legislative fundraising dinner for and reception with Congressman Ted Strickland, a Houston Red Cross blood drive, and fundraising activities for earthquake victims in El Salvador.

The Houston conference is noted to be the largest to date, advancing social justice and advocacy as a core value in counseling psychology. Additionally, this conference brought the membership together with leaders from the four APA directorates, providing an opportunity for dialogue and relationship building. Approximately 40% of participants were students, and all of the counseling psychology programs in the country were represented.

### 2008 International Counseling Conference

The next major conference in counseling psychology is the 2008 conference in Chicago. The conference cochairs are Laura Palmer, past chair of CCPTP, and Linda Forrest, president-elect of SCP. The cochairs are working together with Association of Counseling Center Training Agents (ACCTA), representing a three-part model of organization and the intent to partner the three principal entities in the discipline. The steering committee comprises 13 individuals representing key positions in SCP, CCPTP, and ACCTA. Additionally, students and early career psychologists are members of the steering committee. Nine key committees have been formed; they are cochaired or trichaired by members of the three sponsoring organizations. The title of the conference, *Creating the Future: Counseling Psychologists in a Changing World*, captures the overall goal of the conference: to look at the multiple issues affecting counseling psychology locally and globally. The conference planners, steering committees, and subcommittee members are working toward integrating global colleagues into the planning and hope to host a number of counseling psychologists from many countries. Additionally, there is a strong initiative to develop a conference that will be of interest to counseling psychologists across multiple arenas—practice, teaching, research, industry—through relevant programming. The conference, like those described earlier, includes mechanisms that address identity—particularly as it applies to globalization of training, practice, research, and collaboration; training—with a focus on further

elaboration on discipline-specific competencies and the sequencing of training; and social and political advocacy, which includes training on advocacy, political speakers, and fundraising activities.

Laura Palmer

**See also** Conferences in Counseling (v1); Continuing Education (v1); Counseling, Definition of (v1); Counseling, History of (v1); Counseling Psychology, Definition of (v1); Counseling Psychology, History of (v1); Counselors and Therapists (v2); Professional Associations, Counseling (v1)

### Further Readings

- Brammer, L., Alcorn, J., Birk, J., Gazda, G., Hurst, J., LaFramboise, T., et al. (1988). Organizational and political issues in counseling psychology: Recommendations for change. *The Counseling Psychologist, 16*, 407–422.
- Berg, I., Pepinsky, H. D., & Shoben, E. J. (1980). The status of counseling psychology: 1960. In J. M. Whiteley (Ed.), *The history of counseling psychology* (pp. 105–113). Monterey, CA: Brooks/Cole.
- Commission for the Recognition of Specialties and Proficiencies in Professional Psychology. (1999). *Archival description of counseling psychology*. Retrieved from <http://www.apa.org/crsppp/counseling.html>
- Fouad, N., McPherson, R. H., Gerstein, L., Blustein, D. L., Elman, N., Helledy, K. I., et al. (2004). Houston, 2001: Context and legacy. *The Counseling Psychologist, 32*, 15–77.
- Super, D. E. (1955). Transition: From vocational guidance to counseling psychology. *Journal of Counseling Psychology, 2*, 3–9.
- Whiteley, J. M. (1980). *The history of counseling psychology*. Monterey, CA: Brooks/Cole.
- Whiteley, J. M. (1984). A historical perspective on the development of counseling psychology as a profession. In S. D. Brown & R. W. Lent (Eds.), *Handbook of counseling psychology* (pp. 3–55). New York: Wiley.
- Wynkoop, T. F., & Dixon, D. N. (1994). Organizational and political issues in counseling psychology: An accounting of the Georgia Conference recommendations. *The Counseling Psychologist, 22*, 342–356.

### Web Sites

- Commission of Recognition of Specialties and Proficiencies in Professional Psychology: <http://www.apa.org/crsppp/counseling.html>



---

## CONFERENCES IN COUNSELING

---

Conferences in the field of counseling offer students, practitioners, researchers, and scholars opportunities to gather, interact, and learn within a larger and often diverse environment. Individuals with common interests have formed societies and convened in groups for discussion and debate since the time of Socrates. In the field of psychology, the first formal meeting of professionals was the First International Congress of Psychology held in Paris in 1889, followed closely by the founding of the American Psychological Association (APA) in 1892. In 1952, the American Personnel and Guidance Association was founded. Today, these professional societies and associations provide a forum in which members can discuss affairs and training standards of the association, participate in educational events, engage in professional renewal, strengthen professional identity, and make contacts with others who are interested in psychology and counseling.

### Conferences in Context

Professional gatherings can stimulate creative and intellectual understanding among individuals. In the United States, the first formal professional conference in psychology was held in 1892 with the founding of the APA. This association met annually for members to exchange ideas, set standards for membership, and attend to the business affairs of the association. In 1952, four independent associations joined forces in Los Angeles to discuss and organize a greater and more unified professional voice for counselors. The four associations included the National Vocational Guidance Association (NVGA), the National Association of Guidance and Counselor Trainers (NAGCT), the Student Personnel Association for Teacher Education (SPATE), and the American College Personnel Association (ACPA). These four organizations became one larger organization, the American Personnel and Guidance Association (APGA). In 1983 APGA became the American Association of Counseling and Development (AACD), and later, in 1992, the AACD changed its name to the American Counseling Association (ACA) to reflect the growing unity of purpose among its members.

Interest in the area of counseling and psychology continues to grow as evidenced by the numerous areas

of specialty and subspecialty development within the APA and ACA. Currently there are 54 divisions and 58 state or provincial associations within the APA. The ACA has 19 divisions and 56 branches. Many of these divisions and regional associations also hold annual conferences as a benefit for their members. These conferences in counseling are the organizational descendants of these associations' historic annual meetings.

### Conferences and Other Opportunities for Learning

Many professionals are committed to continuous learning and enhancement of their knowledge base and skills. Today's counselors and psychologists can seek training from a variety of sources (e.g., conferences, workshops, graduate coursework, postdegree certification, independent study) and in a variety of formats (e.g., in person, online, or hybrid). Although all of these entities provide the opportunity for an instructive experience, conferences are unique in that they (1) typically mandate that participants belong to the sponsoring organization, (2) are assumed to attract persons who share a particular vocation or professional identity, (3) are viewed as a benefit of membership, (4) provide members information regarding the financial status of the organization, (5) afford members access to the governing board, and (6) offer a place to discuss the social relevance and purpose and standards of the organization. There is, at a minimum, an implied, if not overt, agreement that the basic beliefs and purpose of the association draw individuals to attend and participate.

### The Functions of Conferences

Conferences in counseling serve both professional and personal functions for counselors. There is, of course, some overlap between these domains, as it is the intent of most associations to serve the needs of individuals by means of the organization's activities. The professional functions of conferences are characteristically related to the needs of the whole group. For example, such functions may include discussing the financial status, professional identity, mission, and legacy of the association; formulating or executing social or legislative policy; determining training and research standards; and providing the development of the next generation of leaders. The personal functions



are typically focused more on the needs of individuals and may include educational sessions, leadership training, networking, mentoring, sponsorship, professional identity development and maintenance, socialization, and conviviality.

### ***Professional Functions***

The three primary professional functions of association-sponsored conferences are financial management, articulation of a professional identity, and review of policies and procedure. These functions are administered through a governance structure, e.g., the board of directors for APA or the governing council for ACA. The officers of these governance groups are responsible to the membership at large for both the day-to-day functioning of and long-range planning for the association.

The first professional function, financial management, provides a means for the officers of the association to formally and regularly inform the membership of the financial status of the organization, which may include a review of the annual financial report, efforts at fundraising and endowments, fee and benefit configurations, and expenditures. Although most members do not participate in these sessions, an annual review of the associations' financial status is typically required by bylaws and is critical to maintaining transparency with respect to the associations' financial transactions.

The second professional function of conferences, articulation of a professional identity, provides an opportunity for the members to clarify and or strengthen the mission and professional identity of members. These two concepts are inexorably linked, as the mission of any association defines the professional behaviors and therefore identity of its members. From time to time, the governance officers of an association identify a theme or issue that is, or has the potential to be, critical to a majority of the membership. An example of this type of conference programming occurred when the counseling psychology division of the APA held four national conferences; these were at Northwestern University in 1951, at the University of Wisconsin's Greyston Center in 1964, at Atlanta in 1987, and at Houston in 2001. These four conferences, along with the APA's 1973 Vail conference, have provided a definition, mission, and training standards for counseling psychologists.

In the late 1970s the APGA (now ACA) sponsored a committee to investigate the need for a national

accrediting agency for counselors. Over a period of 2 to 3 years, representatives from the Association for Counselor Education and Supervision (ACES), the American School Counselor Association (ASCA), and other divisions met at national and regional conferences and determined that such a body was necessary and viable. This agency, the Council for Accreditation of Counseling and Related Educational Programs (CACREP), was founded in 1981 and continues today to set the educational and institutional requirements for counseling programs at the master's and doctoral levels.

As agents and advocates of change, counselors and psychologists take an active role in social and political discussions that affect their clients, profession, and general human well-being. The third professional function of conferences, reviewing policies and procedures, affords participants a wide array of opportunities and options with respect to the type and level of involvement in policies and legislation that could potentially impact the profession. Members may also focus on the internal policies and politics of the association. This type of involvement is often associated with the development of the next generation of leaders with the particular association.

### ***Personal Functions***

Conferences are a gathering of people who are seeking both professional and personal connections. The personal functions of conferences typically center on the individual's desire for educational, mentoring, networking, and socializing contacts. Participants typically attend conferences seeking some form of continuing education or enhancement of skill. Professional associations call for peer-reviewed educational sessions, papers, and workshops. National and international conferences offer a plethora of opportunities to enhance one's knowledge or learn something completely new. Many conferences offer different tracks or themes from which participants may choose. Tracking also allows persons with shared interest (e.g., research findings, new practice approaches) to focus their interests and perhaps meet other professionals with whom they may collaborate.

Conferences are a great benefit to the membership, as many members reconnect with faculty or former peers from institutions of higher learning. Most professional counselors and psychologists have received or are receiving their formal training



in these types of institutions, and many conference participants continue their affiliations with universities as either faculty or students. This affiliation provides a ready-made opportunity for mentoring and sponsorship of colleagues and students. Research findings in the area of mentoring identify a multitude of benefits derived from the personal and professional sponsorship of one's mentor in informal settings such as conferences and the socializing that accompanies them.

The personal and social contacts made during conferences can enrich the personal and professional lives of attendees. Conferences provide a setting for the exchange of ideas, information, employment opportunities, and policies. Individuals can be with subgroups of the association that may have a formal meeting or contact only once a year, or they can sample from a wide variety of areas. It is important to recognize that conferences are a blend of the personal and professional aspects of the individuals who attend that particular conference.

*Linda L. Black and Jenn Capps*

**See also** Conferences in Counseling (v1); Continuing Education (v1); Counseling, Definition of (v1); Counseling, History of (v1); Counseling Psychology, Definition of (v1); Counseling Psychology, History of (v1); Counselors and Therapists (v2); Professional Associations, Counseling (v1)

### Further Readings

- Fouad, N. A., McPherson, R. H., Gerstein, L., Blustein, D. L., Elman, N., Helledy, K. I., et al. (2004). Houston 2001: Context and legacy. *Counseling Psychologist*, 32, 15–77.
- Murdock, N. (2004). Our conferences do everything (and so do we). *Counseling Psychologist*, 32, 134–137.
- Myers, R. (2004). Conferring as a way of knowing. *Counseling Psychologist*, 32, 128–133.
- Street, W. R. (1994). *A chronology of noteworthy events in American psychology*. Washington, DC: American Psychological Association.
- West, J. D., Bubenzer, D., & Osborn, C. J. (2003). *Leaders and legacies: Contributions to the profession of counseling*. Oxford, UK: Routledge.

### Web Sites

American Counseling Association: <http://www.counseling.org>  
 American Psychological Association: <http://www.apa.org>

## CONNERS' RATING SCALES—REVISED

The Conners' Rating Scales—Revised (CRS-R) comprises a set of six standardized measures designed to evaluate behavioral symptoms of attention deficit hyperactivity disorder (AD/HD). The rating scales—each available in long and short form—are completed by teachers, parents, and adolescents. All items contained within the various CRS-R forms utilize a 4-point scale; these include 0 (not true at all), 1 (just a little true), 2 (pretty much true), and 3 (very much true). There are three methods for calculating scores. The clinician can calculate scores using an answer sheet. Alternatively, computer scoring and interpretive reports are available through the publisher. Finally, a computerized version is available that scores the rating scales and provides an interpretive report.

The standardization sample consisted of 8,000 cases, and data were collected from 200 sites in the United States and Canada. According to the manual, more than 95% of all states and provinces in the United States and Canada were included. A total of 1,000 Black adolescents were included in the sample, which—according to the manual—warranted the creation of normative data specifically for Black youth.

The standard error of measurement for the CRS-R was characterized as low. According to Conners, if individuals were assessed simultaneously, 95% of the scores would be within  $\pm 1.96$  SEM of their theoretical true scores. Similar observations were made with respect to the standard error of prediction. Clinicians could have expected an individual's obtained scores to be within  $\pm 1.96$  SEM of predicted scores.

Test-retest reliabilities were secured from samples of 49 to 50 youth; retest intervals spanned 6 to 8 weeks. Correlations ranged from .47 for the Conners' Teacher Rating Scales—Revised Long Version (CTRS-R:L) Cognitive Problems and *DSM-IV* Hyperactive-Impulsive scales to .89 for the Emotional Problems subscale of the Conners-Wells' Adolescent Self-Report Scale Long Form (CASS:L). Internal consistency reliabilities for the CRS-R Parent and Teacher Forms were within the moderate ( $r = .73$ ) to high ( $r = .96$ ) range. Likewise, the Adolescent Self-Report Form evidenced moderate ( $r = .75$ ) to high ( $r = .92$ ) internal consistency reliability coefficients.

Factor analysis used to construct the scales evidenced acceptable construct validity. Convergent and discriminant validity provided additional support for



construct validity. Convergent validity was demonstrated using correlations of long and short forms, which ranged from .95 to .99 on various scales. Discriminant validity was supported by evidence that the CRS-R discriminates between clinical and nonclinical groups.

The psychometric properties of the CRS-R demonstrated considerable improvements over the original measure. The reliability and validity estimates are generally acceptable. However, the standardization sample was not representative of the U.S. population as reflected in census data. Black parents were underrepresented; White parents were overrepresented; and the adolescent scales overrepresented Black youth. Furthermore, several reliability and validity estimates were derived from samples of 100 individuals or fewer; some included fewer than 50 observations. As stated above, the manual reported that the CRS-R significantly delineates clinical from nonclinical groups. It is noteworthy that approximately 38% of the youth within the study sample had an AD/HD diagnosis, whereas base rate estimates for the prevalence of AD/HD within the general population have been 2% and 7%.

*Richard Bunce*

**See also** Attention Deficit/Hyperactivity Disorder (v1); Behavior Rating Scales (v1); Continuous Performance Tests (v1); Learning Disorders (v1); Mental Health Issues in the Schools (v1); Psychometric Properties (v2); Quantitative Methodologies (v1); Test Interpretation (v2)

### Further Readings

- Conners, C. K. (1997). *Conners' Rating Scales-Revised: Technical manual*. North Tonawanda, NY: Multi-Health Systems.
- Conners, C. K. (2006). *Attention deficit hyperactivity disorder: The latest assessment and treatment strategies* (3rd ed., p. 30). Kansas City, MO: Compact Clinicals.
- Sattler, J. M., & Hodge, R. D. (2006). *Assessment of children: Behavioral, social, and clinical foundations* (5th ed., pp. 283–284). La Mesa, CA: Sattler.

---

## CONTINUING EDUCATION

---

Continuing education for individuals in the counseling professions is often required for maintenance of licensure or certification status. Agencies that offer licensing

or certification for counselors include state organizations, professional associations, and specialty or national affiliations. The term *counselors* applies to persons who are licensed or have received specialized training in mental health fields such as rehabilitation counseling, marriage and family counseling, and school counseling. Other professionals who practice counseling may include counseling and clinical psychologists, psychiatrists, psychiatric nurses, and social workers.

Continuing education is intended to promote the maintenance and development of professional competency for counselors and other professionals. Not all regulating bodies require counseling professionals to complete continuing education activities, but required continued education has become increasingly common. States and other regulatory bodies typically mandate that counselors who hold licenses or certifications demonstrate their continued competency through completing continuing education activities. Counseling professionals seeking relicensure or recertification will receive, from the agency overseeing the process, details regarding expected continuing education content and format in addition to requirements for amount and frequency of continuing education hours. Completion of the requirements within the time frame gains the counselor certification or licensure for a time period specified by the state or professional organization.

## Characteristics of Continuing Education

### Purpose

Continuing education serves to contribute to the sustained knowledge and skill acquisition of counselors beyond their terminal degree, licensure, or certification. Continuing education is referred to as both *mandatory continuing education* and as *lifelong learning*. These two perspectives on counselor knowledge and skill acquisition can certainly be related, but they represent different concepts. Mandatory continuing education is a required professional activity for counselors wishing to maintain licensure or certification. Depending on a counselor's degree or certification, continuing education is mandated by state, agency, or organizational policies. Different governing bodies require different types and amounts of continuing education activities, but in general, continuing education serves to advance and maintain a counselor's body of knowledge and skills. More specifically, mandated



continuing education facilitates continued expertise in counselors' field of study as well as awareness of new professional developments, and it protects consumers of counseling through instituting a regulated standard of minimum competencies. Lifelong learning, while an incidental effect of mandatory continuing education, can also be recognized as activities counselors engage in to augment preexisting knowledge for the purpose of personal and professional development rather than to fulfill a professional requirement. Although lifelong learning can be understood as a potential outcome of any continuing educational activity, the term *continuing education* is more commensurate with the formalized professional requirement and therefore mandatory continuing education will be the main focus of this entry.

### **Content**

The content of continuing education activities is sometimes mandated, but it is more often flexible in order to allow counseling professionals to self-select areas of interest or new specializations or skills. States, agencies, and other governing bodies often require licensees and those they certify to obtain knowledge in particular domains to enable counselors to keep their expertise current and to introduce counselors to areas of new professional development. For counselors, those domains vary considerably but can include child abuse, ethics, multiculturalism, and legal issues. Some counseling professionals may be required to access continuing education in a certain topic area for a certain period of recertification or licensure. Continuing education topics reflect the diversity within the fields of counseling and therefore have an extensive scope. For example, school counselors, career counselors, and professors in counseling education will likely choose different counseling-related education opportunities in order to tailor their continued learning. Most regulating agencies approve continuing education opportunities and content endorsed by major national organizations such as the American Psychological Association, American Counseling Association, and American Association of Counseling and Development as well as state and regional organizations.

### **Format**

Continuing education opportunities are offered through a variety of organizations, institutions, and

agencies. Continuing education activities commonly include attendance at conferences, professional meetings, and workshops; participating in professional activities such as roundtable discussions; teaching; and presenting or publishing professional work. Continuing education activities also encompass didactic activities, including specialized coursework, journal readings, and other independent study.

Literature on continuing education supports the assertion that counselors prefer to engage in local and regional workshops, readings, and independent study to meet continuing education requirements. Because continuing education costs are the responsibility of counselors, or less commonly counselors' employers, cost may be a factor in counselors' preferences for continuing education activity format. The format of continuing education may be mandated by state licensing boards or other regulating bodies. Like the content of continuing education activities, the counseling professional is often afforded a considerable amount of decision-making freedom when choosing formats that are most appropriate for accessing topics of interest or that contain required content.

### **Frequency and Amount**

Activities for continuing education are often measured in hours, credits, or units. Formulas for continuing education units often involve a ratio of continuing education units per clock hour of activity. For example, one continuing education unit may equal ten clock hours of an activity. Some regulatory groups require specified numbers of continuing education units, credits, or hours on an annual, biannual, or triennial basis; a minority of regulatory groups have specifications for continuing education to be completed within a 5-year period. All licensing or certification regulatory bodies that require continuing education specify that professionals provide evidence that they have participated in the required number of hours, credits, or units. Some agencies further specify that professionals provide an assessment of whether or not the continuing education knowledge and skills have been learned. Common assessments include a content-specific measure, feedback from a workshop presenter, or reflective comments about the activity.

The amount and frequency of continuing education required varies for professionals within the counseling fields. Because state licensing agencies hold different specifications for continuing education



requirements that may differ from a professional's national affiliations, counselors must work to meet requirements for continuing education for their professional affiliations and their state licensure. There is much variability in the requirements themselves as well as in how professionals choose to meet them. For example, the National Board for Certified Counselors requires 100 hours of continuing education to be accrued within a 5-year period, and the National Association of Social Workers requires that professionals attain 90 hours of continuing education within a 3-year period. Alternatively, the majority of states require psychologists to document participation in 20 to 40 hours of continuing education every 2 years. Despite the range of continuing education requirements across professions within counseling, each governing body requires specific educational activities within a stated time frame for the professionals that the body continues to license or certify.

### Current Trends and Future Directions

With the increased prevalence of mandated continuing education, counseling professionals have begun to discuss its impact on fields within counseling. Regulatory bodies and counselors have raised questions about whether or not continuing education should be mandatory, whether continuing education is effective, and whether counselors participate in continuing education activities without a requirement. Discussion has also been raised regarding the disparity between the concept of lifelong learning and mandated continuing education. Proponents in favor of lifelong learning argue that counselors should engage in professional activities and learning opportunities for their own professional and personal development rather than to meet a general requirement. Future research, theory, and discourse will continue to refine the way in which continuing education is used to ensure quality service provision to consumers, teach professionals about new developments within their field, and prevent decline of professional knowledge and skills.

*Sarah C. Haag and Jennifer M. Hill*

*See also* Conferences, Counseling Psychology (v1); Conferences in Counseling (v1); Counseling Skills Training (v2); Counselors and Therapists (v2); Credentialing Individuals (v1); Postdoctoral Training (v1); Professional Associations, Counseling (v1)

### Further Readings

- Kaslow, N. J., & Echols, M. M. (2006). Postdoctoral training and requirements for licensure and certification. In T. J. Vaughn (Ed.), *Psychology licensure and certification: What students need to know* (pp. 85–95). Washington, DC: American Psychological Association.
- Reich, J. N., Sands, H., & Weins, A. N. (Eds.). (1995). *Education and training beyond the doctoral degree: Proceedings of the American Psychological Association National Conference on Postdoctoral Education and Training in Psychology*. Washington, DC: American Psychological Association.
- Rodolfa, E., Bent, R., Eisman, E., Nelson, P., Rehm, L., & Ritchie, P. (2005). A cube model for competency development: Implications for psychology educators and regulators. *Professional Psychology: Research and Practice*, 36, 347–354.
- VandeCreek, L., Knapp, S., & Brace, K. (1990). Mandatory continuing education for licensed psychologists: Its rationale and current implementation. *Professional Psychology: Research and Practice*, 21, 135–140.
- Wilcoxon, S. A., & Hawk, R. (1990). Continuing education services: A survey of state associations of AACD. *Journal of Counseling and Development*, 61, 93–94.

---

## CONTINUOUS PERFORMANCE TESTS

---

The continuous performance test (CPT) is one group of measures for the evaluation of attention as well as response inhibition (or disinhibition); Fleming, Goldberg, and Gold have described the CPT as the gold standard for measuring sustained attention. The original CPT was developed by Rosvold, Mirsky, Sarason, Bransome, and Beck in 1956 as a research tool to study vigilance. Since that time, the CPT has continued to be used in the study of attention as well as executive control, with multiple variations in the components of the task; today, the majority of CPTs are computer administered.

### Basic Paradigm

The basic CPT paradigm consists of rapid presentation of continuously changing stimuli with a designated “target” stimulus or pattern such that the individual is to respond (or inhibit responding) based on the stimulus presented. It requires selective attention or vigilance for an infrequently occurring target



or relevant stimulus; at the same time, the duration of the task is intended to be sufficient to measure sustained attention. Despite these general similarities, there have been as many versions of the CPT available as there were clinicians who used them. Different CPTs include variations in the basic task (i.e., when to respond or inhibit), the characteristics of the target, variations in the interstimulus interval (ISI), presence or absence of distracters, modality of presentation, duration of the target presentation, duration of task, and so on. The effects of some of these possible variations and modifications to the CPT on performance have been reviewed elsewhere.

### Variables of Interest

CPT variables reported include correct hits (number or percentage of correct responses to targets) and omission errors (i.e., number or percentage of targets not responded to). Both correct hits and omission errors are interpreted as indicative of selective attention or inattention. Commission errors (number or percentage of responses to stimuli other than the target) are reported as an index of response inhibition or disinhibition. In some studies, relative accuracy (percentage of correct responses) or total errors (combining omission and commission errors) may be reported.

Reaction time is another measure frequently reported with CPTs. Reaction time or response latency is believed to reflect the speed of processing as well as the speed of motor responding. For example, a child may demonstrate increased omission errors and a slower rate of responding without an associated increase in commission errors; this type of pattern may be interpreted as supporting a hypothesis of difficulty with the allocation of information-processing resources. The consistency or variability of the individual's performance over time is also of importance; some CPT programs generate the standard deviation of the reaction time across blocks as a measure of consistency in responding and of the ability to sustain attention over time. Alternatively, some researchers report the standard error of the reaction time as an indicator of the consistency or variability of responding over time. Still others use the standard deviation of the standard error over time as an indication of consistency. Rather than using differences in the reaction time as a measure of consistency, some clinicians focus on comparisons of correct and

incorrect responses over differing blocks of time within the same administration (i.e., vigilance decrement).

As an alternative to direct performance scores, some clinicians incorporate signal detection theory (SDT) in generating performance indexes for interpretation. The basic premise of SDT is that the decision to respond is based on the child's setting a certain standard or criterion for responding. SDT variables of sensitivity (also referred to as  $d'$  or  $d$ -prime) and response bias (also referred to as  $\beta$ ) are based on signal to noise (i.e., target to nontarget) ratios. Lam and Beale argued that the sensitivity and bias indexes may be more sensitive to differences in performance on the CPT than omission or commission errors and that SDT procedures may be particularly useful in neuropsychological assessment.

### Technical Adequacy

Ethical and professional standards demand that clinicians use measures that are technically adequate. With CPTs, as with any formal assessment measure, it is important for administration to be standardized consistent with the collection of normative data. As such, it is imperative for the CPT manuals to clearly state the conditions for standardized administration. Ballard reviewed a number of experimenter-manipulated variables that may influence CPT scores and recommended that manuals address these issues (e.g., examiner presence or absence, instructional set). The potential for these changes to affect test performance, possibly invalidating the interpretation of the results, requires adherence to standardized procedures in the administration of any CPT. In addition, given differences in task demands and parameters across CPTs, performance on any one of these CPTs can be interpreted only based on the normative data for those specific task parameters. For these reasons, although the capacity to customize the task may be beneficial for research purposes, clinical use of customized CPTs is not recommended due to the lack of normative data.

### Use and Interpretation

Clinicians also need to be cautious in their interpretation of CPT results. The CPT is only one measure, and multiple sources of information and multiple measures should be used when assessing attention and impulse control problems in order to corroborate CPT findings. Taken together with direct observation,



behavior rating scales, and other psychometric tests, the CPT may provide useful information. The CPT is an objective measure that is not subject to rater bias or observer drift; as such, the level of performance on CPTs may be helpful in ruling out or identifying attentional problems and for monitoring medication effectiveness. However, reliance on CPTs as a primary diagnostic tool in determining the presence of a specific disorder (e.g., attention deficit hyperactivity disorder [AD/HD]) is not warranted and will result in an unacceptably high number of false positive errors or overdiagnosis of AD/HD. Without evidence of both internal consistency and temporal stability, any conclusions related to diagnostic considerations or treatment effectiveness are questionable. Given all of the possible variations to the CPT paradigm, it is possible that some combination(s) will prove more helpful in differential diagnosis than others.

Cynthia A. Riccio

**See also** Attention Deficit/Hyperactivity Disorder (v1); Behavioral Observation Methods, Assessment (v1); Behavior Rating Scales (v1); Connors' Rating Scales—Revised (v1); Learning Disorders (v1); Mental Health Issues in the Schools (v1); Psychometric Properties (v2); Quantitative Methodologies (v1); Technology and Treatment (v1); Test Interpretation (v2)

## Further Readings

- Ballard, J. C. (1996). Computerized assessment of sustained attention: A review of factors affecting vigilance performance. *Journal of Clinical and Experimental Neuropsychology*, 18, 843–863.
- Bock, R. D. (1982). *The role of arousal in Tourette Syndrome*. Unpublished doctoral dissertation, New York University, New York.
- Carter, C. S., Krener, P., Chaderjian, M., Northcutt, C., & Wolfe, V. (1995). Abnormal processing of irrelevant information in attention deficit hyperactivity disorder. *Psychiatry Research*, 56, 59–70.
- Cohen, R. A. (1993). Neuropsychological assessment of attention. In R. A. Cohen (Ed.), *The neuropsychology of attention* (pp. 307–328). New York: Plenum.
- Fleming, K., Goldberg, T. W., & Gold, J. M. (1994). Applying working memory constructs to schizophrenic cognitive impairment. In A. S. David & J. C. Cutting (Eds.), *The neuropsychology of schizophrenia* (pp. 197–213). Hillsdale, NJ: Lawrence Erlbaum.
- Lam, C. M., & Beale, I. L. (1991). Relations among sustained attention, reading performance, and teachers' ratings of behavior problems. *Remedial and Special Education (RASE)*, 12, 40–47.
- Levin, E. D., Conners, C. K., Sparrow, E., Hinton, S. C., Erhardt, D., Meek, W. H., et al. (1996). Nicotine effects on adults with attention-deficit/hyperactivity disorder. *Psychopharmacology*, 123, 55–63.
- Liu, S. K., Hwu, H., & Chen, W. J. (1997). Clinical symptom dimensions and deficits on the continuous performance test in schizophrenia. *Schizophrenia Research*, 25, 211–219.
- Riccio, C. A., Reynolds, C. R., & Lowe, P. A. (2001). *Clinical applications of the continuous performance test: Measuring attention and impulsive responding in children and adults*. New York: Wiley.
- Rosvold, H., Mirsky, A., Sarason, I., Bransome, E. D., Jr., & Beck, L. H. (1956). A continuous performance test of brain damage. *Journal of Consulting Psychology*, 20, 343–350.

---

## CONVERSION THERAPY

---

Conversion therapy (also known as reparative therapy, reorientation therapy, or transformational therapy) has been generally understood to have as its chief goal the cessation or changing of individuals' same-sex attraction and sexual behavior and the adoption of opposite-sex attraction and sexual behavior. Proponents and practitioners of conversion therapy base the rationale for such intervention on medical, moral, or religious traditions that regard homosexuality and homosexual behaviors as unnatural, psychopathological, or morally transgressive.

However, since the 1970s, mainstream mental health organizations (American Psychiatric Association, American Psychological Association) have adopted nosology and policy that reject the idea that homosexual individuals are mentally unhealthy simply because of their sexual orientation. Beginning in the late 1950s, scientific research such as that generated by Evelyn Hooker clearly demonstrated that homosexuals do not suffer any greater frequency of psychopathology than heterosexuals and that common psychodiagnostic tests cannot identify or effectively discriminate between homosexuals and heterosexuals.

In addition, the American Psychiatric Association, American Psychological Association, American Academy of Pediatrics, American Counseling Association, and National Association of Social



Workers have all adopted professional positions that oppose conversion therapy, citing as problematic its portrayal of homosexuals as abnormal, its almost exclusive focus on changing homosexual men while ignoring lesbian women, a lack of scientific support for its effectiveness, questionable ethics underlying such interventions, and the iatrogenic dangers (depression, anxiety, and other disorders) inherent in trying to persuade homosexual individuals that they are “ill” or in need of a “cure.”

### **What Is Conversion Therapy?**

Conversion therapy encompasses a range of techniques and approaches; many distinctions among them are dependent upon the underlying philosophy of the practitioner. Early psychological techniques of conversion therapy focused on long-term, classical psychoanalysis that sought to uncover and provide corrective emotional experiences for theorized Oedipal traumas thought to have arrested sexual development and caused homosexuality. Other approaches have utilized behavioral techniques, seeking to condition an aversion in homosexual individuals to same-sex activities by pairing homoerotic stimuli with unpleasant experiences (electroshock, anxiety, nausea). Some approaches take the form of verbal therapy or counseling, focusing on thoughts, feelings, and behaviors associated with homosexuality and teaching avoidance of these experiences.

Conversion therapy based upon religious traditions often relies on practitioners utilizing interpretations of religious doctrine or texts that forbid and condemn homosexuality; such practitioners seek to help homosexual individuals correct or cease sexual behavior that is found outside what is acceptable according to these doctrines. Such transformational ministries and “ex-gay” ministries (e.g., Exodus International) focus upon homosexuals’ inner turmoil as they attempt to reconcile their chosen religious or spiritual belief systems with their homosexuality.

Many proponents of conversion therapies hold the position that if a homosexual views his or her sexual orientation as unhealthy or as being against personally held beliefs and wishes to convert to heterosexuality (or at least stop same-sex sexual practices), that person has a right to such self-determination and a right to seek treatment to achieve that goal. However, research on sexual identity development suggests that because of societal heterosexism and the inculcation

of antihomosexual and proheterosexual attitudes into our society, it is a part of normal identity development for homosexual persons to experience a strong sense of confusion, fear, doubt, denial, stigma, and even self-hate surrounding their homosexual attractions. If “coming out” (the process of fully realizing and accepting one’s homosexuality) is met with supportive and positive social reactions, this initial difficult phase of identity development can give way to a healthy self-concept and positive self-identification as a homosexual.

### **Does Conversion Therapy Work?**

No program of peer-reviewed research published in mainstream scholarly journals shows that conversion therapy is effective. Those studies that have been conducted are often plagued by sampling problems that make drawing conclusions very difficult. For example, if an investigator examines the efficacy of conversion therapy with a sample of bisexual men (who have sex with persons of both the same and opposite sex), the ability of the men in this study to cease having sex with men for a period of time may be very different than would be found in a study where conversion therapy was provided to men who were strictly gay. As well, operationalization of what constitutes an “effective” outcome has been difficult. For example, the cessation of engagement in same-sex sexual relations is often considered a measure of “successful” conversion therapy; however, it is highly unlikely that behavioral cessation has also fundamentally changed the actual homosexual orientation of clients, who still emotionally and sexually desire same-sex persons and attitudinally think of themselves as homosexual. This latter state of affairs is anecdotally reported by “ex-gays” who have received conversion therapy. Many either have chosen to remain without sexual partners or have tried to forge heterosexual partnerships in an effort to resist their homosexual orientation and desires. Even though same-sex sexual relations have stopped, and heterosexual sexual relations begun, such “ex-gay” clients report still thinking of themselves as gay and desiring same-sex relations; they simply do not allow themselves to have them.

Most scholars have arrived at the consensus that although some homosexual or bisexual persons may be able to resist engaging in sex with same-sex partners, the alteration or transformation of homosexuality into heterosexuality is an extremely unlikely (and



probably unhealthy) event and that an individual's sexual orientation is a relatively stable characteristic.

### What About Homosexuals Who Want to Be Heterosexual?

Most mental health professionals accept the idea that it is the very rare individual who does not undergo some discomfort and period of adjustment upon the realization of being homosexual. Because values and models set heterosexuality as the norm in our society, and because these expectations are internalized, it is consequently difficult for persons finding themselves falling outside the norm to feel comfortable with possessing a nonmajority sexual orientation.

Many mainstream clinicians who encounter a gay or lesbian client who voices a desire to change his or her sexual orientation would first ensure that such a client is not simply in the midst of a typical phase of self-doubt and fear. In addition to these reactions arising from internalized homophobia, such clients may have also encountered highly critical or even hostile social reactions when sharing with others the fact they are homosexual, thereby heightening their concerns over their homosexuality. At a societal level, media messages and conversations about the erosion of gay rights, the push to make gay partnerships illegal and to deny gay partners health insurance, and reports of hate crimes (including murder) perpetrated against gay men and lesbian women would also add up to create a reasonable level of distress, anxiety, and confusion. Finally, as aforementioned, contextual and cultural variables (racial/ethnic, religious/spiritual, intrafamilial) would need to be assessed before arriving at a conclusion that the client is making an informed and healthy decision.

### Summary

Homosexuality and same-sex sexual attraction is not a mental illness, disorder, or pathology. Therefore, not only is the need for psychological treatment or counseling not supported or indicated, but self-reports from persons undergoing conversion therapies demonstrate that such treatments may bring harm to clients. No case can be built that justifies conversion therapy as judged by the ethical standards of major mental health organizations. Finally, there is no documented empirical research that demonstrates the efficacy or effectiveness of conversion therapy; in fact,

almost all evidence of successful outcomes come from anecdotal or single source reports (e.g., therapist or client impressions) without corroborating or longitudinal evidence of stable and true change of sexual orientation or a healthy adjustment to a nonsexual lifestyle or a self-imposed heterosexual partnering.

Loreto R. Prieto

*See also* Behavioral Therapy (v2); Career Counseling, Gay and Lesbian (v4); Gay, Lesbian, and Bisexual Therapy (v2); Harmful Psychological Treatments (v2); Psychoanalysis and Psychodynamic Approaches to Therapy (v2); Sexual Orientation (v4)

### Further Readings

- Croteau, J., Lark, J., Lidderdale, M., & Chung, Y. (2004). *Deconstructing heterosexism in the counseling professions: A narrative approach*. Thousand Oaks, CA: Sage.
- Haldeman, D. (1994). The practice and ethics of sexual orientation conversion therapy. *Journal of Consulting and Clinical Psychology*, 62, 221–227.
- Hooker, E. (1957). The adjustment of the male overt homosexual. *Journal of Projective Techniques*, 21, 18–31.
- McCarn, S., & Fassinger, R. (1996). Revisioning sexual minority identity formation: A new model of lesbian identity and its implications. *Counseling Psychologist*, 24, 508–534.
- Shidlo, A., & Schroder, M. (2002). Changing sexual orientation: A consumers' report. *Professional Psychology: Research and Practice*, 33, 249–259.
- Tozer, E., & Hayes, J. (2004). Why do individuals seek conversion therapy?: The role of religiosity, internalized homonegativity, and identity development. *The Counseling Psychologist*, 32, 716–774.
- Tozer, E., & McClanahan, M. (1999). Treating the purple menace: Ethical considerations of conversion therapy and affirmative alternatives. *The Counseling Psychologist*, 27, 722–742.

---

## CORRECTIONS APPLICATIONS

---

The corrections population in the United States comprises inmates in federal and state prisons, territorial prisons, local jails, Bureau of Immigration and Customs Enforcement facilities as well as military and juvenile facilities, and this population differs across a multitude of variables compared to nonincarcerated



populations. Each of these variables individually and collectively creates challenges in providing counseling services. Counseling services are likely most effective when focused on basic needs that many inmates are unable to meet for themselves. Such needs are likely to include assuring a stable living environment upon release, the means to sustain this environment through steady employment, and the elimination of the destructive patterns, such as substance abuse, that led to a destabilization in meeting these basic needs. Although challenging, working with corrections populations can be among the most rewarding kinds of work for counseling professionals.

### **Growth of Corrections Population**

The corrections population in the United States has grown annually since 1970; over 2 million people are presently incarcerated, and over 7 million are under some form of correctional supervision (probation, parole or other supervised release, or placement in community corrections programs commonly referred to as “halfway houses”). The corrections population in the United States is between 6 and 10 times greater than that of any other industrialized country in the world. Rates of incarceration for racial and ethnic minorities are particularly discouraging. For example, two thirds of all prison inmates are minorities. One in every eight Black males in their 20s is in prison or jail on any given day. Institutional populations often exceed design capacities of the physical structures and allotted staff; state prisons operate at between 1% and 14% above capacity and federal prisons operate at 34% above capacity. This growth has thinned available resources and burdened corrections professionals.

More than half of all prison and jail inmates had a history of mental illness within the last 12 months. Rates of mental illness among female inmates (state 73%; federal 61%; jail 75%) far exceeded male rates (state 55%; federal 44%; jail 63%). Mental health problems among the corrections population are largely associated with criminal history, violent offenses, and physical aggression in prison as well as homelessness and other personal instability in the year before arrest. Estimated rates of mental illness within corrections populations typically incorporate only mood, anxiety, and psychotic disorders in their analyses and exclude developmental and substance-related disorders. Often, adjustment disorders with mood or anxiety symptoms are also not reflected in these statistics, because there

is an assumed period of maladjustment inherent to incarceration. Consequently, statistics provided for the rates of mental illness within corrections populations typically underestimate actual rates, as statistics are based on a discrete set of disorders.

Growth in the U.S. incarcerated population is partly explained by decreases in numbers of patients hospitalized in mental hospitals and asylums. Although progressive movements in the 1950s and 1960s attempted to deinstitutionalize mental illness and provide for more humane treatment within the community, limited viable alternatives to mental hospitals and poorly equipped community programs contributed to increased rates of incarceration for individuals with mental illness. Quite simply, prisons have become the modern-day mental asylum.

Substance abuse is also a significant problem within the corrections population. Over 80% of all inmates were incarcerated for a drug-related offense, were under the influence of a substance at the time of their offense, committed their offense to obtain money for drugs, or were abusing substances in the month prior to their arrest. These rates have also continued to grow over the last 30 years because of changes in public policy that resulted in increased resources to arrest and convict drug offenders, mandatory sentencing laws, cutbacks in parole releases, and increases in the revocation of probation or parole. Although drug treatment programs are by far the most widely offered forms of treatment in corrections settings, the percentage of inmates reporting participation in drug treatment programs dropped across the 1990s for both state and federal facilities.

### **Health-Related Issues**

Providing for the medical needs of the corrections population has been highly politicized since the 1976 landmark U.S. Supreme Court decision in *Estelle v. Gamble* (429 U.S. 97). This decision prohibited corrections professionals from passivity or indifference in their treatment of inmates' health problems. Although aggressive prevention and treatment of health problems is preferred, this task can be daunting given that the corrections population has far more medical illnesses than the average population, correctional institutions often have limited financial and medical resources to assure adequate treatment, and the typical inmate is not often health conscious. For example, the prevalence rates for communicable diseases among the corrections population far exceed those of the average



population; the proportion of inmates with HIV/AIDS is 5 times greater than in the total U.S. population, the proportion with hepatitis C is 9 to 10 times higher, and the proportion with tuberculosis is between 4 times higher (for prison inmates) and 17 times higher (for jail inmates). Hepatitis B and other sexually transmitted diseases (i.e., syphilis, gonorrhea, chlamydia) are also present among significant proportions of the corrections population. The prevalence rates for chronic diseases are also quite high, including heart and cerebrovascular disease, cancer, diabetes, and respiratory disease. Often, because of individual and socioeconomic barriers, illnesses are either first diagnosed in a corrections setting, or the first sustained treatment to which the inmate has access is within a corrections institution. These challenges coupled with an increasing geriatric population in prisons make successful treatment more intensive and costly.

### Substance Abuse Counseling

Although the rates of inmate participation in drug treatment programs have decreased, such programs remain a staple of psychological and rehabilitative services in correctional settings. Evidence suggests that participation in such treatment programs decreases both recidivism and continued drug use upon release. For example, the Federal Bureau of Prisons found that inmates who completed the Drug Abuse Program (DAP) were 73% less likely to be rearrested in the first year after release than untreated inmates. Additionally, a comparison of urinalyses showed that DAP inmates were 44% less likely to continue using substances after release than inmates who did not complete DAP. Research on state facilities has shown similar reductions in recidivism of around 50%. The most effective of these programs are those that combine treatment during incarceration with community aftercare upon release.

### Vocational and Academic Counseling

Some degree of vocational or academic development while incarcerated remains the most consistent factor predicting rates of recidivism. In other words, inmates who participate in vocational programming, a specific occupational apprenticeship, or an academic advancement program are less likely to reoffend upon release. According to Moore, one study conducted by the Florida Department of Corrections (DOC) concluded

that inmates who earned a GED were 8.7% less likely to recidivate than those inmates without a GED. Inmates who obtained a GED and improved their scores on the Test of Adult Basic Education to the ninth grade level or higher were 25% less likely to recidivate. Inmates who completed a vocational development program were 14.6% less likely to recidivate than those who did not complete any vocational programs. The impact of vocational and academic programs in reducing recidivism is not exclusive to Florida, as similar results are seen in other state and federal institutions.

Aside from the direct benefit to the inmate and his or her family for remaining free from further incarceration, there is a direct benefit to correctional institutions and their taxpayers. The reduction in recidivism rates for inmates who obtained a GED in the Florida study translated into approximately 100 inmates not returning to prison. The reduction in recidivism rates for inmates who completed a vocational program translated into approximately 169 inmates not returning to prison. The Florida DOC estimated that the amount saved by not having to reincarcerate the 100 inmates with a GED was approximately \$1.9 million; the savings for the 169 inmates who participated in vocational programs was \$3.2 million.

### Release and Reintegration

Approximately 97% of the U.S. incarcerated population will be released to the community. Release is extremely challenging for inmates as is evidenced in dramatically increased rates of suicide and accidental death by either overdose or homicide immediately upon release. Consequently, nearly all counseling with corrections populations should focus on release preparation.

*Nicholas C. Larma*

*See also* Affect (Mood States), Assessment of (v2); Career Counseling (v4); Career Counseling Process (v4); Chronic illness (v1); Conduct Disorder (v1); Dementia (v2); Developmental Disorders (v1); HIV/AIDS (v1); Panic Disorders (v2); Personality Disorders (v2); Physical Health (v2); Substance Abuse and Dependence (v2)

### Further Readings

Binswanger, I. A., Sterns, M. F., Deyo, R. A., Heagerty, P. J., Cheadle, A., Elmore, J. G., et al. (2007). Release from prison—a high risk of death for former inmates. *New England Journal of Medicine*, 356, 157–165.



- Bureau of Justice Statistics. (2006). *National corrections populations*. Washington, DC: Department of Justice.
- Federal Bureau of Prisons. (1998, February). *New research reveals federal inmate drug treatment programs reduce recidivism and future drug use*. Retrieved January 24, 2006, from [http://www.bop.gov/news/press/press\\_releases/ipatriad.jsp](http://www.bop.gov/news/press/press_releases/ipatriad.jsp)
- Harrison, P. M., & Beck, A. J. (2006). *Prisoners in 2005: Bureau of Justice Statistics bulletin*. Washington, DC: Department of Justice.
- James, D. J., & Glaze, L. E. (2006). *Mental health problems of prison and jail inmates: Bureau of Justice Statistics special report*. Washington, DC: Department of Justice.
- Mauer, M. (1999). *The race to incarcerate*. New York: New Press.
- Moore, M. W. (2001). *Analysis of the impact of inmate programs upon recidivism*. Retrieved January 24, 2006, from <http://www.dc.state.fl.us/pub/recidivismprog/index.html>
- National Commission on Correctional Health Care. (2002, May). *The health status of soon-to-be-released inmates: A report to Congress*. Chicago: Author.
- Pratt, D., Piper, M., Appleby, L., Webb, R., & Shaw, J. (2006). Suicide in recently released prisoners: A population-based cohort study. *The Lancet*, 368, 119–123.
- Sentencing Project. (2006). Facts about prisons and prisoners. In *The sentencing project: Research and advocacy for reform*. Retrieved January 24, 2006, from <http://www.sentencingproject.org/PublicationDetails.aspx?PublicationID=425>

---

## COUNSELING, DEFINITION OF

---

Professional counseling is a skilled activity that involves assisting others in managing and resolving psychological, emotional, behavioral, developmental, relational, vocational, and other personal challenges (chronic or acute) in order to facilitate adjustment to changing life circumstances; promote personal growth, needs attainment, and overall wellness throughout the life span; and prevent the development of more serious conditions. At its essence, professional counseling involves the formal application of theoretical and empirically supported psychological, developmental, and learning principles to facilitate desired change or growth within a larger system of ethical and professional practice standards. These principles are implemented through specifically tailored cognitive, affective, behavioral, and systemic strategies and

interventions delivered through therapeutically oriented conversations and interactions.

### Types of Professional Counseling

Originally derived from the Latin root, *consulo*, meaning to advise, deliberate, or consult, counseling can be conceptualized in a number of different ways. Professional counseling is provided within the context of individual, couples, family, and group formats. Some counselors define their work on the basis of developmental life stages (i.e., child counseling, adolescent counseling, adult counseling, and geriatric counseling). Counseling can also be distinguished temporally, whether it is intended to be very short-term crisis counseling, brief counseling, or long-term counseling. Distinct subspecialties within the profession of counseling include school counseling, career counseling, and mental health counseling. Counseling is also sometimes defined by the distinct underlying theoretical orientations upon which the professional counselor draws (e.g., solution-focused counseling, person-centered counseling, existential counseling).

### Differentiating Professional Counseling

There is a clear difference between professional counseling and lay counseling, with the former being bound by professional ethical standards and premised on sound theoretical and research-supported principles. Professional counseling is different from other helping activities such as guidance and health or psychoeducation in that these other activities are primarily directed at providing information and advice in an emotionally neutral context. In relation to other mental health professions, professional counseling is best distinguished by an emphasis on normal development, adaptation to changing life circumstances, and positive growth.

Although the terms *counseling* and *psychotherapy* are often used interchangeably, the two are distinct. A simple perspective may conceptualize counseling and psychotherapy as falling on a continuum, with counseling designed for normal populations and psychotherapy designed for clinical populations. To state this another way, some individuals see counseling as more concerned with adjustment to mainstream life transitions and normative stressors, while psychotherapy is seen as more concerned with psychological disorders and psychopathology. An alternative



conceptualization is to attend to the traditional paradigmatic differences between the two. Counseling typically follows a growth-oriented, developmental, and preventive framework. In contrast, psychotherapy typically adopts a medical (i.e., diagnose-and-treat) model. Although the practice of counseling is not intended specifically to diagnose and treat psychiatrically classified mental disorders in the tradition as the medical model, it is intended to facilitate wellness, personal growth, needs attainment, and adaptation to changing life circumstances. Consequently, when professional counseling is employed with individuals who meet the criteria for specific disorders, the emphasis remains on the person's ongoing adaptation, personal growth, wellness, and needs attainment. Through facilitating positive movement and change in these areas, the person's diagnosable condition may improve.

*Robinder P. Bedi and José F. Domene*

**See also** Bilingual Counseling (v3); Career Counseling (v4); Counseling, History of (v1); Counseling Psychology, Definition of (v1); Counselors and Therapists (v2); Counseling Process/Outcome (v2); Counseling Theories and Therapies (v2); Couple and Marital Counseling (v1); Crisis Counseling (v2); Developmental Counseling and Therapy (v2); E-Counseling (v1); Family Counseling (v1); Genetic Counseling (v1); Individual Therapy (v2); Multicultural Counseling (v3); Outcomes of Counseling and Psychotherapy (v2); Personal and Career Counseling (v4); School Counseling (v1)

### Further Readings

- Council for Accreditation of Counseling and Related Educational Programs. (2006, September). *Choosing a career in counseling*. Retrieved from <http://www.cacrep.org/careerincounseling.html>
- International Association for Counselling. (2000, December). *The nature and scope of counselling*. Retrieved from <http://www.educ.sfu.ca/iac/>
- Society for Counseling Psychology. (2007, February). *What is the difference between a clinical psychologist and a counseling psychologist?* Retrieved from <http://www.div17.org/students/difference.htm>

broad field of psychology, and though much of the history of each is unique, counseling and psychology are branches of the same mental health tree. The counseling field developed from the guidance movement in response to recognition of a need for mental health and guidance counseling for individuals facing developmental milestones. This entry provides a historical context for the development of the counseling profession, the key contributors to the profession, and the development of organizations providing professional context and accountability. An overview focuses on three threads: societal changes that influenced the profession in response to human need, changes in psychological theory, and educational reform.

### Early 20th Century

The counseling profession developed in many ways from responses to changes in society. In the early 20th century, when counseling was first emerging, humanistic reform, with an increased emphasis on the value of all human beings, was also emerging. Human qualities such as choice, creativity, self-realization, and ultimately the value of all people became the focus of human change and intervention. During this period of humanistic reform, society saw changes in conditions of prisons, asylums, and factories based on the humanistic principles noted above. The focus was toward treating all clients, regardless of circumstance, in a way that regarded and supported their potential for success and remediation. Concurrently, the school system was taking a lead in this transformation through its focus on humanistic education, including student-centered learning with the teacher as a facilitator, development of the self-actualized student, and student cooperation. Humanistic reform led to a new way of viewing the individual and the facilitation of human well-being.

Also during this time, America was in the midst of the Industrial Revolution, a time of great change resulting in a shift in human need. One of the primary consequences of the dramatic changes occurring in American society was the movement from farms to the city. As a great influx of people moved to cities to work in industry and in the factories, people were severely overcrowded, which ultimately resulted in an increase in disease and the beginning of slums and poverty. An additional consequence was the disorganization of the family. Before the industrial revolution, families lived close to one another, worked together, and relied on one another for support. Once families

---

## COUNSELING, HISTORY OF

---

The counseling field, though relatively new, has a rich history. It is important to note the influence of the



moved to the cities to work in the factories, the family structure changed, and the human population became increasingly isolated. These changes created new needs for the individual and the family.

In education, this time period saw the ongoing development of progressive education led by John Dewey. The focus of this movement was child learning through real-world experience and an emphasis on schools reflecting the overall life of society. Also part of this movement was respect for the child and the implementation of a curriculum that allowed for children to develop personal interests; this curriculum included agricultural education, industrial education, and social education with an emphasis on the acculturation of immigrants. Progressive education coupled with the humanistic movement shed light on the growing need to attend to the overall well-being of children, beyond the walls of the school. Another key figure in the change of American schools was Horace Mann, who is often referred to as the father of American education. Mann believed in the development of a system of common schools: universal, free, and nonsectarian education.

These early forerunners (Dewey and Mann) were focused on training and advice, in particular education and vocational guidance, and on interpersonal relationships. To this point in history, the helping professions were dominated by mental health giants such as Sigmund Freud, Alfred Adler, and Viktor Frankl. Freud's psychoanalytic theory had, and continues to have, a profound impact on counseling and psychotherapy.

The early 1900s saw the beginning of political support for compulsory education. Compulsory education allowed for education for all and is based on the fundamental principle that education is a basic human right. Specifically, compulsory education requires by law that children receive education and that government provide education to all. Educating children decreased the number of children in the labor force and was a primary force in the change of society.

During this time in France, Alfred Binet was part of a commission concerned with retardation in school children. Binet rejected some original tenets of intelligence testing and worked on the development of intelligence scales. With the changes in the educational system driven by education reform in a response to urbanization and industrialization, schools needed assistance to handle diverse learning capabilities. Binet developed a scale to differentiate children

struggling to learn from those more capable of school demands. Binet collaborated with Theodore Simon, a physician, and together they developed a measure of intelligence. The primary intent of this 1905 intelligence scale was to discriminate between slightly "retarded" children and the normal school population.

Three key figures influenced the early roots of the counseling profession, specifically Jesse B. Davis, Frank Parsons, and Clifford Beers. A front-runner in the response to educational reform, Jesse B. Davis, was the first person to develop public school counseling and guidance programs. As a principal, Davis required his students to write about their vocational interests on a weekly basis. Davis believed that character development was central to preventing behavioral problems and to creating good relationships with other students. Davis was strongly influenced by Mann and Dewey and believed that if children were given proper guidance, the challenges of an increasingly industrialized society could be met. Therefore he advocated for the infusion of vocational development into traditional curriculum. The goals of the vocational focus were to assist students in understanding their character and in becoming socially responsible workers.

Parsons, often called the father of guidance, founded Boston's Vocational Bureau in 1908. Parsons believed the more people understood themselves and the career choices available to them—specifically their aptitudes, interests, and resources, the more capable they were of making informed and reasonable occupational choices. In 1909 Parsons wrote *Choosing a Vocation*, a highly influential book that called for the designation of school teachers as vocational counselors. Other schools took Parsons's example and began implementing their own vocational guidance programs.

During this same time Beers, author of *A Mind That Found Itself* in 1908, was the impetus for the mental health movement. This book was an autobiographical account of his experience with institutionalization following a suicide attempt. After discovering the condition of these facilities and finding the treatment of mental illness ineffective, Beers committed himself to changing the treatment of the mentally ill. In this book, he exposed the conditions of mental health facilities and eventually prompted national reform in the treatment of persons with mental illness. His work was the forerunner of mental health counseling.

The above professional forces were working toward the development of the counseling profession.



Early changes across three professional movements—guidance counseling and educational reform, mental health reform, and the psychometrics movement—came together to create the foundation of the counseling profession.

As the 1900s progressed, several events occurred that impacted the profession. The first event was the founding of the National Vocational Guidance Association (NVGA) in 1913. In 1915, the NVGA published the first *National Vocational Guidance Bulletin*, and by 1921 it was publishing it regularly. In 1924, the title was changed to the *National Vocational Guidance Magazine*. The publication evolved over the years to eventually become the *Journal of Counseling and Development*, the publication's current title. The development of the NCGA signified the first effort toward unifying those invested in the pursuit of scholarly information related to vocational guidance. Also during this time, the Smith Hughes Act of 1917 was passed by Congress. This act provided funding for public schools to provide vocational guidance programs and allowed schools to separate their vocational guidance programs from standard curriculum courses.

The beginning of World War I brought many new challenges to the United States and other countries involved in the war. The U.S. Army, in response to one of their challenges, commissioned the development of the Army Alpha and Army Beta intelligence tests. During this time, counseling became increasingly recognized as the army implemented these instruments to assist in selection, placement, and training practices for army personnel. After the war ended, these instruments were used with the civilian population; this marked the beginning of the psychometrics movement, one of the professional origins on which the counseling field was largely based.

### The 1920s

The 1920s saw the emergence of an even greater influence of school guidance. During this time, the profession was becoming increasingly focused, and vocational guidance became the primary focus of training programs, starting with Harvard University. The major influences on the profession at this time were theories of education and governmental support of guidance service for war veterans. Recognition of the importance of vocational assessment and guidance continued to pull the counseling field into more solid development and recognition of the need for increased

professionalism. In response to this pull came the development of the first standards for occupational inventories and guidelines for their development and evaluation, providing further impetus for psychometric evaluation. The primary orientation during this time was the medical model and testing.

With the standards for development and evaluation of psychological instruments came an increase in the publication of these materials, most notably the Strong Vocational Interest Blank (SVIB), created and published by Edward Strong in 1927 (now called the Strong Interest Inventory). The Strong Vocational Interest Blank was developed based on the assumption that patterns of individual interests indicate likely occupational choices. The inventory indicated the occupations in which a person will be more likely to be satisfied and perhaps even continue with long-term employment.

### The 1930s

The Great Depression in the 1930s had a profound influence on both researchers and practitioners; specifically there was an increased need for helping processes and counseling for employment placement. During this time period, E. G. Williamson developed the trait-factor theory based on modifications of Parson's theory. Williamson's theory was direct and focused on the counselor's direction, primarily through teaching and mentoring. The focus of trait-factor counseling was to define behavior by traits such as aptitudes, achievements, personalities, and interest, and based on these and a variety of factors, statistically evaluate them to assist an individual toward becoming an effective and successful individual. Williamson's theory was most popular in the 1930s and 1940s when it was used by the military in World War II for selection.

In addition to the influence of the economic climate, the greatest influence on the counseling profession during this time may have been the government's interest in supporting guidance and counseling efforts. In 1936, the George-Deen Act was approved by Congress; this act allowed for the creation of the Vocational Education Division of the U.S. Office of Education. An extension of this act was the introduction of the position of state supervisor of guidance in state departments of education. The George-Deen Act represented the first time funds were directly allocated for vocational guidance counseling, and guidance counselors saw an increase in support for their work.



Also during this time, the U.S. government instituted the U.S. Employment Service, which published the first edition of the *Dictionary of Occupational Titles (DOT)*. The *DOT* was the first publication to define jobs of all types. The *DOT* continues to serve individuals seeking employment to this day.

Despite great strides in the counseling profession during this time, some professionals in the fields of education and psychology were criticizing the narrow focus on the guidance movement. In particular, Edward Thorndike felt that the focus of the guidance movement was too narrow.

### The 1940s

The 1940s represented another decade of increased recognition for counseling and the ongoing development and definition of the profession. One of the most significant events was World War II. During the war, the U.S. government employed counselors and psychologists to assist in selection and training of specialists for both the military and industry. The war also brought with it a necessary increase in the number of women in the workforce. With so many men fighting in the military, women were needed to fill the vacant positions. The role of women in the workplace during such an important time for the United States radically changed the traditional sex roles formerly dominating the workforce.

Another significant event for the field of counseling that occurred during the 1940s was a growing interest in psychotherapy. There was an emergence of diverse theories—Carl Rogers’s client-centered and nondirective theory in particular. Rogers grew in popularity after the publication of his book *Counseling and Psychotherapy*. He challenged Williamson’s directive way of working with clients and focused on the clients’ responsibility for their own growth. As is evident from the history to this point, the focus of counseling and guidance prior to Rogers was on testing, assessment, and vocations. Through Rogers’s influence, the focus of counseling shifted to relationship dynamics, counseling technique, training of counselors, and refinement of the goals of the counseling relationship. Rogers’s theory came to the forefront of counseling and psychology theories, but new counseling theories emerged as well.

Following the war, several events occurred that further promoted the counseling profession. The George Barden Act of 1946 was passed, which

allocated vocational education funds for counselor training programs: This included funding for counselor educators, research, state program supervision, local guidance supervisors, and school counselors. Also during this time, the U.S. Department of Veterans Affairs (VA) gave grants for counselors and psychologists and paid for internships for graduate students. With the combination of the George Barden Act and support from the VA, graduate training programs began defining their curriculum more clearly.

### The 1950s

Building on the major changes that occurred during the 1940s, the 1950s saw great changes and the professionalization of counseling. As mentioned previously, the counseling profession developed in the context of historical events. The 1950s were a time of great change with such historical events as the launch of Sputnik, the baby boom, the women’s rights movement, and the civil rights movement. While these events were drastically changing the country, additional simultaneous events were occurring that changed the counseling profession. Specifically, these events were the passing of the National Defense Education Act (NDEA), professional developments, the introduction of new guidance and counseling theories, and the emergence of diverse marriage and family counseling theories.

The National Defense Education Act (NDEA) was initiated in response to Sputnik, a space satellite launched by the Soviet Union. The purpose of the NDEA was to promote studies in math, science, and foreign languages. The NDEA sought to identify children with particular abilities in these academic areas. Although this was the original intent of NDEA, this act also provided funding for improving school counseling programs and for training counselors. This decade saw the greatest increase in the number of school counselors in a decade.

Concurrent to the growing numbers of counselors nationwide, the profession itself was growing and changing. 1952 saw (1) the establishment of the American Personnel and Guidance Association (APGA), (2) the establishment of Division 17, the Division of Counseling Psychology of the American Psychological Association, and (3) the founding of the American School Counselor Association (ASCA). A year after ASCA was founded, it became a division of the APGA.



Finally, the 1950s saw the emergence of many different theories. Prior to this time there were essentially four primary theoretical orientations: psychoanalysis, trait-factor theories, client-centered theories, and behavioral theories. Within these four primary orientations, practitioners worked with either nondirective or directive counseling, but during this time, new theories emerged, including cognitive theories, behavioral theories, learning theories, and career theories. Also, marriage and family therapy emerged to an even greater extent, and major theorists in the marriage and family therapy field, such as Gregory Bateson, Virginia Satir, Jay Haley, Murray Bowen, Carl Whitaker, and Salvador Minuchin were solidifying the marriage and family movement.

### The 1960s

In the 1960s, the baby boomers were growing up, and the conservatism of the 1950s was changing to reflect a new way of thinking, thus radically changing American culture. The civil rights movement saw sit-ins, protests, and assassinations. During this time, women were entering the workforce in greater numbers, and the National Organization of Women was exposing the “glass ceiling.” Also during this time, crime and drug use were increasing, and the United States was once again at war, this time in Vietnam. The societal changes of the times contributed to many changes in the counseling profession, in particular a solidification of the profession and a focus on the needs created by the societal changes during this time.

In 1963, the Community Mental Health Act was enacted. This act provided federal funding for community mental health centers and was pivotal in changing the dissemination of services for the mentally ill. It allowed for individuals who would formerly have been institutionalized to live in the community and receive mental health support and services. The Community Mental Health Act also provided funding for building new community mental health centers through the National Institute of Mental Health, thus providing additional support for the provision of community-based care. In addition to major developments in the care for the mentally ill, this act provided employment opportunities for counselors.

This decade also saw increased professionalism in the field of counseling. Specifically, the APGA published its first code of ethics, providing guidelines for ethical practice and ultimately protecting the public

and increasing professionalism. Also during this time, an APGA report was edited that defined the role of and the training standards for school counselors. The American Psychological Association, Division 17, continued to clarify the definition of the counseling psychologist and published its first professional journal, *The Counseling Psychologist*.

Another influence of the government on the development of the counseling profession was the 1966 establishment of the Education Resources Information Clearinghouse (ERIC). Specifically related to the counseling profession was the ERIC section on Counseling and Personnel Services (ERIC/CAPS) at the University of Michigan. The ERIC was funded by the Office of Educational Research and Improvement through the U.S. Department of Education. The ERIC/CAPS provided a comprehensive resource on counseling activities and trends in the United States and internationally. In addition to the development of the database, conferences on counseling were sponsored, bringing together leaders in the profession.

In 1962, Gilbert Wrenn wrote a seminal piece that further defined the role of the school counselor. Specifically, Wrenn wrote that the school counselor should fill four functions: counsel students; consult with parents, teachers, and administrators; study the changing student population and interpret this information for administrators and teachers; and coordinate counseling services in the school and between the school and the community.

As the profession grew and training standards became more rigorous, the provision and regulation of quality services also increased. This decade saw considerable growth in the group movement and a shift toward small group interaction and interpersonal growth and awareness. Other major influences on the profession during this time were the emergence of Maslow’s humanistic counseling theory and of behavioral counseling, which emphasized learning as the root of change.

The counseling profession was paralleling the societal changes of the times. Specifically, counselors were being employed in more diverse settings, such as mental health centers and community agencies. Counselor training programs were also increasing in number, meaning that more counselors were competing for jobs as the programs graduated students. Along with the increased availability of training and more diverse employment opportunities, counselors were seeking and receiving specialized training. The



term *community counselor* began to be used, paralleling the diversification of employment opportunities, with the new title implying a professional with diverse roles and responsibilities.

A pivotal movement in the counseling profession during this decade was for state and national licensure. Restrictions on counselors' ability to acquire psychology licensure led to this movement. The APGA started a task force to address licensure for counselors, and a benchmark for its success was the passing of successful licensure legislation in Virginia in 1976. Two additional states, Alabama and Arkansas, also had licensure legislation by the end of the decade.

### The 1970s

In the 1970s the profession became increasingly strong. Headquarters for the APGA were established in Alexandria, Virginia, and several strong divisions were chartered, including the Association of Counselor Education and Supervision (ACES), the American Mental Health Counseling Association (AMHCA), the Association for Religious and Value Issues in Counseling (now ASERVIC), the Association for Specialists in Group Work (ASGW), the Association for Non-White Concerns in Personnel and Guidance (ANWC), and the Public Offender Counselor Association. During this time, ACES published its first standards for master's degree programs in counseling, and it approved guidelines for doctoral education in counseling. As the profession became stronger, the APGA began questioning professional identity, as the personnel and guidance focus seemed increasingly outdated and narrow.

### The 1980s

The 1980s saw divorce rates increasing, violent crime increasing, and prisons overflowing. Drug use was considered an epidemic with the emergence of crack cocaine, and acquired immunodeficiency syndrome (AIDS) was claiming lives and demanding attention. The counseling profession continued to grow and to become a distinct profession, ultimately changing in response to divergent societal needs.

In 1981, the Council for Accreditation of Counseling and Related Education Programs (CACREP) was formed. CACREP revised the original standards developed by ACES in the 1970s. With those standards,

they standardized counselor training (counselor education) programs for both master's and doctoral students in the areas of school, community, mental health, marriage and family counseling, and personnel services.

At the same time, the National Board for Certified Counselors (NBCC) was formed in 1983. The initial intent of the NBCC was to certify counselors on a national level. A large part of this process included developing a standardized test covering eight major subject areas: (1) human growth and development, (2) social and cultural foundations, (3) helping relationships, (4) groups, (5) lifestyle and career development, (6) appraisal, (7) research and evaluation, and (8) professional orientation. Passing the exam, meeting experiential and educational requirements, and character references allowed a person to earn the National Certified Counselor (NCC) credential. Accreditation and certification standards attracted many to the profession.

A conversation continued from the late 1970s became more prevalent during the 1980s, as leaders in the APGA recognized that "personnel and guidance" no longer fit in describing the work of the members. In response, the APGA was changed to the American Association for Counseling and Development (AACD). Professional identity and commitment was increasingly important to members of AACD. Representative of this commitment was the formation of Chi Sigma Iota, the academic and professional honors society for counselors. Chi Sigma Iota was formed by Thomas J. Sweeney to promote excellence in the counseling profession.

AACD saw an increase in membership and an increase in the number of divisions, highlighting the diversification in the counseling field. Throughout this decade, the focus on developmental issues across the life span was led by developmental theorists such as Erik Erikson and Lawrence Kohlberg. A new division of the AACD, the Association for Multicultural Counseling and Development (AMCD) represented an increased focus on recognizing the challenges of counseling individuals from diverse ethnic and cultural backgrounds.

### The 1990s

The technology boom, low unemployment rates, and highly publicized violence (the Los Angeles riots, the World Trade Center bombing, the O. J. Simpson trial,



the Oklahoma City bombing, and school shootings) marked the 1990s. During this time the counseling profession was continuing to define itself professionally, was demanding appropriate supervision in response to the diverse needs of counseling consumers, and was dealing with restricted funding. Two primary influences in the 1990s, in addition to advances in technology, were managed care and an increase in accountability.

In 1992, the AACD instituted another name change, this time to the American Counseling Association (ACA). Also in 1992, counseling was included in the healthcare human resource statistics compiled by the Center for Mental Health Services and the National Institute of Mental Health, marking counseling as a primary mental health profession. A final key event that occurred in 1992 was the writing of multicultural counseling standards and competencies by Derald Wing Sue, Patricia Arredondo, and Roderick McDavis.

Finally, during this time there was a return to emphasizing counseling the whole person; this meant counselors took into consideration the importance of societal influences and the context of a client's life, such as his or her spirituality, family, and occupation. Organizations established in the 1970s and 1980s such as CACREP, Chi Sigma Iota, and NBCC experienced continued growth during this time, more states were passing licensure legislation for counselors, and both ACA and APA were publishing articles and books on counseling.

*Heather M. Helm*

**See also** Code of Ethics and Standards of Practice (v2); Conferences in Counseling (v1); Counseling, Definition of (v1); Family Counseling (v1); Ivey, Allen E. (v1); Ivey, Allen E.: Counseling Theory and Skills Training (v3); Parsons, Frank (v4); Professional Associations, Counseling (v1); Rogers, Carl R. (v2); School Counseling (v1); Strong, Edward Kellogg, Jr. (v4); Williamson, Edmund Griffith (v4)

### Further Readings

- Aubrey, R. (1977). Historical development of guidance and counseling and implications for the future. *Personnel and Guidance Journal*, 55(6), 288–295.
- Aubrey, R. (1982). A house divided: Guidance and counseling in 20th-Century America. *Personnel and Guidance Journal*, 61(4), 198–204.
- Beagle, A. V. (1986). Trivial pursuit: The history of guidance. *The School Counselor*, 34, 14–17.
- Engels, D. W. (1980). Looking forward via hindsight: A rationale for reviewing our ideological roots. *Personnel and Guidance Journal*, 59, 183–185.
- Gladding, S. (1984). History and systems of counseling: A course whose time has come. *Counselor Education and Supervision*, 24, 325–331.
- Heppner, P. P. (Ed.). (1990). *Pioneers in counseling and development: Personal and professional perspectives*. Alexandria, VA: American Association for Counseling and Development.
- Sheeley, V. L. (2002). American Counseling Association: The 50th year celebration of excellence. *Journal of Counseling and Development*, 80(4), 387–393.
- Smith, H., & Robinson, G. (1995). Mental health counseling: Past, present, and future. *Journal of Counseling and Development*, 74(2), 158–162.
- Stone, L. A. (1985). National Board for Certified Counselors: History, relationships, and projections. *Journal of Counseling and Development*, 63, 605–606.

### Web Sites

American Counseling Association: <http://www.counseling.org>

---

## COUNSELING PSYCHOLOGY, DEFINITION OF

---

Division 17 of the American Psychological Association (APA), known today as the Society of Counseling Psychology, has endured several challenges in formulating and refining a description of what defines it as a specialty. Prior to the creation of Division 17, the core of counseling as a profession had primarily been in vocational guidance. In 1946, Division 17 of the APA, titled the Division of Counseling and Guidance, was created. Although counseling psychology became a separate division at this time, the division still lacked a defining description that separated it as a unique specialty. Since Division 12 (Clinical Psychology) was already well established, the Division of Counseling and Guidance was encouraged to establish standards for training and practice in the same way that clinical psychology had. It wasn't until 1951 that the field of counseling psychology emerged as a separate specialty. It was during this year that the job title of counseling psychologist came into use.



In 1951, Division 17 sponsored the Northwestern Conference on the Standards for Training Counseling Psychologists. During this conference participants discussed defining descriptions of the roles and functions of counseling psychologists. It was also during this time that the name of Division 17 was changed to the Division of Counseling Psychology. Under this new title the description of counseling psychologists included the following:

The counseling psychologist is to foster the psychological development of the individual. This includes all people on the adjustment continuum from those who function at tolerable levels of adequacy to those suffering from more severe psychological disturbances. The counseling psychologists will spend the bulk of their time with individuals within the normal range of functioning, but their training should qualify them to work to some degree with individuals at any level of psychological adjustment. Counseling stresses the positive and preventative. It focuses upon the stimulation of personal development to maximize personal and social effectiveness and to forestall psychologically crippling disabilities.

Within this new definition, counseling psychologists extended their role beyond the primary confines of vocational guidance and attempted to help people with all types of life adjustments. However, there continued to be conflicts regarding the status and proper focus of this new specialty. Another conference held in Atlanta in 1987 provided increased clarity on the focus and status of counseling psychology. At this conference the “valued characteristics” of counseling psychology were explicated. These characteristics included an emphasis on positive mental health, strengths-based adjustment and coping, empowerment of individuals, advocacy, political involvement, and direct teaching of skills. Promotion of mental health was not only encouraged at the individual level but extended to groups and systems. Counseling psychology was considered to impact development across the entire life span, to address adjustment and satisfaction in vocational as well as personal spheres, and to incorporate prevention and remediation strategies. In addition, viewing people and their behavior within a sociocultural context influenced by variables of culture, ethnicity, gender, sexual orientation, age, and sociohistorical perspectives was also considered of paramount importance.

In 1999, the APA published the *Archival Description of Counseling Psychology* that recognized and affirmed counseling psychology as an applied specialty. The current definition and parameters of the profession are described as follows:

Counseling Psychology is a general practice and health service–provider specialty in professional psychology. It focuses on personal and interpersonal functioning across the life span and on emotional, social, vocational, educational, health-related, developmental, and organizational concerns. Counseling psychology centers on typical or normal development issues as well as atypical or disordered development as it applies to human experience from individual, family, group, systems, and organizational perspectives. Counseling psychologists help people with physical, emotional, and mental disorders improve well-being, alleviate distress and maladjustment, and resolve crises. In addition, practitioners in this professional specialty provide assessment, diagnosis, and treatment of psychopathology. Within the context of life-span development, counseling psychologists focus on healthy aspects and strengths of the client (individual, couple, family, group, system, or organization), environmental/situation influences (including the context of cultural, gender, and lifestyle issues), and the role of career and vocation on individual development and functioning. (p. 589)

*Graham Chumley*

**See also** Conferences, Counseling Psychology (v1); Counseling Psychology, Definition of (v1); Counseling Psychology, History of (v1); Counselors and Therapists (v2); Counseling Process/Outcome (v2); Counseling Theories and Therapies (v2); Couple and Marital Counseling (v1); Crisis Counseling (v2); Developmental Counseling and Therapy (v2); E-Counseling (v1); Family Counseling (v1); Genetic Counseling (v1); Individual Therapy (v2); Multicultural Counseling (v3); Outcomes of Counseling and Psychotherapy (v2); Personal and Career Counseling (v4); School Counseling (v1)

### Further Readings

American Psychological Association, Division of Counseling and Guidance, Committee on Counselor Training. (1952). The practicum training of counseling psychologists. *American Psychologist*, 7, 182–188.



- American Psychological Association, Division of Counseling and Guidance, Committee on Counselor Training. (1952). Recommended standards for training counseling psychologists at the doctoral level. *American Psychologist*, 7, 175–181.
- American Psychological Association. (1999). Archival description of counseling psychology. *The Counseling Psychologist*, 27, 589–592.
- Blocher, D. H. (2000). *The evolution of counseling psychology*. New York: Springer.
- Kagan, N. I., Armsworth, M. W., Altmaier, E. M., Dowd, E. T., Hansen, J. C., Mills, D. H., et al. (1988). Professional practice of counseling psychology in various settings. *The Counseling Psychologist*, 16, 347–365.
- Munley, M. H., Duncan, L. E., McDonnell, K. A., & Sauer, E. M. (2004). Counseling psychology in the United States of America. *Counseling Psychology Quarterly*, 17, 247–271.
- Pepinsky, H. B. (1984). A history of counseling psychology. In D. H. Blocher, (2000), *The evolution of counseling psychology*. New York: Springer.
- Rude, S. S., Weissberg, M., & Gazda, G. M. (1988). Looking into the future: Themes from the third national conference for counseling psychology. *The Counseling Psychologist*, 16, 423–430.
- Super, D. E. (1955). Transition: From vocational guidance to counseling psychology. *Journal of Counseling Psychology*, 2, 3–9.
- Whiteley, J. N. (1984). Counseling psychology: A historical perspective. *The Counseling Psychologist*, 12, 3–109.

---

## COUNSELING PSYCHOLOGY, HISTORY OF

---

Counseling psychology emerged as an applied specialty within the American Psychological Association (APA) in the 1940s. It has been recognized as a specialty by the APA since 1946, and this recognition was reaffirmed in 1998 when the APA initiated a new period of application for specialty recognition. Landmarks in the history of counseling psychology include the establishment of the discipline in relation to the overall profession of psychology, the creation of key professional journals, and important conferences held across the years. Two organizations are considered key in the formation and development of counseling psychology: the Society of Counseling Psychology (SCP) of the APA and the Council of Counseling Psychology Training Programs (CCPTP),

the organization for directors of training programs in counseling psychology. Prior to 2004, SCP was typically referred to as “Division 17,” so reviewers of original historical material should note this reference. In the present entry, the terms *SCP* and *Division 17* will be used as seems historically appropriate.

John Whiteley, a noted historian of counseling psychology, identifies the most distant seeds of counseling psychology in the vocational guidance, mental hygiene, and psychometrics/individual differences movements along with the emergence of nonmedical and nonpsychoanalytic forms of counseling interventions such as Carl Rogers’s person-centered therapy. Later, the growth of counseling psychology was spurred by the demand for psychological services created by the veterans returning from World War II. Negotiations among representatives from the APA’s divisions 12 (Clinical Psychology) and 17 (then called Counseling and Guidance) and what was then the Veterans Administration’s Central Office Staff in Clinical Psychology resulted in the creation of a new position for psychologists in the VA system, “Counseling Psychologist (Vocational)” in 1952 to aid veterans in their readjustment to civilian life. Because helping veterans gain employment and education opportunities required different knowledge and skills than addressing psychopathology and neurological injuries, this new position helped counseling psychology to differentiate from psychiatry and clinical psychology and resulted in the growth of the vocational guidance movement.

In 1946, APA recognized Division 17, Counseling and Guidance. Counseling psychology topics began to be regularly reviewed in the *Annual Review of Psychology* under this title. The *Annual Review of Psychology* helped to further legitimize the specialty by creating a place for routine evaluation of the literature. In the 1950s, the explosion of enrollment in higher education and the needs of the returning World War II veterans spurred significant research in the areas of career development and counseling orientations. Theories of human development and behavior grew out of these economic and social forces during this time period, and client-centered, directive, learning, psychodynamic, humanistic, and existential theories further developed.

Counseling psychologists held the first major conference on counseling psychology, the Northwestern conference, in 1951. T. C. Gilbert Wrenn, the president of Division 17 at the time of the conference, addressed



the circumstances that he considered critical leading up to the conference, focusing mainly on the content of training for doctoral-level counseling psychologists, including practicum training. The Northwestern conference resulted in the first set of standards for doctoral training in counseling psychology and the formation of the Division 17 Committee on Definition. In 1956, the committee's report, *Counseling Psychology as a Specialty*, was an attempt to create a more inclusive statement defining counseling psychology. Donald Super, the next president of Division 17 after Wrenn, expanded on the statements made at the Northwestern conference. He helped to clarify the functions of the division by assigning the Committee on Definition the task of developing a formal statement regarding the boundaries and focus of the specialty and discussing the need to differentiate between counseling and clinical psychology.

In 1952 the official name of Division 17 was changed to Counseling Psychology, and the American Board of Examiners in Professional Psychology announced that its diplomas would include the term *Counseling Psychology* rather than *Counseling and Guidance*. The appearance of the *Journal of Counseling Psychology* in 1954 and the continued reviews in *Annual Review of Psychology* helped further establish the professional identity of counseling psychology.

### A Crisis of Identity

Following this period of scientific and theoretical developments, disagreement emerged within the specialty regarding the role and definition of counseling psychology. Milton E. Hahn's Division 17 presidential address in 1954 highlighted the differing conceptions of the developing profession by attempting to differentiate clinical psychology from counseling psychology. He argued that although training in clinical and counseling doctoral programs were similar, there was evidence that students were not being trained to assume the same professional roles and functions. Emphasizing counseling psychology's concerns with less severely disturbed individuals (and pointing out that they worked with *clients*, not *patients*), Hahn saw counseling psychologists as more interested in research and administration than were clinical psychologists. Clinical psychologists were likely to work in medically related modes and settings and were more oriented toward personality reorganization.

Counseling psychologists were trained to help clients to change attitudes and value systems and to address vocational concerns. In Hahn's view, they were taught to stress psychological strengths and health rather than psychopathology, diagnosis, and remedial psychotherapies.

The crisis of identity, however, did not resolve, and in 1959, the APA Education and Training Board commissioned four appraisals regarding the status of counseling psychology. The reports were so divergent that one of the four was suppressed and the other three remained unpublished for 20 years. The most negative of these reports argued that counseling psychology was on the decline and that its scientific basis was inadequate. Leaders of the specialty responded quickly, and Leona Tyler, David Tiedeman, and C. Gilbert Wrenn formulated a response refuting the gloom and doom orientation of the original reports. Their statement documented the historical grounding of the specialty (e.g., official statements on definition and on education and training), studies of the roles and functions of counseling psychologists, and social demands for counseling psychologists. It was approved by the 1960–1961 and 1961–1962 Executive Committees of the Division of Counseling Psychology.

### A Pivotal Conference

One of the most important events in the history of counseling psychology was the Greyston conference in 1964. Before the conference, counseling psychology was at a crossroads regarding identity issues and the future direction of the specialty. The purpose of the Greyston conference was to examine the professional preparation and work of counseling psychologists and to develop specific recommendations in these areas. Six formal papers provided a starting point for the conference, documenting the history of the specialty and discussing identity issues. A formal conference report was issued that presented a comprehensive picture of the profession through a review of the positions counseling psychologists held, a review of the settings in which they worked, and a summary of the important statements and official documents of Division 17.

### The First Formal Definition

Previously, statements on the definition of the specialty of counseling psychology had been circulated mostly within the membership of Division 17. The first



comprehensive, widely circulated statement regarding the definition of the specialty was published by the Teacher's College Press and copyrighted by the APA in 1968. The definition began as a project of the Professional Affairs Committee of Division 17 and was officially sanctioned by the division's Executive Committee. The definition stipulated that counseling psychologists perform administrative tasks, professional practice, and research. Three different roles were described for counseling psychologists: remedial or rehabilitative, preventive, and educative and developmental. The definition also included information about counseling psychologists' jobs and work settings.

### A Second Journal Established

*The Counseling Psychologist* was founded in 1969. Proposed by founding editor John M. Whiteley, *The Counseling Psychologist* is the official publication of the SCP. Issues are organized around specific topics and contain a major contribution accompanied by invited critical analyses from prominent scholars or practitioners. The authors of the major contribution are then invited to respond to the analyses. The issues of *The Counseling Psychologist* are based on substantive research; they have focused on human development, counseling theory, counseling methods, and professional issues. Early major contribution topics were vocational development theory, client-centered therapy, student unrest, and behavior counseling. Recent issues of *The Counseling Psychologist* include major contributions titled Social Justice and Multicultural Competence in Counseling Psychology, A Work-Oriented Midcareer Development Model, Evidence-Based Scientist-Practitioner Training, and the Internationalization of Counseling Psychology. Historically, *The Counseling Psychologist* has functioned as a repository for historical material and debates about professional identity; more recently, it also publishes the minutes of the SCP Executive Board meetings and the yearly presidential address.

### The 1960s and Early 1970s

Changes in social attitudes born in the 1960s and early 1970s affected counseling psychology in a variety of ways. These new social attitudes had sprung from a number of sources: (1) the Vietnam War, (2) emerging conceptions of self and the actualization thereof prevalent in the 1970s, and (3) challenges of traditional

attitudes and authority and the disruption of the Watergate era. Significant changes in society brought concern for equality and calls for equal rights for racial and ethnic minorities, women, and the physically challenged. Counseling psychologists responded by emphasizing psychoeducation and prevention as the 1960s trend for the search of the ideal self and personal fulfillment prevailed. The roots of counseling psychology's expertise in issues of cultural and individual diversity strengthened during this time.

Cultural themes promoting personal fulfillment and the exploration of personal relationships also created an increased demand for services that counseling psychologists provided. Consequently, counseling psychologists were found engaged with diverse clients in a wide variety of employment settings. Behavior therapy and existential approaches to counseling were two of the major theoretical issues being debated during this period, and there was continued elaboration of research on theories of career, occupational, vocational, and personality development as well as psychotherapy and counseling.

### Further Initiatives in Identity

The late 1970s and early 1980s were characterized by further examinations of the professional identity of the specialty. Whiteley identified four initiatives of organized counseling psychology in this time period. The first initiative was set in motion by Bruce Fretz, who organized views of professional identity from (1) individuals who primarily identified as counseling psychologists, (2) professionals who worked closely with counseling psychologists, and (3) two previous presidents of SCP. In 1977, these views were published in *The Counseling Psychologist*. The second initiative was led by Whiteley to project what adaptations would be needed in order for counseling psychology to have an important role into the 21st century, resulting in a book by Whiteley and Fretz and an issue of *The Counseling Psychologist* on the future of counseling psychology. The third project, organized by the APA, was to further define the specialties within psychology by issuing statements on the significant characteristics, certification, and licensing of counseling psychologists.

The fourth initiative was the Next Decade Project of Division 17, initiated by the Division 17 Executive Board and led by Norman Kagan. Similar to the second initiative, the Next Decade Project defined



challenges and the needed direction for professional practice, education and training, definitional concerns, and scientific affairs. The project was intended to strengthen the future of the profession through providing (1) a long-range guide for the division's major standing committees, (2) statements regarding licensing, and (3) documents to describe counseling psychology to future students and other professions and specialties within and outside of the profession of psychology. The findings of the Next Decade Project were published in *The Counseling Psychologist* in 1982.

Reviews of counseling psychology research published in the *Annual Review of Psychology* between 1978 and 1984 were titled Career Development, Counseling Psychology, and Career Interventions. In 1983, the publication of the first handbooks, the *Handbook on Counseling Psychology* and the *Handbook of Vocational Psychology*, further underscored the solidifying professional identity of counseling psychology. Studies of psychometrics, college student development, career and vocational psychology, and counseling process and interventions continued to enhance the profession through the theoretical and research literature. Between 1977 and 1983, 5 new volumes of *The Counseling Psychologist* and the first 10 books in the Book Series in Counseling Psychology focused on theoretical approaches to counseling, counseling supervision, and professional roles and settings. Two issues of *The Counseling Psychologist* separately addressed counseling men and women, a harbinger of the diversity movement to come.

### Emphasis on Diversity

In the late 1980s and 1990s, issues of cultural and individual diversity, long integral to counseling psychology, rose in prominence more broadly in the profession of psychology and in society at large. The origins of the specialty in career and vocational psychology prompted counseling psychologists to attend closely to individual differences, and the orientation toward strengths further supported this focus. Over the years since the emergence of the specialty, counseling psychologists have produced significant scholarship on diversity issues and have been leaders in this area within organized psychology. In 1970 the APA directed attention to the issues faced by women when it created the Task Force on the Status of Women. This task force was charged with the objective of creating recommendations about the treatment of women in

the profession of psychology and included a significant number of counseling psychologists. Division 35: The Psychology of Women was recognized by APA a short time later, in 1973, with many counseling psychologists as members then and now.

In the 1980s, issues based on race and ethnicity along with gender and sexual orientation became a focus for Division 17. To address these issues Division 17 focused on three main initiatives. These initiatives addressed increasing diversity (1) in the governing body of Division 17, (2) among the students in counseling psychology programs, and (3) in the theoretical and methodological structures of counseling psychology.

In 2002 the APA Council of Representatives adopted a set of guidelines about how psychologists should approach multicultural education, training, research, practice, and organization. Crafted as a joint effort between Division 17 and Division 45 (the Society for the Psychological Study of Ethnic Minority Issues), these guidelines originated in a writing group chaired by counseling psychologists Nadya Fouad and Patricia Arredondo; the group also included Allen Ivey and Michael D'Andrea. The guidelines attempted to fulfill four primary goals: (1) to explain the necessity for cultural awareness within psychology as a profession, (2) to present research to support the recommendations, (3) to define directions for further education in cultural awareness, and (4) to introduce perspectives that would broaden the focus of the profession of psychology. Other guidelines for diverse groups have been promulgated across the years as well; these have dealt with gay, lesbian, and bisexual clients and with older adult clients. The *Guidelines for Psychological Practice With Girls and Women* have recently been adopted. Counseling psychologists have been involved in all of these efforts.

Organizationally, counseling psychology has attended to issues of diversity by establishing within the SCP an APA Council of Representatives seat to be filled by a minority individual. Sections and interest groups of the SCP have formed around racial and ethnic diversity; advancement for women; lesbian, gay, and bisexual awareness; older adults; and men and masculinity.

### Independent Practice

As the 1980s moved into the 1990s, an increasing number of graduates from counseling psychology programs were moving into independent practice resulting in several new problems that the field of



counseling psychology had to address. Prior to the 1970s, psychologists mainly were paid directly by the government or by the people that came to see them. However, the advent of mental health coverage within health insurance policies brought an increase in third-party payers in the 1980s and 1990s. The Section on Independent Practice was created in 1996 in an effort to address these issues within Division 17. In addition, counseling psychologists began to recognize a need for the specialty to have a voice when professional and legal issues related to practice were debated. With increasing monitoring of the healthcare profession in the 1990s and new laws and policies being drafted that would have an impact on how counseling psychologists functioned within the healthcare system, it was increasingly important for Division 17 to be involved. In 1995 the SCP created the position of federal advocacy coordinator with Sandy Shullman as the first person to hold the position.

### Reorganizations of Division 17

In the early 1990s, the leaders of Division 17 began to realize that the structure of the division was not sufficient to support the growing needs of counseling psychology. In 1992 a retreat was held by the Executive Board, led by Punky Heppner and Jean Carter. The resulting plan was implemented over several years, ranging from 1993 through 1995.

The plan proposed that the governing structure of Division 17 should resemble that of the APA. Interest in increasing participation in the division prompted the implementation of a new structure for groups of members that shared common interests. This new structure included sections—groups of 50 or more members with a common interest, and special interest groups for 10 to 49 members. Special task groups could be created by the president for the accomplishment of specific objectives. In addition to the standard positions of president, secretary, and treasurer, one of the changes to the structure of Division 17 was to add new vice president positions for four issues: diversity and public interest, education and training, professional practice, and scientific affairs.

In 2002 Division 17 underwent another adaptation by formally changing the name of the division to the Society of Counseling Psychology. The intent of the name change was to perceptually define more organizational autonomy within the APA. In addition, the change would further differentiate the division from other divisions to students learning about the structure

of the APA. Most recently, in 2006 a proposal was made to again change the SCP bylaws, creating another new position within the leadership: vice president of communication. This new vice president will manage the transfer of information within SCP membership, to APA and other professional organizations, and to the general public.

### The Council of Counseling Psychology Training Programs

The Council of Counseling Psychology Training Programs was formed in 1975 for two purposes. The first was to represent counseling psychologists wherever issues concerning education and training of counseling psychologists arose. The second purpose was to disseminate information relevant to education and training to those involved in it. Over the years, CCPTP has monitored accreditation issues; gathered information on counseling psychology programs, faculty, and students; and established model policy and curriculum. In 1998, a joint initiative of CCPTP and Division 17 resulted in the Model Training Program in counseling psychology. The Model Training Program identifies the philosophy endorsed by those who train counseling psychologists (e.g., scientist–practitioner model, orientation toward strengths vs. pathology) and identifies content areas integral to education and training in counseling psychology (e.g., supervision, career and vocational psychology, diversity) beyond the core content of professional psychology.

### Contributions to Supervision

Starting in the late 1970s, counseling psychologists began to focus on one of the unique processes of becoming a counseling psychologist: the supervisory relationship. Although psychologists had ruminated over the issue of the supervision relationship since the beginning of psychology training, only recently has research and theory in the area really begun to develop. In 1979 J. M. Littrell, N. Lee-Borden, and J. A. Lorenz proposed a model of the supervision relationship. Models developed by Carol Loganbill, Emily Hardy, and Ursula Delworth and then by Cal Stoltenberg and Delworth followed in 1982 and 1987, respectively. These contributions sparked interest in theory and research on supervision that continues in the 2000s. Supervision is also considered a key element in the education and training of counseling psychologists and is therefore an important element in the Model Training Program.



## Integrating Science and Practice

One of the ongoing debates within Division 17 is the implementation of the scientist–practitioner model, specifically, how to balance attention to scholarship and practice with attention to theory, research, practice, and training. In the early years of Division 17, most of the governing body consisted of full-time academic psychologists. In the 1980s, and especially in the 1990s after the division’s reorganization, the presence of full-time practitioners of counseling psychology increased.

In the early 1990s, a task force was assigned the objective of developing recommendations for integrating science and practice within counseling psychology. The task force was chaired by Puncy Heppner, and its recommendations were published in 1992. The recommendations emphasized integrating science and practice in doctoral training and enhancing training in research methods for counseling psychology students.

Counseling psychologists continue to contribute significantly in understanding the integration of science and practice. Partially in response to clinical psychology’s efforts to compose a list of empirically supported treatments, counseling psychologists formulated a position on empirically supported treatments. The SCP Executive Board supported this position by forming a special task group to promote it in 2004. In 2005 a special task group was formed by APA to draft recommendations on the integration of science and practice; counseling psychology was represented by three members. Also in 2005, the APA adapted a new policy on evidence-based practice derived from the recommendations of the special task group.

Counseling psychology continues to be a major force in professional psychology in the 2000s. Members of the specialty contribute to professional psychology and to the public through research, training, practice, and service. Although counseling psychologists are found in many settings and jobs, the specialty retains its emphasis on client strengths and resources in providing preventive, educative, and remedial interventions.

Nancy L. Murdock, J. Rico Drake,  
and Ashley M. Heintzelman

*See also* Career Counseling (v4); Code of Ethics and Standards of Practice (v2); Conferences in Counseling (v1); Counseling, Definition of (v1); Counseling, History of (v1); Counseling Psychology, Definition of (v1); Family Counseling (v1); Professional Associations, Counseling (v1); School Counseling (v1); Rogers, Carl R. (v2)

## Further Readings

- Gelso, C., & Fretz, B. (2001). *Counseling psychology* (2nd ed.). Fort Worth, TX: Harcourt College.
- Heppner, P. P., Casas, J. M., Carter, J., & Stone, G. L. (2000). The maturation of counseling psychology: Multifaceted perspectives, 1978–1998. In S. D. Brown & R. W. Lent (Eds.), *The handbook of counseling psychology* (3rd ed., pp. 3–49). New York: Wiley.
- Wampold, B. E., Lichtenberg, J. W., & Waehler, C. A. (2002). Principles of empirically supported intervention in counseling psychology. *The Counseling Psychologist*, 30, 197–217.
- Whiteley, J. M. (Ed.). (1984). Counseling psychology: A historical perspective. *The Counseling Psychologist*, 12(1).
- Whiteley, J. M. (1984). A historical perspective of the development of counseling psychology as a profession. In S. D. Brown & R. W. Lent (Eds.), *The handbook of counseling psychology* (pp. 3–55). New York: Wiley.

---

## COUNSELING THE ELDERLY

---

The continued growth of the elderly population in society has placed renewed focus on providing older adults with quality mental health care. The aging of the baby boomers in combination with research indicating that psychotherapy is effective with an older population highlights the need for those with expertise in counseling the elderly.

Providing therapeutic services to an older adult population has not historically been considered an option, as age and developmental status were thought to be key determinants of psychological appropriateness. This negativistic view of counseling for the elderly appears rooted in the Freudian tradition, with the assumption that older adults were too rigid in their character structures for therapeutic change to occur. Newer theories have extended the idea of psychological mindedness into the later years of life, with counseling as a useful option for providing therapeutic support and intervention for those nearing the end of the life span.

## Universality

There are no single characteristics that accurately describe “older adults,” as this cohort encompasses an array of different life experiences, personality traits, and goals for counseling. Thus, counseling the elderly must begin with basic knowledge of the aging process,



such as normal versus pathological aging, fact versus fiction, and stereotypes. Counselors should be versed in the physical, mental, and emotional aspects of older clients and adept at clinical diagnoses specifically applicable to this population, such as differentiation between depression and dementia.

The majority of counseling approaches build upon a foundation of respect, empathy, and support. Creating a culture where mentally healthy older adults are considered “normal” is paramount to the field of geriatric counseling. Counselors must promote the idea that old age in itself is not pathological and does not necessarily require counseling. However, when symptoms increase beyond the level of the older adult’s ability to function, counseling should be an option, regardless of age.

### **Common Presenting Concerns and Psychological Disorders**

Although advanced age is not equated with psychological problems, the elderly in this society experience common areas of concern during later life. Misdiagnosis often occurs due to the belief that all older adults are depressed and that negative thoughts and feelings are normal for someone in this stage of life.

#### ***Presenting Issues***

Many older adults experience grief and loss, whether it be in their occupation (e.g., retirement), mobility (e.g., becoming reliant on a walker), independence (e.g., not being able to drive), or interpersonal relationships (e.g., death of spouse or friends). By definition, elderly clients have experienced the loss of youth and therefore all too often their own perceived value in today’s youth-focused society. Issues of loss, death and dying, physical and mental health changes, chronic illness and disability, and debilitating pain are often intertwined for the older client.

The fear of cognitive decline or “losing one’s mind” often becomes increasingly prevalent with age. Older adults are often more susceptible to delirium (a disturbance of consciousness and a change in thought process that develops over a short period of time) due to infections, medication interactions, or dehydration. Dementias (multiple deficits in thought, including impairment in memory) are varied; they may be Alzheimer’s type, vascular, or the result of other disease processes. When cognitive decline occurs,

counselors must be not only astute in detection and differentiation of cause but also aware of the client’s capacity to participate in the decision-making process—including participation in counseling.

#### ***Psychological Disorders***

As many older adults are likely to visit their primary care physician first when experiencing problems, psychological problems may be reported in somatic terms. Elderly clients may express concerns about sleep disturbance, headaches, loss of appetite, or weight change rather than identifying anxiety, feelings of hopelessness, or depression. Counselors will gain increased understanding by assessing to what extent client symptoms are due to psychological factors and to what extent they are due to biochemical disturbance.

The most common psychological disorders in the elderly population include anxiety, depression, insomnia, cognitive impairment, and adjustment disorder. If an older adult is living in an assisted living facility or nursing home, the chance of experiencing these disorders increases. Each disorder has various levels of severity. For example, depression can range from a reactive sadness (stemming from minor occurrences) to grief (a normal response to painful loss) and to clinical depression with symptoms causing impairment in daily functioning. Risk for suicidal ideation increases with depressive symptoms, and it should not be overlooked in an elderly population. Older White men are one of the fastest growing groups at risk for suicide. In general, older adults complete 20% of all suicides, although they make up only 13% of the population. In assessment for suicide risk, the counselor must be savvy in regard to identification of suicidal ideation and the possibility of taking action to cause death in contrast to verbalization of “wanting” or “being ready” to die.

In addition to the above disorders, the counselor should be aware of the possibility for substance use, including abuse of alcohol and prescription medications. Substance abuse or dependence is often overlooked within this population because of their reduced social and occupational functioning. Signs may more often present as poor self-care, unexplained falls, malnutrition, and medical illnesses.

Counselors should also be able to identify chronic mental illness and personality disorders when they occur in elderly clients. As young people with a chronic mental illness age, they become older adults with a chronic mental illness. Although the severity of



behaviors associated with personality disorders is often thought to diminish with age, the severity may increase under stress or as individuals experience a loss of control, such as a change in living situation.

## **Types of Counseling**

Counseling has been found to be effective for older adults experiencing distress, and it's clearly superior to medication because of the increased risk of pharmacological side effects in the elderly. When indicated, a combination of medication and counseling can be a successful intervention for psychological symptoms.

Both individual and group counseling are available for older adults seeking mental health treatment. Individual counseling provides older clients the time and privacy to discuss thoughts and feelings they may be experiencing. Group counseling has also been shown to be efficacious with an elderly population, and it provides an additional benefit of decreased isolation through interaction among members. Common types of groups include reminiscence (integrating past memories into present-day functioning), interpersonal (exploring personal interactions and relationships), current events (encouraging attention to current news), and adjustment (focusing on transitions).

Regardless of the type of counseling intervention, a thorough assessment of the client's needs is required. A clinical interview is often sufficient, but additional age-sensitive instruments (e.g., Geriatric Depression Inventory) can be used when further assessment is needed. In addition, counselors should be knowledgeable of when to refer (e.g., to a primary care physician to rule out medical concerns, to a specialist such as a neuropsychologist for cognitive testing, or to a nutritionist for further exploration of diet) as well as aware of appropriate community resources.

## **Adaptations to the Counseling Process**

Once an elderly client accesses mental health care, several adaptations to the traditional format allow the counseling experience to be of maximum benefit. Counselors need to be aware of the social context in which their older adult clients exist and the challenges of navigating an ageist world. For many older adults, entering into counseling is a new and possibly intimidating experience. Education about the counseling process may assist with rapport building and setting

appropriate expectations. By outlining the logistics of the sessions (e.g., how long each meeting will last, the cost, and duration of therapy) and describing the process of therapy, the counselor can potentially alleviate concerns, allowing older clients to be active participants in the course of treatment.

Counselors may allow for additional time to explain the progression of counseling, describing their theoretical orientation and therapeutic approach in a jargon-free manner, using concrete terms and examples when possible. Choice of terminology is significant, as counselors may wish to refrain from using more informal language (e.g., "that's cool" or "I get it"). Counselors should also be cautious of using terms with potential negative meaning too quickly, as older clients may not identify with being "depressed" but may instead more readily agree to "feeling blue," "being down in the dumps," or "having low spirits." Older clients may indicate anxiety by noting they are "climbing the walls" or stating something such as, "I don't feel right in my skin." Other aging clients may be more comfortable beginning the conversation about symptoms by sharing, "I just haven't felt like myself."

The development of rapport and client conceptualization is also assisted when the counselor understands the broad historical timeline of events that may have influenced an elderly person's perspective on life. A general awareness of the social impact of wars, the Great Depression, and other historical events may help clients to feel that the counselor is interested in understanding their stage in life. Although each person will experience events in a unique way, a basic understanding about major events this cohort has survived may facilitate the therapeutic process.

Older clients may exhibit physical declines that affect the course of therapy. They may have difficulty hearing, and provisions can be made to ease the frustrations of both parties to the counseling relationship. This may mean that the counselor must enunciate more clearly, speak louder, speak in a deeper voice, and possibly speak more slowly, or it may mean that the client requires assistive devices such as hearing aids or an amplification set. Because some clients may have decreased eyesight, counselors may wish to have written materials in large print. They should be prepared if older clients experience physical limitations preventing them from completing paperwork or providing a signature.

In addition, counselors may want to decrease the pace of therapy; this may be an effective method of



ensuring client understanding. Clinicians should be prepared for clients that have overall changes in memory functioning; clinicians may need to use more repetition, provide hands-on material, and focus on events and emotions that are more easily recalled. Complex and jargon-filled interpretations will likely not be successful, as many older adults may be more receptive to pragmatic and problem-solving techniques.

In addition, modifications to therapy may be necessary due to caregiving issues or living situation. As a person ceases working outside the home, becomes less able to participate in the community, or experiences family and friends passing away, the potential to become isolated intensifies. Focus is often placed on a spouse or family members, but this is accompanied by conflicting feelings, as many older adults worry about becoming a burden to their family. On occasion, caregivers might be included in the counseling process to explore such concerns.

Unique issues also arise given various living environments, as older adults who live independently in the community experience different challenges than those living with family, those with the help of a caregiver, or those living in an assisted living facility or long-term care facility. Counselors need to understand the system in which the client lives, so they can better recognize and appreciate the corresponding challenges that may arise. For instance, if a client living in a long-term care facility complains of clothes that are missing and being worn by someone else, the counselor must determine if the client is demonstrating signs of paranoia or memory deficits, describing a thief that is employed in the building, or describing a situation that the facility must address within their laundry department.

### ***Transference and Countertransference***

As both client and counselor learn more about societal perceptions of older adulthood, they must be aware of the potential dynamics that may develop. Transference involves the attribution of characteristics, traits, or behaviors to a person based on ideas about who the person is reminiscent of or who he or she represents. Thus, older clients may look at a younger therapist and reflect on their own mortality, their loss of relationships or independence, or their physical impairments. They may think it impossible that someone so much younger could understand their thoughts and feelings at the later stage in life. A younger therapist may focus too much on illness or death, or may

treat an older client as “grouchy” or “fragile,” or may think of the client as a “kind grandparent-like” individual. When appropriate, talking about the possibility for misperceptions can lead to fertile conversations about age and the counseling process.

Although it is rarely mentioned, a potential challenge of working with older clients is the increased likelihood of experiencing a client’s death. Counselors may be aware of their reaction to client death as being a double-level experience. As humans, they may face grief, guilt, and loss similar to others who have lost a close relationship. But counselors may also be cognizant of the client’s death in terms of their special role in that person’s life. This can have the potential to be confusing, emotionally draining, and isolating for counselors working with the elderly.

### **Reducing Barriers to Counseling Services**

Older adults often face multiple challenges in obtaining counseling services due to physical, financial, and cultural obstacles. Limited physical mobility and restricted access to transportation can make attending appointments difficult. For those coping with such a loss of independence, “nonessential” activities such as therapy may quickly be cut from the list of priorities. Similarly, for those on a limited financial budget, interventions that are not quickly determined to be useful may likely be discontinued. Some clients may also need assistance navigating the tricky waters of Medicare benefits. This leads to the need for therapy to be accessible, financially feasible, and most important, something that is valued by the client as helpful. In an older population that may view counseling as something for those only with severe psychological problems, overcoming the stigma of therapy can be a challenge in itself.

In addition to reducing possible barriers, counselors working with the elderly are encouraged to operate within a multidisciplinary approach, working closely with other care providers involved, such as the primary care physician, a case manager, or a concerned family member. Creating a trusting relationship with the client may be more easily facilitated if the person has confidence in the network of those providing care.

### **Conclusion**

There are endless events and experiences to recall in counseling for those who are nearing a century of life.



Older adulthood, although not synonymous with psychological health, does symbolize a certain resiliency. Helping those older adults experiencing distress to remember the strengths they have utilized throughout their lives and discussing ways to enhance these personal resources has the potential to be a rewarding experience for those counseling the elderly.

*Tammi Vacha-Haase and Kate Fitzpatrick*

**See also** Adult Development (v1); Aging (v1); Chronic Illness (v1); Chronic Pain (v1); Clinical Presenting Issues (v2); Death and Dying (v1); Dementia (v2); Depression (v2); Gerontology (v1); Mental Status Examination (v2); Physical Health (v2); Quality of Life (v2); Substance Abuse and Dependence (v2); Transference and Countertransference (v2)

### Further Readings

- Duffy, M. (1992). Challenges in geriatric psychotherapy. *Individual Psychology*, 48(4), 432–440.
- Hill, R. D. (2005). *Positive aging: A guide for mental health professionals and consumers*. New York: Norton.
- Knight, B. G. (2004). *Psychotherapy with older adults*. London: Sage.
- Laidlaw, K., Thompson, L. W., Dick-Siskin, L., & Gallagher-Thompson, D. (2003). *Cognitive behavior therapy with older people*. Chichester, UK: Wiley.
- Nordhus, I. H., Nielsen, G. H., & Kvale, G. (1998). Psychotherapy with older adults. In I. H. Nordhus, G. R. VandenBos, S. Berg, & P. Fromholt (Eds.), *Clinical geropsychology* (pp. 289–310). Washington, DC: American Psychological Association.
- Qualls, S. H., & Abeles, N. (Eds.). (2000). *Psychology and the aging revolution: How we adapt to longer life*. Washington, DC: American Psychological Association.
- Stickle, F., & Onedera, J. D. (2006). Depression in older adults. *ADULTSPAN Journal*, 5(1), 36–46.

counseling is more intense and at times more complicated than work with individuals. Previously referred to as *marital counseling*, the term was limiting, as it did not include nonmarried cohabiting couples or committed same-sex couples. Subsequently the term *couple counseling* is often used to more broadly encompass any intimate, committed couple.

This entry provides an overview of the history of couple and marital counseling, approaches to couple and marital counseling, common issues in couple and marital counseling, and challenges often encountered in doing couple and marital counseling.

### Historical Underpinnings

As a distinct professional counseling service, couple and marital counseling is relatively young. Broderick and Schrader trace the history of couple and marriage counseling in four phases: the pioneer phase, the establishment phase, the consolidation phase, and the formative stage. Prior to the pioneer phase and the couple and marriage counseling movement, marital counseling was done informally by friends, other family members, or religious leaders. Also, prior to the 1930s, the theory and practice of counselors and psychologists centered on helping the individual. As families in the United States became less centralized and more geographically expansive, extended family members and other community supports were less available, and relationship counseling became increasingly necessary.

Each of the phases listed above was marked by significant events. In the pioneer phase of the early 1930s, three professional centers for marriage counseling were established: a center in Los Angeles called the American Institute of Family Relations, a center in New York, and a center in Philadelphia called The Marriage Council. From these examples, other training, research, and service centers emerged throughout the mid-1930s to mid-1940s. However, an increased need for professional unity emerged. In 1945, professionals working with couples in a counseling relationship organized to form the American Association of Marriage Counselors (AAMC). This early association included professionals from diverse backgrounds, including clergy, physicians, social workers, and family guidance professionals. These professionals were primarily responsible for some other type of work but counseled couples as part of their primary role. This signified the emergence of the establishment phase.

---

## COUPLE AND MARITAL COUNSELING

---

Couple and marital counseling helps couples, married or not, identify problems, manage difficulties, and ultimately improve their relationship. The intensity of an intimate relationship makes it one of the most important relationships one encounters in life. Because couple and marital counseling deals with two people and the dynamics that exist in their relationship, the



To further develop the professionalism of this emerging field, standards for marriage counseling were published, and marriage counseling was established as a specialty of family counseling in 1949. Signifying the consolidation phase was the first legal recognition of the marriage counseling profession in California in 1963. In 1970 the name of the association was changed to the American Association of Marriage and Family Counselors (AAMFC), and in 1978 it changed again to the American Association for Marriage and Family Therapy (AAMFT).

For many years, most of the attention and focus in the field was on the family; however, over time the couple and marriage counseling movement advanced. In the 1980s, the *Clinical Handbook of Marital Therapy* by Jacobson and Gurman was published and contributed significantly to advancing the specialization of couple and marital counseling. The formative phase saw an increase in the number of education programs offering training specifically on counseling with couples. Additionally, the profession experienced major growth and a subsequent clarification of training standards and competencies for practice. Couple and marriage counseling is now considered a distinct approach with published research with information on the science of the relationship.

### Approaches

There are many approaches to working therapeutically with couples. These approaches differ in focus, process, and goals. A comprehensive review of all theories in the couple and marriage counseling field is too broad for the scope of this entry. However, several will be discussed briefly.

Psychoanalytic couple counseling focuses on helping individuals recognize their own unconscious processes as well as those of their spouse or partner. This theory tries to uncover childhood conflicts that have gone unresolved and are therefore influencing the state of the current relationship. The psychoanalytic couple therapist attempts to understand current interactions and their connection with interactions that occurred at early developmental levels. One of the primary goals of this theory is to encourage each person in the context of the relationship to become a distinct individual self. The psychoanalytic approach views the individual as one who chooses a partner based on dynamics that existed in early parent-child interactions. As with

traditional and individual psychoanalysis, this is a long and intense form of counseling.

Behavioral couple counseling is widely used and thoroughly researched and focuses on observable behaviors. This type of couple counseling focuses on improving the couple relationship by attempting to improve positive exchanges while decreasing negative interactions. Like individual behavioral therapies, behavioral couple counseling views the environment as a major influence on creating and sustaining the intimate relationship. The practitioner applying this theory pays particular attention to the cycles each member of a couple engages in to control the behavior of the other. Homework, assessment tools, and at-home and in-session observations are used regularly in this approach. In general, this is time-limited and symptom-focused counseling.

Cognitive-behavioral couple counseling focuses not just on the behavior of each person in the relationship but on the interpretation that each makes about the other person's behavior. The goal of this counseling is to assist the couple in identifying the thoughts that contribute to the marital problems, to test whether or not the thoughts are valid or accurate, and to modify the thoughts accordingly. For example, when couples use language such as "always" and "never" when talking about each other, the counselor may encourage the couple to seek exceptions related to these statements. A cognitive-behavioral couple counselor might also seek to discover assumptions that are not accurate and assist the couple in discovering more accurate assumptions. For example, if someone believes happy couples never fight, the therapist might help him or her form more accurate assumptions.

Emotionally focused couple counseling views problems in the relationship as relating specifically to attachment. According to this theory, attachment problems that develop in the earliest stages of life interfere with the emotional connection of the relationship, and couples will hide emotions both primary (fear and insecurity) and secondary (anger and defensiveness). Relationship difficulties emerge when the relationship fails to provide security for one or both partners. Often, attachment difficulties lead to additional fears such as abandonment. A focus of counseling using this theory is on the feeling and expression of emotion. Through the expression of emotion, couples are more able to discover functional ways of interacting and ultimately satisfy their need for attachment.



Systemic couple counseling views the couple as a unique system in and of itself. Systems theory examines the context in which individuals live. Whereas individual psychology traditionally focused on internal processes causing problems, systems theory focuses on the family or couple system as the source of problems. Systems theory uses a holistic perspective, meaning the complexity of individuals in the context of their lives is considered when determining a problem's source. The parts of systems interact with each other in a dynamic way, as each element in the system affects the others. A systemic couple counselor might use such techniques as having each person develop a family genogram (a diagram outlining family history and relational patterns) or sculpt family dynamics (a physical representation of couple dynamics and positioning), or the counselor might encourage the couple to discuss myths and stories. Homework assignments for the couple are an important part of this type of counseling.

The field of couple and marriage counseling has grown tremendously over the past 70 years, and in that time, theories related specifically to the treatment of difficulties in couples emerged. Many counselors do not rely on only one theory of counseling but use an integrative approach in response to the couple's needs and to assist couples with many different types of difficulties.

### Unique Process

The increase in divorce rates in the United States is one example of the complexity of an intimate relationship and the challenges in maintaining the intimate bond of a marriage or committed relationship. Often couples enter counseling when they feel they have no other options for maintaining the relationship, creating a greater intensity in the counseling process. It is typical with many relationships that when there are problems, each member blames the other for the problems and may even expect the other to make significant changes to make the relationship work. Because both members in the relationship are invested in being right, each may attempt to establish with the therapist that he or she is right. Therefore it is essential that the counselor remain neutral and objective, honoring the viewpoint of both, as both are the client in this regard. The counselor must recognize the contributions both make to the relationship struggles.

Because couple counseling is dynamic and intense, it requires the counselor to be active and direct. When

negative interactions occur between individuals in a couple, the counselor must block their communications and redirect them to more facilitative, respectful, new patterns of communication. A positive counseling experience allows the couple an opportunity to explore new behaviors and practice the skills they learn.

A consideration unique to couple counseling is whether to see both members together at all times or to explore whether separate individual sessions would at times be helpful. Each couple and marriage therapist makes this decision based on his or her therapeutic approach. Some therapists first see the couple together and follow up with individual sessions to determine individual concerns. Often in these cases the counselor is also seeking to determine individual commitment to the relationship to assess the degree to which the counseling is likely to be successful. Other couple and marriage counselors see couples together only.

Secrets also are an important consideration for the couple and marriage counselor. Specifically, one partner may not be aware of how close the other partner is to ending the relationship, or there may be an undisclosed affair or some other secret that is impacting the relationship. Couple and marriage counselors differ on how to handle secrets in couple and marriage counseling. As mentioned above, some counselors only see couples together to avoid being drawn into a secret. Other couple and marriage counselors are willing to hear secrets so they know the information about the relationship, regardless. Often counselors inform the couples before the counseling begins how they will handle secrets, specifically whether they will reveal the secret to the other partner if a secret is revealed.

### Common Issues

In general, when either person in a partnered relationship views the dynamics in the relationship as problematic, the couple may be appropriate for couple counseling. Although the list of reasons why a couple may seek couple counseling is endless, there are broad categories of problems that are common problems presented by couples.

A study conducted by Whimson, Dixon, and Johnson indicated that communication problems were the most frequently reported difficulties, with power struggles, unrealistic expectations of spouse, sex, and problem-solving being the next most frequently reported problems, in that order. A few of the couple problems that were ranked as most difficult to treat



were a lack of loving feelings, alcoholism, extramarital affairs, and power struggles. There are several problems presented in couple and marriage counseling that require the counselor to make challenging decisions, and these often require a unique set of skills; specifically, these problems are intimate partner violence and extramarital affairs. Couple and marriage counselors face barriers such as secrecy, trust, and safety when working with couples on such difficulties. Additionally, with couples who experience violence in the relationship, secrecy is often an unspoken expectation that creates a large barrier in the counseling process.

### Challenges

The practice of couple and marriage counseling is facing, and will continue to face, unique challenges as the nature of the intimate relationship also changes. Specifically, the field is responding to the demand for a broader definition of *couple* to address the needs of diverse couples. Diversity in relationships refers to cultural and ethnic differences not only between counselor and couple but between partners in the relationship. Diversity also includes religion, sexual orientation, couples remarrying, and the aging of couples. An additional challenge to couple and marital counseling is the prevalence of violence among couples. A call to the profession is to develop more programs for treating violence in the intimate relationship.

Heather M. Helm

**See also** Adult Development (v1); Adults in Transition (v4); Behavioral Therapy (v2); Cognitive-Behavioral Therapy and Techniques (v2); Counseling Process/Outcome (v2); Family Counseling (v1); Gay, Lesbian, and Bisexual Therapy (v2); Group Therapy (v2); Psychoanalysis and Psychodynamic Approaches to Therapy (v2)

### Further Readings

- Bischof, G. H., & Helmeke, K. B. (2003). Couple therapy. In L. Hecker & J. L. Wetchler (Eds.), *An introduction to marriage and family therapy* (pp. 297–336). Binghamton, NY: Haworth Press.
- Broderick, C. B., & Schrader, S. S. (1981). The history of professional marriage and family therapy. In A. S. Gurman & D. P. Kniskern (Eds.), *Handbook of family therapy* (pp. 5–35). New York: Brunner/Mazel.
- Christensen, A., & Heavey, C. L. (1999). Interventions for couples. *Annual Review of Psychology*, 50, 165–190.
- Doss, B. D., Thum, Y. M., Sevier, M., Atkins, D. C., & Christensen, A. (2005). Improving relationships: Mechanisms of change in couple therapy. *Journal of Consulting and Clinical Psychology*, 73(4), 624–633.
- Jacobson, N., & Gurman, A. S. (1986). *Clinical handbook of marital therapy*. New York: Guilford Press.
- Lebow, J. (2000). What does the research tell us about couple and family therapies? *Journal of Clinical Psychology*, 56(8), 1083–1094.
- Whisman, M. A., Dixon, A. E., & Johnson, B. (1997). Therapists' perspectives of couple problems and treatment issues in couple therapy. *Journal of Family Psychology*, 11(3), 361–366.

---

## COURTOIS, CHRISTINE A. (1949– )

---

Christine A. Courtois is best known for her pioneering work in understanding, diagnosing, and treating post-traumatic stress disorder (PTSD) in survivors of sexual abuse, particularly incest. Beginning with her graduate studies and continuing throughout her career, she has been groundbreaking in her commitment to the well-being of the patients she serves and to the expansion of knowledge about dissociative disorders and PTSD. She is presently in independent practice in Washington, D.C.

Courtois received her Ph.D. in counseling from the University of Maryland Department of Counseling and Personnel Services in 1979 after completing her internship at the University of Maryland Counseling Center in 1978–1979. Her dissertation (*Characteristics of a volunteer sample of adult women who experienced incest in childhood or adolescence*) and her volunteer work with rape crisis centers during her graduate training marked her entry into the area of sexual abuse and its aftereffects.

After receiving her Ph.D., Courtois moved to Cleveland, Ohio, where she held a staff counselor position at Cleveland State University. On her return to Washington, D.C., she served as a staff counselor at the counseling center at the University of Maryland, as a counseling psychologist at the U.S. General Accounting Office's Counseling and Career Development Center, and as a staff psychologist at the Women's Medical Center of Washington, D.C. In 1983, Courtois moved to independent practice in Washington, D.C., where she maintains her own



practice, with associates, focused on individual and group time-limited and long-term counseling and psychotherapy; clinical supervision and consultation; and international, national, regional, and local training and consultation services on a variety of mental health and organizational topics.

In addition, beginning in 1989 and continuing until 2007, Courtois was a cofounder (along with Joan Turkus) of and clinical consultant for an inpatient dedicated treatment unit for individuals traumatized by abuse and experiencing posttraumatic and dissociative disorders. The original unit (Abuse and Dissociative Disorders Recovery Unit) was founded in 1989 at HCA Dominion Hospital in Falls Church, Virginia. In 1991, the unit was moved to the Psychiatric Institute of Washington (Washington, D.C.) as The Center: Posttraumatic Disorders Program, and a partial hospitalization program was added. Principles of enhancing strengths and empowerment, drawn from Courtois's training in counseling psychology and feminism, serve as the foundational principles for the program.

Although Courtois's primary commitment has been to the highest quality of her own treatment for survivors of trauma (particularly sexual trauma and incest), she also maintains a deep commitment to both scientific and scholarly understanding of sexual assault and its aftermath and to education and training for practitioners, researchers, and theorists. As she has been in the practice arena, Courtois has been tireless and prolific in her contributions in these arenas.

Courtois has written three books on incest and sexual abuse. *Healing the Incest Wound: Adult Survivors in Therapy* was published by W. W. Norton in 1988 with a paperback edition released in 1992 and a Chinese translation in 2002, reflecting the remarkable longevity and impact of this groundbreaking work and making it a classic in the area. In 1993, she published *Adult Survivors of Child Sexual Abuse: A Workshop Model*, and this was followed in 1999 (paperback in 2002) by *Recollections of Sexual Abuse: Treatment Principles and Guidelines*, again published by W. W. Norton. In addition, she has published two special issues of journals (*The Counseling Psychologist: Victimization and Its Aftermath* with James O'Neil in 1988 and *The Journal of Traumatic Stress*, special section on complex trauma, with Bessell van der Kolk in 2005) and numerous book chapters and articles on trauma, traumatic memory, sexual abuse, incest, and recovery with multiple publications every year since

she received her doctorate. She has an extensive history of service on editorial boards and as an ad hoc reviewer as well.

Courtois's commitment to education and training is reflected in both her contributions to scholarly literature and her faculty appointments, which include positions at the Smith College School for Social Work, Harvard Medical School, and Georgetown University. Recently she has worked with the Maryland Psychological Association to develop a Post Doctoral Institute on Trauma and Dissociation. She gives many talks and workshops annually, nationally and internationally.

Courtois's contribution to the profession through volunteer service in professional organizations is no less noteworthy. She has held numerous appointed and elected positions with the International Society for the Study of Dissociation (ISSD), the International Society for Traumatic Stress Studies (ISTSS), and the Society for Counseling Psychology (Division 17) of the American Psychological Association (APA) as well as other appointed positions with the APA, other professional associations, and numerous community organizations.

Courtois's commitment, dedication, and contributions to the field have been recognized many times over. She is a Fellow of APA Divisions 17 (Society for Counseling Psychology), 29 (Psychotherapy), 35 (Psychology of Women), and 42 (Psychologists in Independent Practice) and the ISSD. The awards she has received have been significant. In 1996, the APA presented her with one of its premier awards, the Award for Distinguished Professional Contributions to Applied Psychology as a Professional Practice. She has received the John Black Award (1995) and the Section for the Advancement of Women "Woman of the Year" award (1994) from the Society for Counseling Psychology. The ISTSS awarded her the Sarah Haley Award for Clinical Excellence in 2003, and the ISSD awarded her the Cornelia Wilbur Award in 2001. She was elected a Distinguished Practitioner in Psychology of the Psychology Academy of the National Academies of Practice in 1998.

Jean A. Carter

*See also* Abuse (v2); Child Maltreatment (v1); Disasters, Impact on Children (v1); Posttraumatic Stress Disorder (v2); Secondary Trauma (v2); Sexual Harassment (v4); Sexual Violence and Coercion (v1)



### Further Readings

- Courtois, C. A. (1988). *Healing the incest wound: Adult survivors in therapy*. New York: Norton.
- Courtois, C. A. (1993). *Adult survivors of child sexual abuse: A workshop model*. Milwaukee, WI: Families International.
- Courtois, C. A. (1999). *Recollections of sexual abuse: Treatment principles and guidelines*. New York: Norton.
- Courtois, C. A., & O'Neil, J. (Eds.). (1988). Victimization and its aftermath [Special issue]. *The Counseling Psychologist*, 16(4).
- Courtois, C. A., & van der Kolk, B. A. (Eds.). (2005). Special section on complex trauma. *Journal of Traumatic Stress*, 18(5).

---

## CREDENTIALING INDIVIDUALS

---

The credentials and credentialing processes described in this entry are recognitions that a practitioner voluntarily seeks. They provide indications of advanced training and skill as well as evidence that the practitioner has passed certain examinations. All of the credentials described are obtained after a degree has been completed and, in many instances, after a license to practice has been obtained. Credentialing informs the public that counselors not only adhere to a code of ethics and have met minimum requirements of education and experience but have completed advanced training, submitted their professional work for peer review, and/or successfully passed postdegree and postlicensing examinations. The counseling profession demonstrates to the public that the profession is dedicated to setting and meeting higher, self-imposed standards through these credentialing efforts.

### Master's Level Credentials

#### ***National Certified Counselor***

The National Certified Counselor (NCC) is the principal credential of the National Board for Certified Counselors (NBCC). Established in 1982, the NBCC is an independent nonprofit credentialing body for counselors. The NBCC was developed by the American Counseling Association (ACA) and designed to be a separate, independent credentialing body for counselors. The NBCC recognizes counselors who have voluntarily sought to meet standards set by counseling

professionals, not state legislators. Candidates seeking the NCC credential (an NCC credential may be sought at both the master's and doctoral levels) must meet requirements in education, work experience, and supervised experience. They must also pass the National Counselor Examination (NCE).

In addition to the NCC credential, there are three additional specialty credentials offered by the NBCC: the National Certified School Counselor (NCSC), the Master Addictions Counselor (MAC), and the Certified Clinical Mental Health Counselor (CCMHC). Each of these subspecialties is outlined below.

#### ***National Certified School Counselor***

The National Certified School Counselor (NCSC) credential recognizes those school counselors who have voluntarily submitted an application and passed a national examination. The NCSC credential has multiple benefits for a school counselor, the public, and community agencies. This credential promotes counselors' professional identity, holds professionals to a high standard of accountability, encourages professional growth, and heightens the professionals' national visibility.

To receive an NCSC credential, a counselor must

- Hold the NCC credential
- Do additional coursework in school counseling

#### ***Master Addictions Counselor***

In a collaborative effort, the Master Addictions Counselor (MAC) specialty credential was created by the ACA, the International Association of Addiction and Offenders Counselors (IAAOC), and the NBCC. This specialty credential aims not only to encourage professional development but to recognize those who have taken the initiative to meet all national professional standards in addictions counseling. A MAC credential benefits the individual counselor by increasing visibility and professional identity in the community and simultaneously benefits clients by raising counselor standards for training, skills, and accountability.

To receive a MAC credential, a counselor must

- Hold the NCC credential
- Complete additional coursework in the area of addictions



- Have supervised experience as an addictions counselor
- Pass the Examination for Master Addictions Counselors (EMAC)

### ***Certified Clinical Mental Health Counselor***

In 1993, the National Academy of Clinical Mental Health Counselors (NACMH) worked with NBCC to form the Certified Clinical Mental Health Counselor (CCMHC) specialty credential. This credential was created to set standards for competency among professional clinical mental health counselors.

To receive a CCMHC credential, a counselor must

- Hold the NCC credential
- Meet additional educational requirements in counseling, including a supervised practicum
- Have additional supervised work experience
- Pass the Examination of Clinical Counseling Practice (ECCP)
- Submit an audio or videotape of a counseling session for approval

### ***Certified Family Therapist***

Initiated by the International Association of Marriage and Family Counselors (IAMFC), the National Credentialing Academy (NCA) began offering the Certified Family Therapist (CFT) credential in 1994. The CFT credential identifies professionals who have met NCA national standards related to training, experience, and ethics in family therapy. The CFT promotes professional accountability and encourages ongoing professional growth and development of marriage and family counselors. To receive a CFT credential, a counselor must meet one of five distinct combinations of criteria. The combination varies depending on

- The candidate's graduate degree
- The candidate's supervised experiences as a marriage and family therapist (e.g., as evidenced by state licensure requirements)
- The requirements the candidate has met in an accredited graduate program
- The candidate's clinical membership in the American Association of Marriage and Family Therapists (AAMFT)

In addition, two references or endorsements are required.

### ***Certified Rehabilitation Counselor***

The Commission on Rehabilitation Counselor Certification (CRCC) was chartered in 1973 as a non-profit organization designed to establish standards for the profession of rehabilitation counseling and improve the quality of care to persons with disabilities. Those professionals credentialed as a Certified Rehabilitation Counselor (CRC) have demonstrated good moral character and a minimum level of competency based on nationwide standards of professionalism set by the CRCC. The CRC credential recognizes those counselors who have the training and experience to provide vocation, person, or socialization counseling to persons with disabilities. To be eligible for the CRC credential, the professional must meet one of six sets of criteria that include

- A master's or doctoral degree in counseling or rehabilitation counseling
- Specific coursework in rehabilitation counseling
- Supervised internship or acceptable employment experience

## **Doctoral Level Credentials**

### ***American Board of Professional Psychology***

The American Board of Professional Psychology (ABPP) was formed in 1947 with the support of the American Psychological Association (APA). Since that time, the ABPP has become a separate entity and is a unifying governing body for separately incorporated specialty boards. The ABPP identifies a specialty as "a defined area in the practice of psychology that connotes specialty competency acquired through an organized sequence of formal education, training, and experience." Counseling psychology, of course, fits this definition. Presently, there are 13 specialties recognized by ABPP.

The specialty of counseling psychology is represented within the ABPP by the American Board of Counseling Psychology (ABCoP) and the American Academy of Counseling Psychology (AACoP). The AACoP has three primary functions. First, it advocates for the profession of counseling psychology within legislative and other governmental bodies, such as state licensing boards. Second, it has an education role both in terms of educating the public and providing continuing education for board certified counseling psychologists. Third, it is primarily responsible for



marketing, recruiting, and mentoring qualified counseling psychologists into and through the application and examination process.

The ABCoP is primarily responsible for developing and implementing the examination process that leads to board certification in counseling psychology. The ABCoP accepts applications for board certification from counseling psychologists who provide a variety of professional services, including psychotherapy in private, educational, medical, or governmental settings; career and vocational interventions; teaching or supervision of core counseling psychology courses; consultation; and academic administration or counseling.

The examination process has three stages. First, counseling psychologists must submit their credentials to ABCoP in order to prove that they have the appropriate educational background, training, and work experience to qualify as practicing counseling psychologists. Candidates may meet the education requirement in the following ways:

- Holding a doctoral degree in professional psychology accredited by the American Psychological Association (APA) or the Canadian Psychological Association (CPA)
- Completing a program listed in the publication *Doctoral Psychology Programs Meeting Designated Criteria*
- Completing a designated program of the National Register of Health Services Providers or in the Canadian Register of Health Service Providers
- Holding a current Certificate of Professional Qualifications in Psychology (CPQ)
- Holding a degree in psychology and completing postdoctoral study to receive a license to practice psychology in a recognized jurisdiction in the United States or Canada.

Additional requirements include the following:

- A current license to practice psychology in the jurisdiction in which the psychologist lives (an exception for this requirement is granted to active duty military psychologists)
- Completion of a predoctoral internship
- Completion of 1 year of postdoctoral supervision
- At least 2 years of postlicense experience

Once the counseling psychologist's credentials have been verified, he or she is advanced to the Practice Sample stage of the process. This stage requires

a professional self study (PSS) and a case study (CS). The PSS is a personal narrative of one's theoretical, philosophical, and/or personal approach to the practice of counseling psychology. It is expected that this narrative will include mentions of professional articles, books, or mentors that have influenced the applicant's work and ideas as well as descriptions of experiences in training, background, and practice that have informed the applicant's approach to counseling psychology practice. The requirements for the CS are determined by the competency area in which the applicant is submitting his or her professional expertise and vary depending upon whether the case to be used for the sample involves an individual client, the supervision of another psychologist or trainee, a career or vocational intervention, or a demonstration of the role of a counseling psychologist in an administrative setting. Any situation in which a clinical intervention is submitted as a case requires a videotape to accompany the CS.

The PSS and CS are reviewed by two board certified counseling psychologists; once these studies have been accepted, the applicant is invited to attend the oral examination, at which a number of applicants will be examined on the same day. The oral examination is a day-long process that includes five areas of competency. Each section of the examination typically includes two examiners. The areas covered by the oral examination are assessment, intervention, consultation and supervision, ethics, and professional issues.

The ABCoP also provides a Senior Option for psychologists who have been licensed and practicing for more than 15 years. In general, the Senior Option allows the applicant to substitute his or her published works or professionally developed, implemented, and documented programs for the CS.

### ***Certificate of Professional Qualification in Psychology***

The Association of State and Provincial Psychology Boards (ASPPB) is a professional organization of psychology licensing boards in the United States and Canada. The purpose of the Certificate of Professional Qualification in Psychology (CPQ) is to address the problem of license mobility across states and Canadian provinces. Because state and provincial licenses are not widely recognized outside the jurisdictions in which they were issued, the ASPPB sought to find a way to facilitate the normal and expected movement of psychology professionals from one



licensing jurisdiction to another. The CPQ was established in 1998 with two primary strategies to meet this goal. First, licensed psychologists who meet established criteria are issued a certificate (CPQ). Second, a credentials bank has been created in which individuals may store the documents demonstrating their eligibility for licensure, and it may be used by licensing boards to determine the requirements an individual must meet for licensing in their jurisdiction. To receive a CPQ, applicants must

- Meet educational requirements in psychology
- Have a current license to practice psychology
- Have a history of supervised experience
- Pass the examination for professional practice in psychology (EPPP)
- Pass an oral examination or interview related to competence to practice
- Have at least 5 years of postlicense experience
- Have no history of disciplinary actions

Psychologists who do not meet the requirements of the CPQ may store their license-related materials in the credentials bank and then ask the ASPPB to forward these materials to any jurisdiction. The CPQ, of course, is not a license to practice and does not automatically guarantee that a licensing board will accept the credentials presented, but the ASPPB does advocate with boards to accept the CPQ as evidence that basic requirements for licensure have been met. ASPPB member boards may have additional requirements, and any applicable fees must be paid in that jurisdiction.

### ***Certificate of Proficiency (Treatment of Alcohol and Other Psychoactive Substance Use Disorders)***

The American Psychological Association Practice Organization's College of Professional Psychology developed Certificates of Proficiency in order to recognize licensed psychologists whose scope of practice includes the treatment of alcohol and other psychoactive substance use disorders. This certification is designed to demonstrate that a professional has the specialized training in chemical abuse disorders that is frequently required by health maintenance organizations, preferred provider organizations, and some legislative jurisdictions. The Certificate of Proficiency has been accepted as evidence that the psychologist is qualified to offer these specialized services. The

certificate provides national, uniform documentation that a psychologist

- Has a current license to practice psychology
- Has at least 1 year's experience treating chemical abuse disorders (within the last 3 years)
- Is an active health service provider
- Has passed the college of professional psychology's examination in alcohol and other psychoactive substance use disorders

### ***National Register of Health Service Providers***

The National Register of Health Service Providers is a membership credentialing service that has, for more than 30 years, provided a list (register) of qualified psychologists both to the public and to health services providers. A Health Service Provider in Psychology is defined by the register "as a psychologist, certified/licensed at the independent practice level in his/her state, who is duly trained and experienced in the delivery of direct, preventative, assessment and therapeutic intervention services to individuals whose growth, adjustment, or functioning is actually impaired or is demonstrably at high risk of impairment."

The register verifies the credentials submitted from prospective members for healthcare providers. To be listed in the register, applicants must comply as follows:

- Have a doctoral degree in psychology that is accredited by the American Psychological Association (APA) or the Canadian Psychological Association (CPA) or have completed a program designated as meeting criteria established by the Association of State and Provincial Psychology Boards (ASPPB) or have completed a doctoral program in psychology designated by the National Register of Health Services Providers
- Have completed a minimum 1-year predoctoral internship (1,500 hours)
- Have completed a minimum of 1 year of postdoctoral supervision (1,500 hours)
- Hold a current license to practice psychology
- Provide an official transcript from the doctoral degree-granting institution
- Demonstrate that they have been subject to no disciplinary actions

In addition to its credentialing function, the register provides a number of services to its members,



including licensure mobility, continuing education, and publication of *The Register Report*, and it acts as an advocate for psychologists' practice concerns with legislative bodies. The register also recognizes psychologists' achievements through awards and other forms of recognition. The National Register is one of the most widely recognized credentialing bodies in the United States and Canada, and its credential is accepted by most healthcare organizations in identifying healthcare providers qualified to practice psychology.

*I. David Welch and Len Jennings*

**See also** Accreditation by the American Psychological Association (v1); Accreditation by the Council for Accreditation of Counseling and Related Educational Programs (v1); Code of Ethics and Standards of Practice (v2); Continuing Education (v1); Counseling, Definition of (v1); Counseling Psychology, Definition of (v1); Counseling Skills Training (v2); Counselors and Therapists (v2); Ethical Codes (v1); Postdegree/Prelicensure Supervision (v1); Postdoctoral Training (v1); Professional Degrees (v1)

### Further Readings

- American Psychological Association Commission on Education and Training Leading to Licensure. (2001). *Final report and recommendations of the Commission on Education and Training Leading to Licensure*. Washington, DC: American Psychological Association.
- Kaslow, N. J., Rubin, N. J., Bebeau, M. J., Leigh, I. W., Lichtenberg, J. W., Nelson, P. D., et al. (2007). Guiding principles and recommendations for the assessment of competency. *Professional Psychology Research and Practice*, 38(5), 441–451.
- Koocher, G. P. (1979). Credentialing in psychology: Close encounters with competence? *American Psychologist*, 34, 696–702.
- Nelson, P. D. (2007). Striving for competence in the assessment of competence: Psychology's professional education and credentialing journey of public accountability. *Training and Education in Professional Psychology*, 1(1), 3–12.
- Rehm, L. P., & Lipkins, R. H. (2006). The examination for professional practice in psychology. In T. J. Vaughn (Ed.), *Psychology licensure and certification* (pp. 39–54). Washington, DC: American Psychological Association.

### Web Sites

- National Register of Health Service Providers in Psychology: <http://www.nationalregister.org>

## CUSTODY EVALUATIONS

A child custody evaluation, also known as a parental responsibility evaluation, is a process by which recommendations are made to a family court with respect to the best interests of a child. They may include responses to parents' requests for parenting time or access to their children as well as evaluations of who should have decision-making authority regarding the child's education, health care, and religion. Such evaluations are performed by qualified mental health professionals who have been appointed or recognized by a family court or by privately qualified mental health professionals. Typically, the need for such an evaluation arises where there has been a high-conflict divorce; where there are accusations regarding one or both parents' parenting practices; where there are concerns about a parent's mental health problem, child abuse, or substance use or abuse; where the primary care parent is relocating, or in any other circumstances that may have a negative impact on the child's best interest. While divorce rates in the United States remain high, about 90% of child custody disputes are settled out of court. The remaining 10% often involve protracted litigation.

### Historical Perspectives

From colonial times until about the middle of the 1800s, child custody decisions were based upon British common law. These laws were gender biased and gave custody to fathers based upon paternal entitlement. This practice continued until around the time of the Industrial Revolution, when women's groups began protesting these laws. By the 1880s, most states had adopted the *tender-years doctrine* for custody decisions. The tender-years doctrine basically stated that when all other factors are equal, children under the age of 13 should reside with their mothers. If fathers wanted to retain custody, they had to prove that the mother was unfit or had committed adultery. The fitness of parents was heavily influenced by the perceived morality of the time. This often resulted in discrimination against homosexual or cohabiting parents.

Starting in the mid-1960s, the *best-interest doctrine* was adopted as a gender-neutral, child-centered model for custody decisions. The Uniform Marriage and Divorce Act, passed in 1974, attempted to standardize best-interest criteria. The criteria included



consideration of the wishes of the parents and child, the physical and mental health of all parties, parent-child interactions, the child's adjustment in multiple areas of life, and any special matters relevant to parental fitness. The first joint custody statute was passed in North Carolina in 1957, but due to lack of a favorable reception, records show shared parenting rulings were not widely recognized until the 1980s. Recent studies by the American Bar Association have shown that the number of sole custody decisions has decreased dramatically since that time, and joint custody is a far more common outcome. In most cases, permanent physical custody is awarded to the parent with whom the child will live the majority of the time. The custodial parent will have joint custody with the noncustodial parent, and they will share important decisions related to matters such as health care and education. In most cases the courts will also order scheduled visitation or temporary custody to the non-custodial parent.

The best-interest doctrine has increased attention to children's emotional and developmental needs when making custody decisions and has necessitated the involvement of mental health professionals in custody disputes. In fact, the best-interest standard has replaced parental preference, thus allowing child custody to be granted to grandparents as highlighted by the landmark case of *Painter v. Bannister*.

By law, custody evaluations are supposed to answer the question of what outcome is in the best interest of the child. That is the standard for all jurisdictions in the United States, and it serves as the basis for the judge's custody and visitation decisions. Therefore, it is important that custody evaluators be impartial and avoid advocating for either parent. The assessment goals are to identify the developmental needs of the child, to highlight strengths and needs of all parties, to observe and collect information pertaining to interactions of all relevant parties with children, and to develop a plan reflecting the best interest of the child.

Methodologies vary from one evaluator to the next; however, all evaluators must collect enough data to make their recommendations referencing the family court statutes criteria on best interests of the child. A thorough evaluation involves home studies, clinical interviews, clinical assessments, and self-reporting from involved parties as well as interviews or case notes from collateral contacts to substantiate the evaluator's recommendations. Collateral contacts may be anyone from family members to experts. Examples of

individuals listed as collateral contacts are teachers, school administrators, counselors, psychiatrists, medical doctors, social service personnel, parole officers, and court-ordered supervisors for parenting time.

The assessment tools used in custody evaluations can vary; however, the two most popular testing assessment tools used today in custody evaluations are the Minnesota Multiphasic Personality Inventory-2 (MMPI-2) and the Millon Clinical Multiaxial Inventory-III. The evaluator will use profiles that emerge from the assessments along with the parties' self-reports and the background offered by collaterals to evaluate and respond to the statutes' criteria and subsequently formulate recommendations.

In addition to the criteria identified in the best-interest standards, the court may also ask the evaluator to investigate specific issues (e.g., drug or alcohol abuse, domestic violence, special needs of a parent or child.) The evaluator will then be ordered by the court to report on the specifics of the recommendations. The order from the court has three areas of investigation: allocation or modification of parenting time, allocation or modification of decision-making responsibilities, and relocation of the primary residential parent. The court may order the evaluator to investigate all pertinent issues identified and make recommendations on any or all of the above areas. The recommendations from the evaluator are submitted to the court as well as to the involved parties either *pro se* or through counsel via mail within 90 to 120 days of the initial court order. Once the recommendations are submitted, the evaluator is considered to have completed the case, unless he or she is summoned into court by subpoena as an expert witness.

Debra A. Govan

*See also* Child Maltreatment (v1); Disasters, Impact on Children (v1); Ethical Decision Making (v1); Family Counseling (v1); Legal Issues in Parenting (v1); Parent-Adolescent Relations (v1); Parenting (v1); Personality Assessment (v2); Quality of Life (v2); Teenage Parents (v1)

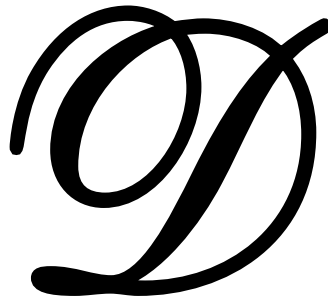
### Further Readings

- Ackerman, M. J. (1995). *Clinician's guide to child custody evaluation*. New York: Wiley.
- Ackerman, M. J., & Kane, A. W. (2002). *Psychological experts in divorce actions: 2002 cumulative supplement*. New York: Aspen.



- Ackerman M. J., & Schoendorf, K. (1994). *Ackerman-Schoendorf scales for parent evaluation of custody*. Los Angeles: Western Psychological Services.
- American Academy of Child and Adolescent Psychiatry. (1997). Guidelines for child custody evaluations. *Journal of the American Academy of Child and Adolescent Psychiatry*, 36, 17–84.
- American Psychological Association. (1994). Guidelines for child custody evaluations in divorce proceedings. *American Psychologist*, 49, 677–680.
- Binder, R. L. (1998). American Psychiatric Association resource document on controversies in child custody: Gay and lesbian parenting, transracial adoptions, joint versus sole custody, and custody gender issues. *Journal of American Academy of Psychiatry Law*, 26, 267–276.
- Bricklin, B. (1995). *The custody evaluation handbook: Research-based solutions and applications*. New York: Brunner/Mazel.
- Gould, J. W. (2006). *Providing scientifically crafted child custody evaluations* (2nd ed.). Morristown, NJ: Professional Resource Press.
- Kass, A. (1998). Clinical advice from the bench. *Child and Adolescent Psychiatric Clinics in North America*, 7, 247–258.
- Lee, C. M., Beauregard, C. P., & Hunsley, J. (1998). Lawyers' opinions regarding child custody mediation and assessment services: Implications for psychological practice. *Professional Psychology*, 29, 115–120.
- McGleughlin, J., Meyer, S., & Baker, J. (1999). Assessing sexual abuse allegations in divorce, custody, and visitation disputes. In R. M. Galtzer-Levy & L. Kraus (Eds.), *Scientific basis of child custody decisions* (pp. 357–388). New York: Wiley.
- National Interdisciplinary Colloquium on Child Custody. (1998). *Legal and mental health perspectives on child custody law: A deskbook for judges*. Danvers, MA: West Group.
- Pruett, K. D., & Pruett, M. K. (1998). Fathers, divorce, and their children. *Child & Adolescent Psychiatric Clinics in North America*, 7, 389–408.
- Shear, L. E. (1998). From competition to complementarity: Legal issues and their clinical implications in custody. *Child & Adolescent Psychiatric Clinics in North America*, 7, 311–334.
- Uniform Marriage and Divorce Act, §402, 9A U.L.A. 561 (1988).





---

## DEATH AND DYING

---

Death describes the cessation of life, and dying speaks to the manner in which death occurs. Although these are simple concepts to understand intellectually, the realms of personal experience and counseling to which they refer are quite complex. As noted by Schneiderman, death entails many contradictions given the various ways in which it may be perceived. For some death is the destroyer, for others it is a redeemer. Similarly, it may be seen as both the greatest cruelty and as a means of release. Whereas fear of death tends to be universal, there are those who actively pursue it. Despite the reality that all are subject to death, each person's experience is unique. We live with the fact of our death from the moment of birth and yet have little knowledge of the phenomenon. We thus tend to be fascinated by the subject even as we fear it.

### Societal Perceptions

During the 19th century, the worlds of the living and of the dead generally were closely intertwined, with meaning flowing freely between them. However, as advances in medical technology and health care during the 20th century led to dramatic improvements in birth survival rates and exponential increases in life expectancy, a hope that death might eventually be conquered evolved. In the West, this hope gave birth to a culture that, until very recently, was reluctant to embrace death as either an integral part of life or a phenomenon to be studied and understood. Ours has been described as a death-denying society, with fear

the norm and perceptions of death so negative that it is a topic studiously to be avoided.

Many explanations have been offered regarding the desire to bypass conversations about death. These include the fear that talking about death will encourage or bring it forth and the related thought that avoiding the subject will preclude its appearance. Additionally, most have great concerns about the dying process as well as the inevitable unanswered questions about what happens after they die and distress at the thought of losing the one life we are given. Awareness of a lack of meaning in our lives, negative associations around the decay of our bodies, apprehension about judgment, dread of the unknown, and fear that nothing awaits us on the other side of death all lead to a general sense of trepidation. Despite such pervasive attitudes, however, within the mental health professions the topic of death and dying has become an important area for consideration.

### Professional Developments

The late 1960s and early 1970s were a highly volatile era in our social history, characterized by significant growth in awareness of and responses to the previously unmet needs of those who were dying. The concepts of hospice and palliative care were pioneered in England by Dr. Cecily Saunders, and in the United States, Dr. Elisabeth Kübler-Ross was at the forefront of the field of thanatology. The evolution of a new movement was marked by the first meeting, in 1974, of what eventually became the International Work Group on Death, Dying and Bereavement. In 1976, in response to the needs of a growing number of professionals



involved in this work, the Forum for Death Education and Counseling, subsequently renamed the Association for Death Education and Counseling, was created. Today, many books, journals, conferences, and training opportunities on the many aspects of death and dying are available, and a variety of research investigations have shed a great deal of light on this subject.

### **Interpretations of Death**

Kastenbaum proposed that interpretations of death may be understood on a continuum that proceeds from its perception as a diminished mode of life and continues to the idea of personal existence continuing much as usual; to its being construed as part of an ongoing process of spiritual development; to its perception as a progression composed of the three phases of waiting, judgment, and eternal culmination; to the notion of recycling as one is born, dies, and is reborn again and again; and to the idea of death as nothingness. In addition to the need to acknowledge individual interpretations of death, we now also recognize the importance of understanding the many ways in which death and dying can occur.

### **Unexpected Death**

When death is unanticipated, persons who have died may have made no arrangements nor had an opportunity to express their wishes regarding such issues as organ donation, funeral arrangements, and burial preferences. Survivors of this type of death tend to experience lack of closure, having had no opportunity for farewells and often being left with feelings of guilt regarding unresolved conflicts. They may experience acute feelings of unreality, disbelief, shock, and a sense of many loose ends. Additional ramifications may include dissonance in terms of beliefs and meaning systems, particularly if the death occurred under tragic circumstances or involved the loss of a child. In the latter instance, the feeling of a death out of time may be extremely significant. A further complicating factor for survivors relates to the type of unanticipated death experienced.

### **Accidents**

Guilt for not having done things differently, and thus somehow being involved in causing the fatality, is typical following death by accident, given the connotation of chance or fluke associated with this term.

Irresponsibility on the part of another who contributed to the death also may add complexity, especially when not acknowledged appropriately.

### **Physical Problems**

Sudden death caused by a physical problem may lead to the perception that it could have been prevented. Survivors thus may tend to blame themselves or others for not having responded properly.

### **Violent or Wrongful Death**

Survivors may worry about the suffering experienced by victims of violent or wrongful death in the process of dying. They may rage about the injustice at the same time that they have to deal with disfigurement or mutilation of the body of the person who has died. Involvement with the media or the legal system may prolong their agony.

### **Suicide**

Those left behind in the wake of a completed suicide typically desire privacy. They may have guilty feelings and experience an inability to speak about the death given the social stigma involved.

### **Anticipated Death**

With anticipated death, dying persons may put their affairs in order, participate in funeral arrangements and burial decisions, and achieve closure in significant relationships. They also have an opportunity to assimilate what is happening and realign their beliefs and meaning systems. At the same time, foreknowledge tends to initiate a period of anticipatory mourning for everyone involved. Further, in an extended dying process, significant stress may be placed on caretakers, and dying persons may feel a sense of remorse about being a burden. When the sick person dies, feelings of relief may be accompanied by feelings of guilt for what are perfectly normal, if mixed, reactions. Throughout the dying process, many additional issues also may require attention.

### **Acknowledging Death**

An important task faced by dying persons involves coming to terms with imminent death. Kübler-Ross



described this process as involving the five stages of denial, rage, bargaining, depression, and acceptance. However, it is unlikely that all dying persons go through each stage, or that they necessarily follow the same sequence of emotions. Indeed, many have little or no trouble accepting the fact of their dying, experiencing it in a variety of ways.

Once the inevitability of imminent death is acknowledged, issues around how a person wishes to die arise. If the person prefers to die at home, hospice may be an option. Advocates of hospice believe that supportive, palliative care until physical death has been medically determined is the most appropriate response to a terminal diagnosis. However, candidates for hospice must meet criteria pertaining to the anticipated time until death and the presence of appropriate caregivers. When hospice is not an option or not preferred, the choice may be to die in a hospital and often to continue treatments aimed at cure until all efforts in that regard have been exhausted.

### The Impact of Technology

The development of highly sophisticated technology, including various life-support systems and advancements in the realm of organ transplantation, has greatly enhanced the ability of medical science to prolong life. Given these developments, both the medical and legal communities often struggle around questions regarding when death has occurred and when life-prolonging mechanisms should be discontinued. One of the earliest efforts to alleviate confusion involved the delineation of the differences between a vegetative state and brain death.

A set of standards, formulated in 1968 by a group of physicians at the Harvard Medical School and now known as the Harvard Criteria, has become the means for determining when the brain has reached a condition in which it is considered to be irreversibly non-functional. Accordingly, death is understood to have occurred when the patient is unresponsive and unresponsive, there is no spontaneous respiration or muscular movement, the usual reflexes are absent, the brain is devoid of any electro physical activity, and there is no circulation of blood to or within the brain.

In addition to standards used as a basis on which to make difficult decisions, the field of bioethics has evolved. Those who work in this realm seek to formulate appropriate responses to dilemmas around the use or withdrawal of medical treatment. The overarching

goal is making morally and ethically prudent decisions in the face of biotechnology that has advanced to the point that the boundary between life and death often is blurred.

### Euthanasia

Euthanasia is the intentional termination of life by someone at the request of the person who is dying, while assisted suicide refers to the provision of help to patients at their request so they may terminate their own lives. In the medical realm, *voluntary active euthanasia* (VAE) occurs when the physician gives a medication or somehow intervenes to cause death at the request of the patient; *physician-assisted suicide* (PAS) occurs when the physician provides either information, resources, or direct assistance but the patient terminates her or his own life; and with *physician aid-in-dying*, the physician discontinues treatment at the request of the patient.

Despite the various ways euthanasia may be construed and implemented, Oregon is the only state in which PAS is legal. Although there are no states in which either suicide or attempted suicide is prohibited, 36 states have statutes according to which assisted suicide is a criminal act. In seven states, assisted suicide is a criminal act through the common law, and in six other states, the laws around assisted suicide are unclear. However, according to the U.S. Supreme Court, there are two constitutionally permissible means of alleviating pain for dying persons when all other methods fail: When these persons are treated with either a "morphine drip" administered at a level to eliminate pain or with "terminal sedation" that produces continuous anesthesia, death ultimately will occur. Patients become eligible for such procedures by means of advance directives prepared in compliance with state law and legally witnessed or notarized.

### Advance Directives

The validity of advance directives varies by states, although many have followed California in enacting living will statutes and other legislation that focuses on procedures that have the goal of prolonging life. Passed in 1976, the California Natural Death Act permits individuals, in specific situations, to make prior plans for treatment at the end of life. This statute legally sanctions advance directives and also "protects physicians from being sued for failing to treat incurable illnesses."



According to the federal Patient Self-Determination Act of 1990, healthcare providers must give patients information about their right to make advance directives, have written institutional policies regarding advance directives, and document whether or not a patient has executed one. Advanced directives include instructions regarding end-of-life decisions, ideally made prior to serious illness. They may be designed as either a living will or a healthcare proxy. Living wills detail instructions regarding desired medical intervention should persons become incapacitated. With a health care proxy, created by means of a durable power of attorney, persons designate someone to be responsible for making health care and treatment decisions in the event of future incapacitation.

Advance directives may focus on either clinical conditions or the values history. With the former, the circumstances under which persons would or would not want to live are specified. With the latter, the circumstances under which life is not preferred, even when further medical treatment is available, are described. In either case, persons creating advance directives must be competent and able to understand what they are doing, act voluntarily, be fully informed regarding all ramifications, and freely give consent to implementation. Ethnic and cultural variations and values should be taken into consideration, documents must be internally consistent, and they must focus only on those dimensions included within the scope of standard medical practice.

### Nearing Death Awareness

Hospice nurses have noted that as those who are terminally ill move closer to death, they may experience visions or sense the presence of departed loved ones, spiritual beings, or a bright light, or they may experience awareness of being in a particular place. They may report sensations of great warmth and love. They may attempt to communicate important messages to family, friends, and other caregivers. Engaging in a life review is also likely. While dying persons generally have little fear as the end approaches, there often is great concern about those who will be left behind.

*Dorothy S. Becvar*

**See also** Aging (v1); Bereavement (v1); Cancer Management (v1); Caregiving (v1); Coping (v2); HIV/AIDS (v1); Physical Health (v2); Suicide Prevention (v1); Suicide Potential (v2)

### Further Readings

- Annas G. (1991). The health care proxy and the living will. *New England Journal of Medicine*, 324, 1210–1213.
- Battin, M. (1994). *The least worse death*. New York: Oxford University Press.
- Beauchamp, T., & Childress, J. (1994). *Principles of biomedical ethics* (4th ed.). Oxford, UK: Oxford University Press.
- Becker, E. (1973). *The denial of death*. New York: Free Press.
- Becvar, D. S. (2001). *In the presence of grief: Helping family members resolve death, dying and bereavement issues*. New York: Guilford.
- Byock, I. (1997). *Dying well*. New York: Riverhead Books.
- Callanan, M., & Kelley, P. (1992). *Final gifts: Understanding the special awareness, needs, and communications of the dying*. New York: Bantam Books.
- Choice in Dying, Inc. (1991). *Refusal of treatment legislation—A state by state compilation of enacted and model statutes*. New York: Author.
- Kastenbaum, R. J. (1986). *Death, society, and human experience* (3rd. ed.). Columbus, OH: Charles E. Merrill.
- Lambert, P., Gibson, J., & Nathanson, P. (1990). The values history: An innovation in surrogate medical decision-making. *Law, Medicine & Health Care*, 18, 202–212.
- Shneidman, E. S. (Ed.). (1980). *Death: Current perspectives* (2nd ed.). Palo Alto, CA: Mayfield.
- Watts, D. T. (1992). Assisted suicide is not voluntary active euthanasia. *Journal of the American Geriatrics Society*, 40, 1043–1046.

---

## DELWORTH, URSULA (1934–2000)

---

Ursula Delworth was a pioneer in many ways in counseling and counseling psychology. In fact, she was one of the early counseling psychologists who easily made her home in both counseling and psychology, and her contributions were outstanding in both professional domains.

Delworth was the first of two daughters born to a U.S. naval officer and his wife in 1934. She received a bachelor's degree from California State University, Long Beach in 1956 and worked for several years in school guidance and counseling. She then chose the University of Oregon for her doctoral study in counseling psychology, and she earned her Ph.D. in 1969. Her dissertation compared the work of members of a



group of professional counselors and counselor support personnel conducting group counseling with students of junior high school age. This research interest was paralleled by activities during graduate school as educational director of Anytown USA, a peer support network in Los Angeles, California.

Her professional career began with an appointment at the Counseling Center of Colorado State University. At that point in time, unrest over civil rights was at a peak, and Delworth began her lifelong interest in outreach, using outreach teams on campus to address racial tensions. She continued that interest with her next professional appointment to the Western Interstate Commission on Higher Education, where she provided training and consultation to many institutions of higher education on the use of campus mental health systems and prevention and outreach programs.

Delworth joined the faculty at the University of Iowa in 1976. She served as director of the counseling center there and as a faculty member in the counseling psychology program, where she supervised many students and served as an encouraging mentor to many more who may have had other advisors but counted on Delworth for support and direction. Her research interests were in supervision, consultation, outreach, and prevention, and she published widely in these areas.

Within the fields of counseling and psychology, Delworth was a passionate advocate for change, and change for the better. She took on issues of equality, diversity, the rights of women and underserved populations, students, early career professionals, and the like with commitment, enthusiasm, and activism. She nominated people for awards, advocated for positions for them within the profession, and mentored many new professionals. Her achievements were recognized with a variety of awards: the Contribution to Knowledge Award from the American College Personnel Association, the Outstanding Contribution to Literature Award from the National Association of Student Personnel Administrators, and the Leona Tyler Award from the Counseling Psychology Division of the American Psychological Association (APA); she was also named one of the 100 Outstanding Women in 100 years of APA.

Perhaps one anecdote illustrates her vibrant commitment to those she believed were under-recognized and underserved. During her year as president of Division 17 of the APA, she began several projects to recognize and promote early career psychologists. Her presidential address that year focused on the need

to mentor and encourage those in the beginning stages of their careers. At the end of the talk, she invited all in attendance who had just earned their degrees to join her at the upcoming social hour, where she would personally buy each of them a drink. And she did! And she was surrounded by a happy, chattering group of new professionals who, it is believed, saw a bright future in counseling.

Her death in May of 2000, literally a month away from her retirement, cut short a life that would have clearly kept on giving to psychology, to counseling, and to her own community. She is deeply missed still by colleagues and friends.

*Elizabeth M. Altmaier*

**See also** Consultation (v2); Counseling, Definition of (v1); Counseling Psychology, Definition of (v1); Counseling Skills Training (v2); Personal and Career Counseling (v4); Postdegree/Prelicensure Supervision (v1); Mentoring (v1); Supervision (v1)

### Further Readings

- Delworth, U. (1989). *Student services: A handbook for the profession*. San Francisco: Jossey-Bass.
- Loganbill, C., Hardy, E., & Delworth, U. (1982). Supervision: A conceptual model. *The Counseling Psychologist*, 10, 3–42.
- Stoltenberg, C., & Delworth, U. (1987). *Supervising counselors and therapists: A developmental approach*. San Francisco: Jossey-Bass.
- Stoltenberg, C., McNeill, B., & Delworth, U. (1998). *IDM supervision: An integrated developmental model for supervising counselors and therapists*. San Francisco: Jossey-Bass.

---

## DEPARTMENT OF VETERANS AFFAIRS

---

The Department of Veterans Affairs (VA) operates the largest integrated healthcare delivery system in the United States. Counseling has had an important and increasingly prominent role in the VA healthcare system since its establishment over 60 years ago. Administered by the Veterans Health Administration (VHA), the VA healthcare delivery system contains the nation's largest mental healthcare system. The VA is the largest provider of mental health services in the country and is among the nation's largest employers



of psychiatrists, psychologists, social workers, and mental health nurses.

To meet the diverse psychosocial needs of veterans, the VHA provides a full spectrum of counseling services, including individual, group, and family psychotherapy; intensive case management; vocational rehabilitation; medication management; psychoeducation; skills training; psychological, cognitive, and neuropsychological assessment services; and psychosocial rehabilitation (PSR) for veterans with serious mental illness. Counseling services (and related psychological services) provided by VHA emphasize evidence-based approaches to a variety of mental health and substance use disorders (including comorbid conditions) and behavioral medicine conditions (e.g., smoking cessation, sleep disturbance, weight management, medical adherence) and to facilitate readjustment to and maximum functioning in the community.

Counseling services are provided to veterans in both VA medical centers (VAMCs) and in VA community-based outpatient clinics (CBOCs). As of January 1, 2007, there were 155 VAMCs and over 700 CBOCs. In addition, a range of readjustment counseling and outreach services (e.g., bereavement counseling, military sexual trauma counseling, vocational counseling, referral services) are provided to veterans and eligible family members in 209 VA Vet Centers located in all 50 states, the District of Columbia, Guam, Puerto Rico, and the U.S. Virgin Islands.

### **Continuum of Care**

Counseling services in VHA are provided across the full continuum of care, including inpatient and residential settings, outpatient mental health and behavioral health settings, and general and psychiatric long-term care settings. Within the inpatient sector, the VHA provides a large array of individualized counseling and related services. In addition to services provided in general and psychiatric hospitals and psychiatric intensive care units, the VHA provides 24-hour therapeutic treatment in psychosocial residential rehabilitation treatment programs to patients with severe mental health symptoms requiring care in a residential setting. Mental health residential treatment services are also provided in VA domiciliaries, which provide homeless veterans with coordinated rehabilitative clinical care in a structured residential treatment setting. In addition, a variety of counseling services are provided to older and younger veterans in VA nursing

homes and other long-term care settings as well as in hospice and palliative care settings.

In recent years, the VA has placed increasing emphasis on community-based mental health care and support services in an effort to promote independence and recovery and reduce the focus on acute stabilization and rehospitalization, even among the most seriously mentally ill veterans. As part of this effort, the VHA has established the Mental Health Intensive Case Management (MHICM) program, which provides evidence-based psychosocial and community support services to veterans with serious mental illness, based on the Assertive Community Treatment (ACT) model. MHICM teams travel to patient homes and throughout the community providing a variety of individualized services to improve patient functioning, community adjustment, and quality of life as well as to reduce hospitalization.

Outpatient counseling services are provided in a variety of specialty settings, including those for mental health, behavioral medicine (e.g., psycho-oncology, smoking cessation), primary care, and rehabilitation (e.g., spinal cord injury, blind rehabilitation). As a comprehensive integrated delivery system, the VA provides unique opportunities for providing interdisciplinary care, which often leads to enhanced safety, efficiency, and clinical outcomes. In many of the outpatient and inpatient settings where counseling services are provided, VA mental health staff serve as active, fully integrated members of treatment teams. This model of care is different from more traditional, fragmented approaches to providing counseling services. The VA's systemwide electronic medical record system further promotes professional coordination and collaboration in the delivery of care.

### **Research and Training**

In addition to providing health care to veterans, a major part of the VA's mission involves conducting clinical research and providing education and training to healthcare professionals and trainees. These functions have become major VA roles in the area of mental health. The VHA is currently a national leader in research on mental illness and mental health treatment. In 1998, the VA established the first three mental illness research, education, and clinical centers (MIRECCs) to conduct clinical research and provide education to promote best practices in VA mental health care. There currently are 10 MIRECCs, each



with a specific area of focus (e.g., substance abuse, causes of serious mental illness, schizophrenia, suicide prevention). In addition, VA geriatric research, education, and clinical centers (GRECCs), which now total 21, work to promote quality of life and care for aging veterans. The VA National Center for Posttraumatic Stress Disorder (NCPTSD) promotes research on and treatment of PTSD and stress-related disorders and is widely recognized as a world leader in PTSD research, education, and training. In addition, the VA has several mental health Centers of Excellence that conduct cutting-edge research in mental illness, posttraumatic stress, and substance abuse.

The VA is the nation's largest provider of clinical training in mental health care delivery, offering practicum training, predoctoral internships, residencies, and postdoctoral fellowships at VA medical facilities throughout the country. Between 1946 and 2005, the VA funded approximately 36,000 training positions in psychology alone. During the 2006–2007 training year, approximately 11% of all psychology predoctoral internship positions and 11% of postdoctoral fellowship positions were in VA facilities.

The VA's roles in conducting innovative clinical research, delivering high-quality care, and providing broad clinical training are enhanced by the agency's close working relationship with the academic community. VA medical centers throughout the country collaborate closely with universities and academic medical centers in each of these three areas. The intellectual and resource partnership has spawned a very successful long-term and mutually beneficial relationship.

### Transformation of Care

To most effectively meet the current and anticipated mental health needs of veterans, the VA is in the process of transforming its mental health care delivery system. In April 2002, President George W. Bush's Executive Order 13263 created the President's New Freedom Commission on Mental Health and charged it with conducting a comprehensive study of the U.S. mental health care delivery system and with providing the president with recommendations for improving the service system. In July 2003, the commission issued its final report, in which it called for a transformation in the nation's mental health care delivery system to improve service access and quality. In July 2003, the undersecretary for health of the VHA charged a workgroup to review the New Freedom Commission's final

report "to determine the relevance of the Commission's goals and recommendations to veterans' mental health programs and to develop an Action Plan that is tailored to the special needs of the enrolled veteran population." This effort led to the development of the VHA action agenda: "Achieving the Promise: Transforming Mental Health Care in America." In June 2004, a mental health task force was established to operationalize the goals and recommendations outlined in the VHA action agenda. This culminated in the development of a comprehensive VHA mental health strategic plan (MHSP): "A Road Map for Transforming VA Mental Health Care." Since 2005, VHA has implemented over 40 mental health enhancement initiatives, which directly implement key provisions of the MHSP. Among the most significant and unique aspects of the MHSP and the mental health enhancement initiatives is the focus on innovation and expanding the process of care.

In an effort to increase access to high-quality mental health services and promote care coordination, the VHA has developed a national initiative to integrate mental health services in primary care. This model of care is designed to break down the traditional "silos" of specialty mental health and primary care settings and allow highly specialized resources to be concentrated on serving veterans with more serious mental health needs. As part of the MHSP, the VHA is also promoting the delivery of evidence-based psychological treatments throughout the VA health care system. The VHA is implementing several dissemination initiatives designed to increase the availability of state-of-the-art psychological treatments for PTSD (e.g., cognitive processing therapy, prolonged exposure therapy) and other mental health conditions.

Also consistent with the recommendations of the President's New Freedom Commission report and the MSHP, the VHA is moving toward a *recovery-based* model of care for veterans with serious mental illness. In the recovery-oriented treatment culture, the focus of care is on instilling hope, optimism, and individual potential through a process of psychosocial rehabilitation. Several VHA initiatives have been developed to expand psychosocial rehabilitation services throughout the VA healthcare system.

Several initiatives are also underway to reach historically underserved populations, such as individuals living in rural areas and older adults with chronic and disabling medical conditions. As part of this effort, the VHA is expanding the availability of telehealth services for veterans in remote areas and is enhancing



specialty mental health staff throughout the country to provide mental health assessment, treatment, and prevention services in the homes of homebound veterans with chronic and disabling medical conditions.

Among the VA's highest current priorities is effectively providing for the mental health needs of returning veterans serving in the Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF) conflicts. In addition to the initiatives noted above designed to increase access to and quality of mental health services, several outreach, screening, and treatment initiatives have been implemented with a specific focus on OEF/OIF veterans. Providing individualized, effective, and accessible care to these and all veterans in the years ahead is a challenge that the VHA is actively meeting. Significantly, with the implementation of the MHSP, there has been a steady increase in the number of mental health providers employed by the VHA. As of January 1, 2007, the VA employed over 9,000 front-line mental health providers.

In short, counseling has enjoyed a rich and continuously evolving history in the Department of Veterans Affairs. Over the course of its 60-year existence, the VA has become widely recognized as a world leader in mental health care delivery, research, and training. With the nation's largest integrated healthcare system, the VA provides unique opportunities for providing innovative, interdisciplinary mental health services in a wide variety of treatment settings. In the years ahead, the mental health care landscape in the VA will continue to evolve, as the VA works to transform the process and culture of mental health care to ensure the availability of accessible and effective mental health services for the veterans of today and tomorrow.

*Bradley E. Karlin*

**See also** Caregiving (v1); Chronic Pain (v1); Community-Based Health Promotion (v1); Physical Health (v2); Posttraumatic Stress Disorder (v2); Psychological Well-Being, Dimensions of (v2); Schizophrenia, Adults (v2); Stress-Related Disorders (v1); Traumatic Brain Injury and Rehabilitation (v1); Suicide Potential (v2)

## Further Readings

Association of Psychology Postdoctoral and Internship Centers. (2007). *APPIC directory: Appendix*. Retrieved April 13, 2007, from [http://www.appic.org/directory/appendices/2006-2007\\_AppendicesAB.pdf](http://www.appic.org/directory/appendices/2006-2007_AppendicesAB.pdf)

Baker, R. R., & Pickren, W. E. (2007). *Psychology and the Department of Veterans Affairs: A historical analysis of training, research, practice, and advocacy*. Washington, DC: American Psychological Association.

---

## DEVELOPMENTAL DISORDERS

---

The field of developmental disorders has experienced multiple scientific and social changes in the last decade. Many changes involve the perception of disabilities and have been referred to by Dennis Harper as a shift in paradigms. Some of these changes in the definition of developmental and learning disorders have resulted in changes in societal responses to children and adults with disabilities. In addition, advances in neuropsychological research, imaging, and genetics have refined researchers' understanding of developmental and learning disorders.

### Definition of Developmental Disorders

The implications of developmental disorder classification and resultant diagnostic labels have a major impact on diagnostic systems, scientific study of developmental disorders, and service-based educational intervention and treatment programs for children and youth. The largest impact on children and youth is related to how such definitions become incorporated into administrative rules for the delivery of special education services in schools and related supports in community-based rehabilitation and treatment settings.

Early definitions of developmental disability are relevant to the understanding of the current status of developmental disorders. The earliest definitions of developmental disabilities were crafted in Public Law 91-517 in 1970. This law was an outgrowth of the work of several forward-thinking individuals who assisted on the president's panel on mental retardation at the request of President John F. Kennedy in 1961. This effort was directed toward prevention in mental retardation worldwide. This panel and its outcomes set the stage for subsequent legislation related to developmental disabilities and later, developmental disorders. This presidential panel made important contributions that expanded early definitions and approaches to the treatment of developmental disabilities. These contributions included keeping children with disabilities in their



normal or local environments; supporting those with physical impairments; encouraging a blended continuum of medical, educational, and social care throughout the life span; recognizing a coordinated, interdisciplinary treatment approach; focusing intervention on local and state levels; and encouraging coordination between university medical professionals and state provider agencies. This panel laid the structure for many important aspects of defining and treating developmental disorders in the next several decades.

Over the next three decades (1970–2000), the definition of developmental disabilities changed in scope and complexity. Most important, in 1975, Public Law 94-103 broadened the developmental disabilities definition to include autism and a few specific learning disabilities (e.g., dyslexia) if those learning disabilities related to existing and concurrent developmental disorders. The Developmental Disabilities Act (Public Law 95-605) of 1978 was a detailed explanation that set federal policy and state educational treatment for developmental disorders for many years to come. Newer definitions became less categorical and emphasized functional limitations. Use of the term *impairment* was also advocated and reference to disease was often removed.

### **Contemporary Issues in Defining Developmental Disorders**

Contemporary research and practice for developmental disorders evolved with a more specific focus on components of learning difficulties, or subtypes of learning difficulties. Researchers primarily in the United States separated learning disorders from mental retardation and identified the components of learning disorders in children and adults. Attention focused on memory factors, attentional characteristics, and visual-spatial skills of the learner. In addition, there has been a move toward functional perspectives with particular developmental disorders or disabilities. This approach focuses on more discrete description of skills and adaptive behaviors that individuals need to perform in daily situations. In the past, often the relationship between specific medical diagnostic etiologies and learning disorders did not appear to capture what most individuals needed with respect to their instructional assistance and functioning.

The current definitional trend in developmental disorders also reflects the importance of support-based paradigms in specifying treatments and services

for developmental disorders, as noted by Ruth Luckasson and colleagues. These movements, largely focusing on individuals with mental retardation, do affect the diagnosis and treatment of developmental disorders. Proponents of this support-based orientation of defining disabilities emphasize the opportunity for greater flexibility in diagnosing and classifying such disorders. This shift in thinking is not without controversy. The seemingly simple idea of providing a general diagnosis based upon functional differences related to available supports raises many questions about service provisions, inclusion in instruction, and who has a developmental disorder.

An equally complicating task in defining developmental disorders is related to comorbidity of the developmental problem. In its simplest terms, comorbidity is the condition when two different “disease processes” are present in the same individual. It is relatively common for learning disorders to be associated with attention difficulties, either as a primary diagnosis or as a secondary and concurrent problem. This comorbidity extends to all other emotional and behavioral disorders, and its co-occurrence clearly complicates the diagnostic evaluation procedure and treatment recommendations and potential remediation of the developmental disorder. Progress in the remediation of developmental disorders may often be related to its coexistence with other disorders.

It is also important to ascertain which disorder, if either, is primary. This has implications for all aspects of treatment and types of remediation. Steven Pliszka, Caryn Carlson, and James Swanson have noted multiple diagnostic treatment issues for attention deficit hyperactivity disorder (AD/HD) with comorbid learning disorders. They describe “an overlap between LD and ADHD” for varying learning disorders (reading, spelling, and arithmetic). Furthermore, they report average percentages of 20% to 30% for co-occurrence of AD/HD with learning disorders (LD). More generally, learning disorders coexist with other psychiatric disorders. It has been estimated that 10% to 25% of people (children and adults) with LD as defined in the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV)* have coexisting disorders such as conduct disorder, oppositional defiant disorder, AD/HD, and depressive disorders. Such comorbidity clearly can complicate the diagnosis and treatment of any developmental disorder.

Defining and “diagnosing” a learning disability has reflected and continues to reflect multiple viewpoints,



and this is emphasized in the recently defined Individuals with Disabilities Education Act (IDEA) legislation (Public Law No. 105-17). This information, which appears in the Federal Register for 1997, delineates a definition of “specific learning disability” and outlines criteria for learning disabilities. This is an important definition and details many issues in the definition of learning disability. It indicates that a learning disability must result from a deficit in one or more basic learning areas such as memory, reasoning, organization, and perception; must manifest itself in the form of one or more significant learning difficulties in one or more of seven areas—oral expression, listening comprehension, written expression, basic reading skills, reading comprehension, mathematic calculations, and mathematical reasoning—compared with other children of the same age; must be evidenced by a significant discrepancy between intellectual ability and academic achievement in at least one of these cited seven areas; and must not be caused by mental retardation, hearing or vision impairment, motor impairment, emotional or behavioral disorder, or environmental disadvantage. This is a very general description of learning disabilities, and it encompasses a large number of possible characteristics. It consists of multiple characteristics for inclusion as well as exclusion.

Another contemporary method of defining a learning disability appears in the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR)*. The *DSM-IV-TR* defines three major types of learning disorders—reading disorder, mathematics disorder, and disorder of written expression—and also a learning disorder not otherwise specified (NOS). No general definitions of learning disability are offered. Also a discrepancy must appear between achievements in the areas of deficit and an individual’s measured intelligence. This ability/achievement discrepancy is probably the most contentious issue in the area of defining learning disabilities at this time.

There are multiple concerns in using the ability/achievement discrepancy as a key factor in defining learning disorders or learning disorder subtypes. Several authors (e.g., Keith Stanovich & Jack Fletcher, David Francis, Byron Rourke, Sally Shaywitz, and Benny Shaywitz) have noted that such discrepancy models do not differentiate subtypes of learning disorders, fail to consider the complex etiologies of learning disorders, obscure differences associated with the identification of gifted children, and may overidentify more intelligent children as learning

disabled. Using the ability/achievement discrepancy as a key proxy for learning disorders appears to be an oversimplification of the complex processes involved in defining and understanding learning disorders.

Contemporary approaches to defining learning disabilities have focused on a neuropsychological assessment. John Obrzut and George Hynd present an especially balanced view of the relevance of neuropsychological data to learning disabilities. A few key points are worth noting. First, general ability testing does not provide much guidance in the specifics of remediation for learning disorders. The hallmark of neuropsychological evaluation is identifying the relationship between certain “brain-related” functions and central nervous system (CNS) locations and functional behavior. Neuropsychological tests provide data concerning perception, attention, memory, motor skill, language, and reasoning. At its best, such assessment relates status factors to actual function. Neuropsychological assessment independently seldom contributes to the amelioration of learning disorders. It can provide documentation of acquired deficits as they relate to learning performance. Rather significantly it is the neuropsychologist’s knowledge of brain and behavior relationships that provides useful information, not the tests or their outcomes per se. Although obvious, this mundane point is central to the diagnostic process in understanding the diagnosis and remediation of learning disorders and information provided by competent neuropsychologists.

## Causes of Developmental Disorders

Hypotheses regarding the causes of learning disorders are well outlined by the team of Daniel Hallahan, James Kauffman, and John Lloyd and by Obrzut and Hynd. There is evidence for neurological differences in the brains of those with dyslexia based upon magnetic resonance imaging (MRI) and positron emission tomography (PET) studies. Evidence suggests functional and structural differences in the CNS of those with reading disorders. Family studies by Christopher Chase, Glenn Rose, and Gordon Sherman have implicated heredity in dyslexia. However, the specifics of genetic transmission are yet to be clarified for dyslexia or specific learning disorders. Teratogens such as alcohol, cigarettes, and illegal drugs have been associated with possible learning disabilities. Perinatal influence such as prematurity and postnatal events such as head injury, lead poisoning, and malnutrition have all been



implicated but only in a general sense. The human genome studies will undoubtedly provide some specifics in the next few years.

### **Subtypes of Developmental Disorders**

For purposes of clarity and specificity, this entry focuses on learning disorders as classified in the *DSM-IV-TR* (2000).

#### ***Learning Disorders***

Learning disorders are diagnosed when the individual's achievement on individually administered, standardized tests in reading, mathematics, or written expression is substantially below that expected for age, schooling, and level of intelligence. Assessment of this last item—level of intelligence—is a requirement for diagnosis of all developmental disorders listed in *DSM-IV-TR*. The learning problems significantly interfere with academic achievements or activities of daily living that require reading, mathematics, or writing skills. A variety of statistical approaches may be used to establish that a discrepancy is significant. "Substantially below" usually refers to a discrepancy of more than 2 standard deviations between achievement and measured IQ. A smaller discrepancy between achievement and IQ is also used, especially in cases when an individual's performance on an IQ test may have been compromised by an associated disorder in cognitive processing, a comorbid mental disorder, a general medical condition, or the individual's ethnic or cultural background. If a sensory deficit is present, the learning difficulties must be in excess of those usually associated with the deficit.

Deciding what is a significant deficit is not easily accomplished. It is unclear what should be considered the "measured IQ point," the total score, or particular subsets, all of which are affected by the underlying learning disorder. This is true for all subtypes. Learning disorders persist into and through adulthood; however, they change in their presentation as functions of time and experience. Residual aspects are difficult to clarify in long-standing learning disabilities especially when impacted by motivational aspects. It is generally estimated that the prevalence of learning disorders ranges from 2% to 10%, depending on the nature of ascertainment and the definitions

applied. Reportedly, 5% of students in public schools in the United States are identified as having a learning disorder.

#### ***Reading Disorder***

Reading disorders are characterized by reading achievement substantially below that expected for age, intelligence, and educational level and that significantly interferes with academic achievement or activities of daily living and in excess of any reading difficulties due to otherwise present sensory deficits. Reading disorder, often called dyslexia, is characterized by oral reading distortions, substitutions, omissions, slow reading, and limited comprehension. Symptoms of reading disorder may occur as early as kindergarten, but it is rarely diagnosed before the beginning of first grade when formal reading instruction begins. In children with high IQ, it may not be diagnosed until after fourth grade, because they may continue to function at or near grade level. A reading disorder follows familial trends, being more prevalent among first-degree relatives of individuals with learning disorders, and it is more prevalent among males. The prevalence of reading disorder in the United States is estimated at 4% of school-age children.

#### ***Mathematics Disorder***

The criteria for mathematics disorder include having mathematical ability substantially below that expected for a person's age, intelligence, and education. This learning disorder must interfere with academic achievement or activities of daily living and supersede mathematical difficulties associated with other present sensory deficits. Such mathematics disorders are estimated to be present in approximately one in every five cases of learning disorder, affecting approximately 1% of school-age children. Multiple skills are impaired in mathematics disorder: linguistic skills—understanding and naming math operations, concepts and decoding written problems, perceptual skills—recognizing numerical signs and symbols, and attentional skills—copying numbers, recalling and completing arithmetic functions, following sequences, and multiple step operations. This disorder reflects a complicated set of deficits in learning skills applied to mathematical concepts and computations. Characteristics of a mathematics disorder may appear as early as



kindergarten; however, it is rarely diagnosed before formal mathematics instruction occurs, usually at the end of first grade. If mathematics disorder affects children with high intelligence, they may continue to function at or near grade level in early grades, resulting in the disorder not becoming apparent until they are in the higher grades.

### ***Disorder of Written Expression***

Disorders of written expression are characterized by writing skills substantially below those expected for an individual's age, intelligence, and education. This learning disorder must interfere with academic achievement or activities of daily writing, and if sensory deficits are present, the difficulties must be in excess of those associated with the current sensory deficit. The difficulties in writing skills are generally apparent in a combination of grammatical or punctuation errors, poor paragraph organization, multiple spelling errors, and excessively poor handwriting, although poor handwriting and spelling errors alone are not necessarily indicative of a disorder of written expression. Poor handwriting and spelling, also called "poor graphomotor skills," is often overdiagnosed as the primary problem. A disorder of written expression rarely occurs separate from other learning disorders, and its exact prevalence is unclear. Characteristics of the disorder of writing expression may appear in first grade, but it is usually more apparent in second grade or after formal writing instruction has occurred. Currently less is known about this disorder.

### ***Learning Disorders Not Otherwise Specified***

This category is for learning disorders that do not "meet criteria" in *DSM-IV-TR* for any particular disorder. When all three features of the subtypes co-occur, this category is used. When the data are equivocal, this is the diagnosis. In some instances, those with other less defined learning disabilities (nonverbal LD) are given this diagnosis.

It is quite clear that the subtype definitions of learning disorders as appearing in *DSM-IV-TR* are not easy to diagnose and are affected by the ability/achievement discrepancy model definition. These subtypes should be used as guidelines for understanding the possible learning disorders and need to be combined with other behavioral, achievement, and assessment characteristics. The criteria as outlined for each disorder in

*DSM-IV-TR* are again guidelines for initial inclusion of these diagnostic categories.

### ***Other Learning Disability Subtypes***

Nonverbal learning disorders (NLD; often referred to as *right-hemisphere learning disorders*) have been identified for some time and are well outlined by Rourke. Currently, the "NLD syndrome" is quite broad and has a variety of characteristics associated with it. According to Sue Thompson, the NLD syndrome reveals itself in impaired abilities to organize the visual-spatial field, adapt to new or novel situations, or accurately read nonverbal signs and cues. Individuals have difficulties in situations requiring speed and adaptability. Nonverbal learning disabilities reportedly involve performance processes often thought of neurologically as originating in the right hemisphere. Much of the initial discovery of NLD syndrome reportedly began in the early 1970s with research involving groups of children with learning disabilities identified by discrepancies between their verbal and performance intelligence abilities. Again such discrepancies are noteworthy but are only a starting point for the diagnostic process.

Thompson lists the following common characteristics of nonverbal learning disorders: "performance IQ significantly lower than verbal IQ, early speech and vocabulary development delayed, remarkable rote memory skills, attention to detail, early reading skills, excellent spelling skills, expresses himself eloquently, lack of coordination, severe balance problems and difficulties with fine motor skills, lack of image and poor visual recall, faulty spatial perceptions, difficulty with spatial relations, lack of ability to comprehend nonverbal communication, difficulties adjusting to transitions and new situations, and significant deficits in social judgment and interaction" (p. 15).

A clear designation of these characteristics is difficult given the current state of research and the wide array of characteristics often reportedly associated with NLD Syndrome. It should, however, be acknowledged that such problems do exist and need to be understood within the context of developmental disorders.

### **Concluding Comment**

Developmental disorders are neither easily diagnosed nor easily remediated with existing instructional techniques. All definitions are guidelines—helpful, but



rarely definitive in their application or discrimination. Assessment and remediation of learning disorders is best accomplished by several individuals. Evaluations completed by a competent neuropsychologist and an educator who are both familiar with developmental processes, measurement methods, CNS functioning, and specific remediation techniques are mandatory. In some instances, the learner's neurological status may require review by a medical professional. Rarely is vision the key reason for a LD. With adults, one is often dealing with comorbid disorders and some long-standing failure and its resultant impact on the learner's self-esteem.

Dennis C. Harper

**See also** Attention Deficit/Hyperactivity Disorder (v1); Conduct Disorder (v1); Developmental Counseling and Therapy (v2); *Diagnostic and Statistical Manual of Mental Disorders (DSM)* (v2); Externalizing Problems of Childhood (v1); Individuals with Disabilities Education Act (v1); Internalizing Problems of Childhood (v1); Learning Disorders (v1); Mental Retardation and Developmental Disabilities (v1); Oppositional Defiant Disorder (v1)

### Further Readings

- American Psychiatric Association. (2000). *Diagnostic and Statistical Training Manual of Mental Disorders* (4th ed., Text rev.). Washington, DC: Author.
- Chase, C. H., Rosen, G. D., & Sherman, G. F. (1996). *Developmental dyslexia, neural, cognitive, and genetic mechanisms*. Baltimore: York Press.
- Definition and criteria for defining students as learning disabled, 64 *Federal Register* 48 (1999).
- Fletcher J. M., Francis, D. J., Rourke, B. P., Shaywitz, S. E., & Shaywitz, B. A. (1992). The validity of discrepancy-based definitions of reading disabilities. *Journal of Learning Disabilities*, 25, 555–561.
- Hallahan, D. P., Kauffman, J. M., & Lloyd, J. W. (1996). *Introduction to learning disabilities*. Boston: Allyn & Bacon.
- Kirk, S. A., Gallagher, J. J., & Anastasiow, N. J. (1997). *Educating exceptional children* (8th ed.). New York: Houghton Mifflin.
- Harper, D. C. (1991). Paradigms for investigating and adaptation to childhood disability and chronic illness. *Journal of Pediatric Psychology*, 16, 533–554.
- Luckasson, R., Coulter, D. L., Polloway, E. A., Reiss, S., Schalock, R. L., Snell, M. E., et al. (1992). *Mental retardation: Definition, classification, and systems of support* (9th ed.). Washington, DC: American Association on Mental Retardation.
- Obrzut, J. E., & Hynd, G. W. (Eds.). (1991). *Neuropsychological foundations of learning disabilities: A handbook of issues, methods and practice*. San Diego, CA: Academic Press.
- Pliszka, S. R., Carlson, C. L., & Swanson, J. M. (1999). *ADHD with co-morbid disorders: Clinical assessment and management*. New York: Guilford Press.
- Rourke, B. P. (1989). *Non-verbal learning disabilities: The syndrome and the model*. New York: Guilford Press.
- Stanovich, K. E. (1991). Discrepancy definitions of reading disability: Has intelligence led us astray? *Reading Research Quarterly*, 26, 7–29.
- Stanovich, K. E. (1993). A model for studies of reading disability. *Developmental Review*, 13(3), 225–245.
- Summary of Existing Legislation Affecting People with Disabilities*. (1992). Washington, DC: Office of Special Education and Rehabilitative Services, U.S. Department of Education (Contract #43J47100266).
- Thompson, S. (1997). *The source for nonverbal learning disabilities*. East Moline, IL: LinguiSystems.

---

## DISASTERS, IMPACT ON CHILDREN

---

Children are likely involved in disasters wherever they occur. For example, the much-studied 1972 Buffalo Creek flood in West Virginia left 125 dead, 52 of them children. Thousands of children were affected by the tsunami that devastated Southeast Asia in December 2005 and the terrorist attacks in the United States on September 11, 2001. Children are passengers on planes when they crash, are located in buildings when they burn, and live in areas that are flooded. They may even be specifically targeted because of the emotional impact that their victimization has on the community, as evidenced by the 1995 bombing of the Alfred P. Murrah Federal Building in Oklahoma City, which killed 168, 19 of whom were infants and young children.

Although children have always been involved in disasters, the study of disasters and their impact on children is relatively young. Until the early 1980s, it was commonly believed that little, if any, treatment was needed after a traumatic event touched the lives of children. Following groundbreaking work by Robert Pynoos and others, it is now understood that children have significant reactions and that they need mental health services to improve overall outcome. Unfortunately, children's lives are affected regularly by



traumatic events, including child maltreatment, domestic violence, and community violence. When large-scale events occur, such as terrorist attacks or natural disasters like recent hurricanes Katrina and Rita on the Gulf Coast, calamities that directly affect thousands indirectly affect many times that number through the media, and that increases children's awareness of the horrors that can accompany large-scale disasters. Children are considered one of the highest-risk groups for adverse reactions and consequences. However, the mental health needs of children do not seem to be addressed adequately in the preparedness, response, or recovery phases of planning for disasters. This finding is highlighted in a recent report by the National Advisory Committee on Children and Terrorism.

### **Children's Responses**

Children's responses to disaster can be viewed in four categories: cognitive, emotional, physiological, and behavioral. The cognitive reactions include problems with attention and concentration. This difficulty may be coupled with problems with impulse control and decision-making abilities. Problems with memory also may arise. Unfortunately, the professional and the lay communities have been sensitized to interpret the combination of many of these problems as evidencing attention deficit/hyperactivity disorder (AD/HD). Therefore, following disasters or other traumatic events, children may be referred for AD/HD assessment and medication. It is important to evaluate onset of the problems and exposure to trauma in making the diagnosis. (Note: children with AD/HD can be affected by trauma, and their AD/HD will need to be taken into account when assessing their responses.) Another common cognitive reaction is the presence of intrusive thoughts. Children may have images or thoughts of the disaster coming unbidden, often disrupting concentration in school. There may be an increased focus on the event. This will be evident in their repeated discussions of or questions about the disaster. Decreases in self-esteem and ideas of self-blame are two other cognitive reactions seen in children following disaster.

There are many emotional reactions after disaster, with worries, anxieties, and fears related to the event and its aftermath among the most common. Children's worries generally revolve around issues of safety and security for themselves and for others. The sphere of worry expands with a child's age. Very young children may worry about the security of themselves and their

immediate family. As children develop empathy, they may worry about those in their school system, neighborhoods, and community. Older children's and adolescents' worries may include concern about those they may not know who could be touched by the disaster or future similar events. For example, many in this age group may be concerned about children living in Afghanistan and Iraq impacted by the global war on terrorism or about soldiers serving overseas. Anxiety about a reoccurrence of the disaster is extremely common after an event. This anxiety may be exacerbated by trauma reminders. For example, children who experienced Hurricane Katrina may have feelings of worry, fear, and anxiety with thunderstorms and with each new hurricane season, and children living in new and perhaps strange locations may experience loss reminders on a daily basis after the disaster.

Emotional reactions can include a sense of helplessness, guilt, and grief related to the disaster. Children, like adults, may experience emotional numbing, but this appears to be seen more in older than in younger children. Mood swings and irritability, often the hallmark of childhood, may increase after a disaster. Therefore, such reactions should not be viewed merely as a function of the "terrible twos" or the teenage years. Clinicians should look for a change in mood and irritability with friends and family from before to after the disaster.

Physiological effects after disaster can be thought of as bodily reactions. These often include changes in sleep patterns, with problems either falling asleep or staying asleep. Nightmares are common. Unfortunately, when children are not sleeping well, it can impact other areas of their lives, such as learning. Appetite also may be affected by disasters, resulting in either weight gain or weight loss. Many children experience somatic complaints after a disaster, including headaches, stomachaches, fatigue, and flu-like symptoms. Concerned parents may seek medical consultation related to these physical symptoms. It is, therefore, important for mental health professionals and their medical colleagues to work together to assure a comprehensive understanding of common reactions after disaster. Agitation may increase after disaster. For school age children, this response may look like fidgeting at their desks, increasing adults' concerns related to a diagnosis of AD/HD. Children may become hypervigilant after a disaster, with their bodies preparing to respond to any perceived threat. Finally, an increased startle response



may be experienced after a disaster; it can be triggered by loud noises (e.g., sirens, thunder, a car backfiring) or similar unexpected, unpredictable happenings. Once startled, children may have difficulty settling back down and refocusing their attention.

Behavioral effects of disaster are, perhaps, the most observable reactions. Young children may show more separation anxiety. They may be more clingy and whiny than before the disaster. A regression in behaviors also may be noticed: They may have toiletting accidents despite being reliably potty trained, make demands for pacifiers given up long ago, or use baby talk that had been abandoned. Although young children are very proud of self-care skills such as dressing themselves, they may request more help from caregivers and teachers. Older children and adolescents may show a change in social relationships. They may become more irritable and argumentative with family and friends than they were before the disaster. Increased aggression also may be seen. Withdrawal behaviors may be noticed; for example, children of all ages may wish to avoid activities that they once enjoyed, including time with friends, extracurricular activities, or family outings.

Behaviorally, impairments in meeting responsibilities at home and at school may be seen. For example, children may not complete chores as they did prior to the disaster. A brief decline in school performance may occur, such as a failure to complete in-class assignments or homework, a drop in grades, or frustration with learning new material. Although the brief decline is common, clinicians also should be mindful of children who show a significant improvement in their academic performance after a disaster. Generally, these children will become wholly focused on schoolwork to the exclusion of their friends, extracurricular activities, and hobbies. While this focus may seem positive from an academic standpoint (improvement in grades, increased commitment to study and to excel), it should be viewed as problematic if all other activities are avoided or ignored and their importance minimized by the child.

Special attention should be shown to adolescents in the aftermath of a disaster. Adolescents are at risk for experiencing a sense of foreshortened future. Because of this, they may seek new experiences, including those considered high-risk, such as substance use, promiscuity, and reckless driving. Adolescents may become fascinated with death. Depression may be experienced. This combination, coupled with diminished impulse control, poor decision-making, and

withdrawal, places this age group at increased risk for suicide after a disaster.

## Mediating Factors

Children's responses to disaster can be mediated by a number of factors. Perhaps one of the strongest predictors is exposure to the event. The greater the child's exposure, the more likely the adverse reactions will be. Exposure includes being a direct witness to the disaster, including injury and exposure to injury or loss sustained by family members, and perception of the disaster as a threat to the child's life or the lives of family members. Exposure also includes destruction by the disaster of the child's or the child's family's personal property. Loss is a unique category after disaster. Loss includes death of a family member or a pet. When a child experiences the death of a family member due to traumatic circumstances, he or she is at risk for child traumatic grief—the trauma experience may interfere with how grief is processed. With media coverage of disasters being constant and intense, the relationship between media exposure and posttraumatic symptoms has been examined. Results from research studies indicate a strong correlation; however, causation is not clear.

Children of all ages feel more secure in times of crisis when they are with parents or caregivers. The longer children are separated from these important adults in their lives, the greater the risk that the children will have difficulties. Therefore, connecting children with family as soon as possible after a disaster is important. Children also benefit from routine. Disasters disrupt routine, including routines of school, home, extracurricular activities, and community service. Disrupted routine is positively correlated with posttraumatic symptoms (the greater the disruption, the greater the symptoms reported). Routine includes day-to-day activities as well as rules of behavior. Children generally find comfort and stability in order and consistency, so the randomness of disasters or the malicious intent of terrorism may be incomprehensible to them, and they may feel confused and respond with fear and heightened anxiety. It is important to remember that while a return to routine is necessary, it is generally not sufficient to help children in the aftermath of disaster.

When considering which children may be at greatest risk for difficulties after a disaster, it is important to consider which children have previously been identified as being at risk. Preexisting conditions, whether psychiatric or physical, and limitations, such



as mental and educational capacity, condition the child's response to the disaster and postdisaster symptoms. Children who have a history of special services in school or are involved in therapy services should be considered at risk. Similarly, children with a prior history of traumatic events in their lives are also included in this at-risk group. As prior history of the child can help in determining risk, so too can prior history of the family. Factors that can contribute to problems after disaster include how the family was functioning prior to the event. Consider stressors in the family (financial and emotional). Stressors can be both positive and negative. The loss of a job can be stressful, and so too can a move to a new home, especially if this involves a change in school and friends for the child. One of the best predictors of how well children cope after a disaster is how well their parents or caregivers adjust to the event. Adults who are having problems coping with the disaster may not be able to continue fulfilling their appropriate roles as guide, moral compass, and interpreter of the outside world; the child is then unclear about how he or she is expected to behave in a situation. Therefore, when assessing the emotional well-being of children after disaster, it is also important to assess how the family is faring.

Taking a developmental perspective with children in the aftermath of disaster can increase understanding of how children understand, react, and cope with what has happened. The child's developmental level helps predict his or her physical, cognitive, and emotional capacities. For example, preschool children may believe that thinking about something will cause it to happen and so believe that they caused the tornado or the plane crash or the shooting, and the resulting guilt can be overwhelming for them. Young children may not understand "replay," and seeing media coverage of a disaster may give them the impression that the event is happening over and over again, increasing their fears and anxieties. Older children may have a greater appreciation for the unpredictability of disasters and can understand the extent of loss and devastation, leading to concerns about their future, also increasing fears, anxieties, and depressive feelings. Adolescents, because they are closely aligned with friends, view any disruption in being able to see them or talk with them as very distressing. They may, therefore, "overreact" to the closing of their school, the inability to get together with friends, and the possibility of relocating, further contributing to their emotional responses to the disaster. Biological sex, in and

of itself, is relevant only insofar as it relates to the expectations the children learned from their culture; for example, girls may have learned to express emotional reactions, such as crying, and boys may have learned to express cognitive and behavioral reactions, such as behaving stoically or acting out.

Culture, which includes the language, values, beliefs, traditions, and customs that bind people together, provides the context both for interpreting the cause of a disaster and for how to respond to it. Cultures vary in the emphasis they place on the importance of privacy, whether an individual or group perspective is "right," how to comfort others, which emotions are appropriate to express under different conditions, how adults and children are supposed to interact, and whether asking for help is acceptable—and all are involved in predicting a child's reaction to a disaster.

Perhaps the most well-known—certainly the most well-publicized—reaction following a disaster is posttraumatic stress disorder (PTSD). This adult-oriented diagnosis has few reactions that are specific to children. As a result, children may be underrepresented in having this disorder.

For example, an investigation of children's reactions to Hurricane Andrew found PTSD symptoms 44 months after the hurricane in 40% of the children studied, with re-experiencing, hyperarousal, and avoidance or psychic numbing symptoms the most prominent ones. Although PTSD is one disorder that is common after disaster, anxiety disorders, depression, and behavioral problems should also be considered. While a formal diagnosis may be present, it is more likely that symptoms rather than a full diagnosis will exist.

Just as symptoms and pathology may exist, it is also important to focus on strengths. Consider that children have factors that can enhance their ability to bounce back after a disaster. Resilience is this ability to bounce back *quickly* and *effectively* after a crisis. This can be enhanced or taught. While many, if not most, children may be resilient in the face of adversity, this does not mean that interventions are not needed. Children may be resilient in one situation but not in others. While any one of the numerous factors—characteristics of the disaster, dimensions of risk and resiliency, the child's developmental level, and so on—can provide the basis for predicting how a particular child may respond to a particular disaster, the best predictions take into account as many factors as possible.



## Interventions

A full discussion of interventions with children in the aftermath of disaster is beyond the scope of this entry. The appropriateness of individual interventions will depend on how long it has been since the disaster occurred. Consider a mental health triage assessment to determine the need for various levels of intervention. A promising model for this is PsySTART, which helps determine need for as well as allocation of mental health resources following a disaster. In the immediate aftermath of a disaster, Psychological First Aid (PFA) may be useful. There are several models for this, including one sponsored by the American Red Cross and another titled Listen, Protect, and Connect.

Cognitive behavioral treatment approaches to interventions with children after disaster are the most promising for effective outcomes. An intervention for young children after disaster that can be delivered in a group format in various settings is Healing After Trauma Skills. An evidenced-based treatment to be delivered in a school setting to older children who have been exposed to violence or disasters is Cognitive Behavioral Intervention for Trauma in Schools (CBITS). The intervention with the strongest empirical findings for use with children after trauma is Trauma-Focused Cognitive-Behavioral Therapy (TF-CBT). Originally developed for children who have been abused, it has been successful with children who have experienced other traumas, including disasters. If loss is present, TF-CBT has been adapted for this circumstance and it is strongly recommended. A 10-hour free Web-based training in TF-CBT and more information are available at the TF-CBT Web site.

Mental health professionals are instrumental in bringing about overall positive outcomes for children and families after a disaster. To maximize the role of mental health providers, their involvement should begin with all stakeholders in the community in the preparedness phase and continue through the response and recovery phases. Continuous training on this topic is important, as potential events and state-of-the-art responses are always changing.

*Robin H. Gurwitch and Lawrence B. Rosenfeld*

*See also* Attention Deficit/Hyperactivity Disorder (v1); Child Maltreatment (v1); Cognitive-Behavioral Therapy and Techniques (v2); Depression (v2); Externalizing Problems of Childhood (v1); Internalizing Problems of Childhood (v1); Posttraumatic Stress Disorder (v2)

## Further Readings

- Cohen, J. A., Mannarino, A. P., & Deblinger, E. (Eds.). (2006). *Treating trauma and traumatic grief in children and adolescents*. New York: Guilford Press.
- Gurwitch, R. H., Kees, M., Becker, S. M., Schreiber, M., Pfefferbaum, B., & Diamond, D. (2004). When disaster strikes: Responding to the needs of children. *Prehospital and Disaster Medicine*, 19(1), 21–28.
- Gurwitch, R. H., & Messenbaugh, A. K. (2005). *Health after trauma skills*. Retrieved from [http://www.nctsn.org/nctsn\\_assets/pdfs/edu\\_materials/HATS2ndEdition.pdf](http://www.nctsn.org/nctsn_assets/pdfs/edu_materials/HATS2ndEdition.pdf)
- LaGreca, A. M., Silverman, W. K., Vernberg, E. M., & Roberts, M. C. (Eds.). (2002). *Helping children cope with disasters and terrorism*. Washington, DC: American Psychological Association.
- Pfefferbaum, B. J., Reissman, D. B., Pfefferbaum, R. L., Klomp, R. W., & Gurwitch, R. H. (2007). Cross-cutting intervention issues: Building resilience to mass trauma events. In L. S. Doll, S. E. Bonzo, J. A. Mercy, & D. A. Sleet (Eds.), *Handbook of injury and violence prevention* (pp. 347–358). New York: Springer.
- Rosenfeld, L. B., Caye, J. S., Ayalon, O., & Lahad, M. (2005). *When their world falls apart: Helping families and children manage the effects of disasters*. Washington, DC: NASW Press.
- Scribner, M., & Gurwitch, R. (2006). *Listen, protect, and connect: Psychological first aid for children and parents*. Retrieved from [http://www.ready.gov/kids/\\_downloads/PFA\\_Parents.pdf](http://www.ready.gov/kids/_downloads/PFA_Parents.pdf)

## Web Sites

- American Red Cross: <http://www.redcross.org>
- Cognitive Behavioral Intervention for Trauma in Schools (CBITS): <http://www.hsrcenter.ucla.edu/research/cbits.shtml>
- Trauma-Focused Cognitive-Behavioral Therapy: <http://tfcbt.musc.edu>

---

## DISTANCE EDUCATION/ DISPERSED LEARNING

---

In the current digital age, information is available in greater volumes and with faster access than in any prior time in history. Harnessing this information effectively can be a challenge and an opportunity for counseling educators and students. Technological innovations are changing the educational environment and allowing for a wide array of flexible education



opportunities. Many universities are offering options to traditional face-to-face, on-campus education programs and continuing education opportunities. Distance education can be a cost-effective mode of instructional delivery, accommodating the schedules of a nontraditional student (i.e., older adults with job and family responsibilities). On many college campuses, on-campus students are also opting to enroll in distance education courses and distance delivered course sections to take advantage of flexible scheduling and the opportunity to study when their work and nonschool schedules allow.

### **Universal Design for Learning and Best Teaching Practices**

The underlying premise of distance education is that educational opportunities are available anytime, anywhere, and are designed for everyone (universal design for learning). Underlying the concept of universal design for learning is that a curriculum includes alternatives that make the learning accessible and applicable to students with different backgrounds, learning styles, abilities, and disabilities. When an instructor varies the way a lesson is taught, be it in person or at a distance, more students benefit.

Universal design for learning (UDL) is defined by Bremer and colleagues as an environment and course materials that allow all students, regardless of their abilities and backgrounds, the same access to academic success. The principles of UDL propose adapting instruction to individual student needs through the following:

1. Multiple means of presentation of information to students (e.g., digital text, audio, video, still photos, images, and all with captions as appropriate)
2. Multiple means of expression by students (e.g., writing, speaking, drawing, video-recording, assistive technology)
3. Multiple means of engagement for students (e.g., choice of tools, adjustable levels of challenge, cognitive supports, novel or varied grouping)

Learning increases when different methods, such as slides, videos, music, role-playing, or small group activities are incorporated into the classroom or instructional materials. Flexibility is essential in the learning process. When the design of instruction takes

into consideration the many different types of learning styles, the classroom setting, local events, and the students' personalities, the classroom environment is enhanced, and everyone benefits. UDL builds upon educational traditions and best teaching practices that are very well established in practice and documented in the research literature.

Best teaching practices stand the test of time and are enhanced with technology innovations. The seven principles of best practice, as identified by Chickering and Gamson, are as effective in a distance education environment as they are in a traditional face-to-face classroom. UDL provides a blueprint for creating flexible goals, methods, materials, and assessments that accommodate learner differences.

### **Distance Education Development and Delivery**

Distance education can be developed and offered using a variety of tools and methods. Today's available technology tools for delivering Web-based learning and developing Web-based learning materials can include systems for content and learning management (e.g., Blackboard, WebCT) and designed Web sites (e.g., live, dynamic-interactive). There are many reasons for choosing one learning management system or delivery method over another as there are systems and methods. Blackboard and WebCT are similar and operated by the same organization. They both allow for secure administration of a wide array of online instructional units and materials and for student information management across the PC and Mac hardware platforms. Both products allow for faculty or instructional designers to develop online instructional units using the templates, tools, and components of the learning and content management system. eCollege is a very similar product to Blackboard and WebCT, but the online instructional unit development is often handled by the company using the contracting institution's or faculty's content. The integration with student information systems is similar in Blackboard, WebCT, and eCollege. For a contracted fee with the delivering institutions, most content and learning management systems can manage and deliver HTML, flash, and multimedia instructional materials as well as share content through file exchange tools and manage communication as e-mail redirection portals. There is a wide variety of proprietary learning management systems,



developed within educational institutions, that perform similar functions.

### Principles for Designing Web-Based Learning Materials

Regardless of the tool or vehicle for distributing educational materials, successful Web-based learning materials are based on solid cognitive theory and instructional design theory. Morrison, Ross, and Kemp ask critical questions to frame the instructional design process: What is the purpose of the instruction? What can learners do to demonstrate they understand the material? How can you assess whether the learners have mastered the content? What type of content and performance are specified in the objectives? What is the best way to implement your instructional strategies? How do instructional objectives dictate the selection of evaluation methods? These questions need to be answered taking into consideration how they affect the cognitive domain. Effective learning objectives address information or knowledge, naming, solving, predicting, and other intellectual aspects of the learning process. When these questions have been considered, the real work of developing effective instruction begins.

Materials should be organized in such a way that the learner can easily understand the instructional procedures and policies of the course. The instructor should set clear communication guidelines and expectations. All course information that is delivered orally in a traditional classroom needs to be explicitly listed on the course Web site. Deadlines for the course should be established and published to encourage regular participation from the students and to alleviate procrastination on the part of the student or the instructor. When developing course materials, consider putting the content in modules to break up the information flow into manageable chunks—quite often the course textbook will guide this process, as many textbooks are developed in units, chapters, or sections.

An effective instructional design model encompasses the instructional problem, learner characteristics, a task analysis, development of instructional objectives, sequencing of content, strategies of instruction, message design, instructional development, and evaluation and assessment tools. By taking into account the principles of UDL, counseling educators designing educational materials for in-class, traditional, or distance environments will be preparing

materials that will serve the programs, students, and future clients well.

*Laurie MacDonald*

*See also* Communication (v3); Continuing Education (v1); Credentialing Individuals (v1); E-Counseling (v1); Low-Context Communication (v3); School Psychology (v1)

### Further Readings

- Bremer, C. D., Clapper, A. T., Hitchcock, C., Hall, T., & Kachgal, M. (2002, December). Universal design: A strategy to support students' access to the general education curriculum [Information brief]. *Addressing Trends and Developments in Secondary Education and Transition*, 1(3). Retrieved November 7, 2007, from <http://www.ncset.org/publications/viewdesc.asp?id=707>
- Chickering, A. W., & Gamson, Z. F. (1991). *Applying the seven principles for good practice in undergraduate education*. San Francisco: Jossey-Bass.
- Mercurio, M., MacDonald, L., Bottenberg, D., & Johnson, B. (2003). *Universal design in distance education*. Retrieved November 17, 2006, from [http://www.unco.edu/equip/Resources/resources\\_faculty/Universal%20Design%20in%20Distance%20Education\\_files/frame.htm](http://www.unco.edu/equip/Resources/resources_faculty/Universal%20Design%20in%20Distance%20Education_files/frame.htm)
- Morrison, G. R., Ross, S. M., & Kemp, J. E. (2004). *Designing effective instruction* (4th ed.). Hoboken, NJ: Wiley.
- Summers, J., Waigandt, A., & Whittaker, T. (2005). A comparison of student achievement and satisfaction in an online versus a traditional face-to-face statistics class. *Innovative Higher Education*, 29(3), 233–250.

---

## DOUCE, LOUISE (1948– )

---

In her autobiographical writings and speeches, Louise Douce described herself as coming of age personally and professionally amidst the “wave of feminism” in academia in the 1970s and early 1980s. She identified feminist values as a core part of her identity and has consistently embodied those values as a clinician, administrator, educator, mentor, scholar, and professional leader. Indeed, her career can be seen as an exemplar of the passionate implementation of the values of empowerment, advocacy, and equality. She once used an image of standing on a bridge to describe significant work that she had done as a counseling psychologist. She indeed has toiled in the



construction of bridges over which the fields of counseling and counseling psychology have moved toward feminism; lesbian, gay, and bisexual (LGB) affirmation; and multiculturalism. She has labored to build bridges that span the integration of science and practice, to lead the way toward effective responses to the changing milieu of professional practice, to connect the counseling professions with a more global perspective, and to link the counseling professions to the future through more effective approaches to professional training.

Douce grew up on a small farm in southern Ohio in what she described as a “small-town Christian family, with missionaries and ministers on both sides.” Her undergraduate education at Ohio State University (OSU) during the Vietnam War era of the late 1960s was a time of great social change and of great personal change for Douce. She described herself as beginning those years believing that the war in Vietnam was justified and ending that era as an ardent feminist who wore a peace sign on her arm at graduation. From 1971 to 1977, she went to graduate school in counseling psychology at the University of Minnesota and did her internship at the Student Counseling Bureau there. She was one of a cadre of feminist women students in counseling who would come to forever change the profession. She has spoken and written about her experiences with sexism in graduate studies, but she has also noted it was an exciting time for young women like her to be feminists and to come out as lesbians. She has discussed the crucial role mentors played in her own development at this time, and she has passed on this legacy of mentoring by becoming a powerful mentor to so many.

Upon completion of her doctoral program in 1977, she became a staff psychologist at the Counseling and Consultation Service at OSU and has remained there for almost 30 years, providing extraordinary service and leadership to one of the most prestigious and respected university counseling centers in the country. Douce became the director for the graduate and predoctoral training program in 1980 and then became the director of the center in 1987. Her work in administering the training program, in providing clinical supervision, and in mentoring have had a significant impact on scores of graduate students and interns. It is safe to say that virtually every counseling center in the United States has been touched by Douce’s work as a trainer and mentor to its staff members. She remained significantly involved in training at OSU even as she became

the director responsible for providing vision and leadership to a staff of almost 20 with a budget of several million dollars. Of particular note for its impact, and for its significance to Douce personally, is that she has been a pioneer in the training of LGB counseling psychologists. In the LGB psychology community, she is a true elder of the tribe and grand-mentor to an entire new generation of LGB psychologists.

Douce’s record of leadership in multiple professional organizations over the last 25 years is far reaching and extensive. Congruent with Douce’s commitment to university counseling centers and professional training, one of the first national organizations for which she assumed a major leadership role was the Association of Counseling Center Training Agencies (ACCTA). She served as secretary from 1981 to 1985 and as president from 1985 to 1988. During this time she provided leadership for the organization in developing policies on intern selection and training, in providing some of the first presentations and workshops on LGB issues, and in establishing an active diversity committee. Around that same time, she also was involved with the American College Personnel Association (ACPA), helping found and lead both the task force on AIDS/HIV and the committee on LGB issues. Douce has also been involved in leadership for the Association of Psychology Postdoctoral and Internship Centers (APPIC), serving on APPIC’s Executive Board from 1988 to 1994, as vice chair from 1989 to 1990 and 1993 to 1994, and as treasurer from 1991 to 1992. During this time, she made a lasting impact on predoctoral internship training in psychology through leadership efforts toward standardizing both APPIC’s internship application and its definition of what constitutes a *practicum hour*.

In the late 1980s Douce’s professional leadership focus began to center on the American Psychological Association (APA). Her strongest involvement has been in APA’s Division 17, the Society for Counseling Psychology. She has served on and/or chaired many committees, task forces, and sections in the division, including those addressing the advancement of women, proficiencies and specialties in counseling psychology, awards, and fellowship status. Douce has been recognized as contributing significantly to the founding of both the society’s section that addresses LGB issues and the section that addresses women’s issues, being a “founding mother” of the latter. She was elected vice president for education and training for 1995–1997 and was elected to the highest office in



counseling psychology as division president for 2002. Though some have identified her as the first LGB president of the division, in her presidential address she identified herself as the first LGB psychologist who became president at a time when open identification would be met with fewer negative consequences. Selecting the globalization of counseling psychology as her presidential focus, she pushed the profession to expand toward a global perspective that would be free from U.S. cultural imperialism. She has represented the division externally in several important ways, including as a representative to APA's governing council beginning in 2006. Currently, she also serves on the APA's Board of Educational Affairs.

Douce has also authored a number of important scholarly publications and presented widely at professional conferences. Her scholarly contributions have focused on issues related to the needs of women, particularly in the career area; HIV/AIDS; LGB affirmative training and practice issues; and professional training and education. There can be no doubt that through her scholarship and the aforementioned professional organization leadership, she has had a significant impact on the education and training of psychologists. In addition, she has participated in a host of major national conferences formulating model training policies, including the national conferences on internship training (1987) and on postdoctoral training (1992), the Joint Council on Professional Education in Psychology (1990–1993), the conference on psychology supply and demand (1997), and the APPIC/BEA competencies conference (2002).

Her commitment and service to counseling and counseling psychology have been recognized through numerous prestigious awards. Douce achieved fellow status with Division 17 of APA in 1995. In 2001, the division awarded her the John D. Black Award for outstanding achievement in the practice of counseling psychology as well as the Woman of the Year award from the society's section on the advancement of women. She received the Distinguished Service Award from the Academy of Counseling Psychology in 2002 and received the Education Advocacy Distinguished Service Award from the APA Board of Educational Affairs in 2005. Her lifetime of service, leadership, and advocacy as a university counseling center psychologist has earned her a number of prestigious lifetime achievement awards from professional organizations that include the Ohio College Personnel Association, ACPA's Commission for

Counseling and Psychological Services, and the American University and College Counseling Center Director's Association.

Colleagues would find little disagreement with Douce's own self-description as bringing "emotional intensity" and a "passionate espousal of values" to her work. There can be no doubt that she has wisely employed that passion and intensity in her work as evidenced by the scope and impact of her work advocating for social justice, developing effective professional education, and advancing the relevance and impact of counseling on society.

*James M. Croteau and Jessica L. Manning*

**See also** Counseling Psychology, Definition of (v1);

Counseling Psychology, History of (v1); Feminist Therapy (v1); Feminization of Psychology (v1); Gay, Lesbian, and Bisexual Therapy (v2); International Developments, Counseling (v1); International Developments, Counseling Psychology (v1); Mental Health Issues in the Schools (v1); Professional Associations, Counseling (v1); Sexism (v3); Supervision (v1)

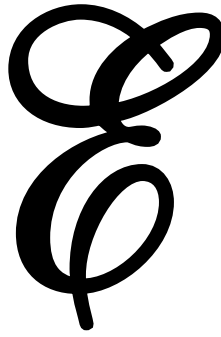
### Further Readings

- Boggs, K. R., & Douce, L. A. (2000). Current status and anticipated changes in psychology internships: Effects on counseling psychology training. *Journal of Counseling Psychology, 28*, 657–672.
- Buhrke, R. A., & Douce, L. A. (1991). Training issues for counseling psychologists in working with lesbian women and gay men. *The Counseling Psychologist, 19*(2), 216–234.
- Douce, L. A. (Ed.). (1993). AIDS: Hopes and challenges for the 1990's [Special section]. *Journal of Counseling and Development, 71*, 259–309.
- Douce, L. A. (Speaker). (1996). *New fellows symposium* (Cassette Recording No. APA-6-3252). Washington, DC: American Psychological Association.
- Douce, L. A. (2002, August). *Riding the waves: A feminist's journey to multiculturalism*. Invited address for the Woman of the Year award, presented at the American Psychological Association Symposium, Chicago, IL.
- Douce, L. A. (2004). Globalization of counseling psychology. *The Counseling Psychologist, 32*, 142–152.
- Douce, L. A. (2005). Coming out on the wave of feminism, coming to age on the ocean of multiculturalism. In J. M. Croteau, J. S. Lark, M. A. Lidderdale, & Y. B. Chung (Eds.), *Deconstructing heterosexism in the counseling professions: A narrative approach* (pp. 59–64). Thousand Oaks, CA: Sage.









---

## E-COUNSELING

---

One reflection of the explosion of technology in our lives is the increasing use of technology for delivering counseling and psychotherapy as well as other psychoeducational interventions. An individual can use the Internet to locate a counselor, to gain information about psychological conditions and treatments, to obtain counseling, and to share with others in chat rooms or online support groups. In addition to facilitating the exchange of written or audio content, the Internet can provide individuals with face-to-face contact through the use of video technology.

One of the prime advantages of the Internet in delivering mental health services is that clients who have difficulty obtaining face-to-face contact because of health conditions, remote locations, or other barriers can obtain services that would otherwise not have been available. Examples would be clients living in remote areas where a long drive to obtain clinical services cannot be regularly accomplished; clients whose physical health conditions limit their mobility; clients who live in areas where psychologists, counselors, or other mental health care providers are sparsely distributed; and clients whose psychological condition makes them less likely to seek face-to-face delivery of services but more likely to use the less personal nature of the Internet for chat rooms or support groups. Another advantage of the Internet is that it can be used as an adjunct to regular treatment. An example is that of pain patients who can log on to a Web site where they can enter data about their pain levels, obtain materials about coping strategies they

have already been taught, post questions to therapists or other patients, and obtain support between regular treatment sessions.

### **Ethical and Legal Issues**

However, using technology as the sole or adjunctive means of delivering psychological services poses significant ethical and legal issues. The APA ethical code does not have a separate section on electronically transmitted services. Rather, codes incorporate online treatment as deemed necessary within appropriate categories. For example, the standard on informed consent says that psychologists delivering online treatment must warn clients of the limits of confidentiality inherent in this type of communication.

Mallen, Vogel, and Rochlen outlined several areas where the ethical code may be tested in online formats. One such area is the duty to warn: to protect clients if they pose a danger to themselves or to warn others if the client poses a danger to them. If services are being provided at a distance, it may be difficult to meet this standard. Another example is confidentiality: By their very nature, online interactions are vulnerable to hacking or being penetrated by a third party. If an online exchange is saved by either the client or counselor, the data are equally vulnerable to breaches of confidentiality. Encryption is a possible security step but cannot be relied upon to provide complete protection.

A different type of confidentiality issue is the protection of tests and assessments. Psychologists are ethically obligated to maintain the security of psychological tests and assessment methods. However, if



such assessments or tests are transmitted to clients, their security cannot be maintained. In a research setting, when tests are used in online surveys, similar concerns apply.

Legally, psychologists and counselors practice under a license issued by their state. Online treatment tests this limit of practice, because psychologists and counselors may be treating clients in their own state, an adjoining state, a different state, or a completely different country. Mobility issues for psychologists from state to state are being addressed, as are mobility issues for psychologists from country to country. But the advances of online technology have surpassed any advances in mobility in regard to licensure and credentialing.

### Training Issues

In spite of the advances in technology that faculty and students use on a daily basis (e.g., to conduct literature searches via online databases or to download research articles), training in counseling and psychotherapy still adheres primarily to a supposition that counselors will be treating their clients in the traditional face-to-face, office-based, 45- or 50-minute session. Clearly, not all counselors or psychologists are interested in delivering online services, and not all faculty are able to prepare students to do so in future careers. But several training issues apply.

First, at a minimum, students should be competent in computer-aided communication. This competence would extend to chat rooms, encryption, and various hardware and software programs.

Perhaps more important is communication via text. Counselors are skilled at empathy: picking up on client's verbal and nonverbal cues and recognizing the affect behind them. This skill is much more demanding with text communication. Counselors may need to learn to ask questions in a different manner than they do in person and to convey their responses much more directly than they might usually do in conversation.

Ethical and legal issues that may arise in online counseling must be considered during graduate education in the same way that ethical and legal issues arising from in-person treatment are considered. While practica may not provide opportunities to identify these issues, faculty teaching courses in ethics and issues can include a section on online treatment and might profitably include a panel of local practitioners

who deliver online services and have wrestled with relevant ethical issues.

*Elizabeth M. Altmaier*

**See also** Computer-Assisted Career Counseling (v4); Ethical Codes (v1); Ethics in Computer-Aided Counseling (v1); Human Subjects Review in an Online World (v1); Technology and Treatment (v1)

### Further Readings

- Derrig-Palumbo, K., & Zeine, F. (2005). *Online therapy: A therapist's guide to expanding your practice*. New York: Norton.
- King, R., Bambling, M., Lloyd, C., Gomurra, R., Smith, S., Reid, W., et al. (2006). Online counselling: The motives and experiences of young people who choose the Internet instead of face to face or telephone counseling. *Counselling and Psychotherapy Research*, 6, 164–168.
- Kraus, R., Zack, J., & Stricker, G. (2004). *Online counseling: A handbook for young professionals*. San Diego, CA: Elsevier.
- Mallen, M. J., Vogel, D. L., & Rochlen, A. B. (2005). The practical aspects of online counseling: Ethics, training, technology, and competency. *The Counseling Psychologist*, 33, 776–818.
- Recupero, P. R., & Rainey, S. E. (2005). Informed consent to e-therapy. *American Journal of Psychotherapy*, 59, 319–331.

---

## EMDR

---

**See** EYE MOVEMENT DESENSITIZATION  
AND REPROCESSING

---

## EMPIRICALLY BASED PROFESSIONAL PRACTICE

---

Professional practice based on reliable and valid empirical findings of effectiveness—empirically based professional practice (EBPP)—has increasingly influenced the work of mental health practitioners over the past two decades. The appeal of EBPP is based on the conviction that using evidence-based assessments and treatments in preference to those



without empirical support makes sense, because EBPPs have been compared systematically to alternative treatments by appropriate and powerful methods and, for that reason, should provide practitioners assurance of superior efficacy.

Many believe that medical practice has long been heavily influenced by the most current available scientific data. However, that assumption may not be valid. The roots of evidence-based medical practice (EBMP) are shorter than many may have thought: They are usually traced to a statement published in the *Journal of the American Medical Association* by a group of physicians led by a Canadian internist that advocated evidence-based medical practice over medicine as an art. The article led to a debate about power, ethics, and responsibility in medicine that appears to have radically altered healthcare practices. Although this change has led physicians away from intuition (the art in medicine) toward empirical data (the science in medicine), divisions among physicians over the value of intuition continue. Some have said that the EBMP position is unequivocal: There are reliable, validated data, and then there are data that aren't reliable and validated, and the difference between the two is what is important.

Parallels between the nature of and reactions to evidence-based medical practice and evidence-based mental health practice are clear. What advocates for evidence-based treatments in psychology, psychiatry, and social work hear from their critics is strikingly similar to what those who support evidence-based medical practices hear from their critics, as are the efforts of advocates for evidence-based mental health practice and advocates for evidence-based medicine to counter those criticisms with data.

### **History of Concern for Evidence of Efficacy in Professional Psychology**

The issue of the evidence base of clinical practice in psychology has a lengthy and important history that dates back more than 60 years to the period of explosive growth of professional psychology during and after World War II that transformed it from a small, primarily academic discipline to one of the core mental health professions. As long ago as 1942, social psychologist Theodore Sarbin predicted, on the basis of some of his own data, that actuarial prediction methods ("science") would ultimately be able to outperform humans ("art") along a variety of judgment dimensions. In 1954, Paul Meehl, who was to become

one of the towering figures in clinical psychology over the next several decades, published a book that summarized his data confirming the consistent superiority of statistical prediction ("science") over clinical prediction ("art"). Although advocates for art rather than science in clinical and counseling psychology since then have been heard from, support from behavioral scientists for the positions Sarbin and Meehl took so long ago on this issue has been strong and consistent.

Notwithstanding opposition to evidence-based practice by some mental health professionals, increasing efforts are being expended to require mental health practitioners to follow practice guidelines, and practice guidelines are becoming more prescriptive. Managed care organizations, third-party reimbursers, and state and federal agencies have come increasingly to expect psychologists, psychiatrists, and social workers whenever possible to employ practices with empirical support. As a consequence, many psychology and social work students and psychiatric residents receive training that emphasizes these practices as mandated by their professions. Practice guidelines incorporating evidence-based treatments have been put forth by the American Psychological Association and the American Psychiatric Association as well as by the U.S. Department of Veterans Affairs and the U.S. Agency for Health Care Policy and Research. And more and more patients have come to expect their therapists to know and use empirically supported treatments whenever possible.

Despite these developments, disagreement continues to divide mental health professionals on the strength and legitimacy of the evidence base that underlies evidence-based practices. Three pressing unresolved issues underlie this controversy; they are briefly considered below. Resolution of these issues appears to be essential to the future of evidence-based practices. If some or all of them can finally be resolved, agreement by most mental health professionals on the worth of evidence-based practices would likely be assured. By the same token, if few or none can be settled, the momentum toward evidence-based practices might well slow.

### **Issue #1: Efficacy Model Versus Effectiveness Model**

Which of two psychotherapy outcome research models—the efficacy model or the effectiveness model—best captures the most crucial differences among therapy techniques and procedures and, hence, can be relied on to provide the most accurate picture



of therapy outcomes? The *efficacy model* describes most carefully controlled, time-limited psychotherapy outcome research, much of it involving random assignment of patients to treatments, done largely by psychotherapy researchers in laboratory or other controlled settings, using therapists intensively trained to provide the experimental treatment and psychotherapy patients carefully selected diagnostically to receive it. The *effectiveness model* describes psychotherapy research done in real-world clinical settings, utilizing clinicians in their usual treatment settings doing the kind of psychotherapy they customarily do with the patients who customarily come to see them in those settings.

Most of the research that has led to identification of evidence-based treatments to this time has been done according to the efficacy model. As a result, critics of the evidence underlying evidence-based treatments have claimed that efficacy studies do not reflect therapy outcomes “in the real world.” While supporters of the efficacy model have mounted a vigorous defense of the treatment model, the question of which of the two models provides the most valid picture of psychotherapy outcomes remains unresolved. Until it is, the evidence base of evidence-based treatments will remain suspect.

The efficacy model and the effectiveness model represent quite different approaches to studying behavior change. Because neither model by itself appears to capture the entirety of what makes a treatment effective, clinical researchers have begun to try to integrate the two approaches in the design of psychotherapy research in the effort to gather the most broadly based empirical support for the treatments being evaluated and resolve the controversy.

## Issue #2: Common Factors Versus Treatment Factors

The controversy over Issue #1—the relative validity of efficacy versus effectiveness studies in assessing treatment outcomes—came to a head with the publication of practice guidelines by the American Psychiatric Association and the Division of Clinical Psychology of the American Psychological Association. However, the appearance of these guidelines also led critics of evidence-based practices to step up the amplitude of a related continuing controversy: This issue has to do with whether differences in psychotherapy outcomes are more strongly associated with specific types or schools of psychotherapy (as advocates for empirically supported treatments affirm) or with therapist, patient,

and therapy process variables common to all psychological treatments.

*Treatment factors* refer to the array of therapeutic behaviors and techniques a therapist is taught and must learn as he or she acquires the skills appropriate to the practice of a specific intervention. By contrast, *common factors* refer to factors influencing outcomes presumed to be independent of the specific treatment employed, including patient attributes like age, gender, and personality; therapist attributes like interpersonal and social skills; and the nature of the relationship between therapist and patient.

Therapist variables thought to impact on therapy outcomes regardless of the kind of therapy techniques the therapist uses range from the therapist’s demographic characteristics and sociocultural background to subjective factors like values, attitudes, and beliefs. Prominent psychologist Larry Beutler believes that therapist variables reflecting behaviors specific to the therapeutic relationship, including the therapist’s professional background, style, and choice of interventions, may exert the most powerful effects on therapy outcomes. After an extensive review of outcome research data, Michael Lambert and Allen Bergin concluded that about 30% of psychotherapy outcome variance is attributable to therapist variables, prominently including therapist empathy, warmth, and acceptance of the patient.

In contrast to the voluminous data on the impact of therapist variables on therapy outcomes, patient variables have failed to demonstrate a robust relationship to outcome variables. In a well-known National Institute of Mental Health Treatment of Depression Collaborative Research Project (NIMH-TDCRP) comparative study of treatments for depression, for example, no single patient variable correlated significantly with outcome. More recently, the National Institute on Alcohol Abuse and Alcoholism’s Project MATCH failed to identify relationships between patient-treatment matches and outcomes of treatment for alcohol abuse and dependence.

Therapeutic process variables—factors influencing therapists’ reactions to patients’ behavior and attitudes and vice versa—have also been claimed to affect therapy outcomes. To this end, David Orlinsky and Kenneth Howard concluded that process variables, which they believed include the strength of the therapeutic bond, the skillfulness with which interventions are undertaken, and the duration of the treatment relationship, all impact positively on outcomes. Others have also stressed the central role of the therapeutic alliance in determining outcomes. Most



recently, Louis Castonguay and his colleagues reviewed the extensive data on relationship factors in the treatment of dysphoric disorders, concluding that these factors positively influenced treatment outcomes. Nonetheless, critics of process research have continued to emphasize the difficulties associated with the reliable collection of process data.

### Issue #3: The Dodo Bird Effect

The dodo bird effect, so designated by Saul Rosenzweig in a prescient 1936 article on common factors in diverse psychotherapies, is named after the well-known race in Lewis Carroll's *Alice in Wonderland*. At the conclusion of that contest, the dodo bird declares that since the racers, including Alice, had failed to keep to the racecourse, it was impossible to know who had won and, so, "Everyone has won and all must have prizes." Thus, the dodo bird effect in psychotherapy research refers to findings that indicate that there are few or no meaningful differences among psychotherapies in effectiveness and that, accordingly, outcomes of therapy don't really depend on the kind of therapy patients.

Acknowledging their debt to Rosenzweig for his initial reference to the dodo bird, Luborsky, Singer, and Luborsky wrote a review chapter in the 1970s in an edited volume on psychotherapy evaluation, "Comparative studies of psychotherapies: Is it true that 'everyone has won and all must have prizes'?" Luborsky and his colleagues compared outcomes from group and individual psychotherapy, time-limited and open-ended psychotherapy, and client-centered and psychodynamic therapy, concluding that most studies of psychotherapy have found insignificant differences in the effectiveness of different psychotherapies.

More recently, the dodo bird effect has been taken to refer to efficacy comparisons among psychotherapies by means of meta-analyses that have failed to find differences in efficacy. By now, a number of psychotherapy researchers besides Luborsky and his colleagues have adopted the same position—that most psychotherapies are effective in inducing behavior change, but that they do not differ in efficacy. A number of behavioral researchers, however, have vigorously disputed this position. They point to data from a number of randomized clinical trials that strongly suggest that some psychosocial treatments—most of them behavioral or cognitive behavioral—do appear to yield significantly better outcomes than do other psychotherapies. In so doing, they also cite data finding substantial problems with meta-analysis as a means of

comparing the differential efficacy of psychotherapies. As noted above, the drafters of practice guidelines by the American Psychiatric Association, the American Psychological Association, and the Mental Health and Behavioral Science Service of the Veterans Administration, among others, have taken similar positions in recommending some treatments over other treatments on the basis of outcome studies.

### Present Situation

The well-known complexity of the psychotherapy process—in particular, the range of variables in the relationship between patient and therapist that are capable of influencing therapy outcomes—has led advocates for and critics of evidence-based treatments to the present situation. On the one hand, advocates point to voluminous data attesting (a) to the power of efficacy studies to differentiate among therapies in outcome, (b) to the association of specific kinds of treatment, most often cognitive-behavioral, with positive outcomes, and (c) to the failure of "art" through history in its struggle with science for primacy. On the other hand, critics have no problem citing research in each instance that supports their view that these questions cannot be resolved nearly as simply and expeditiously as the advocates would like.

While the most attractive solution to this conundrum is to suggest that partisans on each side of this issue tone down their rhetoric until enough data have been gathered to resolve these questions, that solution is unlikely to satisfy either side.

Peter E. Nathan

*See also* Behavioral Therapy (v2); Clinical Interview as an Assessment Technique (v2); Cognitive Therapy (v2); Counseling Process/Outcome (v2); Counseling Skills Training (v2); Counseling Theories and Therapies (v2); Evidence-Based Treatments (v2); Individual Therapy (v2); Meehl, Paul E. (v2); Outcomes of Counseling and Psychotherapy (v2); Psychometric Properties (v2); Therapist Techniques/Behaviors (v2)

### Further Readings

- Barlow, D. H. (1996). Health care policy, psychotherapy research, and the future of psychotherapy. *American Psychologist*, 51, 1050–1058.
- Beutler, L. E., Machado, P. P. P., & Neufeldt, S. A. (1994). Therapist variables. In S. L. Garfield & A. E. Bergin (Eds.), *Handbook of psychotherapy and behavior change* (4th ed., pp. 229–269). New York: Wiley.



- Boisvert, C. M., & Faust, D. (2003). Leading researchers' consensus on psychotherapy research findings: Implications for the teaching and conduct of psychotherapy. *Professional Psychology: Research and Practice*, 34, 508–513.
- Chambless, D. L., & Ollendick, T. H. (2001). Empirically supported psychological interventions: Controversies and evidence. In S. T. Fiske, D. L. Schacter, & C. Zahn-Waxler (Eds.), *Annual review of psychology* (Vol. 52, pp. 685–716). Palo Alto, CA: Annual Reviews.
- Garfield, S. L. (1996). Some problems associated with “validated” forms of psychotherapy. *Clinical Psychology: Science and Practice*, 3, 218–229.
- Guyatt, G. H., Haynes, R. B., Jaeschke, R. Z., Cook, D. J., Green, L., Naylor, C. D., et al. (2000). Users' guide to the medical literature XXV. Evidence-based medicine: Principles for applying the users' guides to patient care. *Journal of the American Medical Association*, 284, 1290–1296.
- Lambert, M. J., & Bergin, A. E. (1994). The effectiveness of psychotherapy. In S. L. Garfield & A. E. Bergin (Eds.), *Handbook of psychotherapy and behavior change* (4th ed., pp. 143–189). New York: Wiley.
- Luborsky, L., Singer, B., & Luborsky, L. (1976). Comparative studies of psychotherapies: Is it true that “everybody has won and all must have prizes”? In R. L. Spitzer & D. F. Klein (Eds.), *Evaluation of psychological therapies* (pp. 3–22). Baltimore, MD: Johns Hopkins University Press.
- Meehl, P. E. (1954). *Clinical vs. statistical prediction: A theoretical analysis and a review of the evidence*. Minneapolis: University of Minnesota Press.
- Nathan, P. E., Stuart, S. P., & Dolan, S. L. (2000). Research on psychotherapy efficacy and effectiveness: Between Scylla and Charybdis? *Psychological Bulletin*, 126, 964–981.
- Sarbin, T. R. (1942). A contribution to the study of actuarial and individual methods of predictions. *American Journal of Sociology*, 48, 593–602.
- Strupp, H. H. (1973). *Psychotherapy: Clinical, research, and theoretical issues*. New York: Jason Aronson.
- Task Force on Promotion and Dissemination of Psychological Procedures. (1995). Training in and dissemination of empirically-validated psychological treatments: Report and recommendations. *The Clinical Psychologist*, 48, 3–23.

---

## ETHICAL CODES

---

Ethical issues are often complicated and multifaceted and can be challenging for counselors if they attempt to create simple solutions when dealing with difficult

issues. Many ethical issues are gray, not black and white, and it is common for biases and personal values, beliefs, and morality to enter the decision-making process. As a result, ethical codes are designed to provide guidelines and general standards for counselors to deal with a variety of ethical issues and situations.

Ethical issues are regulated by laws and ethical codes. However, most people do not understand the inherent difference between the two. *Law* is a set of rules established by governments, and it defines the minimum standards that people in society tolerate. *Ethics*, on the other hand, is a set of ideal standards established by a profession as moral principles that members should adopt as a guide for conduct. As a result, ethical codes are generally broad instead of precise and specific. In addition, ethical codes are edited frequently due to the emergence of new issues or the clarification of old ones. For instance, more clients seek counseling using technology than was the case decades ago; thus, there is a need to address potential issues that might occur when integrating technology into counseling. No clear-cut lines separate ethics and laws; hence, counselors often make ethical decisions based on their maturity, philosophy, experience, and knowledge.

### Ethical Codes in the Counseling Profession

The first American Counseling Association (ACA) ethics code was established in 1961, and revisions were made during 1974, 1981, 1988, 1995, and 2005. The first version of the Code of Ethics for Marriage Counselors was developed in 1962, and the eighth revision was published in 1991. The ACA code of ethics is the most well known and practiced by counselors.

### Moral Principles in Making Ethical Decisions

The primary reason for counselors to follow an ethical code is to protect clients' welfare, and the following six basic moral principles are priority guidelines designed to help them make most appropriate decisions. *Autonomy* refers to counselors allowing clients to make their own decisions, with the therapist respecting any choices made. *Nonmaleficence* means doing no harm, and counselors should strive at all times to avoid hurting clients, even when intentions are worthy. *Beneficence* means counselors doing what



is good for clients. *Justice* means counselors providing equal treatment to all individuals, regardless of their background, age, gender, religion, ethnicity, etc. *Fidelity* means counselors making honest promises and honoring their commitments to their clients. *Veracity* refers to being truthful.

Ethical codes are not blueprints, and therapists will likely be challenged during an ethics application process. It is essential for mental health professionals to understand that potential problems exist and are encountered when counseling ethically. For instance, (a) some issues cannot be handled by simply checking ethical codes, (b) some codes are opaque and difficult to follow, (c) at times, conflict exists within ethical codes as well as among the codes of other organizations, (d) ethical codes are more likely to be reactive than proactive, and (e) conflicts may arise between institutional policies and practices.

### ACA Code of Ethics

The ACA code of ethics consists of seven sections: Section A: the counseling relationship; Section B: confidentiality, privileged communication, and privacy; Section C: professional responsibility; Section D: relationships with other professionals; Section E: evaluation, assessment, and interpretation; Section F: supervision, training, and teaching; Section G: research and publication; and Section H: resolving ethical issues.

#### Section A

This section addresses ethical issues involved within the counseling relationship. The first issue concerns clients' welfare. A mental health counselor's primary responsibility is to ensure his or her clients' dignity and welfare; counselors may achieve this goal by following the guidelines in this section. Counselors should keep sufficient and timely records, and these should reflect clients' progress as well as different services provided by the counselor.

The second issue concerns informed consent. Clients have the right to detailed information regarding counseling services and the counselor before making a decision to continue with counseling. Counselors have the responsibility to review informed consent both verbally and in writing with the client concerning his or her responsibilities and rights. Therapists explain the type(s) of counseling services the client will receive as well as the counseling purpose, goals, techniques,

procedures, limitations, potential risks, and benefits. Counselors should provide professional information about themselves, such as their qualifications, credentials, experiences, etc. When dealing with clients unable to give consent, counselors need to obtain assent from an appropriate collateral (e.g., parent, guardian).

The third issue deals with the professional relationships that a client may have with other mental health professionals. Under such circumstances, a counselor requests a release from the client to inform those other professionals about the counselor's work with the client. The counselor also tries to establish positive professional relationships with the other health professionals working with the client. The fourth issue addresses how counselors can avoid harm by not imposing their values on the client. Counselors respect their clients and are aware of their own personal values while avoiding the temptation to inculcate them into their clients.

The fifth issue concerns counselors' roles and relationship with their clients. Any sexual or romantic relationship is strictly prohibited. When counselors are involved with their former clients sexually or romantically, a document must prove their last professional contact was at least five years earlier. In addition, other documents must show that their new relationship will not psychologically harm the former client. When counselors engage in nonprofessional relationships with clients, the counselor must provide documentation to prove that the clients benefit from such a relationship. When the counselor's professional role changes, he or she needs to obtain new consent from the client.

The sixth issue discusses counselors' and clients' roles and relationships at different levels, such as individual, group, institutional, or societal levels. When roles change, counselors must examine any potential barriers that might restrain clients' growth. The seventh issue concerns counselors providing counseling services to multiple clients. Under such circumstances, counselors clarify their relationship with each specific client. The eighth issue centers on group work. It is essential for counselors to select group members who have goals that are compatible with those of other group members. In addition, counselors need to protect group members from physical, emotional, and psychological damage.

The ninth issue discusses potential ethical issues when dealing with terminally ill clients. Counselors need to provide high-quality end-of-life care to clients while enabling them to engage in decision



making regarding their end-of-life care. Meanwhile, counselors have the responsibility to provide appropriate referral information while ensuring that clients receive adequate assistance. In addition, counselors must recognize their personal, moral, and competence issues when working with terminally ill clients. If terminally ill clients decide to accelerate their own demise, therapists need to follow applicable state law and decide whether to break confidentiality. However, before making such a decision, counselors seek consultation or supervision from appropriate professional parties.

The tenth issue is about fees and bartering. While establishing fees, counselors need to take clients' financial status into consideration. If the established fee structure is inappropriate for a client, the counselor has the responsibility to assist the client in finding comparable services at an acceptable cost. When clients fail to pay their fees, clients need an opportunity to make payment before counselors use collection agencies. If clients suggest bartering, and it is acceptable among professionals in their community, counselors may accept it. When determining whether or not to accept gifts from clients, counselors consider how it might affect the therapeutic relationship.

The eleventh issue is about termination and referral of counseling services. Counselors never abandon clients under any circumstances, such as illness, vacation, and so on. In fact, counselors need to arrange for clients to continue treatment if the counselor is unavailable to continue providing counseling services. If the client rejects the referral, the counselor needs to terminate the counseling service. In addition, counselors should terminate the therapeutic relationship when the client will not benefit from further services, the client fails to pay fees, or there is potential harm for the client. After termination, counselors need to make appropriate referrals for the client.

The twelfth issue concerns potential ethical issues when integrating technology into counseling. It is the counselor's responsibility to inform clients regarding any benefits and limitations while implementing technology into counseling services. Counselors need to be aware of their clients' intellectual and emotional capability as well as the appropriateness of the type of technology they plan to use in the counseling session. When counselors realize long-distance counseling service is not appropriate, they provide face-to-face counseling sessions to their clients. Counselors are responsible to ensure the technology implementation

does not violate the law. Counselors also receive informed consent from the client, which must address any potential technological issues concerning the counseling sessions. In addition, when counselors maintain sites on the Web, they regularly update the content and stay current with the activity on their sites. They also need to have other modes of communication with the clients if the technology fails.

## ***Section B***

Section B addresses ethical issues regarding confidentiality, privileged communication, and privacy. The first issue concerns counselors respecting the rights of their clients. When working with clients whose ethnic or cultural background is different from theirs, counselors are aware of and sensitive to their clients' culture, recognizing that it might have impact on confidentiality and privacy issues. Counselors respect clients' privacy and seek personal information from the client only when the relationship can gain from acquiring it. Counselors may share a client's information with others only when they have the client's consent and a legal or ethical justification for this action. In addition, counselors must inform clients regarding the limitations of confidentiality, identifying specific situations when confidentiality must be breached.

The second and third issues center on how counselors disclose clients' personal information. Counselors disclose only when the client is in danger of hurting him- or herself or in danger of injury from someone else. When counselors are under a court order to release clients' personal information, it is important for them to obtain informed consent from the client and to disclose as little information as possible. Counselors have the responsibility to ensure that clients' private information is not revealed to other professional parties, such as employees. If clients are involved in treatment, they should be informed that their personal information might be shared with other professionals as well as the purpose for doing so. Counselors discuss clients' information only when they are sure that privacy will be maintained.

The fourth issue is about potential ethical issues regarding group and family counseling. Because more than one client is involved in such a counseling relationship, it is essential that counselors clearly explain the importance of confidentiality to each client. The fifth



issue is about clients' capacity to give informed consent. When dealing with incapable clients (minors or adults), counselors need to protect clients' confidentiality based on specific laws and/or ethical codes. In addition, when working with these clients, counselors obtain permission from an appropriate party regarding the release of confidential information.

The sixth issue concerns how counselors handle clients' records. It is essential for counselors to keep clients' records in a secure place where only authorized individuals have access. If counselors need to record or observe counseling sessions, they must obtain clients' permission beforehand. The seventh issue is about research and training. When counselors conduct research, they must receive institutional approval first. In addition, counselors need to be cautious about disclosing any information that might lead to the identification of certain research participants. The eighth issue concerns consultation within the counseling relationship. When counselors consult with others, they have the obligation to protect clients and not disclose information that might lead to identification of certain clients.

### **Section C**

This section is about counselors' professional responsibility. The first issue concerns knowledge of standards. It is a counselor's responsibility to read and comprehend the ethical codes and standards of the profession. The second issue involves professional competence. Counselors should practice counseling based only on their education, training, and professional credentials as well as professional experience. If counselors practice in a specialty area different from the one in which they have been educated or trained, they must take steps to ensure their competence in order to protect potential clients from harm. They should continually monitor and improve their professional skills. When counselors have questions regarding their ethical obligations, they should seek consultation from other counselors. In addition, counselors need to take steps, such as receiving continuing education, to maintain their competence level.

The third issue addresses how counselors advertise for and solicit clients. When advertising, counselors must provide accurate information when identifying their credentials in order to not mislead clients. In addition, when counselors develop professionally related products, they should not use a counseling,

supervising, or training relationship to promote their goods. The fourth issue centers on counselors' professional qualifications. Counselors must truthfully represent their qualifications and accurately describe their professional training, and they may refer only to licenses and certifications that are current and in good standing. Counselors are responsible to state their educational degree as well as the accreditation of their institution at the time their degree was completed. Counselors must distinguish their current from their former association memberships. The fifth issue states that counselors should not discriminate against their clients, supervisees, students, or others based on race, age, culture, religion, and so on.

The sixth and seventh issues discuss counselors' responsibilities to the public and to other professionals. Counselors should not engage in sexual harassment and should strive for accuracy and objectivity when asked to provide professional reports or judgments to third parties.

### **Section D**

This section primarily discusses counselors' relationships with other professionals. The first issue centers on counselors' relationship with their colleagues, employees, and employers. Counselors need to respect others providing counseling approaches different from their own, and they should strengthen their relationships with other colleagues in order to provide the best services for their clients. When counselors are employed in an agency or institution, the implication is that the mental health professionals working there agree with their employers' general policies and principles. However, when counselors identify inappropriate policies or practices of their employers, they take steps for making constructive changes. When such policies have damaged the effectiveness of counseling, they need to refer clients to another appropriate agency.

The second issue is about consultation. When counselors are requested to provide consultation services, they need to ensure their competency as consultants. They are also obligated to review rights and responsibilities for both themselves and consultees. In addition, they seek understanding with their consultees regarding problem definition, goals for consultation, and predicted intervention results. They are also responsible for communicating with consultees regarding related consultation issues, such as the



purpose of the consultation service, costs, and potential risks and benefits.

### **Section E**

This section is concerned with how counselors use instruments to evaluate clients and the accuracy of any interpretation of results. There are 13 issues in this section. The first issue is general information regarding assessment. It is a counselor's responsibility to select reliable and valid instrument(s) to measure a client's personality, ability, interest, intelligence, or performance. In addition, counselors must know how to interpret the assessment results. Their interpretations should be available to clients when requested.

The second issue addresses counselors' competence using and interpreting assessment instruments. Counselors may use only assessments that they have received adequate training to and are thus competent to administer. In addition, if counselors serve as supervisors, they need to hold the same standards to ensure their supervisees' assessment competence. Counselors are responsible for appropriate scoring and the interpretation of instruments used meeting the needs of their clients. Counselors are especially responsible for any decisions made that are based on clients' assessment results. They must have a thorough understanding of the psychometric properties of any instrument used, such as validation criteria, assessment research, and assessment guidelines for development and use.

The third issue discusses informed consent. Counselors should explain to their clients the purpose and nature of the instrument prior to assessment. Meanwhile, counselors need to be aware of their clients' culture and level of understanding of the assessment results as well as the potential impact such information might have on the clients. The fourth issue is about releasing assessment data to other qualified professionals. Counselors may only release clients' data to other qualified professionals after obtaining the consent of the client or the client's legal representative. The fifth issue discusses how counselors should carefully select instrument(s) and appropriate assessment techniques for a mental disorder diagnosis. In addition, when diagnosing diverse clients, counselors need to take into consideration a client's culture. Counselors may abstain from reporting a diagnosis that they believe would bring harm to a client.

The sixth issue addresses how counselors should appropriately select an instrument for assessment purposes. Certain criteria, such as validity, reliability, psychometric limitations, and appropriateness of a particular instrument need to be carefully investigated before selecting the instrument. In addition, counselors need to be cautious when selecting instruments for culturally diverse clients and avoid using instruments that appear to have a lack of psychometric properties for the population the client represents. The seventh issue concerns the administration conditions. If, in an effort to accommodate a client's special needs, a counselor administers an instrument under nonstandardized condition(s), these conditions must be reported in the interpretation. In addition, counselors must understand that the results might be invalid.

The eighth issue regards multicultural issues in assessment. Counselors should be familiar with the effect of a client's age, gender, race, religion, language, and other cultural components. The ninth issue concerns scoring and interpreting the assessment results. Counselors should recognize reservations that exist regarding validity and reliability of the instrument. The tenth issue addresses the need for counselors to maintain security of tests and assessment. Counselors may not reproduce or modify a published assessment prior to obtaining permission from the publisher. The eleventh issue states the need for counselors not to use outdated assessments. The twelfth issue addresses counselors' responsibility to select assessment methodologies based on scientific procedures, relevant standards, and professional knowledge. The thirteenth issue discusses forensic evaluation and evaluation for legal proceedings. When counselors provide forensic evaluations, their opinions must be objective and supported by data gathered during the evaluation.

### **Section F**

This section discusses supervision, training, and teaching issues. The first issue regards clients' welfare with supervision. When counselors serve as supervisors, they are responsible for their supervisee's understanding and following of ethical codes. In addition, supervisees must explain to their clients who will have access to the clients' records. The second issue concerns supervisors' competence level. Before supervisors provide any clinical supervision, they must receive adequate supervision training. The third issue is about supervisory relationships. Supervisors



should explain the professional supervisory relationship to their supervisees and avoid any kind of non-professional relationship with current supervisees. Supervisors are banned from developing any sexual or romantic relationship with current supervisees.

The fourth issue states supervisors' responsibilities. Supervisors ensure their supervisees' awareness of professional and ethical standards and encourage them to follow those standards. In addition, if either the supervisor or the supervisee intends to terminate the supervisory relationship, he or she must give adequate notice to the other before doing so. The fifth issue is about supervision, evaluation, and endorsement. It is essential for supervisors to have periodic formal evaluations with their supervisees and to provide feedback. Supervisors need to be aware of supervisees' limitations and help them understand options. Supervisors also support supervisees for certification, licensure, or employment.

The sixth issue discusses counselors' responsibilities as counselor educators. Counselor educators demonstrate that they are skilled teachers and practitioners. They are knowledgeable about legal and ethical issues, and they help their students become aware of their responsibilities. In addition, counselor educators integrate multicultural materials into classes and workshops for the development of professional counselors. When teaching counseling techniques that lack sufficient and solid empirical research data to prove their effectiveness, counselor educators should explain to students about the lack of research support. Moreover, they should explain any potential risks that might arise when applying these techniques to practice.

The seventh issue refers to students' welfare. Counselor educators should clarify to students what the expectations are for the training program. The program should provide the type of skills and knowledge students need for completing the program. The program needs to provide employment data on their graduates. The eighth issue discusses counseling students' responsibilities. They should follow the ACA codes, sharing the same obligations to clients as professional counselors. The ninth issue is about evaluation and remediation of students. Counselor educators must provide ongoing feedback to their students throughout the training program. In addition, if students request counseling, counselor educators should make appropriate referrals for them.

The tenth issue addresses roles and relationships between students and counselor educators. Any sexual

or romantic relationship between counselor educators and current students is forbidden. Counselor educators must avoid any nonprofessional relationship with students that might potentially harm the student. In addition, counselor educators may not accept any form of service or fee from sites, students, or supervisees. Counselor educators may not provide long-term counseling services to current students.

### ***Section C***

This section concerns potential issues when counselors conduct research. The first issue addresses counselors' responsibilities as researchers. When counselors conduct research, they must report their research following ethical principles and federal and state laws as well as the regulations of the host institution. When counselors recruit humans as research participants, they must avoid harming these participants psychologically, emotionally, or physically. In addition, if counselors do not have access to an institutional review board (IRB), they need to consult with people familiar with IRB regulations.

The second issue addresses the rights of research participants. Before participating in any research, subjects must provide consent. In the consent form, researchers clearly state the purpose of the research, explain procedures in detail, and describe any limitations of confidentiality. In addition, researchers must indicate that participation in the study is voluntary and that participants may withdraw at any point during the process without penalty. If students or supervisees are involved as subjects in research, researchers must inform them that any decision they make concerning participation will not affect their supervisory relationships or the evaluation of their academic performance. In addition, researchers must inform their research project sponsors or institutions about their research results. After a reasonable period of time, researchers must destroy their research data.

The third issue concerns counselors' relationship with the participants in their research. Counselors are not allowed to develop any nonprofessional relationship, such as a sexual or romantic relationship, with their participants. However, if counselors feel any non-professional interaction between them and their participants might benefit their research outcome, their interaction should be documented. In addition, counselors need to acquire consent from their participants prior to engaging in the interaction. The fourth issue



addresses reporting accurate research results. Counselors should not report falsified research results and mislead readers. The fifth issue discusses publication issues. Counselors should not plagiarize others' work and must always recognize others' contributions.

## Section H

The primary issues in this section are centered on resolving ethical issues. Counselors should be knowledgeable regarding the ACA code of ethics and codes of other licensure organizations. Their professional behavior must follow legal and ethical standards. When counselors face ethical dilemmas, they should consult with colleagues or supervisors. If the conflict exists between ethics and law or other regulations, counselors should take appropriate steps to resolve the conflict. When counselors suspect their colleagues are acting in an unethical manner, they take appropriate action. If a violation has harmed an individual or organization and has not been appropriately resolved, counselors should take further action to address the issues.

*Cary Stacy Smith and Li-Ching Hung*

**See also** Code of Ethics and Standards of Practice (v2); Ethical Decision Making (v1); Ethical Dilemmas (v1); Ethics in Computer-Aided Counseling (v1); Ethics in Research (v1); Human Subjects Review in an Online World (v1); Virtue Ethics (v1)

## Further Readings

American Counseling Association. (2005). *Code of ethics*. Alexandria, VA: Author.

Corey, G., Corey, M. S., & Callanan, P. (1998). *Issues and ethics in the helping professions* (5th ed.). Pacific Grove, CA: Brooks/Cole.

---

## ETHICAL DECISION MAKING

---

Ethics as a construct has its intellectual roots in the discipline of philosophy. The term *philosophy* is a translation of the combination of the Greek words *philos*, meaning love, and *sophia*, meaning wisdom. Hence, the study of ethics has as its foundation a *love for wisdom*. The terms *ethics* and *morals* are often used interchangeably. Indeed, they do share similar attributes, such as value-based judgments about

appropriateness and inappropriateness of human behavior and interactions. Yet, many in the field of counseling and psychology differentiate them as follows: *Ethics* or *ethical codes* are the agreed upon standards of aspirational and mandatory behaviors and practices by the members of professional organizations such as the American Counseling Association (ACA) or the American Psychological Association (APA). These standards guide and inform the professional practice of members and promote the expectation that counselors will protect their clients' welfare and freedoms. *Morals* are defined as behaviors or actions that are based on particular groups' culture and or values. Hence, morals are a more generally defined and culturally influenced system of beliefs. Morals are believed to serve the common good for most members of a society.

## Different Types of Ethics

No discussion of ethics would be complete without acknowledging that counselors face confusing descriptions of various types of ethics. An examination of any textbook on ethics would lead the reader through a general discussion of some combination of philosophical, principle, professional, aspirational, mandatory, and virtue ethics.

*Philosophical ethics* describes the study of ethics through the lens of a theoretical perspective. The theory one chooses to use as a foundation determines how one interprets the rightness or wrongness or worthiness of certain behaviors. Because of its theoretical nature, this type of ethics has limited utility in a counseling practice. In contrast, *principle ethics* are pragmatic in nature. Principle ethics are based on moral principles. They are described as a collection of duties *and* a process that provide counselors an immediate method they can follow in order to remedy an ethical dilemma, and the process establishes a format for ethical practice and decision making in the future. Principle-based decision making centers on one's behavior and choices as they relate to socially acceptable practices.

*Professional ethics* are the agreed upon acceptable practices of a professional organization. These practices are typically codified by the membership and provide a guide for both aspirational and mandatory forms of ethics. *Aspirational ethics* illustrate the highest standard of ethical practice. Counselors whose practice is guided by aspirational ethics understand and act on the letter *and* spirit of the ethical codes. Aspirational ethics



call counselors to evaluate their personal behaviors and motivation as well as the ethical code to ensure their clients receive services that exceed the expected standard of care. Aspirational ethics are often identified in ethical codes as the “best practices.”

*Mandatory ethics* are those minimum standards by which all counselors should practice. Counselors who practice at this level are considering what they “must” and “must not” do; this is practicing the letter, but not the spirit, of the ethical code. Mandatory ethics are often identified in ethical codes as “standards of practice.”

The last type of ethics discussed here is *virtue ethics*. Virtue ethics focus on the character traits of the individual counselor and the aspirational aspects of one’s practice. Virtue ethics are not concerned with solving ethical dilemmas per se. They call upon counselors to examine whether or not they are doing what is best for their clients. Hence counselors focus more on what is desirable for a client rather than on a duty. Meara and colleagues noted that professionals practicing virtuously would aspire to the core virtues of prudence, integrity, respectfulness, and benevolence.

In counseling, practitioners are guided by ethical codes influenced by moral principles and the standards of their profession organization. At a minimum, the codes provide a description of the standards that counselors must meet and those to which they may aspire.

### The Purpose of Ethical Codes

Ethics, or an ethical code, is the set of rules professionals develop to guide the practice of the profession. In counseling, numerous organizations like the ACA and APA have established codes that educate all members of the organization on expected and acceptable ethical practice. Yet, ethical codes have many purposes beyond education.

Researchers in counseling and psychology have noted that ethical codes protect the public by publishing the expected standards of behavior and practice of professionals. Second, ethical codes can protect practitioners when their performance or behavior is called into question. If the behavior in question is in compliance with the ethical code, the counselor behavior is more likely to be viewed as conforming to the standards. The ethical codes are a form of professional self-regulation that, when enforced with fidelity and accountability, deter governmental regulation. Finally, the aspirational components of the ethical codes can serve as a catalyst for improving

practice by encouraging counselors to seek more sophistication and accountability in their practice.

### Foundations of Ethical Decision Making

Ethical decision making is a process fundamental to a professional practice of counseling. Ethical codes of conduct generated by professional organizations rest on the general moral principles that guide counselors’ behavior within professional relationships. Counselors have generally agreed that the moral principles of autonomy, beneficence, nonmaleficence, justice, veracity, and fidelity provide the conceptual underpinnings for ethical decision making. *Autonomy* means that counselors respect and foster their clients’ right to freely choose their actions or behaviors that would be in harmony with their personal desires and wishes. Counselors foster clients’ independence in decision making. *Beneficence* means that as professionals, counselors are called to do good and to promote the general health of their clients. *Nonmaleficence* as a principle means to do no harm. Its origins lie in the Hippocratic Oath that calls upon physicians to avoid any act or practice that may harm a client, even inadvertently. The principle of *justice* calls upon the counselor to be fair, just, and equitable in all practices with all clients. Counselors are committed to treating all clients equitably. *Veracity* means that counselors will be truthful in all interactions with clients, colleagues, and professional peers. The final principle, *fidelity*, calls upon professional counselors to practice in a trustworthy manner by honoring their commitments to clients and other professionals.

These principles are presented to counselors as a unified whole, a set of equally balanced and dynamic concepts that are to be considered in the best interest of the client. Yet, at times, these principles may be in conflict, and hence a potential ethical dilemma emerges. This conflict among the principles is the foundation of the definition of an ethical dilemma. First and foremost, an *ethical dilemma* exists when two or more of the moral principles are in conflict or competition. Consider the counselor whose client clearly threatens to kill his or her intimate partner later that afternoon; the counselor has the legal and ethical duty to warn the identified victim of the potential for harm. By upholding his or her professional and legal obligations, the counselor will breach the client’s confidentiality (limiting fidelity) and possibly limit his or her freedom (autonomy—client may require involuntary hospitalization) in order to



protect the potential victim and client from harm and to do good (reinforcing nonmaleficence and beneficence).

## Ethical Decision-Making Models

Ethical decision-making models provide a systematic framework that counselors can use to examine the origins, nature, impact, and potential consequences of a professional's actions and attitudes. Counselors challenged with an ethical decision may feel perplexed and apprehensive. Ethical decision-making models, if used properly, can guide them along the process of decision making in a logical, consistent, and practical manner.

Ethical decision-making models are based on different conceptual foundations (e.g., theoretical, philosophical, or practice-based) and various schools of thought (e.g., rationalism, moral reasoning, feminism, social constructivism, and social justice). Models derived from these foundations provide an organization scheme and particular perspective that give counselors a method from which to work through and analyze potential ethical dilemmas. According to numerous researchers, there are at least nine documented ethical decision-making models in the professional counseling literature. This entry examines five of them.

Kitchener's 1984 *principle* or *rational* model is one of the more widely used paradigms. This model was drawn from the ethical literature in psychiatry. The premise of the rational model is that relying on personal value judgments, or intuition, was not sufficient, and that clear ethical guidelines were a must for sound decisions. Kitchener, and others, noted that decision makers needed to understand and consider the continuum of thinking, from absolutism (dichotomous, rational, non-contextual) to relativism (multiple influenced, relational, contextual) as they critically considered the facts at hand. Therefore, decisions were derived from a structured process of critical thinking and systematic logic rather than a personal or emotional response.

In 1994, Rest devised the *four-component* model, which was touted as one of the most empirically grounded approaches to analyzing moral and developmental behaviors via the works of Kohlberg and others. According to Rest, because the four-component model was based on a large body of existing research on moral development, it could drive further research and instruction in moral education. The four components include (a) interpret one's actions relative to the potential impact on others; (b) devise a moral course of action that would distinguish the moral ideal;

(c) select the more moral outcome from the choices generated; and (d) act or implement one's choice.

Feminist researchers noted, when they examined models of ethical decision making, that most of them rested on a culturally encapsulated view of the White male's worldview. Much like the criticisms that surrounded Kohlberg's work in the 1970s and 1980s (i.e., that the stage model of moral development and reasoning were based solely on White male experiences), feminist scholars warned that the then current ethical decision-making models suffered from a similar flaw. They stated that these decision-making processes may be too linear, dispassionate, and rational, which would ignore the contextual, personal, and cultural considerations of decision makers and clients. The criticism offered by feminists directly questioned the philosophical underpinnings and universality of the earlier rational and moral development models.

*Social constructivists* have posited that ethical decision making should rely on the interactive and mutually constructed nature of reality rather than the traditional beliefs in an objective reality that exists independent of individual perceptions. Social constructivism asserts that there is no objective reality and that reality is the result of social interactions, system influences, and the resulting perceptions. Therefore, the ethical decision-making process will occur with at least one other person who will engage the other in examining and clarifying the information at hand, so that they can negotiate and mutually determine the best course of action.

*Social justice advocates* and multicultural scholars have also questioned the utility and cultural sensitivity of the traditional models of ethical decision making (e.g., rational and moral development). They recognized that the traditional models excluded or appeared to devalue decision making not grounded in the logical positivist tradition. Herlihy and Watson presented a model of ethical decision making based on a social justice paradigm. Counselors using this model would engage in culturally sensitive and competent interactions that were grounded in collaborative decision making and an awareness of virtue ethics.

## Ethical Decision-Making Skills

Counselors are professionals, and there is an expected set of skills that they should acquire from their training, experience, and education. In order to make sound ethical decisions, counselors must possess and



demonstrate an understanding of the impact, importance, and relevance of their actions.

Cottone identified six decision-making skills or attitudes necessary for counselors. First, counselors must be willing to be decision makers and accept the appropriate responsibility for their clients and practice. Delegating or deferring decisions to others demonstrates a lack of professionalism and personal accountability. The next expected skill is that of an intellectual attitude to deal with the complexities of human interactions in a deliberate and systematic manner. Third, counselors must seek and retain current and accurate professional information in order to be of assistance to clients. The reliance on the professional literature is also a characteristic that distinguishes lay counselors from professional counselors. Fourth, counselors continue their learning beyond their formal education and also engage in continued professional development at conferences and by reading trade journals. Ignorance of changes or improvements in the field is not a valid defense of unethical treatment. Fifth, professionals use a framework for decision making that demonstrates thoughtfulness, sound judgment, competency, and credibility. Systematic decision making demonstrates professionalism and accountability. Finally, counselors must be invested professionally. This means that counselors abide by the ethical code and training practice of their profession and that they maintain their skills over their professional lifetime.

Ethical decision making is critical to the professional execution of a counselor's or a psychologist's duties. The process is meant to be orderly and transparent, so that any reasonable person can understand the rationale for the decisions made. Using a recognized model of decision making demonstrates a counselor's professionalism.

*Linda L. Black and Jody Huntington*

*See also* Code of Ethics and Standards of Practice (v2); Decision Making (v4); Duty to Warn and Protect (v2); Ethical Codes (v1); Ethical Dilemmas (v1); Ethics in Computer-Aided Counseling (v1); Ethics in Research (v1); Human Subjects Review in an Online World (v1); Virtue Ethics (v1)

### Further Readings

Burian, B. (2000). Social role–dual role relationships during internships: A decision-making model. *Professional Psychology: Research and Practice*, 31, 332–378.

- Cottone, R. R., & Tarvydas, V. M. (2007). *Counseling ethics and decision making*. Upper Saddle River, NJ: Pearson/Merrill Prentice Hall.
- Houser, R., Wilczenski, F. L., & Ham, M. (2006). *Culturally relevant ethical decision making in counseling*. Thousand Oaks, CA: Sage.
- Kitchener, K. S. (1984). Intuition, critical evaluation and ethical principles: The foundation for ethical decisions in counseling psychology. *Counseling Psychologist*, 12(3), 43–55.
- Rest, J. R., & Narvaez, D. (Eds.). (1994). *Moral development in the professions: Psychology and applied ethics*. Hillsdale, NJ: Lawrence Erlbaum.

---

## ETHICAL DILEMMAS

---

Counselors make hundreds of decisions as they work with clients. They use professional skills and knowledge to gather information in order to assess, clarify, categorize, and respond to client concerns. Most often, counselors, after some consideration and reflection, know how, or if, to respond to situations. Yet, on occasion, counselors may find themselves facing uncertainty, confusion, or doubt in relation to their or their clients' concerns, behaviors, or needs. Supervision and peer consultation are two recognized and typically effective methods that counselors use in order to clarify concerns related to clinical or treatment questions. Occasionally, counselors will encounter questions or circumstances that seem to originate from ethical and/or legal concerns. These questions, by their very nature, can create a heightened sense of concern or urgency for counselors.

*Ethics* or *ethical codes* are standards of behaviors and practices agreed upon by the members of professional organizations such as the American Counseling Association (ACA) or the American Psychological Association (APA). Ethical codes include a general rather than a specific description of mandatory and aspirational behaviors and beliefs. Counselors are expected to be familiar with and to adhere to these codes as a privilege of membership in the organization. Compliance with the ethical codes ensures client welfare, standardizes the practices of the professional, and is a means of professional self-regulation. Counselors use these codes to guide their practice and determine the appropriateness and degree of obligations they may have in relation to their clients. Yet, being



familiar with and adhering to ethical codes will not prevent the counselor from encountering circumstances that are confounding and/or confusing. The ethical codes are necessary but not sufficient to prevent counselors from encountering these circumstances or ethical dilemmas.

### Ethical Dilemmas in Context

A dilemma is generally defined as a circumstance or situation that is perplexing because a decision is required between equally unacceptable or unfavorable choices. An *ethical dilemma* incorporates the concepts in the preceding definition *and* is a situation in which there is an apparent conflict of moral standards or imperatives. In essence, to uphold one standard would mean violating another. For example, many of the ethical codes in counseling and psychology are based on what some define as universal moral principles. The most commonly identified moral principles are autonomy, nonmaleficence, beneficence, justice, fidelity, and veracity. Counselors who uphold these principles will support clients' freedom to be self-determining in word and deed (autonomy), will do no harm to clients (nonmaleficence), will do good or promote clients' health and wellness (beneficence), will be fair and equitable in their treatment of all clients (justice), will be trustworthy and uphold their word and promises (fidelity), and will be truthful in their interactions with clients. These moral principles are typically presented to counselors as a holistic set of discrete and equally occurring ideals, yet in reality these principles are in relative contextual tension to each other. Upholding one principle will have some impact, positive or negative, on the others. Counselors may encounter an ethical dilemma when they consider the circumstances of involuntary hospitalization of an imminently suicidal client. The client's freedoms (autonomy) will be restricted or impeded in order to promote good for the client (beneficence) to keep harm (nonmaleficence) from happening to him or her.

### Identifying Ethical Dilemmas

For most counselors, an ethical dilemma is apparent when they encounter a confounding situation in which they feel hindered in their decision making because (a) there appears to be conflict between or inconsistency among the ethical standards, (b) the situation is so complex that the ethical codes offer little guidance,

(c) there appears to be a conflict between ethical and legal standards, and (d) there appears to be a conflict between the moral principles that underlie most ethical codes. Counselors can be involved in ethical dilemmas directly, as in the case of client care or supervisory responsibilities, or they can be involved as a colleague, as in the case of witnessing a peer, supervisor, or supervisee struggle with a predicament. Ethical dilemmas differ from *ethical violations* in that the counselors have not yet engaged in any action that would violate the rights of the client or the ethical or legal standards.

Ethics have their conceptual roots in philosophy and as such are open to interpretation and influence from many sources (e.g., theoretical stance, cultural and personal factors, morals). Because of these influences, ethical dilemmas vary in their degrees of clarity and distinction. Some issues or questions may be readily apparent to some individuals but not to others, and some dilemmas emerge only upon reflection or after consultation or supervision. Identifying, addressing, and resolving ethical dilemmas is a dynamic *process* that requires counseling professionals to do more than simplistically apply the codes with respect for the uniqueness of each situation or circumstance.

Ethics and ethical codes are bounded by the cultural contexts in which they were produced. An act that might appear to be an ethical violation to a White male counselor may not be considered unethical when viewed by first generation Hispanic American female. For example, consider this scenario: Both counselors are providing counseling to male teenagers from Korea. In the course of the counseling sessions, each counselor asks his or her client to have his family attend the next session in order to begin family counseling. At the next week's session, both clients bring their family members to the session. Each family is composed of some combination at least one biological parent, one biological grandparent, a couple of siblings, two cousins, and another person who is generally described as a neighbor or friend. One counselor allows all the family members into the session while the other counselor does not, because the cousins and neighbor or friend are not really family members. Clearly, these two counselors have very different ideas as to what constitutes "family" and who should have access to client information. Both could be practicing ethically according to their interpretation of the ethical codes, and depending on one's point of view, both may be engendering an ethical dilemma as the result of their actions. The questions are these: Which



actions by the counselors promote clients' welfare, and what actions may the counselors need to take to ensure all parties are fully informed of the consequences of their decisions? Dilemmas are difficult and complex events to resolve, because there are no easy, clear, and definitive answers.

### Making Ethical Decisions and Resolving Dilemmas

Being a professional means engaging in behaviors that demonstrate concern for client welfare, accountability, reflective practice, use of best practices, and recognition of ethical practice. Counselors must be familiar with their respective codes of ethics, use a systematic approach to ethical decision making, employ sound judgment and reasoning, and act in a respectful and deliberate manner.

Researchers have identified no fewer than nine ethical decision-making models in the field of counseling and psychology. These models provide practitioners a framework from which they can systematically evaluate a set of circumstances or a situation that may evolve into an ethical dilemma. Although the various schools of thought (e.g., rationalism, moral reasoning, feminism, social constructivism, and social justice) differentiate the models of ethical decision making, they all possess similar steps to use when analyzing a potential dilemma.

Most models comprise at least five steps. Counselors are encouraged to go through these five steps with a peer or supervisor in order to provide an additional perspective. First, counselors are to *identify* the potential problem from as many perspectives as possible. Next, *recognize* all the potential issues or concerns involved for all relevant parties. This is similar to brainstorming, which requires counselors to think and reflect broadly. In the third step, counselors are to review the relevant *ethical and legal codes* and identify points of support, contradiction, or contention. Fourth, counselors are to *generate a list* of probable courses of action related to each concern. From this list counselors will select one upon which to act. If counselors have not utilized a supervisor or a peer, it is at this point in the process that seeking consultation is strongly recommended. The final step of ethical decision making involves *executing* the course of action and evaluating and documenting the results.

By engaging in an ethical decision-making process, counselors should be able to take an action to resolve

the dilemma that is in the best interest of their clients. The counselors' actions may not represent the *ideal* response, as ideal responses to dilemmas are rare. Rather, counselors' responses to ethical dilemmas that are a result of an appropriate use of the ethical decision-making model demonstrate professionalism, deliberation, and sound judgment.

Linda L. Black

**See also** Code of Ethics and Standards of Practice (v2); Decision Making (v4); Duty to Warn and Protect (v2); Ethical Codes (v1); Ethical Decision-Making (v1); Ethics in Computer-Aided Counseling (v1); Ethics in Research (v1); Human Subjects Review in an Online World (v1); Virtue Ethics (v1)

### Further Readings

- Corey, G., Corey, M. S., & Callanan, P. (2007). *Issues and ethics in the helping professions* (7th ed.). Pacific Grove, CA: Brooks/Cole/Thomson Learning.
- Duska, R. F., & Whelan, M. (1975). *Moral development: A guide to Piaget and Kohlberg*. New York: Paulist.
- Forester-Miller, H., & Davis, T. (1996). *A practitioner's guide to ethical decision making*. Retrieved from <http://www.counseling.org/Files/FD.ashx?guid=c4dcf247-66e8-45a3-abcc-024f5d7e836f>
- Gilligan, C. (1982). *In a different voice: Psychological theory and women's development*. Cambridge, MA: Harvard University Press.
- Kohlberg, L. (1981). *Philosophy of moral development*. San Francisco: Harper & Row.
- Neukrug, E., Milliken, T., & Walden, S. (2001). Ethical complaints made against credentialed counselors: An updated survey of state licensing boards. *Counselor Education and Supervision, 41*, 57–71.

---

## ETHICS IN COMPUTER-AIDED COUNSELING

---

Technology in counseling began with the advent of the desktop computer over 30 years ago. Success in computer-aided services for career counseling and increased comfort with technology were factors in the computer becoming a mainstay in the therapeutic setting. Research has found that the computer enhances counseling services in the areas of testing and assessment, career decision making, intake interviewing, and



personal counseling, and that it enables maintenance and storage of records in a smaller space and improves cost effectiveness. Although Internet access has provided avenues for filing insurance, advertising services, and providing e-therapy, computer-aided counseling refers to applications that are strictly accessed on a basic computer without Internet access. Expanded uses of computer-aided counseling have challenged mental health professionals to understand and take measures to ensure that all ethical standards are met.

The advantages of computer-aided counseling should not lull therapists into ignoring the ethical challenges and considerations that accompany the use of computer technology. All ethical standards that apply to traditional counseling also translate to computer-aided counseling. Further, as the uses of technology have increased, additional ethical standards have been adopted to address the specific unique challenges.

### Ethical Issues in the Use of Computer-Aided Assessments

One of the fastest growing businesses within the field of psychology is that of computerized administration and interpretation of tests (e.g., the Minnesota Multiphasic Personality Inventory-2 [MMPI-2], the Millon Clinical Multiaxial Inventory [MCMI], the Myers-Briggs Type Indicator [MBTI]) resulting in the adoption of the 1986 *APA Guidelines for Computer-Based Tests and Interpretations*. Currently there are over 500 computerized assessments offering computerized interpretations as well. Benefits of computerized psychological tests (CPT) include that little or no supervision of the test-taker is required, little training is required to administer the test, the computer program may generate the report and interpretation, and overall costs are reduced. Other advantages of computerized tests over traditional versions are that the test-taker makes fewer errors and that fewer errors are made when scoring.

Ethical standards further address implications for the development and sales of CPTs and interpretation services. Manuals with clear statements as to the purpose of the test, instructions for administration, validity and reliability scores, and specific interpretation statements must be provided. Most recently, scoring and test interpretation services are also offered to users through mail service or through computer software packages. These services, while helpful, must be considered in light of their limitations. Interpretations must include specific information that might have influenced scoring, such as ethnicity, education, and

physical disabilities. No test scoring and interpretation service should be used if validity, reliability, and specific interpretation information is lacking. It remains the user's responsibility to use and interpret assessments appropriately, regardless of how the tests are scored and interpreted.

One option sometimes offered by automated scoring services is that of providing a copy of the computerized interpretation. Users of these automated services should first investigate to determine how results may be presented and how the client's confidentiality will be maintained. Some services offer to provide a copy of the interpretation, but such a report should not be provided to the client without an explanation in terms understandable to the client. The explanation should include any implications and potential consequences in the future and how the results will be used.

### Competence

Individuals using any type of assessment must be competent in their use. Before computerized versions of psychological tests were created, individuals without the appropriate education and training were discouraged from using such tests due to the intricacies of scoring and interpretation. The ease of computerized testing and interpretation has opened a door to misuse. The developers of computerized tests assume that the user of the test will be competent through education, training, and experience to administer, score, and interpret the results for each specific test. Ethical standards for the use of an electronic assessment include proper selection, interpretation, scoring, and administration in light of research or evidence supporting the purpose, validity, and reliability of the assessment for use with the individual to be tested. Language and cultural differences, disabilities, and familiarity with computers must be considered prior to selecting a specific electronic assessment. Although many computerized versions of the most popular assessments have been found to be psychometrically equivalent to their paper-and-pencil versions, results of research comparing the validity of traditional tests to that of CPTs have been mixed. Not only must CPT users be knowledgeable about the validity and reliability of the tests, they must also be knowledgeable regarding the computerized interpretation system as well. The computerized versions of psychological tests are to be used as enhancements to clinical interviews and knowledge of diagnostic criteria and not as the sole means of making a diagnosis.



When test administration, scoring, or interpretation is delegated to another, only individuals who are judged to have ability to conduct the tasks competently (based upon education, training, or supervision) should be given that authority. Responsibility for the appropriate use and interpretation of assessments remains with the supervising therapist regardless of how the tests are scored and interpreted.

### ***Informed Consent***

Informed consent for any type of assessment should be obtained from the client or guardian and documented, whether consent is written or oral. A clear explanation of the nature, purpose, procedures, format, and duration of the assessment must be given. The explanation of the assessment must also include fees and potential involvement of others (e.g., law, school). If a client is to provide full informed consent, it is important that he or she understand what the assessment is to evaluate (e.g., competency, disabilities) and for what purpose the results will be used (e.g., treatment planning, custody decisions). If results are to be shared with others, the limits of confidentiality must be made clear before informed consent can be obtained. Particularly when an automated scoring service is to be used, the limits of confidentiality must be detailed.

### ***Test Materials and Test Security***

Although maintaining the security of CPTs may seem easier than maintaining the security of paper forms, manuals are also considered test materials and should be secured when not in use. Many tests are now available through the Internet but come with additional security issues. For counselors who wish to provide testing access via their own Web page to their clients, prior to taking such action, consulting with the test developer for permission is advisable. Legal consultation for the use of copyrighted materials through a Web page is also suggested.

### **Maintenance, Storage, and Disposal of Electronic Confidential Records**

As previously stated, one of the earliest uses of computers in counseling was to maintain client records in computer files. The American Psychological Association (APA) mandates that client files must be maintained and stored under the control of the therapist. It is important in maintaining confidentiality that steps are taken

to protect client identification through methods such as assigning case or code numbers regardless of where records are stored. Just as written files are kept in locked filing cabinets within locked storage rooms, electronic files must have equivalent protection.

### ***Storage of Confidential Electronic Records***

While disks can be stored in the same manner as written files, other procedures are required for maintaining confidentiality of files stored on computers. Basic security measures for individual computers with no Internet access are the use of authenticating measures (user names and passwords). For mental health organizations using a computer network with Internet access, multiple combined security measures have been identified as the most effective. The first layer of protection is using authenticating measures to limit record access to only those working with a specific client. A second layer of protection is the use of an intrusion prevention system that detects suspicious network traffic and protects the network by denying access. Encryption provides a third layer of privacy, particularly when individuals are communicating via e-mail.

### ***Disposal of Electronic Files***

Disposal of electronic files has unique problems. Simply erasing a disk or hard drive is not adequate in destroying files, as computer experts can re-create files with little difficulty. It is recommended that computer disks be physically destroyed, as even overwriting may not totally make the information unreadable. For records deleted from a computer's files, secure file deletion utility programs are available to ensure that files cannot be recovered. When a computer must be replaced, the hard drive may be removed and physically destroyed.

### **Improper Use of Computer Treatment Programs and Unrealistic Expectations**

A variety of computer-based psychotherapy intervention programs are now available (e.g., systematic desensitization). Used appropriately as a part of the counseling process, computer interventions have been touted as being quite effective. Ethical considerations include best practices in counseling, competency in the use of the specific intervention, and too great a reliance on the cognitive to the detriment of an exploration of the affective. Clients may also develop a



belief through the instantaneous computer process that a more rapid behavior change will also occur. Information concerning length of time of therapy, including all computer-aided processes, should be explained as a part of informed consent.

Linda Guthrie

**See also** Code of Ethics and Standards of Practice (v2); Computer-Assisted Career Counseling (v4); E-Counseling (v1); Ethical Codes (v1); Ethical Decision Making (v1); Ethical Dilemmas (v1); Ethics in Research (v1); Human Subjects Review in an Online World (v1); Translation and Adaptation of Psychological Tests (v1); Virtue Ethics (v1)

### Further Readings

- American Educational Research Association, American Psychological Association, & National Council on Measurement in Education. (1999). *Standards for educational and psychological testing*. Washington, DC: American Educational Research Association.
- American Psychological Association. (2002). Ethical principles of psychologists and code of conduct. *American Psychologist*, 57, 1060–1073.
- Bersoff, D. N., & Hofer, P. J. (2002). Legal issues in computerized psychological testing. In D. N. Bersoff (Ed.), *Ethical conflicts in psychology* (2nd ed., pp. 327–329). Washington, DC: American Psychological Association.
- DeMers, S. T., Turner, S. M., Andberg, M., Foote, W., Hough, L., Ivnik, R., et al. (2000). *Report of the task force on test user qualifications*. Washington, DC: American Psychological Association.
- Fisher, C. B. (2003). *Decoding the ethics code: A practical guide for psychologists*. Thousand Oaks, CA: Sage.
- Matarazzo, J. D. (2002). Computerized clinical psychological test interpretations: Unvalidated plus all mean and no sigma. In D. N. Bersoff (Ed.), *Ethical conflicts in psychology* (2nd ed., pp. 331–333). Washington, DC: American Psychological Association.
- Millstein, S. G. (1987). Acceptability and reliability of sensitive information collected via computer interview. *Educational and Psychological Measurement*, 47, 523–533.
- Moses, J. (2005). *Steps to implementing a storage and disposal program for confidential electronic files and documents*. Retrieved August 2, 2007, from [http://www.nfib.com/object/IO\\_20330.html](http://www.nfib.com/object/IO_20330.html)
- Rosenberg, J. I. (2006). Real-time training: Transfer of knowledge through computer-mediated real-time feedback. *Professional Psychology: Research and Practice*, 37, 539–546.

Sampson, J. P., Jr. (1986). Computer technology and counseling psychology: Regression toward the machine? *The Counseling Psychologist*, 14, 567–583.

---

## ETHICS IN RESEARCH

---

Ethical issues in social science research are of crucial importance not only to the individuals involved, but also to society. An understanding of what is and is not permissible arose through decades of debate beginning immediately after World War II, when information regarding how Nazi scientists treated prisoners in their care became general knowledge due to the Nuremberg trials. For instance, prisoners were placed into tubs of ice water to gauge the length of time it took to die from hypothermia; this was done in order to research how to save German pilots shot down over the frigid waters of the North Atlantic. The “high-altitude” experiments, in which prisoners were placed in a decompression chamber so the effects of too-little oxygen could be measured, were especially barbaric. Many subjects had their brains extracted and examined, though they were not dead and had not received any medication—they were, in essence, vivisected. Other experiments included injecting deadly poison into Russian prisoners in order to determine the precise amount of time needed for death and amputating the limbs of prisoners in order to see how quickly they bled to death.

Germany was not the only country to engage in unethical experiments. The Tuskegee syphilis study, which took place in Tuskegee, Alabama from 1932 to 1972, withheld vital information from 300 poor, illiterate Black sharecroppers regarding their potentially fatal illness. The authorities lied about what the farmers had contracted, and the sharecroppers did not receive penicillin—a life-saving medication available at any doctor’s office. Instead, they were told that they possessed “bad” blood. Why would American doctors willingly lie to American citizens, though the lie was potentially life threatening? The government was investigating the effects of untreated syphilis and, by the time the subjects were aware of the nature of their illness, many had already died.

During 1961, Stanley Milgram conducted experiments concerning obedience to authority. Milgram grew fascinated with the subject due to stories told by various Nazis during the Nuremberg trials. Without fail (regardless of the defendant’s rank), each stated the same



thing—they were not guilty; rather, all they did was follow orders. When asked if they found their tasks odious, all said yes, but it made no difference because they had been instructed by a superior. Milgram recruited individuals, ranging in age from 20 to 50, with a variety of educational backgrounds. One individual, the “teacher,” would ask the “learner” questions, and if the reply was incorrect, the teacher administered an electric shock. The shock grew stronger with each successive wrong answer. A wall separated the teacher from the learner, and though they could not see each other, they could hear each other’s voices.

The subjects acting as teachers did not realize it, but the “shocks” being administered were fake. In reality, the “learner” was a confederate of the researcher, and the scream the teacher heard was a tape designed especially for the experiment. The study was conducted to see how far an individual would go if instructed by a superior, even if what he or she did was unethical or dangerous. The results were nothing short of stupefying. Each participant could have stopped the experiment at any time, but no one did. Approximately 65% of the teachers administered a “shock” they assumed to be of 450 volts, strong enough to cause death.

In 1971, Stanford psychologist Phillip Zimbardo conducted his famed “prison” experiment. Zimbardo received a grant from the U.S. Navy in order to determine why it was experiencing problems within its prison system. Zimbardo built a prison facsimile in the Stanford psychology building and hired undergraduates to play both prison guards and prisoners. During the study, both groups of participants started deviating from their assigned parts. The prisoners grew weak and docile, while the guards’ behavior grew increasingly vicious and cruel. Zimbardo had to stop the study when it became clear that the participants were losing control. For instance, the guards became increasingly sadistic by forcing the prisoners to exercise until exhausted, by not allowing the prisoners to use the bathroom (causing them to urinate on themselves), and by preventing “bad” prisoners from sleeping.

## Ethical Decision Making

In the years since the studies listed above were conducted, researchers realized that they needed to reassert an ethical imperative to consider all research as potentially resulting in harm to the participant and

bringing that possibility to bear on the decision to conduct the research or not. In order to achieve this goal, research must be designed to meet certain standards with respect to basic moral, legal, and ethical principles. Individuals taking part in a study must give *voluntary consent*. This can only be given if the individual knows the study’s purpose and is fully aware of the potential costs and benefits of inclusion in it. At no point should someone feel coerced into taking part in a study. The use of force is strictly prohibited, and voluntary consent is designed to prevent just such a scenario from developing.

Each individual involved in the study should give *informed consent*. This can only be given if the subject understands fully any inherent risks (either psychological or physical) that could arise from becoming a participant. In addition, informed consent means that each individual has been told all relevant facts regarding inclusion in the study. If a researcher needs children or adolescents for the study, the parent or legal guardian must give consent. In research using people with illnesses, each participant should be told about other therapies that could possibly be beneficial in treating his or her illness.

Each individual taking part should be told that he or she can expect *confidentiality*. This means that any private or personal information gathered during the course of the study will be seen only by those directly involved in the study. The two primary exceptions to the requirement for confidentiality are (a) the participant is in danger of hurting himself or herself, or (b) the participant is in danger of hurting someone else.

Occasionally, moments will arrive when the desire to conduct first-rate research runs head-on against the rights of likely subjects. No set of ethical rules could ever predict each and every ethical dilemma that might arise when using human participants. In order to make sure the rights and liberties of research subjects are never truncated, *Institutional Review Boards* (IRBs) have been created to assist in reviewing research. The IRB is a group of individuals who review research proposals in order to make sure that researchers do not behave unethically with a study’s participants.

Ethical codes were designed to protect subjects, and the following six principles are considered priority guidelines in research.

1. *Autonomy* refers to allowing subjects or clients to make their own decisions, with the researcher or therapist respecting any choices made.



2. *Nonmaleficence* means doing no harm. The counselor's or researcher's responsibility is to avoid hurting clients, even when the counselor's or researcher's intentions are just.
3. *Beneficence* means doing good for clients or subjects.
4. *Justice* means treating all clients with respect, regardless of their race, color, religion, or creed.
5. *Fidelity* means making honest promises and honoring commitments.
6. *Veracity* refers to truthfulness.

Overall, responsibility for ethical conduct of research rests on the individual researcher, the university IRB, and the researcher's profession.

*Cary Stacy Smith and Li-Ching Hung*

**See also** Code of Ethics and Standards of Practice (v2); Ethical Codes (v1); Ethical Decision Making (v1); Ethical Dilemmas (v1); Ethics in Computer-Aided Counseling (v1); Human Subjects Review in an Online World (v1); Virtue Ethics (v1)

### Further Readings

- American Counseling Association. (2005). *Code of ethics*. Alexandria, VA: Author.
- Corey, G., Corey, M. S., & Callanan, P. (1998). *Issues and ethics in the helping professions* (5th ed.). Pacific Grove, CA: Brooks/Cole.
- Elliott, D., & Stern, J. E. (1997). *Research ethics: A reader*. Hanover, NH: Institute for the Study of Applied and Professional Ethics.
- Shamoo, A. E., & Resnik, D. B. (2002). *Responsible conduct of research*. New York: Oxford University Press.

---

## EUGENICS

---

Eugenics is the attempt to deliberately improve the hereditary, genetic traits of a particular race in order to improve the race as a whole. In particular, eugenics, meaning "good birth," describes the regulation and manipulation of reproduction to reduce the incidence of genetically derived problematic traits while increasing the incidence of ideal genetically derived traits. Supporters of eugenics believe that active human intervention can create a stronger society by gaining a

better understanding of genetic traits and their relationship to societal success. Critics of the eugenics movement believe that such attempts violate individual human rights and may remove desirable traits from a population. Further, the critics believe that eugenicists have oversold the power of genetics and have failed to take into account the environmental influences that affect wealth, morality, and mental health.

### Sir Francis Galton

The origin of eugenics is most frequently traced to Sir Francis Galton, a statistician, biologist, geographer, and sociologist who was the first cousin of Charles Darwin, the founder of modern evolution. Galton made numerous contributions to the field of science, including an understanding that intellectual traits were distributed in a manner similar to that of physical traits and an understanding of the heritability of behavioral and intellectual traits. In addition, he created a single numerical representation to measure the correlation between variables.

Through his work, Galton found that human behavioral traits could be passed down from parents to their offspring. Because of this, he believed that humans had the ability to improve themselves by gaining a more thorough understanding of the laws of heredity. Galton hoped that this understanding would help with the identification of select individuals who exhibited desirable traits such as high intelligence or strong moral character. Those identified as having ideal genes could then be encouraged to marry at a young age and have large families.

Galton was greatly concerned at the rate of reproduction of individuals he believed to be least fit. He believed that individuals identified as having undesirable traits should be discouraged from procreating at all. He recommended public health policies such as segregation, sterilization, and other measures designed to prevent individuals from marrying or having children. Galton wrote that the church was performing a great disservice to its societies by preaching the importance of celibacy amongst parishioners—the very churchgoers who presumably had desirable moral fiber and, thus, desirable genes. Galton further criticized social programs that, by providing aid to the sick and to the weak, enabled undesirable genes to persist in a population.

Hoping that societies would be made up of individuals who were stronger, healthier, and more vigorous than societies of his day, Galton promoted eugenics



practice. He supported teaching laws of heredity and systematically studied factors that encourage large families. To advance his eugenic philosophy, Galton employed his statistical expertise to communicate his findings to those individuals with the traits he deemed desirable such that they might have large families. Galton hoped that societal pressures would influence individuals to conform to eugenic requirements of marrying and child bearing with religious-like zeal.

### Assessing Genetic Abilities

Eugenicists felt that it was important to systematically evaluate the genetic pedigree of an individual. One method to identify genetic desirability was to examine an individual's family tree. Through this process, eugenicists would determine the number of ancestors who had particular traits. Families whose pedigrees included academic or business success, long life, strong moral character, and a healthy constitution would be encouraged to breed prolifically. Those who were identified with an ancestry marred by developmental disabilities, criminal records, or psychiatric disorders would be discouraged from breeding.

Intelligence tests were another important component of recognizing an individual's genetic desirability. Those with mental ages below 8 or 12 could be discouraged from procreating or involuntarily sterilized. Other more direct methods of assessment involved simply looking at an individual's accomplishments. Thus, those who were poor or ill were assumed to have undesirable traits such as a poor work ethic and low intelligence.

### Eugenics in the 20th Century

During the 1930s and 1940s, the Fascists in Nazi Germany most enthusiastically embraced the principles of eugenics. Nazi scientists ordered the involuntary sterilization of mentally ill patients and people with inherited diseases, "euthanized" children termed incurably ill, and encouraged the abortion of fetuses of Jews and other members of what they considered undesirable races. Geijman and Weilbaecher note that in 1933, the Law for the Prevention of Genetically Diseased Offspring was passed, resulting in the involuntary sterilization of 400,000 individuals deemed unfit for procreation.

While extreme forms of eugenics are typically associated with Nazi Germany, many eugenic ideas

and practices were espoused in the United States. The American Eugenics Society was founded in 1923. Those directly and indirectly associated with the American Eugenics Society participated in both positive and negative movements. Some groups pushed for strong and fit communities and exhorted families to strive to be as healthy as possible. Positive eugenics movements were the attempts to ensure that healthy people procreated prolifically.

The negative eugenics concepts drew much more controversy. The assumption behind the negative eugenics movement was that children born to criminals or to the "feeble-minded" placed a great burden on society. The American Eugenics Society placed exhibits at county fairs around the nation to delineate the fiscal impact of each individual born with a mental defect. Some eugenicists recommended euthanasia for children they determined would derive no meaning from life.

While euthanasia continued to be viewed as an extreme position of the eugenics movement, the sterilization of the mentally ill gained broader acceptance among psychiatrists and other mental health professionals during the 20th century. As early as the 1890s, guardians of children and adults in mental asylums devised ways to ensure that their clientele did not procreate. Laws promoting the sterilization of individuals deemed incompetent were passed as early as 1909 in Indiana. By the 1920s, a Virginia law legalizing the involuntary sterilization of men and women with developmental disabilities was argued before the Supreme Court in *Buck v. Bell* and found not to violate the 14th Amendment right of equal protection under the Constitution. The Eugenics Society strongly encouraged the practice of sterilization in the 1930s, during which an estimated 60,000 people with developmental disabilities were surgically sterilized.

In other parts of the country, laws restricting marriage were created to prevent the breeding of individuals deemed eugenically unfit. By annulling and disallowing marriages, states hoped to prevent contamination of the gene pool. The first such law was passed in Connecticut in 1895 and was eventually found unconstitutional by the Supreme Court in 1967.

### Eugenics in the 21st Century

It is commonly thought that the eugenics movement died after World War II. Certainly, government-sponsored attempts to prevent groups of people from marrying or procreating currently garner little support



in the United States. Yet, there continue to be strains of eugenics that permeate the popular culture. The use of genetic education may frequently be used to help individuals understand diseases for which they might be at risk. Today, genetic screening is common in the United States. Parents who learn that their child suffers from a genetic abnormality are faced with the decision to give birth to a child with a genetic disorder such as Down syndrome or to abort the fetus. This practice has recently come under attack in the popular press as being eugenic. Fertility practices have continued to move past genetic screening to genetic planning. The Human Genome Project has created the opportunity to understand the relationship between genetics and the phenotypic traits demonstrated within a particular environment. Procedures such as in vitro fertilization and preimplantation screening give parents some control over a child's genes, allowing for the selection of desirable genetic traits.

For those working in the human services fields, the concept of coerced contraception continues to be debated today. While the discussion of improvement of the society's gene pool is not made explicit, there are still concerns that individuals with certain forms of mental illness need to be prevented from procreation—even if only for a limited period of time. For example, a psychiatric patient finding herself to be pregnant may undergo psychiatric decompensation. The treatment of mental illness may be jeopardized by a possible pregnancy or may be dangerous to a fetus. Other patients may have a severe psychiatric disturbance such that they are believed to be incapable of caring for a fetus. These issues may be particularly pronounced in the care of adolescent females undergoing psychiatric treatment.

*David M. Hulac*

*See also* Ethical Dilemmas (v1); Genetic counseling (v1); Mental Retardation and Developmental Disabilities (v1)

### Further Readings

- American Philosophical Society. (2006). *Promoting eugenics in America*. Retrieved November 12, 2006, from <http://www.amphilsoc.org/library/exhibits/treasures/aes.htm>
- Galton, F. G. (1892). *Hereditary genius: An inquiry into its laws and consequences*. Retrieved October 16, 2006, from <http://www.mugu.com/galton/books/hereditary-genius/index.html> (Original work published 1869)

- Galton, F. G. (1904). Eugenics: Its definition, scope, and aims. *The American Journal of Sociology*, 10(1), 1–25.
- Kennedy, F. (1937). Sterilization and eugenics. *American Journal of Obstetrics and Gynecology*, 34, 519–520.
- Kennedy, F. (1942). The problem of social control of the congenital defective: Education, sterilization, euthanasia. *American Journal of Psychiatry*, 99, 13–16.
- Lechaud B., & Renaud, V. (2002). Contraception, sterilisation and the mentally ill: Beyond Manicheism, some reference points. *European Psychiatry*, 13(Suppl. 3), 125–128.
- Paul, D. B., & Hamish, G. S. (1995). The hidden science of eugenics: Hardy-Weinberg principle contradicts old theories in eugenics. *Nature*, 374, 302–304.
- Savulescu, J. (2001). Procreative beneficence: Why we should select the best children. *Bioethics*, 15, 413–426.
- Wehmeyer, M. L. (2003). Eugenics and sterilization in the heartland. *Mental Retardation*, 4, 57–60.

### Web Sites

Society for the Study of Social Biology: <http://www.usc.edu/dept/gero/sssb>

---

## EXERCISE AND SPORT PSYCHOLOGY

---

The impact of exercise and sport on our society is pervasive. They are relevant topics for study both because of their societal importance and because they exert a significant influence on physical and psychosocial development across the life span. This entry provides a brief history of exercise and sport psychology, examines the relationship between counseling and exercise and sport psychology, and discusses changes and challenges for counseling psychologists working in these areas.

### A Brief History

There has been an explosion of interest in exercise and sport psychology over the last two decades even though the first course in sport psychology was taught over 80 years ago, and sport psychology became an organized discipline in North America and Europe in the 1960s. In 1985, the Association for the Advancement for Applied Sport Psychology (AAASP; now known as the Association for Applied Sport Psychology [AASP]) was formed. Membership



in AASP is equally divided between psychologists and exercise scientists. In 1986, the American Psychological Association (APA) created an Exercise and Sport Psychology Division. There are now four journals that serve as publishing outlets for the area: *The Journal of Exercise and Sport Psychology*, *The International Journal of Sport Psychology*, *The Sport Psychologist*, and *The Journal of Applied Sport Psychology*.

### **Counseling and Exercise and Sport Psychology**

Exercise and sport psychology is broadly defined as the scientific study of sport and exercise to enhance competence and promote human development in sport throughout the life span. The two areas share similar historical and philosophical underpinnings. Just as sport and exercise psychologists seek to promote competent performance, counseling psychologists focus on building on one's strengths to enhance psychological functioning. In addition, counseling psychology has enhanced exercise and sport by identifying methods that improve performance, increase adherence to exercise programs, and enhance satisfaction and general well-being in exercise and sport. Conversely, exercise and sport psychology has influenced counseling psychology by demonstrating the positive effects of exercise and sport participation on psychological health.

### **Changes and Challenges**

Three areas of importance related to sport and exercise psychology that have brought recent changes along with challenges for counseling psychologists include a focus on working with athletes, using exercise interventions, and promoting positive youth development.

#### ***Counseling Psychologists Working With Athletes***

The dramatic growth of sport psychology over the last decade has spurred an increase of counseling psychologists interested in working with athletes. Although not typically viewed as a special population with particular needs, many unique and influential factors of athletic systems and subcultures create situations and demands outside of the traditional norms of the manner in which counseling psychologists tend to work. Although the empirical evidence of the

effectiveness of sport psychology interventions is mixed, athletes view the most effective consultants as those who they perceive are interested in sport, establish caring rapport, offer concrete sport-specific advice and feedback, and provide follow-up. Athletes believe that consultants show their interest in sport by attending practices and games, maintaining consistent and sometimes extensive contact, and learning their specific sport.

Although athletes do not always feel it is necessary for consultants to have participated in their sport, they do expect consultants to possess a general understanding of the sport experience and the sport environment in which the athlete is involved. This characteristic often involves working with athletes in different settings and under different circumstances. For example, athletes' needs may differ substantially between try-outs, practice, major competitions, and the off-season. Attending practices and competitions can be time consuming, but these are key opportunities to understand the sport environment, observe the client-athlete in context, gather relevant information, and build the therapeutic relationship. Furthermore, the high visibility of athletes and the public nature of their performances provide the counseling psychologist with frequent evaluations of therapeutic goal attainment. Athletes describe poor consultants as those with bad timing and inappropriate behavior (i.e., crowding them or interrupting precompetition routines).

Athletes are also accustomed to being coached and expect consultants to offer concrete sport-specific interventions and instructional feedback. Counseling psychologists who employ more insight-oriented interventions may find their clients becoming impatient with the pace of the counseling interaction. Athletes appear to respond more positively to specific concrete tasks and expect more active collaboration on the part of the consultant.

The initial contact for consultation services is often made by a coach, a parent, or a sport administrator. By virtue of their initial contact, these individuals become the "client," but rarely do they see themselves as the "patient." This perspective is partly due to lack of experience with sport consultants and psychologists and partly due to an expectation that the consultant or psychologist will turn a team around or "fix" a nonperforming athlete. Thus, it is essential for psychologists to clearly communicate the nature of the consultation relationship with regard to confidentiality, record keeping, program goals, and evaluation



criteria. Considerable effort must be particularly invested to ensure the coach or parent understands the importance of confidentiality and privacy.

### **Exercise Interventions in Counseling**

Counseling psychologists are involved in both the prevention and treatment of mental health difficulties. Presently the most common form of treatment is psychotherapy and, in many cases, medication. Psychotherapy is expensive and can be difficult to access. Recent meta-analyses that have examined the relationship between exercise and the prevention of mental disorders such as depression and anxiety have found a number of positive outcomes for both clinical and nonclinical populations. Research has also shown that engaging in exercise can enhance ability to cope with stress and enhance self-esteem. In addition, research has shown that when exercise is prescribed as a regular component of therapy, therapeutic goals are more frequently met in less time, and continued exercise is related to psychological well-being.

There are a number of benefits of exercise interventions, including affordability, minimal side effects, capacity to reach large numbers of individuals compared to traditional psychotherapy and medication, numerous physical health benefits apart from mental health, and applicability to all ages. However, despite the empirical evidence, many counseling psychologists fail to implement exercise interventions, because they lack experience and knowledge about how to implement and monitor these interventions. Therefore, further research and training, particularly continuing education training, is needed to teach psychologists how exercise interventions should be designed and implemented.

### **Promoting Positive Youth Development**

Promoting positive youth development through sport and exercise psychology is a psychoeducational approach to counseling psychology. Several community oriented approaches to teach life skills through sport have been developed and evaluated and have been shown to be effective. By describing life skills as *skills*, the process of learning these skills parallels the learning of any skill, whether it is throwing a ball, driving a car, or baking a cake. Learning new skills entails explicitly describing, demonstrating, and practicing each component of the skill until it can be used consistently.

Implementation involves knowing both the content of the intervention and *how* to deliver it effectively.

Sport-based life skills programs are designed to help individuals learn both sport and life skills. Therefore, the youth must be able to transfer what is learned in the athletic realm to nonsport settings. The similarity between teaching sport skills and teaching life skills provides an immediate advantage. Both sets of skills must be *taught, not caught*. A Chinese proverb best describes the ideal teaching process: “I listen—and forget, I see—and remember, I do—and understand.”

### **Future Directions**

The future of exercise and sport psychology seems bright, but professional opportunities are limited. Counseling psychologists who wish to work in the area must be more than sport fans or exercisers; they must be prepared to become familiar with a new area with all its inherent challenges, frustrations, and opportunities. Often this means working with young athletes and volunteering. What is so exciting is that pairing counseling psychology with exercise and sport has produced and will continue to produce innovative approaches to improving sport performance, psychological well-being, and physical health. For those counseling psychologists involved in exercise and sport, it also provides an ideal way to meld their avocational interests with their vocation.

*Ian J. Wallace, Tanya Forneris,  
and Steven J. Danish*

**See also** Adventure Therapy (v1); Counseling Psychology, Definition of (v1); Intrinsic Motivation (v2); Leisure (v2); Physical Activity Counseling (v2); Physical Health (v2); Play Therapy (v1)

### **Further Readings**

- Biddle, S., Fox, K., & Boutcher, S. (Eds.). (2000). *Physical activity and psychological well-being*. New York: Routledge.
- Danish, S. J., Petitpas, A. J., & Hale, B. D. (1993). Life development intervention for athletes: Life skills through sports. *The Counseling Psychologist*, 21, 352–385.
- Danish, S. J., Taylor, T., & Fazio, R. (2003). Enhancing adolescent development through sport and leisure. In G. R. Adams & M. Berzonsky (Eds.), *Blackwell handbook on adolescence* (pp. 92–108). Malden, MA: Blackwell.
- Hays, K. F. (Ed.). (1998). *Integrating exercise, sports, movement, and mind: Therapeutic unity*. New York: Haworth Press.



- Hellison, D. (1995). *Teaching responsibility through physical activity*. Champaign, IL: Human Kinetics.
- Orlick, T., & Partington, J. (1987). The sport psychology consultant: Analysis of critical components as viewed by Canadian Olympic athletes. *Sport Psychologist*, 1(1), 4–17.
- Van Raalte, J. L., & Brewer, B. W. (Eds.). (2002). *Exploring sport and exercise psychology* (2nd ed.). Washington, DC: American Psychological Association.
- Weinberg, R. S., & Gould, D. (Eds.). (2007). *Foundations of sport and exercise psychology* (4th ed.). Champaign, IL: Human Kinetics.

---

## EXTERNALIZING PROBLEMS OF CHILDHOOD

---

Externalizing problems in childhood can be broadly defined as disorders characterized by behaviors directed outward. More specifically, these behaviors typically occur in interaction with another person and are represented by disobedience, aggression, temper tantrums, fidgetiness, and overactivity, and they often result in conflict. Beyond differing in their diagnostic criteria, externalizing problems differ from internalizing problems primarily in their expression. However, there is significant evidence that externalizing problems and internalizing problems occur comorbidly. Broadly speaking, the class of externalizing problems in childhood includes attention deficit disorder, attention deficit/hyperactivity disorder, conduct disorder, and oppositional defiant disorder.

### Externalizing Problems Defined

Though not comprehensive, the next section will provide an overview of some externalizing problems in childhood, guided by the diagnostic criteria of the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR)*.

#### **Attention Deficit/Hyperactivity Disorder**

The causes of attention deficit/hyperactivity disorder (AD/HD) are unknown, although it is one of the most commonly diagnosed of the externalizing problems. AD/HD is divided into two distinct categories: the predominately inattentive type and the hyperactive inattentive type. A final category is a combined type. The types are categorized according to the symptoms most predominant in the child.

The most distinguishing characteristic of AD/HD is marked difficulty focusing on a task or activity. Children with AD/HD struggle with successful academic development and often experience challenges with peer relationships. When children struggle primarily with inattention, they have trouble completing tasks and listening to directions and appear to be disinterested even when spoken to directly. When hyperactivity is the predominant symptom set, children demonstrate a high degree of distractive physical and verbal activity, including fidgeting, pacing, and excessive talking. Finally, when the symptom set relates specifically to impulsivity, the children have difficulty waiting for their turn, answer questions before the other person completes the question, and often intrude on others' play and interactions.

#### **Conduct Disorder**

The externalized problem of conduct disorder includes bullying behaviors that include threats to the well-being of people or of animals. Children with conduct-disordered behaviors often get their way through intimidation, including physical fighting. Nonaggressive behaviors may also be exhibited, such as damaging property, stealing, and fire setting. Children diagnosed with conduct disorder have difficulty reading social cues, leading them to interpret the behavior of others as aggressive or threatening. Additionally, these children fail to recognize the impact of their behavior on others and therefore do not empathize with emotional or physical pain or personal loss.

#### **Oppositional Defiant Disorder**

Oppositional Defiant Disorder (ODD) is characterized by the child exhibiting frequent displays of anger, arguing (typically with adults), and refusing to follow instructions. Children diagnosed with ODD often refuse to follow directions, refuse to take responsibility for their mistakes, and appear angry and hostile toward others. Often the child appears to be spiteful or vindictive in even the most mundane situations.

### Diagnosing Externalizing Problems

It is important to note that to be considered significant, all symptoms associated with any of these externalizing problems must be present beyond what is to be expected with normal development and must cause problems with psychosocial and educational



development. Any single symptom cannot lead to a diagnosis of one of the above externalizing disorders, and the behavior must occur in more than one setting, such as in school and at home.

*Heather M. Helm*

**See also** Attention Deficit/Hyperactivity Disorder (v1); Behavior Assessment System for Children, Second Edition (v1); Conduct Disorder (v1); *Diagnostic and Statistical Manual of Mental Disorders (DSM)* (v2); Internalizing Problems of Childhood (v1); Oppositional Defiant Disorder (v1); School Refusal Behavior (v1)

### Further Readings

- American Psychological Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed., Text rev.). Washington, DC: Author.
- Beitchman, J. H., Inglis, A., & Schachter, D. (1992). Child psychiatry and early intervention: IV. The externalizing disorders. *Canadian Journal of Psychiatry*, 37(4), 245–249.
- Farmer, E. Z. M., Compton, S. N., Burns, B. J., & Robertson, E. (2002). A review of the evidence base for treatment of childhood psychopathology: Externalizing disorders. *Journal of Counseling and Community Psychology*, 70, 1267–1302.
- Gilliom, M., & Shaw, D. S. (2004). Codevelopment of externalizing and internalizing problems in early childhood. *Development and Psychopathology*, 16, 313–333.
- Sourander, A., & Helstelä, L. (2006). Childhood predictors of externalizing and internalizing problems in adolescents. *European Child & Adolescent Psychiatry*, 14, 415–423.

---

## EYE MOVEMENT DESENSITIZATION AND REPROCESSING

---

Eye movement desensitization and reprocessing (EMDR) is a psychotherapy approach used to process distressing memories that are the basis of a wide range of clinical complaints. Comprehensive treatment includes attention to past, present, and future not only to address overt symptoms but also to increase attributes associated with a positive quality of life.

Eye movement desensitization and reprocessing is an integrative approach originally developed to resolve symptoms resulting from exposure to a traumatic

event. Its clinical applications are directed by a theoretical model that emphasizes the brain's information processing system and that views symptoms as arising when memories are inadequately processed. In addition to the efficacious treatment of posttraumatic stress disorder (PTSD), EMDR is also now used to process all kinds of negative life experiences, such as rejection, failure, loss, stress, and conflict, and to bring these to an adaptive resolution.

EMDR uses an eight-phase approach to directly address the experiences physically stored in the brain's memory networks. Treatment involves processing the past experiences that set the groundwork for the problem, the current situations that trigger the disturbance, and new memory "templates" for adaptive future functioning. During the processing phases of EMDR, the client initially attends to the disturbing memory while simultaneously focusing on an external stimulus (e.g., therapist-directed lateral eye movements, alternate hand tapping, or bilateral auditory tones). Standardized procedures are used that allow the emergence of new insights, memories, and emotions, until the targeted event arrives at an adaptive resolution. The client then recalls the incident with a new perspective, elicitation of insight, resolution of the cognitive distortions, elimination of emotional distress, and relief of related physiological arousal.

### History

EMDR was introduced in 1989 by Francine Shapiro with the publication of a randomized controlled treatment study with traumatized individuals. At that time, the therapy was called eye movement desensitization, or EMD, because it was thought that the eye movements resulted in desensitization of the memory. However, it became apparent to Shapiro that desensitization was only one of the many changes occurring with treatment. In 1991, she changed the name to eye movement desensitization and reprocessing, or EMDR, to emphasize the role of the information processing system in producing the treatment effects.

Because EMDR is an unusual treatment, it originally attracted a number of critics who erroneously argued that its effects were due entirely to a placebo effect. Since then, EMDR has been rigorously researched, and its efficacy in the treatment of PTSD is now recognized. EMDR has been effectively used



in numerous cultures around the world, and more than 100,000 therapists have received EMDR training.

### ***PTSD Research***

Approximately 20 controlled research studies have established EMDR's efficacy in the treatment of PTSD. These studies have compared EMDR to pharmaceuticals and various forms of psychotherapy, with results demonstrating that it is as effective and long lasting as the most researched cognitive-behavioral therapy (CBT) methods. EMDR is recommended as an "A" level treatment for PTSD in numerous international treatment guidelines. The American Psychiatric Association and the U.S. Departments of Defense and Veterans Affairs also rate it in the highest category of effectiveness and research support.

### ***Eye Movements***

As with any form of psychotherapy, the neurobiological underpinnings of EMDR's treatment effects are currently unknown. Several studies have attempted to determine the direct effect of eye movements on EMDR outcome. Unfortunately, most of these studies had methodological flaws, and no definitive conclusion can be made. For example, one study reported a decrease in PTSD diagnosis of 85% for eye movement conditions and 50% for the non-eye movement group, but the results were not significant because of the small sample size. A meta-analysis of these studies reported marginally significant effects for the eye movement condition with clinical populations.

Laboratory research investigating the effects of eye movements on memory has consistently demonstrated strong effects. Numerous studies have shown that eye movements decrease the vividness and emotionality of memory images. Other studies have demonstrated that eye movements produce a relaxation effect, decreasing heart rate and galvanic skin response. Research has also found that eye movements increase cognitive flexibility and access to episodic memories. While it is thought these effects are integral to the EMDR treatment process, the extent to which eye movements contribute to treatment outcome is not currently known. Noted sleep researcher Robert Stickgold has suggested that the eye movements in EMDR may activate many of the same neurochemicals released during rapid eye movement (REM)

sleep, thus facilitating free associations and memory processing.

### **Adaptive Information Processing Model**

Shapiro developed the adaptive information processing (AIP) model to describe EMDR treatment and to predict its effects. This model posits that humans have an inherent physiological processing system geared to process all internal and external experiences and to bring these to an adaptive and healthy resolution. When a current experience is similar to those stored in memory, related networks are activated and relevant information becomes readily accessible. This adaptive system allows us to function smoothly throughout our daily lives as we engage in every type of task, from grocery shopping to work-related projects, from socializing to parenting. New experiences are consolidated in memory when associative links are created between them and other related material, forging connections to numerous other memory networks. Learning takes place, and the individual is able to access the new information as needed.

Although this system typically operates in an adaptive way, Shapiro hypothesized that highly disturbing perceptions may not always be adequately processed. When this occurs, the upsetting experience is not integrated with other memory networks that contain more adaptive information. Instead, the distressing memory is stored in an isolated network, in what Shapiro referred to as an "unprocessed state," with the original sensory components. When this distressing memory is activated, the individual experiences the emotions, sensations, and cognitions endured at the time of the original event. Furthermore, these negative sensations influence the individual's perception of the current event, often resulting in misunderstandings or overreactions. Then a memory of the current event is stored within the dysfunctional memory network, strengthening and reinforcing it. The unprocessed memory network remains isolated and unable to link up with more adaptive and positive information.

Shapiro recognizes that some psychiatric disorders or symptoms are organic in nature and that some functional impairments are caused by a lack of experience or information. However, she maintains that the majority of Axis I and II disorders result from unprocessed earlier life experiences and that this



processing failure results in a pathological pattern of affect, cognitions, behavior, and sense of identity. Furthermore, she argues that most difficulties in coping with current life stressors are a result of unprocessed memories. The presenting cognitive and emotional symptoms are understood to be a manifestation of the earlier memory. Therefore, it is anticipated that the complete processing and resolution of these memories will result in remission of the diagnosis and elimination of the problematic symptoms.

## Treatment

### ***Phase 1—Client History and Treatment Planning***

The first phase of EMDR shares similarities with most psychotherapies, with the identification of the presenting problem, development of a therapeutic alliance, collection of a thorough history, assessment of current function, and determination of treatment goals. In addition to these elements, during the history-taking process, the EMDR clinician seeks to identify the dysfunctional memory networks and related targets for EMDR processing. The therapist inquires about earlier experiences that have laid the groundwork for the presenting symptoms, current situations that are triggering the memory network, and the client's concerns about related future situations.

For example, John sought treatment to help him cope with workplace stress related to a bullying and critical supervisor. John found himself over-reacting with anger and anxiety, his function was impaired, and he was afraid he would lose his job. When the therapist inquired about earlier similar experiences, John explained that as a child he had been the victim of bullying. The therapist and John identified several specific memories of bullying and harassment that still carried an emotional charge for John. They also discussed current triggers for his feelings of shame and incompetence and John's fears related to a future job evaluation.

From an AIP perspective, John's childhood memories were not adequately processed, and were stored in an isolated memory network that contained experiences of humiliation and derogation. This network was not connected to memories of positive experiences such as John's academic accomplishments. Currently, the harsh criticisms of his employer triggered the dysfunctional memory network, and John's reactions were driven by his childhood experiences.

John was unable to shift out of that state or to access material in more positive, and realistic, networks.

### ***Phase 2—Client Preparation***

In the second phase, the clinician ensures that the client has adequate stabilization before proceeding to process the distressing memories, which can be expected to elicit strong negative affect and cognitions. In particular, the therapist evaluates the client's ability to regulate emotion and handle distressing situations. Some affect management techniques may be taught, such as using safe place imagery to shift out of a negative affective state. If the client lacks skills in this area, or if his or her life situation is unstable or chaotic, Phase 2 may extend for a period of time. John's therapist assisted John in developing a list of affect management techniques that he used regularly. These included a range of exercise activities, recreational pastimes, creative projects, social contacts, and meditation. It appeared that John had adequate stabilization and affect management skills.

### ***Phase 3—Assessment of the Target Memory***

The third phase is structured to fully access the memory network by identifying its major sensory, cognitive, affective, and somatic elements. First the client describes the most salient sensory image of the event. Next, the therapist assists the client in articulating a current negative cognition (NC) about him- or herself that is related to the target memory, (e.g., "I'm incompetent"). The NC is formulated in the present tense to activate the information as it is currently stored in the memory network. This also serves to assist the client in recognizing the impact of the past event on his or her current self-image. The client is then asked to specify a preferred positive cognition (PC; e.g., "I'm competent") and to rate how true the statement feels when combined with the image of the event, using the Validity of Cognition (VOC) scale (where 1 = false, and 7 = completely true). This rating provides a baseline by which the client and clinician can assess progress. In addition to offering the client a "light at the end of the tunnel," the PC forges a preliminary associative link between the isolated memory network and the adaptive information that is expressed in the positive cognition.

After this, the client is asked to identify the negative emotions that are elicited by the memory, and to



rate his or her level of distress on the Subjective Unit of Disturbance (SUD) scale (where 0 = neutral, and 10 = worst possible distress). The baseline is used to assess progress. In addition, the specification of the emotions allows both client and therapist to recognize changes in the type of affect experienced during processing. Finally, the client identifies and locates the body sensations that accompany the disturbance.

The first target memory addressed by John was of himself at age 7, surrounded by a circle of children who were calling him names. His NC was “I’m a social outcast”; his PC was “I’m a socially competent adult” with a VOC of 3. His emotions were anger, fear, and shame with a SUD of 9 and a body location in the stomach.

#### **Phase 4—Desensitization**

This phase begins with instructions to the client to focus on the visual image, NC, and body sensations, and then to “let whatever happens, happen.” The client maintains this internal focus while simultaneously moving the eyes from side to side for 15 to 30 seconds, following the therapist’s fingers as they move across the visual field. Other bilateral stimuli (e.g., bilateral hand tapping or auditory stimulation) can be used instead of eye movements. After the set of eye movements, the client is told to “let it go” and is then asked, “What do you get now?” The client reports any changes in the memory or associative material (image, thought, sensation, or emotion). Following standardized procedures, typically the clinician then directs the client’s attention to the new material for the next set of eye movements, or back to the original target. This cycle of alternating focused attention and client feedback is repeated many times, as associations are forged to other memory networks. The client often spontaneously accesses related thoughts, images, emotions, sensations, and memories. As the process continues, he or she usually reports cognitive insights and shifts in affect and physiological states.

For example, during processing, John recalled other incidents of peer bullying and humiliation. His emotional state shifted as different memories surfaced; he experienced a number of insights, including the realization that as an adult he instantly responded with rage whenever he felt criticized. The therapist did not dialogue with John during this process; instead she simply encouraged John to “just notice” as he continued with the sets of eye movements and internal focus. If John’s processing had stalled, the therapist

would have used specialized interventions worded to reactivate processing.

As processing continues, with associations being forged to more adaptive information, there appears to be a shift in how the memory is stored. The client will often report a change in his or her perception of the memory. For example, John realized, “It was only some children who were mean to me; there were others who were actually quite friendly.” He then remembered a number of positive social interactions with his classmates.

#### **Phase 5—Cognitive Installation**

The fifth phase occurs after the targeted issue is resolved and no further distress is reported when the memory is accessed (i.e., the SUD rating is 0). At this point, the client focuses simultaneously on the targeted memory and the PC, while engaging in sets of eye movements. This PC could be the belief developed in Phase 3, or another PC that emerged during Phase 4. The purpose is to incorporate and increase the strength of the PC until strong confidence is apparent (i.e., VOC of 6 or 7). Often processing continues to consolidate the changes in the memory network. For example, as John worked on installing his PC of “I’m a socially competent adult” he stated, “You know, it is the bullies who have no social skills!” He also realized that there were various responses that he could use when he felt criticized. He felt quite energized as information related to his social value and skills was incorporated from other memory networks.

#### **Phase 6—Body Scan**

Phase 6 occurs after the successful completion of Phase 5. The clinician asks the client to focus on the incident and PC and to notice if there is any tension or unusual sensation in the body. Because body sensations can indicate unprocessed aspects of the memory network, an assessment of these sensations is used to detect any residual material. Any identified sensations are targeted with eye movements until the tension is relieved.

#### **Phase 7—Closure**

This phase occurs at session end. The therapist determines whether the memory has been adequately processed and, if it has not, assists clients with the self-calming interventions developed in Phase 2. The client is told that processing may continue after



the session and is asked to maintain a journal to record any new material that arises.

### Phase 8—Reevaluation

Reevaluation takes place at the beginning of every EMDR session following the first. In this phase, the therapist evaluates the memory targeted in the previous session by collecting the SUD rating and assessing the PC. If the work is incomplete, processing of that incident continues. If the work on a specific memory is complete, the therapist will then shift the focus to other related memories. Once these have been processed, current triggers that are activating the memory network and creating distress are targeted. With John, for example, after successful resolution of the *past* childhood experiences of peer bullying, the focus shifted to the *present* conflict with his supervisor. The target was assessed using memories of specific incidents (using Phase 3), and processed (using Phases 4 through 8). Finally a *future* template was developed to assist John in handling future situations in which he might feel criticized or humiliated, and the template was processed according to the protocol. Attending to all past, current, and future aspects ensures that the entire memory network is successfully processed.

As John's childhood memories of peer bullying were resolved, he began to experience himself as a socially competent, vital, and dynamic individual, capable of high functioning in many life domains. The change in the way that the memories were stored in the brain resulted in a profound shift in his self-perception with alterations in cognitive schemas, behavior, and interpersonal interactions. John was now able to choose from various options in responding to his employer's criticisms and was able to resolve those issues in a mature manner.

Louise Maxfield

**See also** Cognitive-Behavioral Therapy and Techniques (v2); Cognitive Information Processing Model (v4); Crisis Counseling (v2); Panic Disorders (v2); Posttraumatic Stress Disorder (v2); Quality of Life (v2); Stress Management (v2)

### Further Readings

- Christman, S. D., Garvey, K. J., Propper, R. E., & Phaneuf, K. A. (2003). Bilateral eye movements enhance the retrieval of episodic memories. *Neuropsychology*, 17, 221–229.
- Dworkin, M. (2006). *EMDR and the relational imperative*. New York: Brunner-Routledge.
- Lansing, K., Amen, D. G., Hanks, C., & Rudy, L. (2005). High resolution brain SPECT imaging and EMDR in police officers with PTSD. *Journal of Neuropsychiatry and Clinical Neurosciences*, 17, 526–532.
- Maxfield, L., & Hyer, L. (2002). The relationship between efficacy and methodology in studies investigating EMDR treatment of PTSD. *Journal of Clinical Psychology*, 58, 1–19.
- Maxfield, L., & Melnyk, W. T. (2000). Single session treatment of test anxiety with eye movement desensitization and reprocessing (EMDR). *International Journal of Stress Management*, 7, 87–101.
- Rogers, S., & Silver, S. M. (2002). Is EMDR an exposure therapy? A review of trauma protocols. *Journal of Clinical Psychology*, 58, 43–59.
- Shapiro, F. (1999). Eye movement desensitization and reprocessing (EMDR): Clinical and research implications of an integrated psychotherapy treatment. *Journal of Anxiety Disorders*, 13, 35–67.
- Shapiro, F. (2001). *Eye movement desensitization and reprocessing: Basic principles, protocols and procedures* (2nd ed.). New York: Guilford Press.
- Shapiro, F. (Ed.). (2002). *EMDR as an integrative psychotherapy approach: Experts of diverse orientations explore the paradigm prism*. Washington, DC: American Psychological Association.
- Shapiro, F., & Forrest, M. (1997). *EMDR*. New York: Basic Books.
- Shapiro, F., Kaslow, F. W., & Maxfield, L. (Eds.). (2007). *Handbook of EMDR and family therapy processes*. New York: Wiley.
- Shapiro, F., & Maxfield, L. (2002). Eye movement desensitization and reprocessing (EMDR): Information processing in the treatment of trauma. *Journal of Clinical Psychology*, 58, 933–948.
- Stickgold, R. (2002). EMDR: A putative neurobiological mechanism of action. *Journal of Clinical Psychology*, 58, 61–75.





---

## FAMILY COUNSELING

---

Family counseling may be beneficial when a family member or several members of the family experience difficulties with communication, balancing home and work, the loss of a family member, trauma, divorce conflicts, issues in blended or remarried families, family violence, substance abuse, or behavioral or school problems in children. Family counselors practice in community mental health agencies, managed care organizations, hospitals, private practice, employee assistance programs, and other settings. They provide individual, couples, and family counseling; prevention programs, including parent education programs; crisis management, and other intervention and educational services. Consumers of family counseling are best served by asking for a referral from someone they trust to find out if the counselor is a good fit for themselves and their family members. It may be necessary to schedule an initial consultation to determine if a particular family will work well with a particular counselor.

### Historical Overview

The field of family counseling evolved as families were changing, in particular after World War II. During that time, the divorce rates increased, and there were more demands on families as a system. In addition, people became more accepting of the idea of seeking help for family concerns. Counselors began to include family members to understand and treat individual psychological problems. During the 1950s,

counselors and therapists sometimes observed that when an individual's problem got better, someone else in the family developed symptoms. A patient's condition might have deteriorated after he or she returned home from a hospital stay. Therefore, therapists started concluding that if individuals were treated in isolation from their families, it might be nonproductive. At that time, there was also research attempting to understand the factors that contributed to schizophrenia.

In the 1940s, general systems theory was developed by the biologist Ludwig von Bertalanffy, who believed that the parts of a system are interrelated and that the whole is greater than the sum of its parts. The implication for family counseling was that one person's behavior is interconnected and interrelated to the behavior of all other family members.

Nathan Ackerman, the "father" of family therapy, was one of the first to work with the whole family. His work was during the late 1930s to early 1940s. In the 1940s, Gregory Bateson and his wife, Margaret Mead, began looking into patterns and organization in communication. Soon after that, Bateson was influenced by cybernetics, the study of how systems are controlled and how information is processed. Jay Haley and John Weakland also conducted research on the dynamics of schizophrenic communication. In 1959 the Mental Research Institute in Palo Alto, California, was founded. Bateson, Weakland, William Fry, Don Jackson, Jay Haley, and Virginia Satir made significant contributions to an understanding of how families and systems work. This is where concepts such as that of *equilibrium*, which is the tendency of families to resist change, and of *repetitive patterns of interaction* were developed. Haley was also influenced by



Milton Erickson, a hypnotist in Phoenix who developed a treatment called Brief Therapy. Erickson believed that people could make rapid and effective changes if they tried something new.

Murray Bowen, the developer of family systems theory, studied families who had a member who was diagnosed as schizophrenic in the 1940s and 1950s. He came to the conclusion that because the family was the unit of disorder, families needed to be treated together. He was interested in how a sense of identity is transferred across generations. He developed the concept of *differentiation of self*, which refers to autonomy relative to one's family as well as having the ability to separate one's thoughts and feelings. Bowen tried to remain neutral and nondirective in therapy, and he is often contrasted with Carl Whitaker, the developer of symbolic experiential family therapy, who was more experiential and provocative.

Salvador Minuchin was a pediatrician who came from Argentina and in the 1960s worked with poor families who faced several problems. Through his work he developed structural family therapy, which emphasized how a family's organization may be helpful or unhelpful. He became a director of the Philadelphia Child Guidance Clinic in 1965 and began an exchange of fruitful ideas with other colleagues. He paid attention to family boundaries and noticed that in families that were chaotic and tightly connected, the parents were too involved with their children. In contrast, some families had parents who were too uninvolved and distant. In 1974 he wrote the book *Families and Family Therapy*, claimed to be the most popular book in family therapy.

During the 1970s and 1980s, family therapy flourished. Several centers for family therapy and training were developed, and already-existing centers became more established and influential. During these two decades, the different models of family counseling and therapy were independent from one another and were led by charismatic pioneers. The therapists were experts who could diagnose and repair a family's dysfunction. In the 1980s, family counseling was impacted by feminism. Women such as Marion Walters, Olga Silverstein, and others advocated for counselors and therapists to be aware of and counteract gender-based power structures.

In the 1980s and 1990s, the field was transformed by postmodernism, which suggested that there are no universal truths, only points of view, and emphasized language and meaning. Since then, counselors have

collaborated and worked as partners with families to create new meaning or useful views through language. Questions are asked in order to learn, reinterpret, and reframe experiences. Social constructionism is the primary postmodern school, and it includes solution-focused, narrative, and collaborative language systems. Solution-focused therapy was developed in Milwaukee by Steve de Shazer and Insoo Kim Berg, who de-emphasized the family's problem or its causes. Michael White and David Eposon developed narrative therapy in Australia and New Zealand and were interested in creating a new narrative with families. The theory of collaborative language systems was developed by Arlene Anderson and Harry Goolishian, who believed that people create meaning through language.

### **Different Approaches of Family Counseling**

Family counselors with an experiential focus have goals for families to develop a sense of togetherness and autonomy, build self-esteem, relieve family pain, and overcome blocks to personal growth. Transgenerational family counselors focus on reducing anxiety, increasing self-differentiation, and rebuilding trust and fairness. Family counselors with an emphasis in structural family theory have a goal of restructuring the family organization, reducing symptoms, and creating flexible boundaries. Behavioral or cognitive counselors and therapists focus on modifying behavioral sequences, eliminating maladaptive behaviors, alleviating presenting symptoms, and restructuring cognitions. Social constructionists emphasize learning, creating new viewpoints, and giving new meanings to problems. Counselors identifying with the narrative approach focus on alternative stories helpful to the family, separating the person from the problem, re-envisioning the family's past and rewriting their future. All approaches have in common building a strong alliance with a family and its members based on trust and respect, assessment and utilization of support systems, and the negotiation of expectations, hopes, and resources to make counseling useful.

### **Family Developmental Life Cycles and Alternative Families**

Family counselors pay attention to the family life cycle because of the different adaptations family members make. When there is a transition from one stage to another, changes and stresses may interfere



with a family's functioning and well-being. For the average American family, life cycles may include leaving home as a single young adult, joining with another person to become a new couple, the family with young children, the family with adolescents, launching children and moving on, and the family in later life. Life cycles and events such as marriage, the birth of a child, retirement, and others may vary according to the family members' cultural or ethnic backgrounds. Other family events such as marital separation, divorce, illness, death, relocation, catastrophic events, loss of employment, and others have a tremendous effect on families and the strategies and the coping mechanisms they develop to overcome such events. Family counselors can be of assistance to families and family members with the stresses of moving from one stage of family life to another or when other disruptions occur in the family life cycle. Cultural diversity, including religion and spiritual background, history of immigration, race, and ethnicity also influence the family life cycle.

### ***Divorced Families***

Family counselors may work with family members when they are in the process of deciding to divorce, during the actual time of a divorce, or after a divorce has taken place. When the decision to divorce takes place, working on problems of custody, visitation, and finances becomes important. Mourning the loss of the intact family and adapting to living apart and not being attached to a spouse are some of the concerns family members can process in counseling. During the divorce process, working on the emotional separation and overcoming hurt, anger, and guilt may become the focus of counseling.

### ***Blended Families***

Family counselors may assist blended families with clarification of the rights and responsibilities of the stepparents, adjustments of children to stepsiblings, cohesion of the newly formed family, and integration of their separate family histories. In addition, family counselors help members deal with unresolved issues of loss and grief. Family counselors may see some members and not the entire family. Family counselors can help the family members gain different perspectives and develop strategies to cope with their new family life.

### ***Single Parent Families***

Single parent families may be the result of choice, but in many cases they are the result of divorce, or the death of a spouse. Family counselors may assist family members with issues of grief and loss and with stresses such as loneliness, financial pressures, sadness, and anger for both parents and children. Family counselors can be useful to families before, during, and after a divorce has occurred. If children are involved, there can be partial or total loss of a parent, and issues of custody become important as part of the counseling process. Mediation may be necessary for the couple to work out areas of agreement, especially when there is a need to coparent. Issues of children and remarriage may arise during the course of counseling.

### ***Gay and Lesbian Families***

In families in which the parents are gay or lesbian, in addition to the above issues, family counselors may help with issues related to living in a homophobic society and to internalized messages that challenge a client's self-validation due to strong cultural and internal nonacceptance and isolation. Issues of coming out of children to their parents or parents to their children are important issues that can be dealt with in counseling.

## **Special Issues in Family Counseling**

### ***Family Violence and Physical and Sexual Abuse***

Family counselors must assess for abuse in the family, noting the extent of danger and the possibility of lethality. Factors included in the assessment are a history of violence in the family of origin, low self-esteem, isolation, economic stress, male dominance, use of weapons, and substance abuse. Couples counseling is contraindicated if counseling is court mandated for treatment of violent behavior either toward a partner or toward children. If the abuse has been revealed in a private session, bringing it into the couples or family work may risk the partner's safety. Unless adequate safety plans have been made, the abuse may not be discussed with the abusing partner.

In regard to child abuse, family counselors are mandated to report incidents of abuse or reasonable suspicion of abuse. When families have been informed that abuse has been reported, they are often shocked, angry, or in denial. The child may change or recant his or her



story of abuse. It is important for the counselor to find ways to prevent further abuse, help family members recuperate from the effects of the abuse, and develop different ways of interacting within the family.

### **Family Counseling and Substance Abuse Problems**

Substance abuse significantly impacts the sense of well-being of the family system. Adults who are addicted to substances affect their own lives and those of their children. The children experience increased risk for depression, behavioral problems, and substance abuse. Child abuse and neglect is often related to drug and alcohol abuse. Other related issues include mental and physical illness, side effects of drugs, family violence, and criminal activity to maintain the addiction. Family counseling can play an important role throughout the treatment process for both the person who is using substances and for family members. Family-based treatments have been found more effective in reducing adolescent drug use and behavioral problems than other treatments. Adolescents tend to stay longer in treatment and benefit more from family-based counseling.

### **Code of Ethics**

The International Association of Marriage and Family Counselors (IAMFC) has developed a code of ethics for family counseling in order to enhance, inform, and improve the professional's abilities to effectively serve clients. The ethical code increases public trust and improves the integrity of the family counseling profession. The most common ethical issues include client welfare, confidentiality, competence, and multicultural issues. The term *privileged communication* refers to therapists' being prevented from testifying in court about their clients without their consent.

### **Licensure and Certification**

The first state to adopt a marriage and family therapy licensure law was California in 1963. As of fall 2006, 46 states as well as the District of Columbia license and certify marriage and family therapists. In general, to be licensed, family counselors must have at least a master's degree and have received supervised experience following graduation.

### **Professional Organizations**

The primary association for family counselors is the IAMFC, and its official journal is *The Family Journal: Counseling and Therapy for Couples and Families*. The purpose of the journal is to advance theory, research, and practice of counseling with couples and families from a family systems perspective. The specialty for family counselors was emphasized in prevention, education, and remediation. The IAMFC was developed in 1992 with Jon Carlson as the founding editor of the journal. The IAMFC sets the practice standards and establishes the professional identity of counselors working with families. The IAMFC is a division of the American Counseling Association. The National Credentialing Academy for Marriage and Family Therapists is an affiliate of IAMFC and is included in several of the state licensure laws in marriage and family therapy. Another professional organization is the American Organization for Marriage and Family Therapy (AAMFT), which publishes *The Journal of Marital and Family Therapy*.

*Basilia (Lia) Softas-Nall*

**See also** Adult Development (v1); Brief Therapy (v2); Child Maltreatment (v1); Couple and Marital Counseling (v1); Gay, Lesbian, and Bisexual Therapy (v2); Group Therapy (v2); Legal Issues in Parenting (v1); Multiracial Families (v3); Solution-Focused Brief Therapy (v2); Teenage Parents (v1); Transracial Adoption (v3); Work-Family Balance (v4)

### **Further Readings**

- Carter, B., & McGoldrick, M. (2005). *The expanded family life cycle: Individual, family, and social perspectives* (3rd ed.). Boston: Allyn & Bacon.
- Coombs, R. H. (2005). *Family therapy review*. Mahwah, NJ: Lawrence Erlbaum.
- Fagan, R. (2006). Counseling and treating adolescents with alcohol and other substance use problems and their families. *The Family Journal: Counseling and Therapy for Couples and Families*, 14(4), 326–333.
- Gladding, S. (2007). *Family therapy history, theory, and practice* (4th ed.). Upper Saddle River, NJ: Pearson Prentice Hall.
- Goldenberg, I., & Goldenberg, H. (2004). *Family therapy: An overview* (6th ed.). Pacific Grove, CA: Brooks/Cole.
- Nichols, M. P. (2006). *Family therapy concepts and methods* (7th ed.). Boston: Pearson Education.



Papp, P. (2003). Gender, marriage and depression. In L. B. Silverstein & T. J. Goodrich (Eds.), *Feminist family therapy*. Washington, DC: American Psychological Association.

---

## FEEDBACK IN COUNSELING, IMMEDIATE

---

Counseling is a professional and dynamic relationship that requires clinicians to integrate and demonstrate their intellectual and interpersonal skills. This expectation may well have originated with Sigmund Freud, who required all who studied with him to submit to personal psychoanalysis as part of their academic and clinical training. Today, counselors and psychologists prepare for their professional responsibilities through a series of academic and field-based experiences at the graduate level of study. This preparation focuses on an integration of the intellectual, personal, and interpersonal capabilities of individuals.

Counselors-in-training (CITs) receive instruction in a number of subject areas, including, but not limited to, counseling and personality theories, treatment approaches, human life-span development, cultural competencies, research, appraisal and assessment, clinical issues, and treatment. At different points in their education, CITs will treat clients under the supervision of university faculty or other professionals in order to demonstrate a level of competency in providing clinical treatment.

These hands-on or real-world experiences are identified by many terms: *practica* (plural of *practicum*), *internships*, *clinical rotations*, or *field-based placements*. *Practicum*, the common term used here, describes the initial clinical training CITs experience and may take place in a variety of settings utilizing a variety of training formats. Counselors-in-training may see clients in a university-based clinic or training center. Clients and counselors are viewed either in real time through one-way mirrors by an instructor and the counselor's training group or in the previously described setting but with a videotaped rather than live supervision component. Some CITs will treat clients in a community or school setting where sessions may be audio- or videotaped for feedback at a later time. Although the titles, location, and technologies may differ, the common expectations are that

CITs will provide counseling services to clients; receive feedback, instruction, and supervision on those interactions; and integrate that information into their future treatment of client concerns.

### Feedback, Instruction, and Supervision

The terms *feedback*, *instruction*, and *supervision* seem closely related and yet are distinct and well-defined processes in counselor training. *Feedback* is generally described as a brief process of providing specific and behavioral information to CITs about their interactions with clients. Feedback is both content and process oriented. In a live supervised setting, the CITs' practicum instructor and/or peers give feedback in an oral format immediately after the client session is concluded. Systemic counseling approaches have used reflecting teams, not discussed here, during live observations as a method of delivering immediate feedback to couples and family counselors.

In a field-based or community setting, CITs usually receive immediate feedback only when they engage in cotherapy with a supervisor or other clinician. Many field-based settings are not equipped to have counseling rooms with one-way mirrors and recording technology. Field-based CITs usually video- or audiotape their sessions for delayed feedback, which occurs at the next meeting with the supervisor.

*Instruction* includes the direct teaching of a skill, intervention, or process. Prior to enrolling in a practicum, most CITs have a course on helping skills. Students are taught more observable counseling behaviors through an experiential-didactic program. Regardless of the training model used, CITs receive immediate evaluation on their role-played sessions with peers and are expected to incorporate the feedback in order to improve their skills. Instruction differs from feedback in that skill instruction is task-oriented and assumes the CITs have some skill deficit. The focus of instruction is to increase the CITs' knowledge base in order to improve the application of his or her counseling skills.

Most counselor training programs require that counselors-in-training receive weekly individual supervision of their client sessions. *Supervision* is a training intervention in which CITs meet with their supervisors in order to review and assess the CIT's overall counseling performance. Supervision is an



interpersonally focused interaction, in which the CIT and supervisor discuss the CIT's conceptualization of the client concerns, treatment approaches, and the impact of the client and the training process on the CIT. Supervisors serve in many roles relative to CITs, including, but not limited to, those of teacher, counselor, consultant, and evaluator. Feedback and instruction are elements of supervision.

### Immediate Feedback

There are several models of immediate feedback used in counselor training. Two, live observation and interpersonal process recall (IPR), are examined here. Immediate feedback in counselor training is defined as information and critique provided to CITs by their counseling supervisor or peers immediately following the conclusion of a counseling session. When sessions are video- or audiotaped, feedback is provided as the tape is replayed or immediately following its conclusion.

Immediate feedback models described here differ from directive, in-the-moment interventions that occur while CITs are actively engaged with clients. These supervisory instructional practices such as bug-in-the-ear, an in-session electronic voice transmission to CITs; or bug-in-the-eye, an in-room, computer-assisted feedback to CITs; or supervisory interruptions via the telephone or knocking at the door are meant to instruct and redirect the CIT's process with the client. Immediate feedback models also differ from fishbowl or reflecting team models in that clients are not involved in giving or hearing the feedback.

### Live Observation

In settings where live or real-time observation is conducted, CITs meet with their instructor and or training group immediately after the session for no more than 10 to 15 minutes of feedback. This model is not as widely used as it once was due to the costs of the facilities and faculty time. The model is an outgrowth of the training models of the 1970s and 1980s that were based on humanistic and group process approaches.

Numerous scholars have identified guidelines for giving feedback in this type of setting. They note that the supervisor has much the same responsibilities as a group leader and as such should ensure that the guidelines are followed in order to provide structure and safety to the group members. Live, immediate,

postsession feedback sessions closely parallel the process of group counseling in their development through stages, their intensity, and the initial anxiety of members.

The guidelines highlighted in the counseling literature include the following: First, the CIT should be asked to briefly evaluate his or her performance by indicating his or her strengths and weaknesses. The CIT is asked to speak in behaviorally specific terms about what he or she did or did not do. The focus is kept on the CIT's counseling behaviors, and discussion related to the client or the client's issues is kept to a minimum or referred to supervision.

Second, peer feedback should precede supervisor feedback. Peers are to identify behaviorally specific strengths and weakness in the CIT's performance. Peers are to own the feedback they provide the CIT by directly stating: "I observed . . . , I saw . . . , I witnessed . . ." The supervisor provides his or her feedback last in order to summarize the group's input and address or explore any counseling competencies that are directly related to the CIT's concrete actions.

Third, in the early stages of the training group's development, CITs need to hear a balance of positive and corrective feedback. As the group's cohesion and trust grow, CITs can more readily hear more critical feedback. Fourth, supervisors are encouraged to regulate the flow and quantity of peer feedback. The supervisor should ensure that all peers are heard and that the CIT is not overwhelmed by too much information or processing. Some researchers suggest that the CIT on the "hot seat" be allowed to call a time out or break in the feedback if he or she is feeling overwhelmed.

The strengths of this model include (a) a focus on time sensitive training; (b) CITs are provided opportunities to learn directly and vicariously; (c) CITs exhibit greater skill improvement and increased self-efficacy after observing a peer than after observing an expert; and finally (d) the immediate and intense nature of this process provides students the opportunity to interact at multiple levels of cognitive and emotional functioning. This model of immediate feedback is highly dependent on the quality of the supervisor's leadership skills. Therefore, the weaknesses of this model include (a) a dependence on the supervisor's ability to manage the CIT's normal and expected anxiety, (b) a dependence on the supervisor's ability to focus the feedback process, and (c) the cost of maintaining the faculty and facilities.



### Interpersonal Process Recall

Interpersonal process recall (IPR) is a blend of an instructional method and immediate feedback developed by Norman Kagan in the 1980s. In IPR, CITs are given the opportunity to play videotapes of their counseling sessions in order to examine and bring into awareness feelings and attitudes they may have been experiencing in the session. The supervisor functions as a consultant and inquires as to the CIT's understandings and experiences during the session. The CIT can stop the tape at any time. The supervisor assumes that CITs have knowledge of their own experiences but may or may not have consciously examined them. Because the CIT expresses these thoughts and feelings in the moment, without criticism from the supervisor, the CIT's awareness of factors that influence the therapeutic relationship is enhanced.

The strength of the IPR model is that CITs feel a sense of respect and control in directing the feedback session. The IPR experience also encourages CITs to reflect on their personal processes and experiences in a manner that may help them identify and correct old patterns of ineffective behavior. The IPR process can be time consuming and uncomfortable for CITs who are reluctant to experience the discomfort of self-examination and emotion. Finally, the personal nature of the feedback limits its use, for some, in a group setting.

Immediate feedback and the processing that follows are valuable tools to encourage CITs' growth in the areas of self-assessment, self-awareness, and reflective practice skills. Immediate feedback makes the training process personal and authentic.

*Linda L. Black and Varunee Sangganjanavanich*

*See also* Counseling Skills Training (v2); Postdegree/Prelicensure Supervision (v1); Postdoctoral Training (v1); Predoctoral Internships (v1); Supervision (v1)

### Further Readings

- Carkhuff, R. R. (2000). *The art of helping in the 21st century* (8th ed.). Amherst, MA: Human Resources Development Press.
- Hillierbrand, E. (1989). Cognitive differences between experts and novices: Implications for group supervision. *Journal of Counseling and Development*, 67, 293–296.
- Ivey, A., & Ivey, M. B. (2002). *Intentional interviewing and counseling: Facilitating development in a multicultural society*. Belmont, CA: Thompson.

Kagan, N. (1980). Influencing human interaction—Eighteen years with IPR. In A. K. Hess (Ed.), *Psychotherapy supervision: Theory, research, and practice* (pp. 262–283). New York: Wiley.

Stoltenberg, C. D., McNeill, B. W., & Delworth, U. (1998). *IDM supervision: An integrated developmental model for supervising counselors and therapists*. San Francisco: Jossey-Bass.

---

## FEMINIST THERAPY

---

Feminist therapy, rather than being a succinct theoretical model, is a philosophy of psychotherapeutic intervention that recognizes the impact of varied social practices on personal well-being. It has its roots in the feminist and equal rights movements of the 1960s, and it embraces the conviction that “the personal is political”—that is, that which affects the person is representative of and ensues from the macrocosm in which she or he lives. Feminist therapists practice from a variety of feminist and psychological theoretical perspectives and represent a diverse group of individuals striving for political and social changes that exemplify justice and equality for all peoples.

The tenets of feminist therapy include, broadly, recognition of diversity in identity and of multiple oppressions, acknowledgment of power differentials inherent in the therapeutic relationship and in society, and responsibility for personal involvement in engendering individual and social changes that equalize power.

### Multiple Diversities and Oppressions

Feminist therapy acknowledges multiple aspects of human diversity that are likely to affect clients' personal well-being, including but not limited to, sex, heritage, race, class, age, physical ability, religion, and sexual orientation. While each of these aspects alone may create personal difficulties for an individual within society, most individuals suffer from multiple oppressions. In large part, providing didactic experiences that illuminate these inequities provides the framework for the therapeutic process. Additionally, feminist therapists remain aware of the complexity of human diversity and of how their own personal attributes and differences from the client may be affecting the process of healing.



## **The Therapeutic Relationship**

Although feminist therapists strive to achieve equality in their therapeutic relationships and to empower their clients, they are continuously aware of the intrinsic power differential, especially early in therapy, that exists in the therapeutic relationship. Throughout the therapeutic process, there is a continuous focus on equalizing the client-therapist relationship and on avoiding taking responsibility for or coercing the client. The intent of this focus is to work collaboratively with clients, who are considered experts relative to their experiences, to achieve goals that are meaningful to them. A strong emphasis is placed on consciousness raising, which assists clients in understanding the context of their psychological distress. Within this relationship, therapists are far more likely to be self-disclosing, especially in relation to their own experiences of oppression and empowerment, than in most formal schools of psychological thought.

## **Social Change**

Practitioners of feminist therapy are active in efforts to bring about change that equalizes social and personal power. Because feminism is multifaceted, the focus of such change efforts may vary greatly; however, personal investment in altering power differentials is considered of primary importance for the therapist and, eventually, for the client. Advocacy requires continuous awareness of both positive outcomes and unanticipated negative consequences of efforts to equalize power and promote justice.

## **Developmental Issues**

While feminist therapy has no formal theory of development, it does view society's construction of what is right and good as having considerable impact on individual identity development. For example, Chowdrow has suggested that girls develop through connection with their primary caregiver, usually a woman, while boys avoid this connection in favor of autonomy. Girls are expected to adhere to common gender role stereotypes, including nurturance (playing with dolls), sensitivity, and cooperativeness. Boys, conversely, are expected to be sturdy, power seeking, and self-determining. Society, in various forms, stresses similar messages in relation to a plethora of other personal attributes.

## **Psychological Suffering**

Feminist theorists' views of psychopathology, or problems in daily living, are, in some ways, dependent on their theoretical stances. However, there is consistent recognition that psychological distress is engendered by environmental conditions, especially those of disproportionate power and limitations of choice. Thus, as Ballou and Brown note, it is difficult to label an individual with a "disorder" and to believe that this "disorder" is located exclusively within the person, while ignoring the context of distress.

Feminist practitioners maintain awareness that the mental health field has its own discourse that may undermine the well-being of individuals who do not meet narrow standards of psychological wellness. The historical underpinnings of psychology are based in a White, male-dominated society that emphasizes independence and competition and values instrumental (formerly known as masculine) characteristics. Thus, the profession often ignores the voices and knowledge of the very individuals that they are attempting to serve. Feminist therapists generally have a much broader view of acceptable emotions, cognitions, and behaviors than those that are deemed appropriate in a society that is replete with injustice.

## **Therapy**

The various theoretical perspectives of feminist therapists provide guidance in resolution of clients' personal challenges; however, there are several techniques and philosophies that link feminist therapeutic practices.

### ***Consciousness Raising***

Feminist therapists utilize consciousness raising to examine the role that social power differentials and bias play in personal distress and relationships. Helping clients appreciate the systematic nature of personal constructions and relationships following from cultural constructions and mandates provides a holistic perspective of mental distress and well-being that diminishes self-blame.

### ***Personal Validation***

In large part, consciousness raising sets the groundwork for supporting clients' worth and engendering



personal empowerment. Feminist therapy is a practice of interdependence and support.

Feminist therapy strives to assist clients in finding their own voices to tell their own stories in ways that are self-validating and self-enhancing. It is a therapy of personal esteem and empowerment.

Libbe A. Gray

**See also** Feminization of Psychology (v1); Discrimination and Oppression (v2); Diversity (v3); Oppression (v3); Sexism (v3)

### Further Readings

- Ballou, M., & Brown, L. S. (Eds.). (2002). *Rethinking mental health & disorders*. New York: Guilford Press.
- Chowdrow, N. J. (1989). *Feminism and psychoanalytic theory*. New Haven, CT: Yale University Press.
- Worell, J., & Remer, P. (2003). *Feminist perspectives in therapy* (2nd ed.). Hoboken, NJ: Wiley.

---

## FEMINIZATION OF PSYCHOLOGY

---

An increasing number of women are joining the field of psychology. According to the National Science Foundation, the percentage of women receiving psychology doctoral degrees increased from approximately 15% in 1950 to 55% in 1988. In 2002, an American Psychological Association (APA) task force found nearly two thirds of all new recipients of master's degrees and doctorates in clinical or counseling psychology were women. In 1985, 34% of APA membership was female; in 2000 the membership was 49% female, reflecting a 15% increase over 15 years. According to an annual survey conducted by the Council of Counseling Psychology Training Programs (CCPTP), there were on average 29.83 women and 10.75 men enrolled in counseling psychology doctoral programs for the 2004–2005 academic year. The same survey found the ratio of female to male assistant and associate professors in counseling psychology was 53 to 18 and 51 to 27, respectively. For full professors, however, the ratio was 50 females to 58 males. Overall, statistics show that counseling psychology has shifted from a field that was once dominated by males to an academic area consisting mostly of women.

### Understanding the Term *Feminization of Counseling Psychology*

The term, *feminization of psychology*, was coined in order to describe the changing demographics of psychology. Within counseling psychology, however, although reference has been made to its gender constitution, little research has been conducted. In general, confusion has existed regarding how the phrase *feminization* is used. For example, the *feminization of psychology* has often been employed to describe how the sex ratio of women to men is impacting (both positively and negatively) the field of psychology. However, the word *feminization* suggests one is referring to the impact of the female gender on the field of psychology, which shifts the meaning from an essentialist understanding of biological sex to a more constructivist interpretation of the cultural implications of being female. Consequently, it is important to locate the term within the context of sex or gender. Throughout this entry, the term *feminization of psychology* is used to facilitate further understanding of perceived shifts in the field that may result from gender-related change. Finally, the discussion of *feminization of counseling psychology* largely reflects the Western cultural environment within the field, most particularly within the United States.

### Feminization or Gender Prejudice?

How do the perceptions and beliefs of the dominant culture influence the way people conceptualize the increase in the number of women in psychology and, concomitantly, in counseling psychology? It has been demonstrated that, historically, the efforts of women have been less visible than those of men within the field of psychology, despite many contributions of note. It has been evident that women were, for many years, under-represented within psychology across various roles, including those of author, therapist, administrator, and professor. This phenomenon has been attributed to, among other things, a historical cultural White male norm against which gender-related endeavors have been measured and acknowledged. It also likely reflects a societal reality that men often gained access to public roles and professions (including educational opportunities) prior to women. The question of whether a discussion of a masculinization of psychology would have ensued had the male-dominated field persisted has been raised in the



literature. Within this larger context surrounding the changing demographics, a “feminized” perspective might be useful were it to contribute new viewpoints and potentially problematic were it to become yet another norm from which to default. Counseling psychology may differ somewhat from other arenas within psychology, as it is a relatively younger branch of psychology and has not carried as lengthy a history of male predominance. It is also noteworthy that counseling psychology, like other fields, is not a fully evolved entity; consequently, the entrance of women into the profession might be correlated with changes not attributable to its feminization (ethnic, socioeconomic, and other kinds of diversity among psychologists have likely also played a role in broadening the traditional perspectives within counseling psychology).

### **Impact on Status and Prestige**

Historically, fields that consist largely of women (e.g., elementary school teachers, nurses) carry lower social status and prestige than those dominated by men. Some worry that as more women become researchers and practitioners, the field of counseling psychology will lose status. Although this concern has been reflected in general trends in some other professions (e.g., bank telling and book editing), research suggests that the increase in numbers of women in psychology has not *caused* a decrease in prestige. The etiology of this relationship is complicated and likely better accounted for by socialization. Specifically, men have frequently been socialized to pursue prestigious occupations, including those that are more profitable, have better working conditions, and offer greater opportunities for advancement. Women, it has been speculated, often have received the message that they should take up less theoretical space by filling lower status jobs. Finally, the status and prestige of counseling psychology has been impacted by the role of managed care, which limits the type and duration of treatment that practitioners may use.

### **Impact on Research**

Others have linked the increase in numbers of women in the field of counseling psychology to an imbalance in research-practitioner activities. There are more clinical practitioners than there are researchers, and some worry that the scientist-practitioner model (the idea that

research dictates practice and practice dictates research) is waning. Specifically, there has been concern that therapists may rely too heavily on clinical judgment rather than empirically supported treatments. Furthermore, within the research community, some psychologists worry that traditional research methods (empirical techniques) may be replaced by inductive qualitative methods. These fears are also grounded, it should be noted, in the belief that qualitative research is subjective, and therefore less accurate than standard positivist measures. Again, a causal link has been drawn between an increasing number of women psychologists and some aspects of the perceived researcher-practitioner gap. There are inevitably many variables that impact a trend of this nature (e.g., an increase in the number of professional psychology programs that often highlight clinical work instead of research and a decrease in federal funding for community and treatment-outcome mental health research programs).

### **Impact on Psychotherapy**

Special consideration for women and gender has been increasingly represented in the counseling literature and through counseling techniques. In her book, *The Shoulders of Women: The Feminization of Psychotherapy*, Philipson explored how the feminization of psychotherapy affects theory, techniques, and possibly even goals of therapy. If such a phenomenon were to occur, counseling psychology might see a paradigm shift relating to its view of mental health. Thus, the way in which psychotherapy is conducted within counseling psychology might be affected.

With more women entering counseling psychology, there has been a concomitant increase in awareness of gender-related issues. For example, the Division of Counseling Psychology of the APA (Division 17) has a formal group titled Advancement of Women, which is dedicated to “representing the interest of women” in areas ranging from professional support to education and training. With additional research and interest in women and gender, feminist principles seem to have become more prevalent. These principles include contributions that range from an analysis of power and status to a relational view of mental health and therapy to a belief that the personal is political. Feminist tenets have helped to advance both research and practice (e.g., improved egalitarian client-therapist relationships and questioned biased research) by transforming what has been the status quo to a more inclusive



approach. These contributions have generally been associated with the feminization of psychology, but as with concerns outlined previously, they are likely the result of several factors.

With an increase in the number of women in the field of psychology, practitioners and researchers have seemed more willing to question their work structure. Flexible hours, parental leave, and improved reentry policies for employees have been cited as significant shifts in work structure within psychology. With further options for employment arrangements, women and men have had the opportunity to build careers with the ability to create space for additional responsibilities such as family. It is important to note that it is not known whether the feminization of psychology caused a more flexible work structure, only that there is a correlation between improved work conditions and the entrance of additional women into the field. On a final note, the feminization of therapy within counseling psychology may reflect the consequences of a more general reality—that of men departing the caring fields, reinforcing the historical association between helper and caregiver and the female role.

### Future Directions

The notion of the feminization of psychology seemed to elicit a strong reaction from practitioners and researchers in the early 1990s. However, there appears to have been less focus on this topic more recently. Still, some studies have suggested that the increase in numbers of women psychologists is an international trend. Specifically, recent studies by Olos and Hoff and by Boatswain and colleagues found that there were more women than men entering the field of psychology in a majority of European countries as well as in Canada.

Although many psychologists have associated negative concerns with feminization, the increase in numbers of women entering the field has also been related to several positive trends. Again, it is difficult to know whether these factors are related exclusively to changing demographics or if there have been additional circumstances that facilitated these contributions. It has been speculated that due to societal attitudes, although numerical equality or even predominance may exist, this does not guarantee that women will predominately shape the future of the profession. Given the issue's complexity, additional

research is needed to better understand the feminization of psychology and the implications of changing demographics.

*Kathryn Rickard and Samantha R. Strife*

**See also** Bias (v3); Counseling Psychology, Definition of (v1); Counseling Psychology, History of (v1); Feminist Therapy (v1); Prejudice (v3); Recruitment: History and Recent Trends in Diversity (v1)

### Further Readings

- Fowler, R. D. (2002). APA's directory tells us who we are. *Monitor on Psychology*, 33(2), 1–3.
- Goodheart, C. D., & Markham, B. (1992). The feminization of psychology: Implications for psychotherapy. *Psychotherapy*, 29(1), 130–138.
- Olos, L., & Hoff, E. H. (2006). Gender ratios in European psychology. *European Psychologist*, 11(1), 1–11.
- Ostertag, P. A., & McNamara, J. R. (1991). Feminization of psychology: The changing sex ratio and its implications for the profession. *Psychology of Women Quarterly*, 15, 349–369.
- Philipson, I. J. (1993). *On the shoulders of women: The feminization of psychotherapy*. New York: Guilford Press.
- Travis, C. (1998, June 21). A widening gulf splits lab and couch. *New York Times*. Retrieved November 12, 2007, from <http://www.nytimes.com/specials/women/nyt98/21caro.html>

---

## FORENSIC APPLICATIONS

---

Forensic counseling may be defined as the application of counseling values and philosophy to persons involved in the legal process. In order for this to occur, one of four processes must take place. The first is concerned with the counselor's intellectual comprehension of criminal behavior, including sexual crimes, spousal abuse, behavioral problems indicating an antisocial outlook, and continuous criminal offenses. Second, counselors should be aware of deterrence issues and have the ability to diagnose various disorders; moreover, the counselor should be very familiar with the factors that are likely to precipitate illegal behavior. Third, a counselor should be familiar with assessment instruments used in diagnosis and should be able to establish a personalized treatment plan for the offender. Last, the counselor should know how to



initiate a counseling intervention that has a primary goal of eradicating the client's problematic behavior.

### **Custody Evaluations**

Family courts frequently use forensic counselors. For instance, when former spouses contest a judge's ruling regarding custody, an investigation may be ordered to determine the best custodial situation for the child (this is commonly called a custody evaluation). While not obligatory, a custody evaluation is prepared when parents have difficulty reaching an equitable arrangement. A first-class custody evaluation will have the following:

- A bare minimum of one (though it is usually more) separate interview each with the mother and father, with a total of three hours with each
- A minimum of one interview with the child or children with the parents absent
- An interview with the child's preschool, elementary, or high school teachers as well as any other adults that have a connection with the child
- For young children, observation of any contact between the child and the parents
- A criminal background check on each parent

### **Divorce Counseling**

During divorce proceedings, judges often request counseling for couples and their children before agreeing to the attorney's writ of divorcement. Divorce adjustment therapy can aid adults and children during this difficult transition. Children often react to divorce with sadness or resentment or conduct themselves in an inappropriate fashion; consequently, impairment in academic performance occurs. In addition, regression takes place in younger children, and both mother and father report that their child's behavior is what they would expect from a younger child. Any of these symptoms reflects a child experiencing a disturbance, and if the child receives no help, his or her symptoms could grow worse. Mental health counseling aids children and adolescents to come to terms with the changes resulting from the divorce and minimize its influence. An effective counselor assists parents to formulate the best method for managing their children.

Children are not the only individuals needing counseling—their parents need to be taught how to manage themselves throughout the divorce. This is especially true for the individual not seeking the divorce but needing to accept his or her spouse's demand for the

legal termination of their marriage. Common symptoms include depression, anxiety, insomnia, and hypersomnia. The primary goal of therapy in this situation is to help the individual come to terms with the impending demise of his or her marriage.

Many states have the requirement that mediation must be included within the divorce process to ease the disturbed relationship existing between the spouses. Divorce mediation is designed to help the couple find an equitable conciliation regarding both monetary issues and custody for their child or children. After the divorce is finalized, mediation is used to promote cooperation, but the focus is placed on the mother's and father's duties as parents; the specific intent is to capitalize on the child's likelihood for emotional and psychological growth.

### **Anger Management**

Forensic counselors conduct anger management workshops in a variety of settings and are frequent consultants in family and criminal courts. Showing one's anger or losing one's temper is not, in itself, a problem; on the other hand, when an individual acts in an aggressive manner toward someone else, a problem is created. Anger management counseling is common in child maltreatment and family violence cases. If a parent loses his or her control with a son or daughter on a regular basis, the parent may be forced to undergo anger management counseling, or he or she may not be allowed to see the child. After an incident has occurred, the person responsible for the violence will usually enter counseling (the judge requires it) to admit his or her blame regarding any violent acts as well as to learn how to control the anger. Many assaults arise due to a parent's lack of impulse control, and the individual thus charged or found guilty can gain insight and control techniques during psychotherapy. When the counseling is ordered by the judge, the sessions are often overseen by probation officers in order to make sure the perpetrator complies with all rules and regulations.

In anger management training, the counselor attempts to understand what occurs in an individual when that individual loses control due to anger, and the counselor teaches different techniques for the individual to use when angry. These lessons might include, for instance, how to relax by using deep breathing or how to manage anxiety on a daily basis. Techniques of cognitive-behavioral therapy are also used so the client can gain mastery over his or her anger. If needed, the



forensic counselor can send the client to a psychiatrist in order to have medication prescribed.

### **Counseling Victims**

Being the victim of a crime can be a life-threatening event, and many victims find it difficult to come to terms with their injuries. Wounds causing physical disfigurement or those that are physically disabling can cause long-lasting psychic disturbances. In addition, these disturbances can take place even if no substantial injury occurred, for example, when an individual witnesses someone experiencing a criminal assault or an individual barely escapes from being seriously hurt. When an individual experiences such events, he or she may develop posttraumatic stress disorder (PTSD) but could also develop major depression, phobias (specific to an act or situation), the fear of being outside (agoraphobia), generalized anxiety disorder, even a psychotic break with reality.

### **Counseling Adolescents**

When dealing with adolescents, the counselor should remember that illegal actions might be caused by inadequate parenting or from growing up in a highly dysfunctional household. Assessing delinquency is a vital element in the juvenile justice system, because the primary emphasis is on rehabilitation, not punishment. A teen offender might need counseling, educational support, or treatment for an alcohol or drug addiction. If the teen is placed on probation, any therapeutic treatment often decreases the odds of recidivism. This is one reason why adolescents placed on probation must be competently evaluated, and tracking improvement in treatment is essential.

A treatment evaluation procedure contains an appraisal of all indictments as well as a complete examination of any past illegal behavior. For adolescents, the forensic counselor should obtain a copy of academic reports, including records of daily attendance and any data regarding school assessment or classifications. The counselor should see the juvenile in order to evaluate his or her emotional state as well as to identify the presence of any mental problems. If ordered by the judge, the counselor should assess the juvenile's personality using reliable and valid instruments in order to discover any problems, for example, psychopathy, dysthymia, or bipolar disorder. If feasible, it may be that the juvenile's family needs interviewing as well, primarily so the counselor can see family dynamics at work.

A complete psychological assessment will detail, in plain language, the test-taker's results. In addition, the forensic counselor will supply information regarding any logical findings that link the client's known emotional difficulties to his or her criminal behavior. The counselor will give precise detail regarding counseling and will offer prospects concerning whether the individual is likely to recidivate in the future. This is accomplished by showing the client's odds of committing crimes again, whether or not the client has had therapy.

### **Counseling Adults**

Mental health professionals have many opportunities to furnish important data to the courts regarding adult felons. For instance, in cases involving child maltreatment, an assessment of the accused may discover emotional conflicts serving as the foundation for the crime(s), and thus the information gathered can be used to devise a workable treatment plan. If a child is a key witness in a criminal prosecution, counselors may need to testify as to whether the child's testimony is reliable. In cases involving family violence, individuals violating court orders may be assessed to determine their impulsivity as well as any future possibility for criminal behavior.

Many illegal actions are connected to mental and emotional problems that can be successfully treated. In essence, if more criminals received proper therapy, recidivism would likely decline at an enviable rate. However, within many prisons, forensic counseling has been discarded due to increasing costs and the relative incidence of failure. Many courts have stated unequivocally that prisons (both state and federal) and local jails have the ethical responsibility to offer counseling to prisoners, and if the therapy is not provided, the institution could be held liable. Once a prisoner has been released, he or she can be required to receive counseling privately (at community mental health centers with a reduced rate) as a prerequisite for probation or parole, with the cost being borne by the parolee or probationer.

### **Child Maltreatment**

Once an individual has been accused of child maltreatment, he or she will be examined by a host of professionals to gauge whether or not the charge has merit. Counselors are often directed to assess both children and adults to see if a history of ill-treatment exists and to gauge the individual, family, and community factors that might have led to abuse. This



helps to identify a scenario in which abuse might have taken place and to devise therapeutic goals that mitigate the effects of any identified maltreatment. Suggestions might entail the removal of a child from his or her parents' home, the removal of a parent or guardian from the home, restricted visitation rights, abrogation of all visitation, modification or complete alteration of parental custody agreements, psychotherapy for the victim and/or the abuser, and preparation for an eventual family reunion.

When child maltreatment cases are investigated, a forensic counselor is often asked to interview all implicated parties. Various assessment instruments may be used to gauge these individuals' mental ability and to determine whether any disorders or problems are present as well as to establish the existence (or nonexistence) of any potential maltreatment risk factors. All information gleaned throughout this process is provided to the court, with the judge ruling on the admissibility of the counselor's findings.

The majority of child maltreatment cases are tried in family court; however, when the charges are particularly heinous, the case could be moved to criminal court, where the alleged perpetrator will stand trial. Once a case is placed in criminal court, the prosecution must prove beyond a reasonable doubt that the alleged abuser is guilty. Counselors may be called upon to clarify, assess, or analyze data written and compiled by others; to certify that the rules and regulations used by the criminal court were adequate to determine whether the conclusions were reliable and valid; or to explain whether the instruments used for assessment performed as stated by their originators.

*Cary Stacy Smith and Li-Ching Hung*

**See also** Child Maltreatment (v1); Custody Evaluations (v1); Family Counseling (v1); Legal Issues in Parenting (v1); Sexual Harassment (v4); Sexual Violence and Coercion (v1)

### Further Readings

- Blumenthal, S., & Lavender, T. (2001). *Violence and mental disorder: A critical aid to the assessment and management of risk (forensic focus)*. London: Jessica Kingsley.
- Dixon, C. G., & Emener, W. G. (1999). *Professional counseling: Transitioning into the next millennium*. Springfield, IL: Charles C Thomas.
- Ryan, E. S. (2002). *Juvenile forensic counseling*. Lancaster, VA: Anchor Communications.

## FRETZ, BRUCE (1939– )

Bruce Fretz contributed to the field of counseling psychology in a varied and significant fashion. He left lasting impressions on students within the field, facilitated the development of new faculty, and contributed to the growing profession, all from his position as director of the counseling psychology doctoral program at the University of Maryland. Over 20 years of service that included authoring a quintessential textbook, writing numerous articles, and holding various leadership positions, Fretz epitomized influential leadership in counseling psychology.

### Education and Training

In his early years, Fretz did not plan on nor did he believe in the possibility of attending college. He had planned to drop out of school to work to support his mother and younger siblings, as his father had passed away when Fretz was a young boy. However, after he and other teachers discovered that he had an exceptional talent in mathematics, he was switched to the "college track" in school. This sudden change provided him with a boost of confidence that he could perform academically. From there, he progressed academically in a whimsical fashion, with mentors and teachers handing him opportunities that he accepted, by his own admission, with only a half-understanding of their significance.

Fretz was awarded a full scholarship to Gettysburg College and majored in psychology with the original intent of entering the ministry. As he progressed through his undergraduate schooling, he realized that he enjoyed his psychology courses more than his religion and Greek class work. With mentorship and a recommendation from his advisor, Charles Platt, he applied to and was accepted into a graduate program in counseling psychology at Ohio State University. He obtained his Ph.D. in counseling psychology, and in the year 1965, he and his wife were ready to embark upon a new segment of his life near Washington, D.C.

### Overview of Career

Upon graduating with a doctorate degree, Fretz obtained a faculty position with the University of Maryland's Department of Psychology. After a brief



time at his position, he obtained tenure and an associate professor position, as he was steadily publishing research. Then, just four years after graduating with a Ph.D., he was asked to direct the doctoral program in counseling psychology at the University of Maryland, and he held this position for the next 20 years. His leadership helped build a stable and progressive program from one that had previously struggled with its identity, status, and retention of students. Fretz retired from the University of Maryland in 1995, but he continued to play an active leadership role in various organizations in retirement, including participating in the American Psychological Association Council of Representatives.

Over his years working at the University of Maryland, Fretz was cherished by faculty and students as a competent leader and a warm supportive mentor. Students commented on his passionate orientation toward counseling psychology and his ever-present kindness and support. Colleagues emphasized his ability to work with and achieve collaboration among varying staff personalities. Fretz himself suggested that he owed his teaching success to a specific philosophy he had learned from past teachers and implemented. This philosophy consisted of demonstrating one's enthusiasm in the subject, being student-centered, working hard to make the subject matter interesting, being liked by students, and wanting students and the professor to discover the subject matter together. It seems that his attentiveness to the needs of others allowed him to achieve both popularity and success as a professor and program director.

Fretz was a prolific writer, producing texts and articles that expanded the knowledge of the profession and assisted students in learning. His research was consistently on the cutting edge of counseling psychology research, even from his beginnings as a doctoral student researcher. His dissertation project using factor analysis to examine nonverbal communication in counseling initiated the use of factor analysis for this purpose and also formed the foundation for future study of nonverbal communication's impact on the counseling session. He also was the first to perform a meta-analysis on career counseling research. Other research interests included career counseling, sexual attitudes, preparation for graduate study, and preresirement issues. He also wrote articles to guide students in the field of psychology, which further demonstrated his devotion to preparing and mentoring future counseling psychologists. Through such

articles as *Finding Careers With a Bachelor's Degree in Psychology*, *Preparing for Graduate Study in Psychology*, and *Licensing and Certification of Psychologists and Counselors*, he demonstrated his dedication to the next generation of professionals.

Fretz also cowrote one of the most important and influential textbooks in the field, *Counseling Psychology*, which was written primarily for graduate counseling psychology students. Through this text and his other work, he assisted the field in distinguishing itself through a clear definition and vision. In addition to training students, writing textbooks and articles, leading various organizations, and consulting with other graduate programs, he was also editor of *The Counseling Psychologist*. Clearly, he was working hard to improve the profession, directly and indirectly impacting both students and professionals.

During Fretz's career, he held a variety of leadership positions in the field, culminating with his election as president of the American Psychological Association's Division 17 in 1991. He was the Psi Chi national president between the years 1974 and 1978, and he was elected the board chair of the Council of Counseling Psychology Training Programs in 1978. He assisted in the development of some 30 counseling psychology training programs as a site visitor and consultant over the course of 13 years. Clearly, Fretz epitomized leadership in the field, and he played a critical role in developing counseling psychology programs over the course of his career.

## Legacy

Bruce Fretz's legacy is unmistakable. He was passionate and dedicated to fostering the growth of young psychologists, his own counseling psychology program at the University of Maryland, and the profession of counseling psychology as a whole. He did this via a dedication to passionate teaching, a commitment to leadership in local and national arenas, and a prolific writing career. He was respected by colleagues and students for his leadership style and friendliness, and he will be remembered by all for his commitment and devotion to the field of counseling psychology.

Nick Barnecko

**See also** Counseling Psychology, Definition of (v1);  
Counseling Psychology, History of (v1); Mentoring (v1);  
Postdegree/Prelicensure Supervision (v1)



### Further Readings

- Fretz, B. R. (1974). Psychology in counseling psychology—Whither or wither? *Journal of Counseling Psychology*, 22, 238–242.
- Fretz, B. R., Corn, R., Tuemmler, J., & Bellet, W. (1979). Counselor nonverbal behaviors and client evaluations. *Journal of Counseling Psychology*, 26, 304–311.
- Fretz, B. R., & Leong, F. L. (1982). Career development status as a predictor of career intervention outcomes. *Journal of Counseling Psychology*, 29, 388–393.
- Gelso, C. J., & Fretz, B. R. (2000). *Counseling psychology* (2nd ed.). Belmont, CA: Wadsworth.
- Hill, C. (2000). Bruce Fretz: A leader with quiet grace and tact. *The Counseling Psychologist*, 28, 376–396.

---

## FRIEDLANDER, MYRNA L. (1947– )

---

Myrna (Micki) L. Friedlander is best characterized as a brilliant, warm, and delightful individual whose greatest contributions to the profession have brought family therapy into mainstream counseling psychology. Beginning with the first family therapy articles to ever be published in *Journal of Counseling Psychology* in 1984 and 1985, and culminating in 2006 with her book, *Therapeutic Alliances in Couple and Family Therapy: An Empirically Informed Guide to Practice*, Friedlander has contributed much to our understanding of family communication and change. Throughout her career, she has focused on therapist–client discourse and its implications for effective treatment, particularly in family therapy. Her elegant integration of science and practice throughout her career epitomizes the essence of a true scientist–practitioner.

### Career

Reflecting upon her career, Friedlander characterizes it as more serendipitous than planned. She credits the course her professional life has taken to her interest in language, her relationships with supportive mentors and colleagues, and the impetus of the women’s movement. Her academic career began at Case Western Reserve University in Cleveland, Ohio, where she earned a B.A. in French. She taught French to low-income at-risk children in inner-city Boston, when after 5 years she concluded that she was having a greater impact on her students by talking with them about their problems than by teaching them French.

A chance meeting with a high school friend who was enrolled in a master’s degree program in crisis resource teaching prompted her to consider a graduate degree in a helping profession. Friedlander decided to move to Washington, D.C., where she enrolled in George Washington University (GWU). Once again, a chance meeting, this time with the dean of GWU’s college of education, led her to enroll in a graduate counseling course to try it out. Finding counseling a good match with her interests, she decided to pursue a master’s degree in counseling. It was at GWU that Friedlander met her first mentor, Janet Heddesheimer.

As a new doctoral student at Ohio State University (OSU), Friedlander was assigned Ted Kaul as her advisor. Initially skeptical about the “science” of psychotherapy, Friedlander questioned how one could “study” psychotherapy, an “art” that was traditionally the domain of women (i.e., helping people with emotional problems) until a man (Freud) came along and “legitimized” the therapeutic process by calling it a scientific endeavor. These inquisitive thoughts set the stage for an article she would write in 1992, “Psychotherapeutic Processes: About the Art, About the Science.” Ironically, Friedlander has now been studying the “science” of psychotherapy for over 25 years, trying to show that the “art” can be identified, understood, and taught to students.

In graduate school, Friedlander was initially attracted to Stanley Strong’s concept of psychotherapy as a social system, in which change is brought about by specific processes of interpersonal persuasion. She was particularly influenced by sociolinguistic applications to the study of therapy by Harold Pepinsky, a distinguished faculty member at OSU. When Friedlander began her dissertation in 1979, several OSU faculty (including Lyle Schmidt, Ted Kaul, and Don Dell) had concluded that Strong’s theoretical model needed experimental validation with actual clients in treatment. This conclusion led to her decision to pursue a dissertation using role induction as a persuasive method of enhancing therapeutic effectiveness.

While completing her predoctoral internship at Albany Medical Center in Albany, New York, Friedlander received a call from her advisor, Ted Kaul, alerting her to a job opening at the University at Albany (UAlbany), where there was a doctoral program newly accredited by the APA. Although it was early in her internship year and she really enjoyed clinical work, she decided to apply for the position and try out academia. The decision to accept that position became a



pivotal point in her life; it led to a long, productive career as an academic psychologist at UAlbany. At the invitation of another mentor, Reuben Silver, she also served for 19 years (1984–2003) as adjunct clinical assistant professor at Albany Medical College of Union University in the Department of Psychiatry. Friedlander has also maintained a small private practice since 1983 and meets regularly with a peer supervision group.

In her early years at UAlbany, Friedlander found herself, together with colleague Susan Phillips, to be one of only two female counseling psychology faculty members. While navigating new territory for women in counseling psychology, the two became close friends, colleagues, and coauthors. Friedlander also found mentoring support from two other fellow colleagues, Richard Haase and Monte Bruch.

As a professor in the APA-accredited counseling psychology program at UAlbany, Friedlander has served as director of training for the past 7 years. She finds this role to be one of the most gratifying aspects of her work. She truly enjoys supervising and mentoring students, watching them mature, and seeing them transition through graduate school and into clinical and academic positions. Her warmth and sage advice are widely felt by her former students.

### Collaborations and Publications

A serendipitous meeting at an APA poster session initiated a long-term professional relationship with Laurie Heatherington, who shared many of Friedlander's interests in family and gender issues. Their work together on relational control led them to meet Valentín Escudero, professor of psychology and director of the family therapy intervention master's degree program at the University of La Coruña, Spain. Escudero's subsequent invitation to Friedlander and Heatherington to serve as keynote speakers at a conference in Spain marked the beginning of another significant collegial relationship, including a graduate exchange program between La Coruña and UAlbany. Together, Friedlander, Escudero, and Heatherington authored a book that Friedlander refers to as "the crowning joy of my scholarship," *Therapeutic Alliances in Couple and Family Therapy: An Empirically Informed Guide to Practice*. In this book, Friedlander, Escudero, and Heatherington focus on the interchange between and among family members and the therapist, focusing on the use of language to facilitate the healing of families. The authors use their

conceptual model, System for Observing Family Therapy Alliances (SOFTA), to integrate theory, research, and practice. They use their measuring instruments to demonstrate how positive and negative behaviors on the part of both clients and therapists can either strengthen or weaken the therapeutic alliance.

Friedlander collaborated with two other distinguished researchers, Nick Ladany (a former doctoral student of Friedlander) of Lehigh University and M. Lee Nelson of University of Wisconsin–Madison, to author *Critical Events in Psychotherapy Supervision: An Interpersonal Approach*. Together, they closely analyzed transcripts of dialogues to show how problems in group therapy can be identified, explored, and turned into opportunities for growth. This book offers a practical model of supervision and provides empirically based information within a framework of interpersonal relatedness.

Friedlander adopted a daughter as a "gift" to herself once she earned tenure. Given that her daughter was from Paraguay, Friedlander became attentive to children's ethnic identity development long before this was at the forefront of counseling psychology. As she learned more about the process, she wrote three theoretical articles on ethnic identity and international adoption: "Ethnic Identity Development of Internationally Adopted Children and Adolescents: Implications for Family Therapists," "Adoption: Misunderstood, Mythologized, Maligned," and "Bicultural Identification: Experiences of Internationally Adopted Children and Their Parents."

Friedlander has authored numerous other book chapters, articles, clinical training manuals for family therapy, and measurement instruments, including the *Differentiation of Self Inventory* with former student Elizabeth Skowron. Friedlander also has made numerous noteworthy professional presentations in the United States, Canada, Mexico, and abroad in Spain, Portugal, Italy, and Scotland.

### Awards and Distinctions

Friedlander has earned numerous prestigious awards and distinctions. In addition to being named fellow of two APA divisions, Division 17 (Counseling Psychology) and Division 29 (Psychotherapy), she was awarded the Cambridge (U.K.) Diploma of Achievement in Education in recognition of her distinctive contributions to counseling psychology. She also was awarded the title of Distinguished Psychologist by the Psychological



Association of Northeastern New York (2001) and was a recipient of the University at Albany Award for Excellence in Research (2000). In 1991, Friedlander was named a fellow of the American Psychological Society and of the American Association of Applied and Preventive Psychology.

Friedlander has held many leadership positions in national professional associations. She has been exceptionally active as a member of APA Division 17 (Counseling Psychology), serving as communication specialist, division newsletter editor, vice chair of the Section for the Promotion of Psychotherapy Science, member of the Advisory Council of the Science Vice Presidency, member of a special task force on integrating practice and science, and member of several committees (including the Program Committee, Awards Committee, and Fellowship Committee) and special interest groups (Marital and Family Therapy and Qualitative Research Methods). Friedlander has served on the editorial boards of *Journal of Counseling Psychology*; *The Counseling Psychologist*; *Journal of Marital and Family Therapy*; *Psychotherapy: Theory, Research, Practice, and Training*; and *Psychotherapy Research*.

For Friedlander, teaching, mentoring, supervising students, and making a difference in individuals' and families' lives are the most meaningful and gratifying aspects of her career. Undoubtedly, Micki Friedlander's contributions go well beyond the pages in her books; they touch the lives of so many people.

R. Clare Smith and  
Donna E. Palladino Schultheiss

**See also** Behavioral Observation Methods, Assessment (v1); Communication (v3); Couple and Marital Counseling (v1); Family Counseling (v1); Relationships with Clients (v2); Supervision (v1)

### Further Readings

- Friedlander, M. L. (1995). On the process of studying the process of change in family therapy. In L. T. Hoshmand & J. Martin, *Research as praxis: Lessons from programmatic research in therapeutic psychology* (pp. 171–197). New York: Teachers College Press.
- Friedlander, M. L. (1999). Ethnic identity development of internationally adopted children and adolescents: Implications for family therapists. *Journal of Marital and Family Therapy*, 25, 43–60.

- Friedlander, M. L. (2003). Adoption: Misunderstood, mythologized, maligned. *The Counseling Psychologist*, 31, 745–752.
- Friedlander, M. L., Escudero, V., & Guzmán, M. (2001). International exchanges in family therapy: Training, research, and practice in Spain and the U.S. *The Counseling Psychologist*, 30, 314–329.
- Friedlander, M. L., Escudero, V., & Heatherington, L. (2006). *Therapeutic alliances with couples and families: An empirically-informed guide to practice*. Washington, DC: American Psychological Association.
- Friedlander, M. L., & Highlen, P. S. (1984). A spatial view of the interpersonal structure of family interviews: Similarities and differences across counselors. *Journal of Counseling Psychology*, 31, 477–487.
- Friedlander, M. L., Highlen, P. S., & Lassiter, W. (1985). Content analytic comparison of four expert counselors' approaches to family treatment: Ackerman, Bowen, Jackson, and Whitaker. *Journal of Counseling Psychology*, 32, 171–180.
- Friedlander, M. L., Larney, L., Skau, M., Hotaling, M., Cutting, M., & Schwam, M. (2000). Bicultural identification: Experiences of internationally adopted children and their parents. *Journal of Counseling Psychology*, 47, 1–12.
- Ladany, N., Friedlander, M. L., & Nelson, M. L. (2005). *Critical events in psychotherapy supervision: An interpersonal approach*. Washington, DC: American Psychological Association.
- Skowron, E. A., & Friedlander, M. L. (1998). The Differentiation of Self Inventory: Development and initial validation. *Journal of Counseling Psychology*, 45, 235–246.

---

## FUNCTIONAL BEHAVIORAL ASSESSMENT

---

Functional behavioral assessment (FBA) refers to a range of assessment strategies to identify variables that influence behavior in the natural environment. The purposes of FBA are to (1) define and describe problem behaviors, (2) predict when problem behaviors are likely and unlikely to occur, and (3) identify consequences that maintain the behavior (i.e., the functions of the behavior). Learning theory has provided the foundation for the principles of FBA. A variety of processes are used in conducting an FBA, including direct (e.g., behavioral observations) and indirect methods (e.g., interviews) and functional (or



experimental) analysis. FBA data are used to create individualized behavioral interventions that account for the identified predictive variables and behavioral functions.

## Theoretical Principles

Functional behavioral assessment is rooted in the philosophical perspectives of empiricism, contextualism, and determinism. These positions assume that many problem behaviors are learned, that learning occurs through particular interactions, and that these interactions can be altered to produce desired changes in behavior. Learned behaviors refer to behaviors that occur (or fail to occur) because of how they are responded to by significant others or events in the individual's environment. Principles of operant conditioning contribute heavily to the learning theory principles underlying functional behavioral assessment.

The earliest formulation of operant principles is known as the *law of effect*. This law is based on the observation that voluntary behavior is influenced by its effects, namely, its consequences. According to the early version of the law of effect, behavior that produces satisfying consequences tends to become more frequent over time; behavior that produces discomfort tends to become less frequent. Subsequent revisions of the law of effect recognize the importance of relevant situational cues. That is, a behavior may have positive effects in one situation but negative effects in another situation. As a result, individuals become sensitive to situational cues, especially to antecedent cues that precede their behavior and allow them to determine whether a behavior is likely to produce positive or negative effects. Behavior is influenced not only by the effects that follow it but also by the situational cues that precede it.

During operant conditioning, the consequences of a behavior influence the frequency of the behavior in the future. Any operant behavior can be strengthened or weakened depending on the type of consequences that follow the behavior. Reinforcers are types of consequences that strengthen a behavior. Punishers are types of consequences that cause a behavior to become less frequent. Reinforcers and punishers can be either positive or negative, depending on whether the consequence involves the addition or obtaining of something or the removal or escape of something. Positive reinforcement, then, strengthens behavior through the addition of something desirable (e.g., money, smiles). Negative reinforcement strengthens behavior through the removal

of something undesirable (e.g., chores). Positive punishment weakens behavior through the addition of something undesirable (e.g., social disapproval), and negative punishment weakens behavior through the removal of something desirable (e.g., access to a favorite toy or activity). According to behavioral theory, behavior is not random—those behaviors with strong reinforcement histories continue, and those that have been more strongly punished than reinforced will discontinue.

It should be noted that there are often competing consequences for behaviors. A behavior may be followed by multiple consequences, some of which are reinforcing and some that are punishing. Whether a behavior is strengthened or weakened by those consequences depends on whether the overall pattern of consequences is perceived as more reinforcing or more punishing. For example, adolescents who miss curfew may be reinforced by having increased opportunity to socialize with peers, but they may be punished at home. Some adolescents may perceive the reinforcement to outweigh the punishment and so continue to miss curfew. Others may perceive the punishment as strong enough to deter similar behavior in the future. The strength of the consequence, the delay between the behavior and the consequence, and the frequency of the consequences all play a part in their impact.

There are essentially six functions of behavior. Three of these involve positive reinforcement and three involve negative reinforcement:

1. *Obtain internal stimulation:* A behavior may continue because it provides desirable stimulation to the individual. For example, a child might rock back and forth because it is soothing to do so.
2. *Obtain attention:* A behavior may continue because it draws attention from others (attention that is perceived as reinforcing). For example, a female adolescent might dress provocatively because it results in attention from boys at school.
3. *Obtain activities or objects:* A behavior may continue because it results in activities or the acquisition of objects. For example, stealing is reinforced by the objects acquired.
4. *Escape/avoid internal stimulation:* A behavior might be strengthened because doing the behavior allows the individual to avoid an unpleasant sensation. For example, children with ear infections often pull on their ears because it lessens the pain of the earache.



5. *Escape/avoid tasks or activities:* A behavior might be strengthened because it allows the individual to escape or avoid an unpleasant task or activity. For example, children who play with objects in their desk may be doing so because it keeps them from having to do work they do not like.
6. *Escape/avoid attention:* A behavior might be strengthened by helping an individual avoid unwanted attention. For example, an individual might avoid his or her job because at work, the boss continually degrades and belittles the individual.

Antecedents are also important to consider in an FBA. Antecedents are stimuli that precede behaviors and often provide clues about which behaviors will pay off. They do not, however, cause behavior. For example, a red stoplight sets the stage for the behavior of hitting the brakes, because an individual's learning history suggests that doing so will be reinforced (i.e., it is negatively reinforced by the avoidance of getting a ticket or getting in an accident). Antecedent cues that preceded behaviors that were reinforced in the past tend to set up a pattern for repeating those behaviors when the antecedents appear in the future (so most individuals are likely to brake when they see a red stoplight in the future). Antecedent cues that preceded behaviors that were punished in the past signal an individual not to repeat those behaviors in the future.

Not all antecedents immediately precede behaviors. Some antecedents occur very close to the behavior. For example, a teacher asking students to get out their books serves as an antecedent for a child getting out his or her book. Other antecedents are more temporally distant but still impact behavior. For example, *setting events* refer to conditions that impact the occurrence of the behavior, and they often are more distant. For example, a person might be more likely to do a poor job at work (behavior) if he or she did not get a good night's sleep the night before (setting event). All antecedents need to be considered when doing an FBA.

### Historical Progression

By the late 1960s, the methods used to record behavior in laboratories became known as the *experimental operant paradigm*, whereas the consequences that were programmed and their effects on responding became known as the *principles of operant conditioning*. In the

1970s, researchers began applying the principles of operant conditioning to clinically relevant and socially significant problems. For such applications to occur, methods that had been used to program consequences in the laboratory (e.g., schedules of food reinforcement) needed to be replaced with procedures that could be used in clinical and social settings. Similarly, in the absence of mechanical recording devices, systematic observation became the standard means of reliably detecting changes in an individual's behavior. During the 1970s and early 1980s, the term *behavior modification* was coined. Behavior modification is the systematic and scientific use of behavior principles to improve individuals' thoughts, feelings, and actions. It was during this period that many strategies involved in conducting a functional behavioral assessment were developed.

### Processes and Methods

Behavioral analysts incorporate multiple sources of information when making clinical judgments. Each method employed during the course of a functional assessment involves thoroughly describing the problem behavior(s) and gaining an understanding of the events leading to and following the behavior. The clinician gathers information pertaining to the individual client and the function(s) of his or her behavior primarily through the use of interviews, direct observations, and functional analysis.

#### *Indirect Assessment*

Information gathered via interviews is considered to be the launching pad for each of the other FBA procedures. Naturally, conversing with the client about his or her behaviors is often the first step taken by professionals. Clinicians perform interviews with the client and those individuals interacting with the client on a frequent basis (e.g., family members, teachers) to glean rich information pertaining to the problem behavior. Questions typically are designed to elicit information regarding the events prior to and following the client's behavior as well as details about the behavior itself. The interview format may vary in terms of formality based on the professional's preferences and the needs of the individual client.

The behavioral interviewer attempts to gain specific information in order to develop an individualized treatment plan. During each interview, however, the



clinician is also mindful of building good rapport with the client. It is essential that the questions posed by clinicians comprise an interview schedule that sufficiently elicits specific and accurate information concerning high-risk behaviors, such as violence, suicide, and abuse.

Other indirect FBA methods include rating scales and behavior checklists. These tools are used to identify problem behaviors as well as to ascertain relevant setting events, antecedents, and functions (consequences) for those behaviors. Like interviews, other indirect measures may be completed with the client or relevant individuals in his or her environment.

Subsequent to interviews and other indirect measures, hypotheses are often formulated regarding variables that predict behavior occurrence as well as the consequences maintaining problem behavior. In some circumstances, however, indirect information does not elucidate a clear pattern that can be used to make predictions about behavior. Alternatively, the clinician may want to gather additional information before proceeding with an intervention plan. Behavioral observations can provide additional information with which to form hypotheses or to support or disconfirm those made following interviews. Direct observation is frequently informed by the information gained through indirect methods. For example, a clinician may use the specific definitions of a behavior arrived at through interviews as the basis for observing that behavior in the individual's environment.

### **Behavioral Observation**

Systematic observation procedures are an integral component of this empirical approach to understanding behavior. Indirect assessment relies on the client, or another informant knowledgeable about the behavior in question, to recall and accurately report information. In contrast, direct behavioral observation allows the recorder to witness and immediately record information about the target behavior, antecedents, and consequences. The observer may be the professional conducting the FBA or an individual who works with the client frequently (e.g., group home employee, teacher, parent). Alternatively, the client may perform this form of data collection pertaining to his or her own behavior. For example, the clinician may ask the client to record each time he or she smokes a cigarette. Additionally, the client would record the events occurring before and after the smoking behavior.

The observer should receive training on how to accurately record antecedent-behavior-consequence (ABC) observations.

Clinicians are able to choose from several approaches to observe samples of the client's behavior: event sampling, duration recording, and interval recording. *Event sampling* or *frequency recording* involves counting the number of times that the behavior is seen occurring during a specified time period. *Duration recording* accounts for how long an instance of the behavior lasts. *Interval recording* methods provide an indication of the percentage of prespecified intervals during which the behavior is observed to occur. The observer then extrapolates the sample data to help explain the entire behavior. To help ensure that the observer witnesses the target behavior, it is important to schedule the observation period at times when the behavior is most likely to occur. It is also important that observations are scheduled at times and in places where the behavior is not typically seen. Recording observational data in a variety of settings and times throughout the day will allow the clinician to understand when the behavior does and does not occur and can be useful in developing interventions.

The amount of information gained through behavioral observation techniques is vast and can seem overwhelming during the initial stages of investigation. With time, common themes emerge from clients' data. Ideally, behavioral observation should occur until themes emerge from the data concerning the individual client.

### **Functional Analysis**

Clinicians employ functional analysis procedures to better understand the purpose, or function, of the client's behavior. Although the goals of interviews, behavioral observation, and functional analysis are similar, functional analysis procedures require the clinician to directly manipulate the environment. During interview and behavioral observation sessions, the clinician attempts to understand the client's behavior within the context of his or her everyday life. Interviews and behavioral observation allow the clinician to develop hypotheses about the antecedents and consequences that maintain the client's target behavior. The functional analysis process allows the clinician to test the validity of these hypotheses through experimentation. Identified antecedents and consequences are isolated and altered while the target



behavior is monitored. Often, functional analysis includes four conditions—one in which attention is presented contingent upon the problem behavior being exhibited, one in which escape is allowed contingent upon the behavior, a third in which the client is alone, and a fourth in which no task demands are made and reinforcement is available. The clinician utilizes data kept on the target behavior to determine which environmental modifications have the greatest impact. The results of functional analyses allow clinicians to develop individualized, data-based interventions for clients.

### Developing Interventions Based on a Functional Behavior Assessment

Once relevant antecedents and functions of behavior have been identified, they are used in the development of a plan for remediating the problem behavior. With regard to antecedents, the intervention should decrease or minimize antecedents that lead to the problem behavior as well as increase those that are not shown to lead to the behavior. For example, if it is determined that overeating at dinner is more likely when a person skips breakfast and when he or she is dining alone, the intervention likely would include encouraging the individual to eat breakfast every day and to make plans to dine with others as often as possible. Alternatively, it is important to consider those antecedents that precede appropriate behavior and to increase their frequency. For example, if the individual in the example above tends to eat moderately when seated at the dining room table with the television off, the plan might include encouraging the individual to set up those conditions when eating dinner. Both temporally distant setting events and immediate precursors to the behavior should be considered when addressing antecedents.

Building interventions based on functions is a bit more complicated, because there are several factors to consider. According to behavioral theory, all problem behavior is being reinforced (i.e., only reinforced behaviors continue). One part of the intervention, then, is to find a way to decrease the problem behavior, either by punishing it or by lessening its reinforcement value. However, simply decreasing a problem behavior is unlikely to be effective unless an appropriate alternative behavior is put in its place. If, for example, a child learns that he or she can get access to toys by grabbing them from other children, a plan

might involve making sure that an adult prevents the child from playing with the toy after it is snatched from someone else. The plan might also include punishing the behavior of grabbing toys from others (e.g., by having the child play separately from other children for a brief period). In this case, the plan is to ensure that the behavior of grabbing toys does not lead to the reinforcer of getting to play with toys that have been grabbed. If the behavior of grabbing decreases and there is no behavior to put in its place, it is likely that the behavior may return or another inappropriate behavior (e.g., hitting) might appear. It is important, therefore, to include in interventions a way to promote more appropriate behaviors that might serve the same function as the problem behavior. In the above example, the child might be taught how to appropriately ask for toys he or she wants to play with. The idea is that the child learns to get access to toys (reinforcement) for a more appropriate behavior than grabbing at them.

In considering appropriate behaviors to replace inappropriate ones, it is important to recognize that some individuals will need to be taught those behaviors. In the examples used above, an individual might need to be taught how to eat slowly and mindfully to avoid overeating. Children might need to be taught how to ask others to give them a toy.

Overall, comprehensive interventions based on FBA procedures should include multiple strategies, each of which is individually tailored to the client and based on the specific findings from the FBA. Following the FBA process helps ensure that interventions are based less on the topography (or name) of a problem behavior and more on the circumstances surrounding the behavior for a particular individual. Research has shown that such interventions are more likely to result in reduction of problem behaviors and/or increases in appropriate replacement behaviors.

*Michelle S. Athanasiou,  
Rhannon Ducey, and Amanda Stoeckel*

*See also* Behavioral Observation Methods, Assessment (v1); Behavioral Therapy (v2); Behavior Rating Scales (v1); School Psychology (v1); Skinner, B. F. (v2)

### Further Readings

Bandura, A. (1977). *Social learning theory*. Englewood Cliffs, NJ: Prentice Hall.

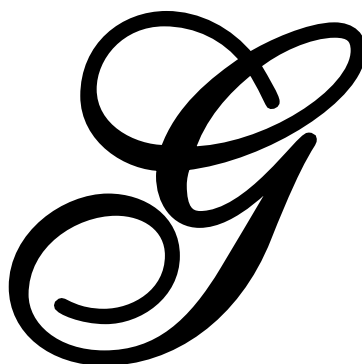


- Bellack, A. S., & Hersen, M. (1998). *Behavioral assessment: A practical handbook*. Boston: Allyn & Bacon.
- Cooper, J. O., Heron, T. E., & Heward, W. L. (2007). *Applied behavior analysis* (2nd ed.). Upper Saddle River, NJ: Pearson.
- Haynes, S. N., & O'Brien, W. H. (2000). *Principles and practice of behavioral assessment*. New York: Kluwer.
- Horner, R. H. (1994). Functional assessment: Contributions and future directions. *Journal of Applied Behavior Analysis*, 28, 401–404.
- Luiselli, J. K., & Cameron, M. J. (1998). *Antecedent control: Innovative approaches to behavioral support*. Baltimore: Brooks.
- O'Neill, R. E., Horner, R. H., Albin, R. W., Sprague, J. R., Storey, K., & Newton, J. S. (1997). *Functional assessment and program development for problem behavior: A practical handbook* (2nd ed.). Pacific Grove, CA: Brooks/Cole.
- Plaud, J. J., & Gaither, G. A. (1996). Behavioral momentum: Implications and development from reinforcement theories. *Behavior Modification*, 20, 183–201.
- Repp, A. C., & Horner, R. H. (1999). *Functional analysis of problem behavior*. Belmont, CA: Wadsworth.
- Skinner, B. F. (1953). *Science and human behavior*. New York: Macmillan.









---

## GAMBLING

---

Gambling has become a major recreational activity in the United States. In the past, legalized gambling was confined to a few states, such as Nevada and New Jersey, but in the past two decades gambling opportunities have expanded. Some form of legalized gambling exists now in all but two states; 37 have lotteries, and 27 have casino gambling. A 1999 survey showed that nearly 90% of the adult population participates in some form of legalized gambling, especially instant lottery games, slot machines, office pools, and card games. In the 23 years from 1974 to 1997, gambling expenditures more than doubled as a percentage of personal income.

While most persons gamble responsibly, between 3.5% and 5% of the general population develops problematic gambling. Pathological gambling (PG), the most severe form of problematic gambling, may affect as much as 1% to 2% of the adult general population, which suggests that more than 2 million Americans suffer from this disorder, with roughly twice that many having gambling related difficulties without meeting the criteria for the disorder as described in *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV)*. PG is characterized by continuous or periodic loss of control over gambling.

Recognized for centuries, criteria for PG were first enumerated in 1980 in *DSM-III*. The criteria are patterned after those used for substance dependencies and emphasize the features of tolerance and withdrawal, both of which have been described in persons with PG and in those with substance dependence.

*The DSM-IV* enumerates 10 specific maladaptive behaviors, and 5 or more are required for the diagnosis.

Research suggests that PG may be even more common among youth. Gambling itself is on the rise; a national survey reported that 82% of respondents had gambled at least once in the past year, with lottery and casino gambling showing the largest rates of increase from earlier surveys. The psychosocial costs of PG include financial, legal, employment, and relationship difficulties as well as psychiatric complications such as depression, substance misuse, and suicide.

Although PG is widely conceptualized as an addiction, its classification remains controversial. Some experts have included PG as part of an "obsessive-compulsive spectrum" of disorders, while others have linked it with impulse control disorders, such as compulsive buying and kleptomania, or even to the mood disorders.

One quarter to one third of all pathological gamblers are women. Women tend to begin gambling later in life, often in their early 30s, while men start in their late teens or early 20s. Women tend to have a more rapid progression to pathological gambling, a phenomenon known as *telescoping*. Special populations at risk for developing PG include adults with mental health or substance use disorders, persons who have been incarcerated, African Americans, and persons of lower socioeconomic status.

Persons with PG are highly likely to have comorbid mood and anxiety disorders and to misuse substances. Other impulse control disorders (e.g., compulsive buying, kleptomania), and attention deficit hyperactivity disorder are also frequently comorbid with PG. Lifetime drug or alcohol dependence has been consistently reported in persons with



PG, and one survey showed that the rate of alcohol or other drug abuse was nearly 7 times higher among persons with PG than among nongamblers or recreational gamblers. From 30% to 50% of treatment-seeking pathological gamblers have histories of substance misuse.

Personality disorders are also relatively common in persons with PG, although there is no specific “gambling personality.” A small but significant subset of persons with PG has antisocial personality disorder, which appears to run in families.

Researchers have attempted to identify subtypes, but this work has not been empirically validated or led to clinically meaningful distinctions among persons with PG. Perhaps the most widely discussed scheme is the distinction among the “escape-seekers” and “sensation-seekers.” Escape-seekers are often older individuals who may gamble out of boredom or to fill time, and they may choose passive forms of gambling, such as slot machines. Sensation-seekers tend to be younger and prefer card games or table games, which involve active input on the part of the gambler.

An association between crime and PG is well established. The prevalence of criminal activity among pathological gamblers has been estimated to range from 20% to 80%. Illegal behaviors reported by persons with PG include writing bad checks and engaging in embezzlement, larceny, tax fraud, and prostitution (among women). The addictive nature of PG is thought to represent an important criminogenic factor.

There have been no careful longitudinal studies to determine its natural history, but PG is widely assumed to be chronic with a continuous, unremitting, or episodic course. Several phases have been described in the progression of PG. During the “winning” phase, increased accessibility of and exposure to gambling-related activities are listed as causes of the gradual progression from social gambling to PG. Many pathological gamblers are thought to derive a substantial proportion of self-esteem from gambling and rely on gambling to manage their disappointments and negative mood states. A string of bad luck or unexpected losses leads to the “losing” phase, a phase that centers on the behavior known as *chasing*. With *chasing*, the gambler desperately attempts to recover the lost money. Wagering is more frequent and often in larger amounts. The gambler may lie to important persons in his or her life, including spouse, parents, and children in order to hide losses. The uncontrollable spiral of losing and chasing losses leads the gambler to the

“desperation” phase, in which the gambler may begin to engage in illegal activities to support the gambling problem. Fantasies of escape and thoughts of suicide are reportedly common during this phase. Some gamblers may experience a fourth phase of “giving up” or hopelessness and may seek treatment, often at the insistence of others. Depression, thoughts of suicide, and stress-related symptoms, including hypertension, heart palpitations, sleep disorders, or gastrointestinal distress may occur.

PG can wreak havoc in nearly all domains of the pathological gambler’s life, including the social, financial, professional, and personal spheres. Persons may begin gambling as a hobby or way to socialize. As gambling interest progresses, the gambler may begin to isolate himself or herself from family or friends; many will develop feelings of loss of control, guilt, or shame in relation to their gambling. One of the first casualties of PG is the loss of support and trust of family members, including the spouse. Work-related problems develop, as urges and thoughts of gambling are difficult to control, resulting in absenteeism or poor work performance; job loss is not infrequent. Bankruptcy filings are relatively common among persons with PG, and in one study nearly 44% of persons with PG reported having no savings or retirement funds; 22% had lost their home or automobile or had pawned valuables to pay off the gambling losses. In some cases, the consequences of PG can lead the individual to attempt or complete suicide. Attempted suicide has been reported in from 17% to 24% of Gamblers Anonymous members in treatment for PG.

Family history data suggest that PG, mood disorders, and substance misuse are more prevalent among the relatives of persons with PG than in the general population. Twin studies also suggest that gambling has a heritable component. Functional neuroimaging studies suggest that among persons with PG, gambling cues elicit gambling urges and a temporally dynamic pattern of brain activity changes in frontal, paralimbic, and limbic brain structures, suggesting to some extent that gambling may represent dysfunctional frontolimbic activity.

There is no standard treatment for PG, but therapeutic approaches have emphasized individual and group psychotherapy, 12-step programs, and inpatient programs. Research suggests that cognitive-behavioral therapy can be effective, particularly when combined with motivational interviewing. Gamblers Anonymous, a 12-step program founded in 1957, may



be helpful. Unfortunately, attendees often drop out in the first year, reducing its potential effectiveness. Inpatient treatment and rehabilitation programs similar to those for substance use disorders may be helpful for selected patients. The use of medications to treat PG is being actively researched but is complicated by a high frequency of placebo response and high dropout rates. The opioid antagonist naltrexone has been shown to be more effective than placebo, as has the opioid antagonist nalmefene, which is not available in the US.

Donald W. Black

**See also** Alcoholics Anonymous (v1); Cognitive-Behavioral Therapy and Techniques (v2); Group Therapy (v2); Substance Abuse and Dependence (v2)

### Further Readings

- Argo., T., & Black, D. W. (2004). The characteristics of pathological gambling. In J. Grant & M. N. Potenza (Eds.), *Understanding and treating pathological gambling* (pp. 39–54). Washington, DC: American Psychiatric Publishing.
- Black, D. W., Monahan, P. O., Temkit, M., & Shaw, M. (2006). A family study of pathological gambling. *Psychiatry Research*, 141, 295–303.
- Blaszczynski, A., & McConaghy, N. (1989). Anxiety and/or depression in the pathogenesis of addictive gambling. *International Journal of Addictions*, 24, 337–350.
- Cunningham-Williams, R., & Cottler, L. B. (2001). The epidemiology of pathological gambling. *Seminars in Clinical Neuropsychiatry*, 6, 155–166.
- Grant, J. E., Potenza, M. N., Hollander, E., Cunningham-Williams, R., Nurminen, T., Smits, G., et al. (2006). Multicenter investigation of the opioid antagonist nalmefene in the treatment of pathological gambling. *American Journal of Psychiatry*, 163, 303–312.
- Gerstein, D., Murphy, S., Toce, M., Hoffman, J., Palmer, A., Johnson, R., et al. (1999, April). *Gambling impact and behavior study*. Report to the National Gambling Impact Study Commission. Retrieved November 12, 2007, from <http://cloud9.norc.uchicago.edu/dlib/ngis.htm>
- Pallanti, S., Ross, N. B., & Hollander, E. (2006). Pathological gambling. In E. Hollander & D. J. Stein (Eds.), *Manual of impulse control disorders* (pp. 251–189). Washington, DC: American Psychiatric Publishing.
- Potenza, M. N., Kosten, T. R., & Rounsaville, B. J. (2001). Pathological gambling. *Journal of the American Medical Association*, 286, 141–144.
- Tavares, H., Zilberman, M. L., Beites, F. J., & Gentil, V. (2001). Gender differences in gambling progression. *Journal of Gambling Studies*, 17, 151–159.

---

## GENETIC COUNSELING

---

The profession of genetic counseling, a relative newcomer to the field of counseling, has been on the leading edge of innovation since its inception in the 1970s. Significant advances in medical technology over the past 40 years have led to breakthroughs in genetic testing along with subsequent improvements in the prevention, analysis, and treatment of genetic disorders. Due to these remarkable developments, the profession of genetic counseling has come to the forefront to meet the challenges of the 21st century and beyond.

Genetic counseling is most commonly defined in the literature as the evaluation of a couple's medical and family history in order to determine the health hazards to a fetus due to a variety of causes. These include exposure to teratogens in the womb (environmental risk factors that adversely affect the fetus), chromosomal damage, and genetic birth defects. According to the Centers for Disease Control and Prevention, approximately 3% of babies are born with birth defects each year.

Some of the most commonly known genetic disorders, such as Down syndrome, congenital heart defects, cystic fibrosis, muscular dystrophy, and spina bifida, are the result of an inherited condition or a genetic mutation at conception or in vitro. Disorders such as Huntington disease and Marfan syndrome can be inherited from just one parent. Other diseases such as Tay-Sachs and sickle cell anemia are found in certain ethnic racial groups and are inherited when both parents carry the gene for the disorder.

Not every expectant parent is a candidate for genetic counseling or testing. Couples are encouraged to seek out this option when the following risk factors are present:

- Prenatal screening tests show abnormalities.
- An amniocentesis procedure uncovers chromosomal abnormalities.
- There is a family history of birth defects or an inherited disease.
- Previous children born to the couple have genetic disorders or existing birth defects.



- The expectant parent is over the age of 35.
- The expectant parent has had two or more miscarriages, a stillbirth, or a child who died early in infancy.
- Either parent is a member of a particular ethnic or racial group that has a high incidence of genetic predisposition to a disease or disorder.
- There is a history of drug and alcohol abuse in either parent.

When expectant parents decide to pursue the option of genetic testing, sophisticated tests are performed to identify the possibilities of passing on inherited disorders. The test results are then analyzed and interpreted by genetic counselors who work in conjunction with the couple's doctor to help parents assess their options and make decisions about how to proceed with the pregnancy as well as the subsequent birth of the child. Genetic counselors function as part of a healthcare team and act as advocates and referral sources to the families they serve. Supportive counseling is also provided to couples who are dealing with emotional issues that arise as a result of learning that their child has a serious genetic condition.

### **Preparing for a Career in Genetic Counseling**

People enter the field of genetic counseling from a variety of specialties, including nursing, social work, genetics, biology, psychology, public health, and counseling. Genetic counselors are highly trained health professionals with specialized education, usually at the master's degree level. Training includes courses in medical genetics, communication, critical thinking and counseling skills, psychosocial assessment, case management, and the legal and ethical considerations inherent to the profession.

In order to be certified as a genetic counselor by the American Board of Genetic Counseling (ABGC), an individual needs to complete academic and supervised clinical training at an accredited graduate program. To date, there are 22 fully accredited genetic counseling programs in the United States, 7 with "provisional accreditation" or classified as "recognized new programs" by ABGC and 1 with "probationary accreditation." Training programs go through a rigorous evaluation process in order to receive accreditation by ABGC. There are also numerous international programs located in Australia, Canada, China, Cuba, France, Israel, Japan, the Netherlands, Norway, Saudi

Arabia, South Africa, Spain, Sweden, Taiwan, and the United Kingdom.

Candidates for certification in the United States must also pass two exams: a general one assessing human genetics knowledge and a specialized genetic counseling exam. These exams are offered in 2-year cycles, and an individual needs to pass both exams in two consecutive exam cycles in order to become an ABGC Diplomate and Certified Genetic Counselor. Professional certification is voluntary, and an individual needs to be recertified every 10 years in order to retain the right to use the registered title of Certified Genetic Counselor. Doctors and nurses specially trained in the field of human genetics also provide genetic counseling.

Demographic information on genetic counselors is collected every 2 years through a detailed professional status survey. The number of certified genetic counselors has increased from 673 in 1993 to a total of 2,035 in 2005. The field continues to grow as new areas for professional development are created. The 2004 survey indicated high job satisfaction in most areas, with the exception of the possibilities for advancement in the field. A portion of the respondents reported that they were considering leaving the field due to job burnout, changing professional interests, and limited opportunities for advancement.

Traditional genetic counselors that specialize in prenatal counseling work in a variety of settings, including medical centers, hospitals, and private practice. A number of genetic counselors work in administrative and research capacities. Today, however, increased opportunities in the field have opened up new career avenues, including those in business, education, and public policy. In 2002, the median income for genetic counselors with master's degrees and up to 5 years of clinical experience ranged from \$47,000 to \$56,000 per annum.

### **A Historical Perspective**

The first class of master's degree level genetic counselors graduated from Sarah Lawrence College, in Bronxville, New York, in 1971. The National Society of Genetic Counselors was incorporated in 1979. Its vision was to become the voice, professional authority, and advocate of the genetic counseling field, and its stated mission was to uphold the burgeoning profession as a distinguished and legitimate part of the healthcare delivery system in this country.

As early as 1973, genetic counseling professionals began to reflect on the feasibility of starting a



professional society at the International Genetics Meeting in Paris. In 1977, the idea took hold with a group of graduates and students from the Sarah Lawrence College training program. By April 1978, a committee to form the society was established and bylaws were considered. However, the society did not have a smooth beginning. At a meeting in Williamsburg, Virginia, to discuss the training role and function of genetic associates, a highly vocal group of physicians protested the use of the term *genetic counselors* to define master's level professionals in the field. They also protested the plan to exclude medical geneticists (physicians with training and fellowships in medical genetics) from full membership in the new society.

By June 1979, after consulting with legal counsel, the title of "genetic counselor" was adopted by the bylaws committee in spite of the continued protests by some in the medical profession. The society took on the name of the National Society of Genetic Counselors (NSCG), and the first two issues of the society's newsletter had been published. Additionally, regional districts had been established, the bylaws had been filed, and the society had been incorporated in New York State by October 1979. Two of the officers in the fledgling society were appointed to the American Board of Medical Genetics as of 1980, further legitimizing the profession. The organization continued to grow and expand throughout the 1980s, and in 1992 the American Board of Genetic Counselors became a separate entity from the American Board of Medical Genetics. Henceforth, the ABGC became responsible for the accreditation of training programs and the certification of genetic counselors, while the NSGC continued as the advocacy and education arm of the profession.

### Recent Innovations

The field of genetic counseling continues to diversify and grow. Genetic counselors come from a variety of backgrounds, such as teaching, graphic design, molecular biology, nursing, fundraising, and the public health arena, and a number of them have multiple degrees. Their former training and multiple degrees make these individuals' skills increasingly marketable in a changing field.

Genetic counselors can be found working in a number of nontraditional settings. These nontraditional roles include conducting research in biogenetic businesses and universities, teaching genetic counseling training programs, and working in diagnostic

laboratories, Internet companies, the pharmaceutical industry, administration, and public health. According to the most recent professional status survey, an increasing number of genetic counselors are becoming health consultants and going into private practice.

*Susan L. Kessner*

*See also* Bereavement (v1); Ethical Dilemmas (v1); Eugenics (v1); Family Counseling (v1); Mental Retardation and Developmental Disabilities (v1)

### Further Readings

- Evans, C. (2006). *Genetic counseling: A psychological approach*. New York: Cambridge University Press.
- Heimler, A. (1997). An oral history of the National Society of Genetic Counselors. *Journal of Genetic Counseling*, 6(3), 315–336.
- Parrott, S., Clark, C., & DeVecchio, M. (2004 and 2007). *National Society of Genetic Counseling professional status survey analyses*. Boston: Information Solutions.
- Resta, R., Biesecker, B. B., Bennett, R. L., Blum, S., Hahn, S. E., Strecker, M. N., et al. (2006). A new definition of genetic counseling: National Society of Genetic Counselors' task force report. *Journal of Genetic Counseling*, 15, 77–83.
- Shiloh, S., Gerad, L., & Goldman, B. (2006). Patients' informational needs and decision-making processes: What can be learned from genetic counselees. *Health Psychology*, 25, 211–219.

### Web Sites

- American Board of Genetic Counselors: <http://abgc.net>
- Human Genome Project: [http://www.ornl.gov/sci/techresources/Human\\_Genome/medicine/genecounseling.shtml](http://www.ornl.gov/sci/techresources/Human_Genome/medicine/genecounseling.shtml)
- Kids Health (Nemours Foundation): <http://www.kidshealth.org>
- March of Dimes: <http://www.marchofdimes.com>
- Medline Plus: <http://www.nlm.nih.gov/medlineplus>
- National Society of Genetic Counselors: <http://www.nsgc.org>

---

## GERONTOLOGY

---

Gerontology is defined as the study of aging, focusing on the physical, social, and psychological aspects of older adulthood. In the most general sense, gerontology draws from diverse disciplines covering all aspects of the aging process in people and animals.



Gerontology is made up of professionals from areas such as nursing, nutrition, psychology, medicine, pharmacology, sociology, and other social-service related fields focusing on the aging experience. Whether they are focused on research or applied science, gerontologists have a mutual interest in the increased understanding of aging and aging mechanisms and an overarching goal of the promotion of successful aging.

In a youth oriented society, aging may carry a negative connotation. Ageism, prejudice or discrimination based on an individual's age, is manifested in negative views of aging held by the general public. One such stereotype is that all older adults are the same, with increasing homogeneity occurring simultaneously with aging. Myths of the aging experience include erroneous beliefs that older adults are rigid, sickly and frail, cognitively impaired, and dependent on others. However, existing literature clearly refutes these stereotypes of an aging population, and the field of gerontology continues to combat ageist misperceptions.

### Physical Aspects of Aging

Much attention has been given to the specific biological processes that occur during aging. Although to date there is not consensus in regard to the causes of aging, there is general agreement that the physical signs of aging result from the body's natural changes in tissues. In older adults, *stroma* (connective tissue) increases, while *parenchyma* (functional tissue) decreases. This process occurs throughout all organs of the body and likely works in conjunction with hormonal changes, resulting in a general aging pattern experienced by most healthy older adults. Physical changes are a normal product of aging and generally occur in the skin, hair, body build, mobility, cardiovascular, respiratory, excretory, digestive, reproduction, nervous, and immune systems. Sensory organs are affected as well, leading to changes in vision, hearing, balance, taste, and smell.

Although the disease process is not automatically indicated with aging, chronic degenerative diseases may assert themselves in older individuals, including diabetes, arthritis, arteriosclerosis, osteoporosis, gout, and anemia. Symptoms such as inflammation, pain, cough, and rigidity may result from injuries incurred over a life span.

Although physical changes occur in the sexual response cycle, sexuality remains an important part of life for older adults, and sexual intercourse can be a

satisfying experience. Research gives no indication of increased health risks involved with having sex as an older adult. In fact, one study showed that those who continued to have sex frequently after the age of 60 had a more active sexual response cycle, had increased hormone flow, reported higher levels of happiness, and indicated living exciting lives.

## Social Aspects of Aging

### *Retirement*<sup>†</sup>

Retirement is the decision-making process and behavioral transition spanning work and leisure activities that many encounter later in life. Planned retirement is a relatively new phenomenon, as prior to the early 1960s, retirement was often a consequence of falling ill or being laid off from a job. As Social Security benefits and earnings increased, retirement became increasingly viewed as favorable and a right earned for a lifetime of hard work.

Transition into retirement is less clear-cut than it once was, when it was a complete withdrawal from the workforce and from work-related activities. With the current economy, some older adults find that they do not have the option to retire, but instead must continue working in order to survive financially. In contrast, those with a higher socioeconomic status may strategize to create a unique transition into retirement. Rather than completely withdrawing from the workforce, these older adults re-enter the work force for social or cognitive benefits, utilizing this period of their life as a time to pursue goals or interests other than their original employment.

### *Social Security*

Social Security, or benefits provided to elderly persons through social programs, was first established in 1935 by the New Deal's Social Security Act. Although the development of social security policy provided much needed relief to older adults living in poverty, it also created a societal notion that older persons were a homogenous group of aid-deserving individuals. Social Security has come under increased scrutiny as the baby boomer population rapidly approaches retirement. Eligibility for Social Security benefits currently begins at age 65, and there are no economic eligibility requirements. It is estimated that the percentage of the gross domestic product spent on



Social Security will increase by one third over the next 20 years, and that this growth will cause Social Security needs to exceed payroll tax receipts by the year 2012. Policy reform is needed to avoid any potential shortcomings facing the Social Security system over the next decade.

### **Options for Living Arrangements**

Whether it is in age-restricted retirement communities or long-term care, elders, their caregivers, and adult children have more choices than ever before in housing options for this phase of life. The desire to remain independent has brought about an increase in active adult and independent living communities, spurring community-based care services designed to help older adults remain in the community through social support programs, adult day care, home-based care, and other care services. Should more care be required, options range from assisted living—where older adults often have private units similar to apartments and receive nursing, meal, and cleaning services to assist in maintaining a degree of independent living—to long-term care units that offer a place of residence to older adults who can no longer perform activities of daily living and who do not have at-home caregivers to assist them. Secured units help residents with decreased functioning due to dementia live meaningful lives without endangering themselves. In addition, hospice care, an approach to providing comfort and care at life's end rather than heroic lifesaving measures, has become increasingly available via in-home services, specialized units, and hospitals.

### **Psychological Aspects of Aging**

Several developmental theories have been formed to explain the journey from birth to death. Erikson's psychosocial model of development contains stages, each with its own conflict, through which he postulated all individuals progress. His stage for older adults entails the conflict of ego integrity versus despair, where older adults face the task of engaging in life review and gaining peace with past successes and failures, thereby achieving ego integrity. To obtain ego integrity, older adults must accept normal changes in their physical, social, and psychological roles as well as navigate the ageist system in our culture.

The burgeoning field of geropsychology focuses on the mental health of older adults. Unique aspects of

psychosocial challenges for older adults—transitions, grief and loss, increased dependency—are increasingly prevalent. A review of the current literature estimates that mental health disorders among the elderly range from 18% to 28%; estimates are even higher if older adults are institutionalized. The elderly have the highest suicide rate of any group in the United States. However, research indicates that clinical interventions are successful in combating mental disorders such as depression and anxiety in older adults, leading to a clearer understanding that old age does not have to be synonymous with mental disorders or inability to benefit from treatment.

Cognitive changes occur with normal aging, but the majority of older adults are able to preserve their cognitive abilities into later life. In general, thought processes slow, and the incidence of certain types of memory errors increases. Although working memory tends to decline with age, in some cases older adults appear more adept at utilizing both hemispheres of the brain during memory tasks and are able to more successfully regulate emotion for increased memory ability.

For some older adults, cognitive decline surpasses that which is normally expected as individuals age. Dementia, a disease process characterized by several cognitive impairments including problems with memory, is thought to increase with age. This is especially true for dementia of the Alzheimer's type; prevalence rates are as high as 1.6% for individuals ages 65 to 69, and this figure rises to 25% for individuals over 85 years of age.

### **Professional Organizations**

Gerontology continues to be a burgeoning field with opportunities in a multitude of professions. Two of the most recognized professional organizations include the Gerontological Society of America (GSA) and Association for Gerontology in Higher Education (AGHE). These organizations bring together professionals from a variety of disciplines to discuss the most pressing needs of the aged and our changing society.

*Tammi Vacha-Haase, Natalie E. Brescian,  
and Krystle M. Balhan*

*See also* Adult Development (v1); Aging (v1); Counseling the Elderly (v1); Death and Dying (v1); Dementia (v2); Physical Activity Counseling (v2); Physical Health (v2); Retirement (v4); Retirement, Implications of (v1)



**Further Readings**

- Atchely, R. C., & Barusch, A. S. (2004). *Social forces and aging: An introduction to social gerontology*. Belmont, CA: Wadsworth.
- Cavanaugh, J. C., & Whitbourne, S. K. (Eds.). (1999). *Gerontology: An interdisciplinary perspective*. New York: Oxford University Press.
- Hooyman, N. R., & Kiyak, H. A. (2005). *Social gerontology: A multidisciplinary perspective*. Boston: Allyn & Bacon.
- Nelson, T. D. (2005). Ageism: Prejudice against our feared future self. *Journal of Social Issues, 61*, 207–221.
- Novak, M. (2006). *Issues in aging*. New York: Pearson Education.
- Silverman, H. L. (2001). Geriatric psychology. In *The Corsini encyclopedia of psychology and behavioral science* (Vol. 2, pp. 630–633). New York: Wiley.
- Sneed, J. R., & Whitbourne, S. K. (2005). Models of the aging self. *Journal of Social Issues, 61*, 375–388.





---

## HEALTH BELIEF MODEL

---

The Health Belief Model (HBM) was originally developed in the 1950s as a way of understanding apparent resistance to seeking preventive treatment in the form of inoculations and screenings for communicable diseases. It can be described as an organizing framework for predicting acceptance of public and individualized health behavior recommendations. Thus, it appears to have applications in the realms of individual intervention, program development, and public policy. The model focuses on health-related motivation, attempting to define what it takes for an individual to engage in health promoting behaviors. This includes not only engaging in preventive actions, but also following interventions prescribed by various health practitioners. As a value-expectancy theory, HBM examines behavior as a function of the subjective value placed on an outcome and the subjective expectation that the action taken will result in the desired outcome. The model also works from the assumption that good health is valued for most people, focusing on the impact of beliefs and values on health-related decision making.

The model includes four primary variables: perceived susceptibility, perceived severity, perceived benefits, and perceived barriers. Perceived susceptibility addresses an individual's belief of vulnerability to the illness or disease when not experiencing symptoms directly. For individuals who have already been diagnosed, this variable has been adjusted to include their acceptance of the diagnosis as well as their perception of resusceptibility to the illness and general susceptibility in regard to overall health. Perceived

severity entails the perception of how serious individuals believe the potential effects of the illness will be on their lifestyles, including the potential impact on social factors like their ability to work and their family interactions. Susceptibility and severity can be combined to create the construct of *perceived threat*, which in turn can be directly compared to the variable of *perceived benefits*.

The perceived benefits describe an individual's belief in the effectiveness of preventive or prescribed actions. Perceived barriers range from practical issues of money and healthcare access to more psychologically and fear-based issues (i.e., denial, not wanting to know if he or she has a serious illness). Albert Bandura's theory of self-efficacy adds the missing piece to explain the power of perceived barriers in an individual's perception of competence to act in an effective manner to prevent or overcome an illness. In this way, self-efficacy acts as a mediating factor as to whether someone will behave in a health-promoting manner. The model's focus on health-related motivation seems directly related to theories of change, with the four primary variables (i.e., susceptibility, severity, benefits, and barriers) providing a combined understanding of an individual's readiness to act in a health-promoting manner. Higher levels of perceived threat (susceptibility plus severity) combined with strong perceptions of the benefit to action and self-efficacy lead to increased motivation to act in health-promoting ways. HBM has been criticized for not directly accounting for non-health-related motivators for various behaviors (i.e., social acceptance) or economic and environmental factors (i.e., hazardous work environment). However, in breaking down and defining the



primary variables of the model, it seems that these factors may be barriers to action.

### Application of the Model

Applications of HBM extend from the individual to the public policy level. In applying the variables of the model to individual therapy, each can provide insight into the development of an effective intervention that a client will be motivated to carry out. It may also be used in identifying various factors that prevent individuals from successfully reaching health-related therapeutic goals. The identification of barriers has been demonstrated by research to be a primary factor in understanding ineffective treatment regimens. From the larger perspective of public policy and the development of intervention programs, HBM provides a flexible, adaptable model that can be applied to multicultural populations, various illness diagnoses, and preventive health-related actions as well as to a wide variety of approaches to intervention and behavioral outcomes. The four primary constructs can be applied to cultural knowledge regarding a specific population or group in the development of interventions such as breast self-examination and AIDS prevention programs, where the model can enhance the effectiveness of the interventions by disentangling differences in age, gender, and culture in regard to the interaction between the constructs for specific groups. Researchers have pointed out the need to pay close attention to how cultural and socioeconomic factors account for differences in measuring the perception of threat, benefits, and barriers.

### Implications for Future Research

One aspect of HBM that is still not well understood or researched is the concept of cues that stimulate the link between perceptions and actions. Researchers have struggled to identify the complex nature of environmental, interpersonal, and intrapersonal cues. It seems that health-promoting programs could have increased participation and success if the developers of these programs had a more comprehensive understanding of these cues. It is possible that the cues correlate to the interaction between the perceived severity of and the susceptibility to an illness, implying that different cues are necessary for individuals with differing levels of perceived severity and susceptibility. Cues to action (e.g., emotional or social

processes) may be internal (i.e., bodily change or symptom, emotional states, desire to seek approval from a significant other) or external (i.e., media exposure to information, pressure from a loved one to seek treatment). The complexity of measuring the level of influence of these various types of cues continues to challenge researchers in developing studies that would provide information on the impact of such cues on various populations.

The model itself has presented challenges in understanding the specific interactions between the primary variables, self-efficacy, and the predicting behavior. The model suggests that individual perceptions of threat, benefits, and barriers to action may be mediated by self-efficacy beliefs and cues to action that may then predict the likelihood of health-promoting action. Research has demonstrated the individual importance of the primary variables but not necessarily their interaction. Better understanding of the interactions of variables within the model might provide greater power to predict, understand, and enhance participation in preventive health programs as well as in follow-through with respect to prescribed treatment. An example of the dynamic nature of the model is demonstrated by its ability to compare (a) the importance individuals attach to prevention in the context of their own perceived susceptibility to illness versus (b) the importance they attach to benefits of treating an illness they have already contracted.

*Gina M. Graham and Terry M. Pace*

*See also* Cancer Management (v1); Chronic Illness (v1); Community-Based Health Promotion (v1); Help-Seeking Behavior (v3); HIV/AIDS (v1); Physical Health (v2); Stress-Related Disorders (v1)

### Further Readings

- Bandura, A. (1997). *Self-efficacy: The exercise of control*. New York: W. H. Freeman/Times Books/Henry Holt.
- Champion, V. L., & Scott, C. R. (1997). Reliability and validity of breast cancer screening belief scales in African American women. *Nursing Research*, 46, 331–337.
- Janz, N. K., & Becker, M. H. (1984). The health belief model: A decade later. *Health Education Quarterly*, 11, 1–47.
- Janz, N. K., Champion, V. L., & Stretcher, V. J. (2002). The health belief model. In K. Glanz, B. K. Rimer, & F. M. Lewis (Eds.), *Health behavior and health education: Theory, research, and practice* (pp. 41–59). San Francisco: Jossey-Bass.



Kiviniemi, M. T., Voss-Humke, A. M., & Siefert, A. L. (2007). How do I feel about the behavior? The interplay of affective associations with behaviors and cognitive beliefs as influences on physical activity behavior. *Health Psychology, 26*, 152–158.

---

## HIV/AIDS

---

In the early 1980s, an unusual collection of clinical entities appeared that were characterized by aggressive opportunistic infections and malignancies in otherwise healthy individuals. These individuals also demonstrated a severe compromise of immune defense mechanisms. The disease was universally fatal. This complex syndrome of signs and symptoms was labeled as acquired immunodeficiency syndrome (AIDS). Within several years, the agent responsible for the disease (a single-strand RNA virus labeled human immunodeficiency virus, or HIV) was identified by several different research groups. The virus selectively infects a cell line in a person's immune defense mechanism (T-helper cells) that is critical for successful detection of infection, elimination of organisms causing certain infections, or removal of potential tumor cells. HIV, a spectrum disease, progresses in stages. First, shortly after infection, there are mild flu symptoms. This is followed by an asymptomatic phase, which may give rise to symptoms resulting from destruction of the immune defense mechanisms, including opportunistic infections and malignancies (usually within 10 to 15 years). Therefore, a person's ultimate demise is not from HIV per se but instead from the consequences of the ability of the virus to destroy the host's immune defense mechanisms. In all phases of the disease, the same inexorable deterioration of immune system is fueled by HIV.

In the not-too-distant past, a diagnosis of HIV/AIDS in the United States was considered tantamount to death. More recently, however, early diagnosis, aggressive treatment, and the advent of drug combinations have transformed HIV/AIDS into a chronic condition that may afford individuals longevity long after diagnosis. In particular, those who can afford and have access to medications and who adhere to treatment regimens have higher rates of survival than ever before. This increased longevity for HIV/AIDS patients is paralleled by a rise in psychosocial issues related to AIDS survivorship.

It should be considered that while the picture in developed nations is improving with regard to prevention and survival, this is not the case in developing nations or those for whom access to medical care for HIV/AIDS is restricted. Although HIV/AIDS is a disease found throughout the world, there is a very high prevalence in sub-Saharan Africa, and a rapidly increasing prevalence in the Indian subcontinent and the countries making up the former Soviet Union. Moreover, there is a shift occurring in the epidemiology of HIV/AIDS; for example, in the United States the number of AIDS/HIV cases attributable to heterosexual contact with what would be considered non-high-risk partners surpasses the number of cases attributable to heterosexual contact with high-risk partners. Women are becoming increasingly vulnerable in that they account for about 44% of AIDS cases worldwide. In addition, the infection rate for African Americans and Latinos is significantly proportionately higher than the rate for Caucasians in the United States.

For those patients who are fortunate enough to obtain state-of-the-art medical care, however, the resulting increase in longevity has driven the current focus on the importance of the individual's psychological state as a determinant of the success of treatment. Thus, comprehensive treatments for persons with HIV/AIDS include social and psychological services in addition to medical services.

### Risk and Risk Factors for AIDS

HIV can be transmitted between individuals by: (1) engaging in unprotected sex with an HIV-positive partner, (2) injecting drugs using needles contaminated with HIV-infected blood, (3) exposing a fetus at the time of delivery to maternally infected blood, and (4) breast feeding an infant with milk from an HIV infected mother. With effective screening of the blood supply in developed countries, blood transfusion and transplantation of body parts are no longer considered risk factors for HIV; however, this is not universally the case due to the fact that meticulous screening of the blood supply is still not accomplished in developing countries. Healthcare workers who are routinely exposed to blood are also at risk. With the emphasis on the education of healthcare workers, the use of universal precautions, and the introduction of shielded syringes, the risk of needle stick transmission to healthcare workers has dropped to less than 0.03%.



Prevention programs have targeted populations that have a high likelihood of exposure such as individuals who engage in high-risk sexual behaviors and those who are less well educated, are heavy alcohol consumers, are moderate to heavy drug users, or are younger in age, especially teens. Research suggests that heavy alcohol consumption is the factor that is most strongly associated with HIV infection. Also, studies consistently show that between 25% and 35% of people living with HIV/AIDS continue unprotected sexual practices with partners who are HIV negative or who have unknown HIV status.

Research consistently demonstrates that brief, focused behavioral risk-reduction interventions grounded in theoretical models of health behavior change contribute to meaningful reductions in HIV risk behaviors. Support groups reinforce safe sexual practices and positive behavioral changes and may use educational and skill-building techniques. Attrition is a difficult challenge with prevention groups, and although individual or small group interventions are shown to be most effective, they are often difficult to implement in public health settings.

### Diagnosis of HIV/AIDS

The medical conditions associated with HIV disease that may indicate infection often depend upon the region in which the patient is diagnosed. In developing countries, infection with mycobacterium tuberculosis, severe and frequent gastroenteritis with subsequent malnutrition, and respiratory infections are frequently life defining.

On the other hand, in developed countries, opportunistic infections such as *Pneumocystis carinii* pneumonia, toxoplasmosis, repeated bacterial pneumonia, lymphoma, disseminated fungal infections, and Kaposi sarcoma are conditions suggesting underlying HIV infection. Death is the result of an immune system so weakened that, even with appropriate therapeutic agents, there is no inherent mechanism to mount a successful host defense.

There are a number of issues involved in testing for HIV that have psychosocial implications. First, patients must confront identifying themselves as at risk for a disease that is socially stigmatizing; they must face the fear of disclosure. Second, there is a waiting period between being tested and finding out the results. Finally, there is the process of coping with the

social and personal implications of an HIV-positive diagnosis. A further complication for health care is that between 9% and 28% of those patients tested do not return for the results of the testing.

When informed of HIV-positive status, many patients experience an increase in anxiety, depression, and general psychological distress. Those who receive stress management treatment prior to knowing if they are infected, however, showed significantly less increase in depression and no increase in anxiety compared to controls.

Following an HIV-positive diagnosis, there may be an asymptomatic period that can last for many years. Several studies have shown that anxiety and depression during this time is in the normal range, although differences do appear after the diagnosis of AIDS (with significant symptomatology). In the vocational, domestic, sexual, and social domains of psychosocial adjustment, men with AIDS are more poorly adjusted than uninfected men and HIV-positive asymptomatic men, who are similar to one another. Moreover, there is some evidence that men with HIV who are depressed when they are asymptomatic may have an overall greater immune system impairment (e.g., CD4 lymphocyte decrement) over time (6 years) than those who were not depressed. Thus, the early diagnosis and treatment of depression might be important for the subsequent well-being of the HIV-positive person.

### Progress in Medical Treatment

Each treatment for AIDS has a unique impact on the coping process. Therapeutic options to treat HIV rather than only the consequences of immune system suppression started in 1987 with the advent of AZT, a medicine that interfered with the life cycle of HIV in the host T-helper cell. The effectiveness of the medicine was usually short lived because of the ability of HIV to mutate and because agents operating at multiple sites of the virus replication were not yet available. A breakthrough in treatment occurred in 1996 when highly aggressive antiretroviral therapy (HAART) became a reality.

Drugs that interfere at three different sites of HIV replication were now available, and the dramatic drop in the annual rate of death from HIV throughout the United States was remarkable. The development of drugs to interfere at other locations in the viral life cycle continues. Additionally, there is significant



drive to reach the elusive goal of developing an effective vaccine to assist the infected host to limit viral replication. Finally, the adherence to treatment regimens has been markedly simplified from 28 pills per day in 1996 to 2 in 2004. Furthermore, the Food and Drug Administration (FDA) just approved a one-pill-per-day regimen, which represents a cooperative effort among several drug companies.

### Psychological Coping

The term *coping* is often used with AIDS in that the disease is conceived of as a threat that may tax the resources of the individual. Men with AIDS who use avoidant coping strategies experience more psychological distress than those who used social support or active-behavioral approaches to problem solving. Also, avoidant coping is associated with higher levels of depression, more health concerns, lower levels of social support, and lower self-esteem compared to active-behavioral coping. A belief in personal control that relates to day-to-day symptoms and to the overall course of the illness were associated with positive adjustment to AIDS. Thus, men who adjust well to AIDS view themselves not as passive victims of the disease but as having control over certain daily aspects of the disease and the overall course of the disease.

### Social Support

The stigmatizing aspects of HIV/AIDS are often accompanied by the fear of loss of social support. Moreover, symptoms may impact social support. The greater the number of physical symptoms reported by a person with AIDS, the less social support is perceived to be available and the greater the concomitant depression and anxiety. Researchers suggest that two processes may operate: First, serious illness may alter the support network significantly, and second, stigmatizing disease such as AIDS may be associated with decreased social support, which may be accompanied by withdrawal by the person with AIDS to avoid future rejection. Reports of higher levels of social support were associated with lower levels of hopelessness and depression, but the latter constructs were not correlated with physical symptoms, suggesting that suicidal ideation may be related more to the loss of support than to the state of the disease. Persons with AIDS who perceived an increase in

social support and those who perceived no loss in support adjusted better than persons who perceived a loss in social support.

### Quality of Life

It has been estimated that individuals with AIDS spend several hours each day on personal medical care, paperwork, getting the extra rest needed to sustain activity, and other activities relating to self-care, which would suggest that quality of life plays a large role in the life of a person with AIDS. HIV/AIDS carries with it the burden of personal health issues that are very time consuming and the social burden of being stigmatized. Thus, quality of life may be affected by both the disease and the social stigma attached to it.

### Long-Term Survivors of AIDS

The Centers for Disease Control and Prevention (CDC) define long-term survival as survival 3 years after diagnosis. Not only has the survival rate doubled in the past decade, but with the advent of HAART the survival rate should increase even more dramatically over the next 10 years. Much of the research in this realm is descriptive but seems to indicate that survivors most often have active coping styles and are relatively free of mood disorders and other psychological distress. In addition, most long-term survivors have had bouts with life-threatening illness and seemed to bounce back after each setback. Moreover, survivors tend to believe that they will experience good times and feel strongly that their lives are important.

Long-term survivors support the use of traditional medicine, particularly to treat opportunistic infection. They are also more likely to believe that chance or personal control are associated with health outcomes rather than the actions of powerful others. That is, they tend to believe that medical interventions can help but are not a panacea. There is very little, if any, use of denial as a coping strategy in long-term survivors. Moreover, there is flexible use of many different types of active coping strategies.

Given that more adults are being infected at later ages, and due to the increased effectiveness of the medical management of HIV/AIDS, there are a number of older persons living with HIV/AIDS. This new phenomenon has both medical and psychological implications. Research suggests that middle-aged and



older persons living with the disease experience significant emotional distress and thoughts of suicide. This particular population may have unique psychological concerns, and they are likely to approach such issues differently than younger persons with HIV/AIDS. Thus, interventions should be tailored to reflect the developmental contexts.

### Psychosocial Interventions to Promote Quality of Life and Longevity

Recommendations have been made concerning the psychosocial needs of AIDS survivors. Essentially, the recommendations include the need to support the survivors' tendency to engage in active coping that is powered by beliefs of personal control. Also, therapists should be mindful of changes in the support network of the person with AIDS. A shrinking social network may portend a less than optimistic outlook for long-term survival.

Research on psychosocial interventions to enhance quality of life has shown great promise for enhancing coping. One approach, which includes a cognitive-behavioral stress management treatment, focuses on recognizing the signs of stress and negative automatic thoughts, relaxation training, and providing information on AIDS and the immune system, sexual risk behaviors, and social support. The stress management and information sessions are alternated with relaxation sessions. This treatment resulted in reduced anxiety and depression for HIV-positive males as compared to a no-treatment control group whose members also had decreased immunological functioning after notification of the results of HIV testing. At 1-year follow-up, coping strategies such as denial and disengagement were associated with increased depression. On the other hand, coping skills such as active coping, planning, and positive reappraisal were associated with a decrease in depressive symptoms. At 2-year follow-up, predictors of disease progression included degree of distress at time of diagnosis, denial, poor attendance in the group, and failure to comply with relaxation homework. Thus, the functional status of men who did not use denial and who participated fully in the intervention was better than those who used denial and who did not adhere to the treatment protocol. In sum, psychological interventions for persons with cancer and HIV have beneficial effects on psychosocial functioning, quality of life, and survival in the case of cancer. Common components of these interventions

include group support, fear reduction, problem solving, and stress management.

*Thomas V. Merluzzi, Carolyn A. Heitzmann,  
and Robert W. Clausen*

*See also* Chronic Pain (v1); Coping (v2); Death and Dying (v1); Physical Health (v2); Quality of Life (v2); Rehabilitation Counseling (v2); Social Support (v2)

### Further Readings

- Kalichman, S. C. (2003). *The inside story on AIDS*. Washington, DC: American Psychological Association.
- Kelly, J. A., & Kalichman, S. C. (2002). Behavioral research in HIV/AIDS primary and secondary prevention: Recent advances and future directions. *Journal of Consulting and Clinical Psychology, 70*(3), 626–639.
- Rabkin, J. G., Ferrando, S. J., Lin, S., Sewell, M., & McElhiney, M. (2000). Psychological effects of HAART: A 2-year study. *Psychosomatic Medicine, 62*, 413–422.

---

## HOMELESS YOUTH

---

Youth homelessness is a complex problem exacerbated by the lack of available information regarding the unique circumstances experienced by these adolescents and further by the fact that this population is often hidden and therefore unnoticed by the general public and researchers. In any given year in the United States, 500,000 to 1.5 million youth will run away or be told to leave their homes. Most runaways return home, but others go on to establish an intermittent or prolonged period of homelessness. The number of homeless youth is difficult to estimate, but one national survey found that 7.6% of youth (1.6 million) between the ages of 12 and 17 were homeless, with approximately 200,000 of these individuals living on the street. Regardless of the exact number, youth homelessness is a cause for concern because of the unfavorable outcomes many of these youth experience: heightened risk of involvement in delinquent activities, drug and/or alcohol abuse, and persistent homelessness hindering their ability to become productive community members or successful adults. Furthermore, information regarding youth who do not survive is scarce.

Community agencies dedicated to assisting homeless persons frequently contribute to what is known



about this population. However, information from this source may overlook a substantial portion of homeless youth given that many choose not to access these resources. Moreover, youth with the most significant challenges can be rejected from such facilities due to histories of substance abuse or psychosocial troubles. Little is known about treatment needs or effective intervention strategies for these adolescents, because research efforts have primarily focused attention on the circumstances that contribute to a youth's decision to leave home. Knowledge about these variables may have implications for prevention efforts, but it is complicated by the variety of reasons adolescents choose to leave home. It is important to note that although some youth may be homeless along with their families, due to financial reasons, the focus of this entry is on youth who are separated from their families.

### Causes of Homelessness in Youth

Homeless youth typically reside in unsafe living conditions that differ greatly from those of their peers both before and after leaving home. The home environment is generally characterized by dysfunctional experiences such as abuse, neglect, exploitation, rigid or inconsistent disciplinary practices, conflict, and parental substance abuse. Youth living in these homes experience a diminished sense of control and decreased self-esteem. In addition to unsafe home environments, many youth have encountered numerous, inconsistent living arrangements in alternative care settings by the time they reach the streets. As a result of these and other compounding adverse experiences, homeless adolescents commonly display many mental health and behavioral problems even before they leave home. These problems may be further compounded by discouraging educational experiences such as underachievement, inconsistent attendance, grade retention, poor relationships with peers and teachers, and disciplinary actions.

### Defining Homeless Youth

Although all of these adolescents can be classified under the term *homeless youth*, several other terms have been used to describe the conditions surrounding a youth's choice (or lack of choice) in leaving home and the unique circumstances the youth encounters while away from home. These distinctions are important, as they define intervention strategies that will be most appropriate for an individual's circumstances. For example, youth who have been asked or forced to leave

home or abandoned by their parents are typically classified as *throwaways*. Youth commonly associated with this category are those whose sexual orientation does not align with their parents' expectations. Gay, lesbian, bisexual, transgender, and questioning (GLBTQ) adolescents represent a significant portion of youth who are asked or forced to leave their home setting. In this circumstance, seeking reunification with a family may not be an appropriate therapeutic goal.

Adolescents who leave home without parental consent or knowledge are termed *runaways* and may exhibit different patterns of runaway behaviors. A *chronic runaway* may demonstrate a pattern of leaving and returning home several times over a period of time while an *acute runaway* is described as an individual who has a single episode of leaving home and staying away for a significant length of time, resulting in the youth returning home for good or never returning at all. These families may be more appropriate for family-focused interventions such as multidimensional family therapy (MDFT) that emphasizes the use of multiple therapeutic models to reduce high-risk behavior and substance abuse in adolescents.

Once youth leave home, they pursue distinctive paths in an effort to survive. Homeless youth tend to reside in one of three environments: the street, shelters, or the system. Youth who live on the streets may or may not maintain contact with their families. For example, some may return home after short periods of working or living on the street, whereas other homeless youth identify the street as their home and have little, if any, contact with their families. These youth commonly have acute mental health difficulties and more significant histories of homelessness than other categories of homeless youth. Additionally, they are less likely to access available community resources. Conversely, there are homeless youth who mainly reside at homeless or emergency shelters and may have no experiences on the streets, similar to those youth who spend a majority of their time residing in alternative care settings such as foster homes, emergency shelters, or juvenile detention centers.

### Risks of Youth Homelessness

Regardless of the location where homeless youth reside, all are at significant risk of unfavorable developmental outcomes. Survival mechanisms, sometimes valued as street skills, employed by homeless youth often place them at increased risk for a host of deleterious consequences. These adolescents lack adult



guidance and support as well as other basic needs such as food, shelter, and health care. Many homeless youth suffer drug and alcohol addictions and may be involved in distribution for monetary gain or in exchange for material needs. Others may engage in prostitution or survival sex, defined as sexual favors exchanged to get basic needs met. Such practices place youth at risk of sexually transmitted diseases, victimization, and exploitation. Activities viewed by mainstream society as delinquent or criminal are often used by homeless youth as a means of survival. In addition to panhandling, various degrees of stealing such as shoplifting, swindling, or pickpocketing may be utilized. The contradictory norms of the general culture and the street culture may contribute to the difficulty these youth experience when attempting to reintegrate into society.

At the most basic level, homeless youth experience poor nutrition, limited access to health care, and unsafe living conditions, which place many at risk for illness, infections, and diseases. In addition to physical harm, they commonly experience multiple mental health problems, many of which were present prior to leaving home and are intensified once on the streets. Many homeless youth have endured significant abuse and assault from trusted authority figures, either at home or while away from home, making it difficult for them to trust others. Fear, loneliness, and feelings of worthlessness are also common amongst this group. Depression and suicidal ideation are maintained due to minimal encouraging experiences.

### Interventions for Homeless Youth

The current literature regarding empirically based interventions for use with homeless adolescents is insufficient. Given that much of the available information addresses the behaviors the youth exhibited and the experiences he or she had prior to leaving home, an appropriate area of focus should be directed toward prevention of youth homelessness. Prevention approaches might include connecting the family to needed resources, family-focused therapy (e.g., MDFT or multisystemic family therapy) for those at high risk, and wraparound services for the youth and family. Because of the complexity of the issues that lead to youth homelessness, it is unrealistic to expect that any unidimensional approach will be sufficient to improve family and youth functioning. A systemic model is needed to more completely address the needs of these youth and their families.

Prevention is critical, because once youth have left home, it is difficult for service agencies to gain access to these adolescents. Few homeless youth choose to approach community resources because of fear and mistrust of adults, lack of willingness to follow the rules associated with an agency, or lack of knowledge of the resources that exist. Therefore, when counseling does occur, it is typically involuntary and tends to be the result of a referral for family therapy by social or shelter services, or it is court ordered for the youth and his or her family. Reuniting young people with their families may seem the most reasonable intervention; however, in some instances this may produce harmful results rather than benefiting the youth. Therefore, it is important to carefully evaluate the reasons why the youth left home and the current family environment before establishing reunification as a goal.

When youth voluntarily access services either for general or for mental health support, there remain a number of barriers that might make effective service provision difficult. Lack of control and constant unsuccessful experiences with adult figures frequently interfere with the ability of these youth to trust others and may result in heightened expressions of resistance. Furthermore, the high mobility rate among this population presents limitations to building a trusting relationship. It has been suggested that the most effective services will be those that are brought to the youth (e.g., parks, urban settings) to facilitate access. Those who provide services need to consider their approach, as coming on too strong might scare youth, yet an approach that is too reserved might inadvertently reinforce the idea that adults do not care. It has also been noted that services should be culturally compatible; that is, the provider should be respectful and understanding of youth and their circumstances. It is important to reinforce the youths' sense of control and choice (as appropriate) and minimize restrictions and requirements. Developmentally, these youth may need to work toward establishing a sense of identity, feelings of competency, and connectedness to others. The therapeutic relationship may also include life skills education such as safe sexual practices, needle exchange, and other mechanisms by which to stay safe.

Because some youth grow tired of living on the street, programs that focus on helping youth reintegrate into society may be appropriate. In doing so, it is critical that youth are taught the skills they need to be successful and reduce the chances of further rejection and disapproval, which might increase their risk



for continued homelessness. One program, *First Voice*, was originally designed to help adolescents in foster care transition to independent living as adults. Its emphasis on independence, belonging, mastery, and generosity (after the circle of courage model) may represent a useful approach for transitioning youth from street or shelter environments to becoming productive community members.

Casey R. Shannon and Robyn S. Hess

**See also** Abuse (v2); Child Maltreatment (v1); Conduct Disorder (v1); Family Counseling (v1); Oppositional Defiant Disorder (v1); Parent–Adolescent Relations (v1); School Refusal Behavior (v1); Substance Abuse and Dependence (v2)

### Further Readings

- Finkelstein, M. (2004). *With no direction home: Homeless youth on the road and in the streets*. Belmont, CA: Thomson Wadsworth.
- Liddle, H. A., & Hogue, A. (2000). A family-based, developmental-ecological preventive intervention for high risk adolescents. *Journal of Marital and Family Therapy*, 26, 265–279.
- Reid, J. S., & Ross, J. W. (2005). First voice: The circle of courage and independent living. *Reclaiming Children and Youth: The Journal of Strength-Based Interventions*, 14, 164–178.
- Rew, L., Whittaker, T. A., Taylor-Seehafer, M. A., & Smith, L. R. (2005). Sexual health risks and protective resources in gay, lesbian, bisexual, and heterosexual homeless youth. *Journal for Specialists in Pediatric Nursing*, 10, 11–19.
- Slesnick, N. (2004). *Our runaway and homeless youth: A guide to understanding*. Westport, CT: Praeger.
- Smollar, J. (1999). Homeless youth in the United States: Description and developmental issues. In M. Raffaelli & R. W. Larson (Eds.), *Homeless and working youth around the world: Exploring developmental issues* (pp. 47–58). San Francisco: Jossey-Bass.

---

## HOSPICE

---

Hospice is a multidisciplinary approach to caring for individuals who have a terminal illness or condition. It is based on a philosophy that affirms life and advocates self-determination. The family is considered the unit of

care and the hospice team of professionals provides medical, emotional, and spiritual assistance to patients as well as to their families and friends. Typically a team includes physicians, nurses, chaplains, social workers, counselors, nursing assistants, holistic practitioners, trained volunteers, and administrative and clerical staff. Services may be provided in an inpatient setting, long-term care facility, or the patient's home.

### History

The word *hospice* is derived from the Latin *hospitium*, an inn for travelers usually maintained by members of a religious order. Jeanne Garnier, founder of the Dames de Calaire in Lyon, France, first used the name with reference to the care of dying patients in 1842. In 1879 the Irish Sisters of Charity opened Our Lady's Hospice in Dublin, and in 1905 they established St. Joseph's Hospice in London. The founder of the modern hospice movement was Cicely Saunders, a physician, who started St. Christopher's Hospice in London in 1967. She was inspired by a patient, David Tasma, with inoperable cancer. The two discussed how the care of dying patients might best be done in a setting specifically created for it, and when Tasma died, he left Saunders money to establish such a place. During the next several years the hospice concept spread throughout the world. In 1974, hospice care was introduced in the United States at Yale University in New Haven, Connecticut.

### Administration and Funding

#### Types

Hospice services are provided in a variety of settings and have multiple avenues of funding. They may be part of a home health agency, have a freestanding facility or space in a local hospital, or be provided to patients in their homes or wherever they may be staying. Hospices may rarely be staffed by volunteers but are usually operated by paid specialists.

#### Admission

To be admitted to a hospice program, a patient must obtain a physician's order. This order can be requested by anyone, including the patient, a family member, or a health-care provider. Any physician can write such an order as long as it states that in the physician's best



medical judgment, the patient has 6 months or less to live, regardless of age or diagnosis. Hospice care will be continued as long as the patient lives, provided a progressive decline can be demonstrated.

### ***Funding***

Once admitted to the hospice program, most patients are eligible for funding under the Hospice Medicare benefit, which does not depend on age. Patients may qualify for other financial resources, such as Medicaid. Hospices also receive funding from grants and donations, fundraising activities, and other state, local, or federal sources. Most hospices have a policy of providing service to those in need even if the usual avenues of reimbursement are not available. Besides those already mentioned, such services typically include paying for any medications related to the patient's diagnosis and providing needed equipment, such as oxygen delivery systems, wheelchairs, hospital beds, and similar supplies.

## **The Hospice Philosophy**

### ***Affirmation of Life***

Hospice philosophy involves affirming and respecting life and honoring death as a natural part of existence. The policy of the National Hospice Association is that hospice does not hasten death or prolong life. The aim of hospice services is to maximize the *quality* of whatever time may remain for every patient and for their families and friends. Hospice nurses are experts in symptom management, particularly pain control, and this knowledge is used to promote patient comfort. Social workers and bereavement counselors assist patients and families with the psychological and emotional factors that may accompany the dying process. Chaplains honor all spiritual and religious beliefs, and can facilitate the attainment of peace and faith at this stage of life. Ancillary personnel, such as nursing assistants, volunteers, and alternative therapists also have as their aim helping the patient and family live a full and comfortable life.

### ***Self-Determination***

Part of honoring life is the acknowledgment that each patient is an individual and has unique values, preferences, and desires. Hospice believes that the

patient and family have the right to make decisions about the types of services they receive and the general management of their care. Hospice team members offer information to assist with these decisions, and can facilitate the decision-making process, but they do not choose which course of action the patient will take. Research has shown that being able to make choices is one of the most empowering things a patient can do. Patients are often distressed if they lose the physical and mental abilities that used to come so easily. But if they are encouraged to continue to make as many decisions as possible about their care, they are able to maintain a sense of control and competence.

## **Psychological Aspects of Hospice Care**

Psychological support provided by hospices generally includes care offered to the patient and family prior to the patient's death, bereavement services after the death, and emergency response and outreach to the local community. During the patient's life, medical social workers assist the patient and family with emotional, financial, legal, ethical, and other concerns that often arise during the last stage of life. Following the patient's death, bereavement specialists, who may be social workers, psychotherapists, counselors, or other professionals, assist family and friends with grief support services. Hospice social workers and counselors may also respond to community crises, such as the death of a student, which may affect large numbers of people.

### ***Psychological Services During the Patient's Life***

When a patient is admitted to hospice care, a medical social worker (MSW) meets with the family to conduct an initial psychosocial assessment. This is an opportunity to become acquainted with the patient, identify particular needs, and evaluate family functioning to highlight strengths as well as possible areas of concern. The MSW does not attempt to radically restructure long-standing family dynamics but instead attempts to maximize the effectiveness of the family's existing coping strategies. Information about living wills and other practical matters is also provided.

Hospice staff use a variety of theoretical approaches, depending on each therapist's orientation and the needs of the family. For example, a person-centered approach may be appropriate as patients and families



relate their history and express feelings about their situation. For individuals seeking to modify distressing thought patterns, a cognitive-behavioral approach might be used.

While every situation is different, most patients and families experience similar feelings and challenges during a terminal illness or condition. The MSW can support the family by normalizing these common occurrences and reassuring clients that they are not abnormal or crazy.

For example, educating families about Elisabeth Kübler Ross's stages of grief can help them understand the emotional turmoil they may be experiencing. Research indicates that individuals are often quite relieved to learn that denial, anger, bargaining, depression, and acceptance are normal aspects of the dying process and can be experienced in various degrees and sequences. The MSW may also suggest strategies for dealing with each of these stages.

Anticipatory grief has long been a phenomenon commonly noted in hospice clients. Mourning may begin as soon as the probable outcome of the patient's condition is known. This may involve increased anxiety, role rehearsal by the survivors, emotional withdrawal of the patient or survivors, and extreme emotional attachment to the patient. The MSW can facilitate understanding and management of these occurrences. Recently, research by Robert Fulton and others suggests that anticipatory grief may be a social construct and its practical and theoretical validity is being explored.

Caregiver stress is another area commonly addressed by the hospice social worker. The physical and emotional manifestations of caring for a terminally ill patient can include exhaustion, feelings of being overwhelmed, guilt, regret, anger, and anxiety. The MSW can suggest stress management techniques and explore other avenues of relief, such as respite care for the patient and volunteers to assist with household tasks or sit with the patient while the caregiver takes a break. Caregiver support groups provide an opportunity to share experiences and coping strategies.

### ***Psychological Services After the Patient's Death***

After a hospice patient dies, grieving survivors often experience a variety of emotional, physical, spiritual, and behavioral distress. The bereavement staff will continue to provide services to family and friends as long as necessary. These are essentially the

same as predeath interventions, with emphasis on the grief process. They include individual and group therapy, reading lists and other similar resources, education, and referral to other mental health practitioners when necessary. Additional techniques for children include the use of sand play therapy, puppets, and animal-assisted therapy.

### ***Community Outreach***

Hospice social workers and counselors also respond to community emergencies when needed. The trauma of natural disasters and the grief experienced by children when a classmate dies are examples of situations where the expertise of hospice professionals may be utilized.

## **Ethical Aspects of Hospice Care**

Withdrawal of advanced life support and the concept of assisted suicide present challenges in caring for hospice patients. Technological advances in acute care make it possible to keep patients alive artificially for extended periods. Hospice workers emphasize the importance of having a living will that specifies the patient's wishes regarding the artificial prolonging of life. This can eliminate the conflict that may arise as the patient declines.

The official stance of the National Hospice Organization is that assisted suicide is not part of the hospice philosophy. However, patients not infrequently ask hospice workers to help them die. Theresa Harvath and others address the personal and professional issues that may arise in this difficult situation. Hospice staff assess and treat any physical symptoms that may contribute to suicidal ideation and encourage the patient to explore unresolved psychological and spiritual issues.

*Susan Schneeberger*

**See also** Bereavement (v1); Cancer Management (v1); Caregiver Burden (v1); Caregiving (v1); Coping (v2); Death and Dying (v1); Hope (v2); Physical Health (v2); Quality of Life (v2); Social Support (v2)

### **Further Readings**

Echteld, M. A., Deliens, L., Ribbe, M. E., Miel, W., & van der Wal, G. (2005). Quality of life change and response shift in patients admitted to palliative care units: A pilot study. *Palliative Medicine*, 19(5), 381–388.



- Fulton, R. (2003). Anticipatory mourning: A critique of the concept. *Mortality*, 8(4), 342–351.
- Harvath, T., Miller, L., Smith, K. A., Clark, L. D., Jackson, A., & Ganzini, L. (2006). Dilemmas encountered by hospice workers when patients wish to hasten death. *Journal of Hospice & Palliative Nursing*, 8(4), 200–209.
- King, D. A., Heisel, M. J., & Lyness, J. M. (2005). Assessment and psychological treatment of depression in older adults with terminal or life-threatening illness. *Clinical Psychology: Science and Practice*, 12(3), 339–353.
- Kissane, D. W., Bloch, S., McKenzie, M., McDowall, A., & Nitzan, R. (1998). Family grief therapy: A preliminary account of a new model to promote healthy family functioning during palliative care and bereavement. *Psycho-Oncology*, 7(1), 14–25.
- Kübler-Ross, E., & Kessler, D. (2005). *On grief and grieving: Finding the meaning of grief through the five stages of loss*. New York: Scribner.
- McLoughlin, D. (2000). Transition, transformation and the art of losing: Some uses of poetry in hospice care for the terminally ill. *Psychodynamic Counselling*, 6(2), 215–234.
- Reese, D., & Raymer, M. (2004). Relationship between social work involvement and hospice outcomes: Results of the national hospice social work survey. *Social Work*, 49(3), 415–422.
- Schoen, K., & Schindelman, E. (1989). AIDS and bereavement. *Journal of Gay & Lesbian Psychotherapy*, 1(2), 117–120.

---

## HUMAN SUBJECTS REVIEW IN AN ONLINE WORLD

---

The World Wide Web has had a substantial impact on research methodology in counseling psychology and in the social and behavioral sciences in general. Indeed, the Internet offers opportunities for research in content areas where traditional methodologies have struggled and special samples have previously been difficult to recruit. However, the Internet also presents many challenges for the ethical conduct of research involving human subjects.

There are two primary types of research utilizing the Internet: online survey research and observational research. Online surveys, created by either the researcher or outside agencies, allow researchers to collect self-report data via an Internet Web page as opposed to more conventional methods (e.g., in person, via mail). Observational research involving chat rooms and discussion boards on the Internet is

the second type; here researchers monitor the social behavior of online groups by examining current or archived written communications (e.g., e-mails). Online data collection has several potential benefits to the researcher, including the possibility of collecting data from respondents across geographical and cultural boundaries, access to specialized or difficult-to-find populations, reduced time spent in collecting data, and decreased cost for discussion.

There is a third, emerging research use of the Internet that involves the delivery and evaluation of therapeutic interventions. Besides the ethical considerations shared with other types of online research, this type presents some additional challenges. (For a discussion of the ethical issues surrounding online therapeutic interventions, see Childress & Asamen, 1998).

This entry presents a general overview of guidelines for protection of human subjects in research as well as a description of the Institutional Review Board (IRB) criteria for work with human subjects that are most critical for evaluating online research. Then it outlines the criteria used by IRBs with respect to the main types of online research.

### General Ethical Guidelines

The Belmont Report, by the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research, presents the basic principles to guide ethical scientific research. The principles put forth in the Belmont Report allow for the weighing of costs or risks to human subjects and the benefits of conducting the research. These principles of *respect for persons*, *beneficence*, and *justice* have been standardized into the federal policy for the Protection of Human Subjects, or the *Common Rule* (Code of Federal Regulations, <http://www.hhs.gov/ohrp/humansubjects/guidance/45cfr46.htm>). The Common Rule established the IRB system to assist those conducting research to comply with the regulation.

The IRB at each college, university, agency, or private research company has its own interpretation of particular policies and procedures regarding human subject protection, but there is a set of criteria common across each IRB. To be considered protective of human subjects, the proposed research should (1) minimize risk to participants, (2) present a favorable benefit/cost ratio, (3) ensure equitable selection of participants, (4) provide informed consent to all participants, and (5) document informed consent.



These goals reflect the principles of *respect for persons* or *autonomy* (i.e., providing and documenting informed consent), *beneficence* (i.e., minimizing risk to participants, presenting a favorable benefit/cost ratio) and *justice* (i.e., equitable selection of participants) put forth in the Belmont Report.

### **Ethical Issues Related to Autonomy for Online Research**

Appropriate documentation of voluntary informed consent from research participants is a requirement of IRBs. However, ensuring understanding of research procedures and obtaining signatures through the Internet presents a challenge to researchers. IRBs have the option to waive this requirement if the research involves minimal risk to the participant or in cases where the documentation would be the only link between the participant and his or her data. Thus, some IRBs have indicated that simply completing the online survey signifies consent to participate.

Of course, the challenge of ensuring understanding is not unique to online research. One study by Varnhagen and colleagues compared the recall of online consent forms to regular paper format versions. Little difference in recall was found between participants who viewed the online version and those who received the paper version. However, on average, participants' recall was quite low across conditions, with participants recalling less than 10% of presented material. This suggests that researchers need to make every effort to attract participants' attention to the information about the study in the consent document.

### **Ethical Issues Related to Beneficence for Online Research**

A primary aim of IRBs is to ensure that researchers minimize the risks to research participants. Two potential sources of risk exist: harm resulting from a breach of confidentiality and harm resulting from direct participation in research. Online research raises several concerns regarding privacy, anonymity, and confidentiality. Discussion of ethical issues on the Internet has focused on whether or not the Internet, and the information posted therein, lies in the public or the private domain. When online behavior is considered public, a research project examining this behavior is considered in the "exempt" category, though it still must receive review and approval from

an IRB. However, chat rooms and bulletin boards may lead an individual to develop an expectation of privacy when, for example, an account and password are required to access the site. This expectation of privacy needs to be considered before conducting research utilizing such sites. Indeed, some have recommended that IRBs evaluate the public versus private nature of each project on a case-by-case basis.

A concern associated with direct participation in online research is data security. According to Im and Chee, online data collection raises the possibility that data may be viewed by others unbeknownst to the researcher. For example, employers may have access to their employees' Internet history and e-mail account, and hackers may attempt to discover individuals' personal information. Researchers should be able to articulate and demonstrate that the data are collected, stored, and transmitted in a way that maintains confidentiality. The more sensitive the data collected, the greater the precautions that should be taken to ensure the protection of this information.

### **Ethical Issues Related to Justice for Online Research**

A touted benefit of online research is the potential for the recruitment of large, diverse samples. However, researchers need to be aware that samples may not represent an equitable selection of potential participants. In fact, researchers may be unintentionally excluding particular groups of people from the research. For example, individuals who cannot be identified via the Internet, who are illiterate, or who are not fluent in the language used in the online survey or on the Web page discussion board may be excluded. Further, researchers have noted the presence of educational, economic, racial, and gender disparities among those who have access to the Internet—the so-called digital divide. There is evidence, however, that these differences are diminishing. In any case, researchers need to provide evidence to IRBs that they are making their best effort to recruit samples that give the most individuals an opportunity for selection.

*Mali Bunde and Jerry Suls*

*See also* Code of Ethics and Standards of Practice (v2); Computer-Assisted Career Counseling (v4); E-Counseling (v1); Ethical Codes (v1); Ethical Decision Making (v1); Ethical Dilemmas (v1); Ethics in Research (v1); Technology and Treatment (v1)



### Further Readings

- Childress, C. A., & Asamen, J. K. (1998). The emerging relationship of psychology and the Internet: Proposed guidelines for conducting Internet intervention research. *Ethics & Behavior*, 8(1), 19–35.
- Code of Federal Regulations, Title 45, Part 46: *Protection of Human Subjects*. Retrieved January 10, 2007, from <http://www.hhs.gov/ohrp/humansubjects/guidance/45cfr46.htm>
- Eysenbach, G., & Till, J. E. (2001). Ethical issues in qualitative research on Internet communities. *British Medical Journal*, 323, 1103–1105.
- Im, E., & Chee, W. (2002). Issues in protection of human subjects in Internet research. *Nursing Research*, 51(4), 266–269.
- Kraut, R., Olson, J., Banaji, M., Bruckman, A., Cohen, J., & Couper, M. (2004). Psychological research online: Report of Board of Scientific Affairs's advisory group on the conduct of research on the Internet. *American Psychologist*, 59, 105–117.
- National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research. (1979, April). *Belmont report: Ethical principles and guidelines for the protection of human subjects of research*. Retrieved January 10, 2007, from <http://ohsr.od.nih.gov/guidelines/belmont.html>
- Rhodes, S. D., Bowie, D. A., & Hergenrather, K. C. (2003). Collecting behavioural data using the World Wide Web: Considerations for researchers. *Journal of Epidemiology and Community Health*, 57, 68–73.
- Sixsmith, J., & Murray, C. D. (2001). Ethical issues in the documentary data analysis of Internet posts and archives. *Qualitative Health Research*, 11, 423–432.
- Varnhagen, C. K., Gushta, M., Daniels, J., Peters, T. C., Parmar, N., Law, D., et al. (2005). How informed is online informed consent? *Ethics & Behavior*, 15, 37–48.

hypnosis and specific hypnotic techniques with a client within an established therapeutic relationship prior to undertaking such procedures. Historically, hypnosis has been viewed with wariness and a fear that one may acquiesce to the commands of the hypnotist and lose control both cognitively and physically. A thorough explanation of the procedures to be used and their purposes can serve to allay these concerns.

Similar to a very deep state of relaxation, hypnosis is an altered state of consciousness. The hypnotized client has a more focused awareness and is open to suggestion or direction by the therapist. Various approaches within hypnosis exist. For example, a therapist might use hypnosis to help a client visualize how to achieve a particular goal; a therapist might also use hypnosis to stimulate vivid images and thereby achieve a focused state of relaxation or expectation. For counseling clients with health-related concerns (e.g., chronic pain), hypnosis appears to be a positive adjunct to ongoing coping skills treatment.

Individual experiences of the hypnotic state appear to vary from person to person. However, positive expectations and comfort of both the clinician and the client affect the likelihood of inducing trance and enhancing suggestibility. Therefore, it becomes important that the hypnotist have the knowledge and experience to create a trusting environment in which the client anticipates success. In addition, the ethical use of hypnotic techniques requires training and supervised application to assure that the clinician is practicing within the bounds of her or his expertise.

Currently, hypnosis is most often used therapeutically in combination with more extensive theoretical approaches and treatment strategies in clinical practice.

Libbe A. Gray

---

## HYPNOSIS

---

While it is difficult to describe the nature of hypnosis scientifically, procedurally a therapist induces a trance, or deeply relaxed state, in a person through the means of suggestion of alterations of sensations, consciousness, and cognitions. As with the broader field of psychotherapy, there is an array of historical, theoretical, and technical assumptions that constitute the underpinnings of clinical hypnosis that are far too extensive for the scope of this entry.

Clients differ in their beliefs, needs, and goals; thus, it is important to explore the usefulness and risks of

**See also** Cancer Management (v1); Ethical Codes (v1); Eye Movement Desensitization and Reprocessing (v1); Mindfulness (v1)

### Further Readings

- Lynn, S. J., & Kirsch, I. (2006). *Essentials of clinical hypnosis: An evidence-based approach*. Washington, DC: American Psychological Association.
- Meyer, R. G. (1992). *Practical clinical hypnosis: Techniques and applications*. New York: Lexington Books.
- Rhue, J. W., Lynn, S. J., & Kirsch, I. (Eds.). (1993). *Handbook of clinical hypnosis*. Washington, DC: American Psychological Association.





---

## IMPAIRMENT

---

Impairment is the inability to practice in congruence with professionally defined and accepted standards of care. Impairment among trainees and professionals is a problem within psychology and counseling. Surveys have revealed that up to 10% of professional psychologists reported difficulties with depression, alcohol and other substances, relationship problems, and physical illnesses, all of which significantly interfered with their carrying out their responsibilities with their usual level of skill and ability.

Ethical codes of counselors and psychologists mandate that professionals practice with the highest levels of care and obtain supervision or intervention when their own concerns and difficulties interfere with meeting this standard set by the codes. It is important to distinguish between *distress* and *impairment* in considering the topic of impairment. Many psychologists and counselors experience difficulties in their own lives that, while distressing, are not of sufficient impact to negatively affect their work. Impairment, however, typically denotes a significant level of distress that interferes with the ability to competently care for clients, complete necessary and appropriate documentation, and so on. Individuals who are impaired may not recognize that their difficulties are causing interference. And finally, impaired therapists may engage in inappropriate or unethical behavior with clients (e.g., dual relationships, sexual relationships) or supervisees.

O'Connor presented data that suggested mental health professionals may have experienced developmental trauma that was unresolved prior to taking on

their caring roles. In his review of this issue, he cited research that indicated between 33% and 50% of psychologists reported alcoholism, physical abuse, or sexual abuse in their family of origin. While a traumatic childhood experience, if resolved, would allow a therapist to more fully identify with similarly treated clients, it also raises the possibility of countertransference issues, problems in separating from clients, substance abuse, and underestimation of the impact of one's own history on work with clients.

Unfortunately, psychology and counseling professions have had difficulty in identifying impairment as a professional issue. Other professions, such as medicine, dentistry, and nursing, have more fully developed impairment programs that encourage self-identification, supervised remediation, and continued practice and treatment. Additionally, psychologists in general are apt to see more egregious ethical violations, such as sexual relationships with clients, as something they would "never do." Yet, under the right circumstances, any therapist can be vulnerable to personal conditions that promote the likelihood of ethical violations or boundary crossings.

Psychology tends to intervene after the fact, after a client or colleague has filed an ethical charge, and then a disciplinary focus takes over in a licensing board or ethics committee approach to adjudicating the case. This is in contrast to professions mentioned above where diversion, monitoring, and supervision are used as opposed to disciplinary hearings and delicensing outcomes.

Detecting impairment during training is the most effective approach to preventing impaired professionals. Yet, as Lamb notes, identifying and responding to



trainees who show evidence of impairment is problematic. In part this difficulty lies in supervisors being insufficiently trained to detect impairment; in part, training programs have not developed policies with which to approach the problem of impaired trainees. It is during training, however, that the three component parts of impairment are most likely to reveal themselves in trainees: an inability or an unwillingness to integrate professional standards into one's own behaviors, an inability to acquire professional skills to reach an acceptable level of competence, and an inability to manage personal stressors and the resulting emotional and behavioral dysfunctions.

Program faculty and supervisors are in the best position to be proactive regarding impairment issues, but the professional community at large also needs to be involved in developing improved methods for detecting and treating impairment.

*Elizabeth M. Altmaier*

*See also* Career/Life (v4); Code of Ethics and Standards of Practice (v2); Ethical Codes (v1); Occupational Stress (v1); Postdegree/Prelicensure Supervision (v1); Standards and Competencies (v4); Supervision (v1); Work Stress (v4)

### Further Readings

- Barnett, J. E., & Hillard, D. (2001). Psychologist distress and impairment: The availability, nature, and use of colleague assistance programs for psychologists. *Professional Psychology: Research and Practice*, 32, 205–210.
- Forrest, L., Elman, N., Gizara, S., & Vacha-Haase, T. (1999). Trainee impairment: A review of identification, remediation, dismissal, and legal issues. *The Counseling Psychologist*, 27, 627–686.
- Kilburg, R. R., Nathan, P. E., & Thoreson, R. W. (1986). *Professionals in distress: Issues, syndromes, and solutions in psychology*. Washington, DC: American Psychological Association.
- Lamb, D. (1999). Addressing impairment and its relationship to professional boundary issues. *The Counseling Psychologist*, 27, 702–711.
- Lamb, D., & Swerdlik, M. E. (2003). Identifying and responding to problematic school psychology supervisees: The evaluation process and issues of impairment. *The Clinical Supervisor*, 22, 87–110.
- O'Connor, M. F. (2001). On the etiology and effective management of professional distress and impairment among psychologists. *Professional Psychology: Research and Practice*, 32, 345–350.

## INDIVIDUALS WITH DISABILITIES EDUCATION ACT

The Individuals with Disabilities Education Act (IDEA) is a federal law that ensures that all children ages birth through 21 receive a free and appropriate public school education regardless of the severity or type of their disability. Before this law was passed, many children with disabilities were excluded entirely from participation in public education or were not receiving an education appropriately designed to meet their needs.

Originally introduced into legislation in 1975 as the Education of All Handicapped Children Act (Public Law No. 94-142), the law was renamed in 1990 and has since undergone two additional reauthorizations. President George W. Bush signed the most recent reauthorization into law on December 3, 2004, and most provisions became effective on July 1, 2005. Final regulations were made available on August 14, 2006. This reauthorization was characterized by several modifications, including revised and added definitions, revised school discipline procedures, an emphasis on progress monitoring and accountability, changes to procedures in funding allocation, and changes intended to better align the act with the No Child Left Behind act. In addition, taking into consideration feedback from several national organizations and the public, the authors included measures to support the needs of at-risk populations, including homeless children and their families, migratory families, children with limited English proficiency, children exposed to family violence, and children in foster care.

Like its predecessors, the revised IDEA outlines state and local education agency responsibilities, procedures and criteria for determining eligibility for services, regulations pertaining to documentation and monitoring of services and student progress, the scope of included services and placements, and safeguards related to parental involvement and privacy. The law is divided into four parts. Part A outlines general provisions. Children ages 3 through 21 are covered under Part B. Part C details unique regulations concerning services for infants and toddlers with disabilities. Part D includes a description of national activities to improve the education of children with disabilities. IDEA also details the provision of funding to local and state agencies that serve children with disabilities in accordance with this law. IDEA is not fully funded



and does not cover all expenses incurred by schools to provide services to individuals with disabilities.

### Role of Mental Health Providers

IDEA groups mental health providers, including counselors, psychologists, social workers, and rehabilitation counselors, under the general umbrella of “related services.” Specifically, related services are defined by IDEA as those services necessary to assist a child with a disability to benefit from special education. IDEA broadly paints the scope of mental health services, indicating that related service providers may be involved in any of the following: direct counseling with students, early identification and assessment of disabilities, social work services, and parent counseling and training. Practitioners may also be responsible for linking school-based services with outside community resources such as primary care physicians, juvenile justice systems, child welfare agencies, and public recreation agencies. The newest revision of IDEA emphasizes the role of mental health providers in creating a safe school environment as indicated by the explicit description of counselors’ role in implementing and monitoring individual and systemwide positive behavioral interventions. School-based mental health practitioners are also likely to participate in disciplinary decisions and should be familiar with revised IDEA regulations pertaining to disciplinary actions with students with disabilities. The revised guidelines explicitly describe procedures for determining whether the conduct of a child with a disability is a manifestation of his or her disability, and they include criteria for determining when a functional behavior assessment and behavior intervention plan must be implemented.

### Assessment and Eligibility Issues

IDEA defines children eligible for services based on whether or not they have a disability outlined in 13 categories, including mental retardation, hearing impairment (including deafness), speech or language impairment, visual impairment (including blindness), emotional disturbance, orthopedic impairment, autism, traumatic brain injury, other health impairment, specific learning disability, deaf-blindness, or multiple disabilities. Practitioners working in schools should familiarize themselves with both the federal definitions outlined in IDEA and their state’s interpretation of these disability categories.

These categories overlap with diagnostic codes of the *Diagnostic and Statistical Manual of Mental Disorder, Fourth Edition, Text Revision (DSM-IV-TR)* but are also markedly different. Practitioners familiar with *DSM-IV-TR* diagnostic criteria will notice that several childhood disorders are not overtly represented in these eligibility criteria. However, these children may qualify for services under one of IDEA’s broader categories. Furthermore, for a child to be eligible for services, one must be able to document that the child’s diagnosable disability has an educational impact *and* that the disability warrants special education services. Therefore, not all children who may meet *DSM-IV-TR* diagnostic criteria would qualify for services under IDEA. For example, a child with a hearing loss may not qualify for services if it is demonstrated that he or she is making academic progress at a rate commensurate with that of his or her peers. Furthermore, several criteria for determining eligibility include provisions stating that the child’s learning problems cannot be due to environmental, cultural, or economic disadvantage. Practitioners should be aware that states receiving IDEA funds must serve students with these recognized disabilities, but many states have adopted classification systems that may expand upon these definitions. IDEA does not require education agencies to label students in order to receive services. Indeed, some states have adopted noncategorical service delivery systems.

Several IDEA disability classifications have fueled long-standing debates. In the most recent revision, the criteria for determining whether a child has a specific learning disability was modified, changing the controversial requirement that a child display a severe discrepancy between intellectual ability and academic achievement to permitting the use of a process based on the child’s response to research-based intervention. Under this response-to-intervention approach, children who demonstrate persistent academic difficulties despite the implementation of empirically supported interventions may be considered eligible for special education services. States may choose to continue to use the discrepancy model between the child’s intellectual ability—typically as measured by a norm-referenced standardized assessment—and the child’s achievement in one of several areas. These include oral expression, listening comprehension, written expression, basic reading skill, reading comprehension, mathematics calculation, and math reasoning. Regardless of the method used, an observation of the



child's academic performance by an observer other than the teacher within the classroom is mandated. Furthermore, in determining eligibility, teams must rule out sensory impairments; mental retardation; emotional disturbance; and environmental, cultural, and economic disadvantage as possible causes of the child's learning challenges.

The federal definition of *mental retardation* has also been scrutinized. To be classified as qualifying for services as a student with mental retardation, a child must show significantly below average performance—generally defined as below two standard deviations below the population mean—on a measure of general intellectual functioning. This is often demonstrated through use of standardized intelligence tests. However, IDEA does not explicitly mandate using intelligence tests. States may choose to use other procedures that are deemed valid and nondiscriminatory. In addition, the child must demonstrate significant deficits in academic functioning and adaptive behavior delays. Adaptive behavior refers to the child's ability to meet age-appropriate expectations for independent personal and social functioning. Critics of this definition have cited the overrepresentation of minority students in special education as indicative of unfair assessment techniques and procedures for identifying students with mental retardation.

*Emotional disturbance* is another IDEA definition that has caused significant controversy. The term includes students demonstrating difficulty learning that cannot be explained by cognitive, sensory, or health factors; difficulty building and sustaining satisfactory interpersonal relationships with peers and adults; inappropriate types of behavior or feelings under typical circumstances; a pervasive mood of unhappiness or depression; or a tendency to develop physical symptoms or fears related to personal or school problems. These problems must occur over a long period of time to a marked degree and must adversely affect the child's academic performance. The federal legislature's decision to exclude children who are socially maladjusted from this category, unless they also meet criteria for emotional disturbance, has sparked the most controversy. Several practitioners believe that the two cannot be treated as distinct problems. Noting differences between the IDEA and *DSM-IV-TR* systems of classifying disorders, practitioners should not assume that a child meeting *DSM-IV-TR*

criteria for an emotional disorder would automatically qualify for services under IDEA.

## Procedural Issues

Practitioners working within school systems should be familiar with several procedural elements incorporated into IDEA. The law outlines detailed procedures for conducting evaluations for determining eligibility. Specifically, IDEA Part B mandates that eligibility decisions are made using a variety of technically sound assessment tools and strategies (e.g., standardized assessment data, information from the parents, curriculum-based assessment measures) and that multiple sources of data must inform eligibility decisions. Assessment tools must also be considered fair for use with the particular child and valid for their intended use. After completing these assessments, a team—whose members are defined by IDEA regulations—must meet to determine whether the child meets eligibility criteria as a child with a disability and whether the child needs special education services.

Once a child has been found eligible for special education services, a team must convene within 30 calendar days to develop an Individualized Education Program (IEP). The IEP is a document that records the child's individualized education plan, including information regarding the child's disability and its impact on participation in the general curriculum, a description of special education services and supports the child will receive—including the extent to which the child will not participate with nondisabled peers in a general education classroom, a plan for monitoring the child's progress toward annual goals, and a plan for transition services.

In making placement decisions, teams must select the "least restrictive environment" in which the child can receive the services needed in a setting as close as possible to an age-appropriate general education classroom. The intention behind this terminology was to ensure that to the greatest extent possible, children with disabilities are educated with their nondisabled peers. School teams should carefully weigh whether the child can be educated within the regular classroom with special education supports, or whether the benefits of a special education classroom would outweigh the benefits of placement with support in the general classroom, including consideration of whether a child's behavior within a general education classroom is too disruptive or dangerous to others. The challenge



to school teams when making placement decisions is to balance a child's right to an education in the least restrictive environment with the right to an appropriate education. Unfortunately, the lack of research-based evidence to support placement decisions can make this decision challenging.

IDEA also contains several safeguards designed to protect the rights of parents and their children with disabilities. Specifically, IDEA outlines procedures to ensure schools obtain written consent from parents before initiating evaluation, eligibility determination, and placement in special education. The law also documents procedures for providing parents with notice of these events, specifically stating that this notice must be provided in the parents' preferred mode of communication. Schools must also provide parents with documentation of their rights and of the protections available to them and their children. Practitioners should familiarize themselves with these statutes and state/district interpretations of these guidelines.

## Part C

IDEA's Part C was developed in recognition of the importance of early identification and intervention for very young children with disabilities. Part C encourages states to develop statewide coordinated multidisciplinary programs to serve the needs of infants and toddlers with disabilities and their families. Each state receiving Part C funding must identify a lead agency (e.g., department of health, education, social welfare) to coordinate and monitor services and an interagency coordinating council to ensure coordination among various agencies providing services. Furthermore, these states must also establish a public awareness program and a child-find system to promote early identification of young children with disabilities.

Children eligible for services under Part C are children under age 3 who are experiencing significant developmental delays in cognition; in fine or gross motor skills; or in communication, social/emotional, or adaptive development or who have been diagnosed with a physical or mental condition that has a high probability of resulting in developmental delay. States may also choose to serve children defined as at risk for developing a significant delay either due to biological or environmental factors.

Procedures for evaluating and determining eligibility for Part C services are fairly similar to those for Part B. However, the legislation was written to ensure

family participation throughout the process. Therefore, the eligibility determination process must include gathering information regarding the family's concerns, priorities, and resources, and identification of services necessary to help the family meet the developmental needs of their child. If a child is found eligible for services, the team—including the parents, a service coordinator, a person directly involved in conducting the evaluations, and persons who will be providing services—convenes to create an individualized family service plan (IFSP) rather than an IEP. The IFSP is similar to an IEP but emphasizes the role of the family. Therefore, the IFSP must contain a statement of the family's resources, priorities, and concerns and may include direct (focused on the child) as well as indirect (focused on the family) interventions in recognition that addressing the family's needs may be necessary to support the child.

Unlike services for school-age children, to the greatest extent possible, services under Part C must be delivered in the child's natural environment. In order to facilitate smooth delivery of services, a service coordinator representing the profession most immediately relevant to the child's or family's needs, and who will be responsible for implementing the plan and coordinating with others, is also identified on the IFSP. The IFSP must also document steps that will be taken to transition a child with a disability to preschool or other services. Unlike an IEP, this plan is reviewed at least every 6 months. Similar to Part B, Part C also outlines specific procedural rights for parents.

## Professional Issues

In aligning more closely with No Child Left Behind and its emphasis on highly qualified professionals and documentation of outcomes, the revised IDEA may be expected to impact service providers in several ways. Although not explicitly stated in IDEA in relation to counselors, language emphasizing "highly qualified" professionals resonates throughout the legislature. As a result, several school systems receiving IDEA funds are requiring counselors and psychologists to demonstrate appropriate credentialing. The revised IDEA is also more outcome-oriented than previous versions, focusing on assessing the progress of students with disabilities. As a result, counselors and psychologists practicing within the schools may be expected to write objective, attainable goals, provide methodology for assessing progress toward these goals, and document



progress. Related to this emphasis on adequate progress, IDEA stresses the use of evidence-based interventions, encouraging counselors to select interventions with a strong empirical foundation when providing services within the schools.

Deborah Witsken

*See also* Americans with Disabilities Act (v1); Autism/Asperger's Syndrome (v1); *Diagnostic and Statistical Manual of Mental Disorders (DSM)* (v2); Evidence-Based Treatments (v2); Low-Incidence Disabilities (v1); Mental Health Issues in the Schools (v1); Mental Retardation and Developmental Disabilities (v1); Persons with Disabilities (v4); School Counseling (v1); School Psychology (v1); Traumatic Brain Injury and Rehabilitation (v1)

### Further Readings

Assistance to States for the Education of Children with Disabilities and Preschool Grants for Children with Disabilities, 34 C.F.R. § 300–301 (2006).  
Jacob, S., & Hartshorne, T. S. (2003). *Ethics and law for school psychologists* (4th ed.). Hoboken, NJ: Wiley.  
Office of Special Education Programs. (n.d.). *IDEA Topic Briefs*. Retrieved from <http://www.ed.gov/policy/speced/guid/idea/idea2004.html#law>

---

## INDUSTRIAL/ORGANIZATIONAL PSYCHOLOGY

---

Industrial/organizational psychology (I/O psychology) is a branch of psychology that explores the principles of psychology in relation to the workplace. Psychology principles applicable to the work setting are those mentioned in learning theory and aspects of social psychology as well as motivational and emotional principles. All of these principles can be used by counseling professionals to develop training and incentive programs, to form work groups and solve interpersonal problems, and to motivate and satisfy employees. Like counseling psychology, I/O psychology is based on the scientist–practitioner model. This model guides I/O psychologists in two ways: (a) conducting research and understanding the scientific principles in working with organizations, which is the scientific portion, and (b) providing the basis for high quality and effectiveness for the organization, which

is the practitioner component. This entry discusses the history of I/O psychology, the services I/O psychologists perform, and the relationship between I/O psychology and counseling.

### History and Major Contributions

It is not known exactly when I/O psychology began; however, in 1897, W. L. Bryan discussed how telegraphers learn the skill of sending and receiving Morse code messages. Six years later, Walter Dill Scott wrote *A Theory of Advertising* in which he applied psychology to business. Lillian Mollen Gilbreth announced in 1908 that human beings are the most important factors in industry and that they were not being acknowledged in the manner that they should. In 1911, engineer Frederick W. Taylor became conscious of how redesigning the workplace can achieve both higher efficiency within a company and higher compensation for employees. These people were the pioneers of the industry and contributed immensely to the world of I/O psychology and to how it is used today.

Although these individuals set the tone for the field, the onset of World War I had the first great impact on I/O psychology. Developed by then–American Psychological Association (APA) president Robert Yerkes and others, Army Alpha and Army Beta tests were used to determine the general intelligence of recruits so they could be placed in the appropriate positions, signifying the role of psychologists in work placement. The Alpha test was used for recruits who could read, and the nonverbal Beta test was used for those who could not read at all or who could not read English. These tests were used in placing recruits into appropriate positions.

As the war ended, it seemed that the use of I/O psychology was ending too. However, in 1920 the Hawthorne studies propelled I/O psychology by suggesting that employees' productivity improved because of the attention they were receiving from managers and employers, not the effects of the workplace lighting as the original research question suggested. This idea, referred to as the Hawthorne effect, had a significant impact in the history of I/O psychology, as it encouraged psychologists to focus more on human relations in the workplace and boosted the importance of this area of psychology.

As psychologists in the field polished their techniques on employee selection and placement, the Army again requested that psychologists develop a



test that would divide recruits into groups based on their ability to learn the duties and responsibilities needed to be a soldier. Psychologists met this request by developing the Army General Classification Test (AGCT); other methods for selecting recruits for officer training, proficiency tests, and aptitude tests were also developed. As World War II continued, I/O psychologists also used their skills to keep the nation's workforce productive to support the war need. Industries were finally realizing that techniques and principles learned from social psychology were applicable in business in areas such as selection, training, and machine design.

As the United States evolved during the 1950s and 1960s, the civil rights movement made its impact on the field of psychology in general and specifically on I/O psychology. With the passage of the Civil Rights Act, business and industry came under scrutiny because they employed disproportionately few minority psychologists; however, because the law enforced the issue of discrimination in employment, the need for I/O psychologists increased. I/O psychology advanced greatly during the 1980s and 1990s, as more sophisticated research tools assisted psychologists in generating more information about psychology and the work world and in developing new tools such as the Armed Services Vocational Aptitude Battery to assist in personnel selection and classification.

Another important factor in the development of I/O psychology is the changing demographics in the workforce. The number of employed women, Latino/as, and Asian Americans continues to increase, and more individuals, such as customers, workers, and vendors, have English as their second language. In addition, minorities such as women are entering higher-level managerial positions. I/O psychologists are needed to help promote diversity in the work environment and to educate employees about navigating diverse environments and resolving conflict that may arise among different groups. With movements toward flexible, family-friendly work schedules and policies, I/O psychology has come to be a cornerstone in keeping an organization running smoothly and efficiently.

### What I/O Psychologists Do

I/O psychology is relatable to human resource management (HRM) in selecting employees and managing the work environment. Although there are similarities in that both are involved in employee

selection, I/O psychology focuses more on the use of psychological principles, psychological tests, behavioral interviews, work samples, bio-data, and assessment centers rather than the use of unstructured interviews and reference checks that HRM professionals employ. Further, I/O psychology places more emphasis on the people of an organization (e.g., motivating and retaining, enhancing productivity) instead of the technicalities of actually running the organization (e.g., policy and procedure enforcement, worker benefits). Finally, a misconception of I/O psychologists is that they provide psychotherapy for employees. Although there are psychologists who do provide in-house psychotherapy to employees with a range of problems, such as those who work in Employee Assistance Programs (EAPs), I/O psychologists do not; instead, they often employ research and interventions with specific organizations to increase effectiveness of that organization.

I/O psychologists provide several different services for those with whom they work, including selection and placement of employees, training and development, developing and evaluating performance appraisal systems, organizational development, enhancing quality of work life, and evaluating ergonomics to name a few. I/O psychologists who provide selection and placement services focus on methods for selection, placement, and promotion of employees by choosing and developing tests aimed at assisting clients in accomplishing these tasks. For example, a psychologist may use testing information to help a company choose who to hire for a manager position. In providing training and development services, I/O psychologists determine what skills and methods are needed to improve employees' job performance. For example, a psychologist may work with a company to implement a leadership development program for managers and potential managers. Those who provide performance appraisal services create ways to determine how well employees are actually performing their job. Last, I/O psychologists who provide services in relation to ergonomics are concerned with the equipment and machinery related to human skills as well as with how the organization is designed. These psychologists usually work with engineers and others in the technical profession to help make the workplace safer and enable employees to be more resourceful.

In addition to these areas, there are several services I/O psychologists provide that relate to the field of counseling psychology. These include (a) enhancing



employee motivation; (b) improving organizational communication; (c) addressing group behavior, team management, and conflict, (d) addressing employee satisfaction, and (e) executive coaching. These services are discussed in more detail below.

### **Motivation**

In addressing motivation, I/O psychologists call on psychological theories such as consistency theory and Maslow's hierarchy of needs to examine individual predispositions related to motivation. Factors that contribute to a motivated predisposition include self-esteem, intrinsic motivation tendency, and a need for power and achievement. More specifically, employees who have a high self-evaluation will work harder so that their behavioral outcomes match their expectations. Although individuals with high self-esteem may be likely to perform better than those with low self-esteem, this may be true only in cultures where superior job performance is socially valued. Individuals who are intrinsically motivated are those who receive satisfaction in accomplishing a goal or task in and of itself and not just in the rewards gained from doing so.

An individual's predisposition for motivation may also be affected by her or his need for achievement and power. For example, Michael Stahl found that individuals who scored high on both need for achievement and power on the Job Choice Exercise could be classified as having a high level of managerial motivation. Thus, individuals with a high need for power and achievement are more likely than those with a low need for power and achievement to be motivated to work for promotions that place them in a position of control and influence. Other factors that contribute to employee motivation include whether or not an individual's needs are being met, achievability of goals, and the incentives received for meeting work goals.

In addressing motivation, I/O psychologists may conduct assessment related to predisposing factors of motivation as mentioned above and assess employees' goals or help employees develop achievable goals. Further, I/O psychologists may work with organizations to develop and assess evaluation and feedback systems and reward systems.

### **Organizational Communication**

An important aspect of any group of individuals is communication. Within an organization, effective communication can increase employee satisfaction

and commitment and can actually help increase the effectiveness of the organization itself. Within an organization, smaller social and functional groups exist in which communication occurs both within and between groups. Types of groups that exist include work teams, levels of management, committees, and social groups. Communication varies in the ways it is both sent and received depending on which groups or individuals are communicating.

Michael Aamodt defined four types of organizational communication: upward, downward, business, and informal communication. Upward communication is that which goes from subordinates to superiors, while downward communication goes from superiors to subordinates. Business information is the relay of information that is business-related and can occur among customers as well as managers and employees. The fourth type is informal communication and consists of unofficial information that is transmitted through groups of workers or the organization itself.

Just as communication occurs within and between groups, another important component is interpersonal communication. Interpersonal communication occurs from one person to another and includes actual spoken words as well as nonverbal cues such as body language and use of space. It is also important to note that much of interpersonal communication is greatly influenced by one's culture. While some cultures value an expressive style of communicating, others pay more attention to the factuality of what is stated.

I/O psychologists address communication issues by assessing the current forms of organization communication through surveys, interviews, and reviews of materials such as manuals and memos. Further, I/O psychologists will work with organizations to improve communication, providing feedback on current communication systems and recommendations for improvement such as incorporating different forms of communication systems. In addition, I/O psychologists may provide training relating to communication skills, such as telephone and e-mail etiquette, interpersonal communication, and verbal and nonverbal communication.

### **Group Behavior, Teams, and Group Conflict**

In order for individuals to be considered a group, they must meet the following four criteria: Members must see themselves as a unit, rewards must be provided to members, something that affects one member in turn affects the entire group, and members



of the group must share a common goal. One of the factors that may affect group performance is group cohesion. An important component of group cohesion is having a shared set of attitudes and beliefs. Typically, members in a group perceive themselves as being more similar to other group members than to individuals not included in the group.

Similar to groups is the concept of teams. Teams are groups of three or more individuals who work together to achieve a specific work-related task or goal. Work teams are distinguished from one another by their specific objectives. Susan Cohen and Diane Bailey defined four different types of teams. *Work teams* are fairly stable teams that have the objective of producing goods or providing a service. Within work teams, there are no supervisors; rather, each member plays an equal role in contributing to the goal of increasing product or service quality. *Parallel teams* are representative of different departments or units and are indeed parallel to the organization as a whole. The objective of parallel teams is to work as a problem-solving unit and to provide feedback or recommendations to superiors within the organization. The next type of team is *project teams*. These teams are formed for a limited time basis with the objective of completing one task or goal for the organization. *Management teams* are responsible for overseeing the work of units below them. For example, a group of managers of an organizational department may be responsible for supervising employees within that department to ensure optimal performance of the department.

Just as conflict occurs among individuals, it also occurs within and between groups. Conflict is a reaction that occurs when someone interferes with an individual's need to achieve a goal or accomplish a task, when rights have been violated, or when expectancies of a relationship are broken. Conflict can be either functional or dysfunctional. Dysfunctional conflict is harmful to the working environment and prevents goals from being achieved, while functional conflict can increase competition as well as prevent larger conflicts later on. Because conflict is unavoidable, the most important aspect of conflict is how it is dealt with. Members of a group should determine early on what attitudes toward conflict will be and how conflict should be handled.

In working with groups and teams, the I/O psychologist will assess the current functioning of the group in relation to its structure and function (e.g., leaders and followers; how work is accomplished), cohesion, communication, and conflict. The I/O psychologists may

provide services such as communication skills training, feedback, and recommendations to enhance group functioning, activities to build group or team cohesion, and instruction and facilitation of conflict resolution.

### ***Employee Satisfaction and Commitment***

Organizational commitment and employee satisfaction are important aspects of an organization that affect employee behavior. Organizational commitment is the amount of allegiance felt by an individual toward an organization and can be broken down into three components: affective, continuance, and normative commitment. *Affective commitment* deals with the emotional ties to an organization and the extent that an individual cares about the organization. *Continuance commitment* is an employee's decision to stay with an organization due to time and effort already expended for the company. *Normative commitment* is commitment based on feelings of obligation toward an organization. The levels of each type of commitment may vary among individuals, and different combinations of strengths and types (affective, continuance, and normative) of commitment will result in differing employee behaviors.

Along with organizational commitment, job satisfaction plays a major role in employee attitudes and behaviors. Job satisfaction is influenced both by individual characteristics and the actual organization as well as by whether or not an individual is a good fit for an organization. Timothy Judge, Edwin Locke, and C. C. Durham proposed four personality characteristics that may contribute to a higher level of job satisfaction: emotional stability, self-efficacy, self-esteem, and an external locus of control. In order for an individual to be an appropriate fit with an organization, it is important that the values, skills, interests, personality, and lifestyle of the individual are similar to those of the organization. Because a great deal of satisfaction and commitment is related to personal characteristics, counseling psychologists can play an important role in helping assess an individual's wants and needs and in determining how they can contribute to job satisfaction.

### ***Executive Coaching and Consultation***

Executive coaching has been in existence since the 1940s but has only recently received a great deal of attention in research on the effectiveness of this practice. Richard Kilburg defines executive coaching as a relationship between a client and an executive coach



(or consultant) who assists the client in identifying organizational goals and implementing interventions to achieve those goals based on a formal agreement. Executive consultants provide an outside perspective to organizational executives by helping organizational leaders during times of organizational transition, with problem employees, and with team and interpersonal conflicts and by improving performance levels.

It is important to distinguish executive coaching and consultation practices from the practices of counseling and psychotherapy. Although there are many similarities between counseling and consultation, consultation and executive coaching have an overarching goal to improve an organization or workplace rather than a single individual. Executive coaching covers a broad array of workplace issues and can last anywhere from a few minutes to several hours. Also, while counseling is dyadic in nature and focuses on personal issues, consultation is triadic and focused on work-related issues.

## Counseling and I/O Psychology

Similar to I/O psychology, counseling psychology's historical roots are tied to the military and the world of work, helping individuals to make the most out of their potential and to develop throughout their work careers. As a specialty of psychology, counseling involves a philosophy and working approach that resemble those of many areas of I/O psychology. For example, Sandra Shullman identified many overlaps between counseling psychology and consultation, a service often provided by I/O and counseling psychologists, such as recognizing and building on strengths, assisting individuals to achieve optimal functioning, identifying and addressing the impact of systems, and empowering consultees or clients to foster change. Counseling psychologists, trained as professional psychologists, develop competency in (a) gathering information and making conclusions or diagnoses; (b) consulting at the individual, group, and system levels to solve problems; (c) providing interventions to address problems; and (d) developing new knowledge through designing, implementing, and evaluating research. These foundational and functional competencies of professional psychology provide the groundwork on which counseling psychologists can offer services, as counseling psychology continues to expand to areas outside of traditional practice arenas and allows counseling psychologists to provide

consultation services in areas such as health care, equal employment opportunity, safety, workers compensation, employee assistance programs, labor relations, employee outplacement, and recruitment. Clyde Crego notes that this overlap and generalization of competencies suggests that it is highly likely that counseling psychologists and students in training to become counseling psychologists can, with appropriate training, adapt their skills in order to provide I/O related services in a variety of settings.

*Michael B. Madson, Anna R. Powe,  
and Kimberly D. Smith*

*See also* Achievement, Aptitude, and Ability Tests (v4); Counseling Psychology, Definition of (v1); Intrinsic Motivation (v2); Job Satisfaction and General Well-Being (v4); Occupational Stress (v1); Performance Modeling (v4); Person–Environment Fit (v4); Personality Theories (v2); Psychometric Properties (v2); Specialization Designation (v1); Translation and Adaptation of Psychological Tests (v1)

## Further Readings

- Aamodt, M. G. (2007). *Industrial/organizational psychology: An applied approach* (5th ed.). Belmont, CA: Thompson/Wadsworth.
- Berman, W. H., & Bradt, G. (2006). Executive coaching and consulting: "Different strokes for different folks." *Professional Psychology: Research and Practice*, 37, 244–253.
- Cohen, S. G., & Bailey, D. E. (1997). What makes teams work: Group effectiveness research from the shop floor to the executive suite. *Journal of Management*, 23, 239–290.
- Crego, C. A. (1985). Ethics: The need for improved consultation training. *The Counseling Psychologist*, 13, 473–476.
- Dougherty, A. M. (2005). *Psychological consultation and collaboration in school and community settings* (4th ed.). Belmont, CA: Brooks/Cole.
- Gerstein, L. H., & Shullman, S. L. (1992). Counseling psychology and the workplace: The emergence of organizational counseling psychology. In S. D. Brown & R. W. Lent (Eds.), *Handbook of counseling psychology* (2nd ed., pp. 581–625). New York: Wiley.
- Gordon, J. R., (2001). *Organizational behavior: A diagnostic approach* (7th ed.). Englewood Cliffs, NJ: Prentice Hall.
- Grice, T. A., Gallois, C., Jones, E., Paulsen, N., & Callan, V. J. (2006). "We do it, but they don't": Multiple categorizations and work team communication. *Journal of Applied Communication Research*, 34, 331–348.



- Hesketh, B. (2000). Prevention and development in the workplace. In S. D. Brown & R. W. Lent (Eds.), *Handbook of counseling psychology* (3rd ed., pp. 471–498). New York: Wiley.
- Inkson, J. K. (1978). Self-esteem as a moderator of the relationship between job performance and job satisfaction. *Journal of Applied Psychology*, 63, 243–247.
- Judge, T. A., Locke, E. A., & Durham, C. C. (1997). The dispositional causes of job satisfaction: A core evaluations approach. *Research in Organizational Behavior*, 19, 151–188.
- Kilburg, R. R. (2000). *Executive coaching: Developing managerial wisdom in a world of chaos*. Washington, DC: American Psychological Association.
- Kristof-Brown, A. L., Zimmerman, R. D., & Johnson, E. C. (2005). Consequences of individuals' fit at work: A meta-analysis of person-job, person-organization, person-group, and person-supervisor fit. *Personnel Psychology*, 58, 281–342.
- Muchinsky, P. M. (2006). *Psychology applied to work* (8th ed.). Belmont, CA: Thompson/Wadsworth.
- Osipow, S. H. (1982). Counseling psychology: Applications in the world of work. *The Counseling Psychologist*, 10, 19–25.
- Rodolfa, E., Bent, R., Eisman, E., Nelson, P., Rehm, L., & Ritchie, P. (2005). A cube model for competency development: Implications for psychology educators and regulators. *Professional Psychology: Research and Practice*, 36, 347–354.
- Shullman, S. L. (2002). Reflections of a consulting counseling psychologist: Implications for the principles and training at the doctoral and postdoctoral level in consulting psychology for the practice of counseling psychology. *Consulting Psychology Journal: Practice and Research*, 54, 242–251.
- Stajkovic, A. D. (2006). Development of a core confidence–higher order construct. *Journal of Applied Psychology*, 91, 1208–1224.
- Vansteenkiste, M., Lens, W., & Deci, E. L. (2006). Intrinsic versus extrinsic goal contents in self-determination theory: Another look at the quality of academic motivation. *Educational Psychologist*, 41, 19–31.

---

## INTERNALIZING PROBLEMS OF CHILDHOOD

---

Internalizing problems of childhood are broadly defined as problems that occur within the child. Children with internalized problems often appear

withdrawn, fearful, and shy. Internalized problems are managed within the child rather than being acted out externally in the environment. Beyond differing in their diagnostic criteria, externalizing problems differ from internalizing problems primarily in their expression. However, there is significant evidence that externalizing problems and internalizing problems occur comorbidly. Broadly speaking, the class of internalizing problems in childhood includes depression and anxiety. Subcategories of childhood anxiety disorders are also internalized disorders and include separation anxiety disorder, panic disorder, social phobia, simple phobia, obsessive-compulsive disorder, posttraumatic stress disorder, and generalized anxiety disorder. Similarly, subcategories of depressive disorders have been identified and include major depressive disorder, dysthymia, cyclothymia, and bipolar disorder.

### Internalizing Problems Defined

Though the next section is not comprehensive, its intent is to provide an overview of some internalizing problems in childhood, guided by the diagnostic criteria of the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR)*. Only the broad categories of depressive disorders and anxiety disorders will be reviewed.

### Childhood Depressive Disorders

As one of the most pervasive disorders, depressive disorder (often referred to as mood disorder) has a tremendous impact on a child's energy, mood, and expression of emotions. Children who suffer from any form of depression experience challenges with peer relationships, familial relationship, academic success, and overall psychosocial development. Though many similarities exist between depression in adults and depression in children, there are some distinct differences. Specifically, children exhibit an irritable mood and, at times, an inability to sit still, including fidgeting or pacing.

Depression has a profound impact on a child's well-being similar to its effect on adults. Children with depression experience profound sadness, frequent periods of crying, feelings of helplessness and/or hopelessness, and a decrease or increase in appetite. Along with these symptoms often come feelings of discouragement or worthlessness and a loss of interest in pleasure and subsequent disinterest in



previously interesting activities. Children with depression may be fearful and anxious and often experience a significant drop in school performance. Finally, these children may experience significant changes in their sleeping habits, specifically an increase or decrease, and they often complain of physical aches and pains that have no medical explanation.

### **Childhood Anxiety Disorders**

Children experiencing significant anxiety often experience intense fear, irritability, worry, and overall uneasiness. Anxiety can have a profound impact on a child's well-being and can influence or profoundly affect the child's school success, relationships with peers, self-esteem, and ongoing anxiety into adulthood. The specific symptoms of anxiety disorders differ according to diagnosis; therefore, below is a general overview of the broad diagnostic category of childhood anxiety.

When children experience a general sense of anxiety, they worry about things that occur in their everyday lives, such as school activities, peer relationships, and extracurricular activities. These fears often result in lower self-esteem, physical complaints without a medical explanation, and a strong need for reassurance. Other anxiety problems may be a result of unrealistic fear of a particular situation or object (phobias). Examples of such phobias may include fear of storms, snakes, spiders, height, water, or social situations. Children with phobias may attempt to avoid situations that may expose them to the environment or object that produces their fears, thus restricting their activity and social interaction. Other types of anxiety may manifest in a child through an intense fear of leaving his or her parents (separation anxiety), through patterns of repetitive thoughts or behaviors (obsessive-compulsive disorder), or a constant replaying of a stressful event (posttraumatic stress). Anxiety overall limits children's willingness and at times capacity to freely experience the world and subsequently impacts their overall psychosocial development.

There is a high degree of comorbidity between anxiety and depression in children, meaning that children with symptoms of one, either anxiety or depression, often eventually exhibit symptoms of the other. It is important to note that to be considered significant, all symptoms associated with any of these internalizing problems must be present beyond what is to be expected with normal development and to a significant degree must cause problems with

psychosocial and educational development. Any single symptom cannot lead to a diagnosis of one of the above internalizing disorders.

*Heather M. Helm*

**See also** Bipolar Disorder (v2); Child Maltreatment (v1); Depression (v2); Developmental Disorders (v1); Disasters, Impact on Children (v1); Externalizing Problems of Childhood (v1); Mental Health Issues in the Schools (v1); Panic Disorders (v2); School Counseling (v1)

### **Further Readings**

- American Psychological Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed., Text rev.). Washington, DC: Author
- Gilliom, M., & Shaw, D. S. (2004). Codevelopment of externalizing and internalizing problems in early childhood. *Development and Psychopathology*, 16(2), 313–333.
- Ollendick, T. H., & King, N. J. (1994). Diagnosis, assessment, and treatment of internalizing problems in children: The role of longitudinal data. *Journal of Consulting & Clinical Psychology*, 62(5), 918–927.
- Sourander, A., & Helstelä, L. (2006). Childhood predictors of externalizing and internalizing problems in adolescents. *European Child & Adolescent Psychiatry*, 14, 415–423.
- Zahn-Waxler, C., Klimes-Dougan, B., & Slattery, M. J. (2000). Internalizing problems of childhood and adolescence: Prospects, pitfalls, and progress in understanding the development of anxiety and depression. *Development and Psychopathology*, 12(3), 443–466.

---

## **INTERNATIONAL DEVELOPMENTS, COUNSELING**

---

Historically, interest in international psychology dates back to professional affiliations created in Paris over a century ago at the First International Congress of Psychology. Since then, a variety of organizations continue to support the professional interests of psychology worldwide (e.g., the American Psychological Association's [APA's] Division 17—International Special Interests Group, and Division 52—International Psychology). From a discipline-specific standpoint, the field of counseling psychology brings several significant strengths to the field of international psychology, including its traditional emphases on mental health, vocational assessment,



and prevention, to name but a few. These strengths, in combination with its longstanding commitment to multiculturalism and diversity, suggest that counseling psychology may be uniquely suited to meet challenges facing the field of international psychology today.

## **Current Growth Within the Field**

### ***Globalization***

Current growth within the field has, by and large, been fostered by the rapid and expansive impact of economic and technological globalization. This expansion is of particular interest at present, as the impact of globalization transforms both personal and professional roles in a variety of cultural arenas. The potential benefits of increasing the international scope of counseling psychology are myriad and include creating a worldwide forum for examining whether accepted traditional psychological paradigms and practices are generalizable to other cultures. Globalization also allows for an expansion of our current understanding of human strengths and resiliency as they relate to cultural context and provides a much-needed opportunity for incorporating diverse international multicultural perspectives within the profession.

### ***Opportunities and Risks***

While an expansion of international psychology offers many new opportunities for cross-cultural collaboration, it also presents several risks. Chief among these is the need to guard against the wholesale exportation of professional ideologies as they relate to practice, education, and research. As training programs, research methodologies, and journal publications based in the United States still account for the greatest proportion of counseling activities worldwide, several significant concerns are worth noting. Many methodologies, theories, and practices derived from current systems may, at best, ignore important and significant cross-cultural differences when transplanted to new cultures, and at worst, they may extend ethnocentric biases regarding human behavior to local psychologies. Examples of this include an over-reliance on diagnostic systems based on traditional medical models and the exportation of commonly used psychological tests to evaluate behavior. The generalization of Western diagnostic systems to other cultures may be inappropriate in many instances and may not reflect cultural norms for

both functional and symptomatic behaviors. The use of psychological tests with individuals for whom their use has not been validated through the construction of appropriate norm groups, or that have been translated without evaluating their appropriate equivalency, may lead to misdiagnosis or an assignment of problems where none exist. A wholesale exportation of current models and methodologies also limits opportunities to expand our knowledge base in valuable ways that have the potential to validate (or invalidate) important concepts and practices through cross-cultural collaboration. Opening the field to alternative methodologies may increase understanding of how biases inherent in traditional systems operate when applied both to one's own and to other cultures.

The expansion of international counseling, by its very nature, has produced a unique set of circumstances that challenge traditional notions of psychological health as they relate to counseling practices. The by-products of globalization, which include socioeconomic conditions such as immigration, economic displacement, and international conflicts, have created a new generation of individuals with human problems for which traditional treatment methodologies may be of limited use. These conditions require the competent professional to be creative in new and innovative ways that may be inconsistent with traditional notions of training and educational practices. Modern conceptualizations of identity and psychological health are changing rapidly as classical notions of identity are displaced along with individuals and cultural traditions. Our understanding of the particular determinants of behavior is very much influenced by whether or not a particular culture embraces an individualist versus collectivist view of identity. While an individualist focus can be essential for understanding certain behaviors, it often ignores context and underestimates the complexity of the many sociocultural determinants of behavior. Nor can the impact of social policies on the global community or issues of social justice be ignored, as they profoundly influence how we choose to localize the causes and, ultimately, the treatment of psychological problems.

## **Critical Issues in Professional Development**

### ***Professional Collaboration***

The creation of a truly international form of counseling psychology will require professional



collaboration at many levels to identify and prioritize aims and objectives. Currently, counseling psychology exists as a specialty, by name, in only a handful of countries, although the common practices of counseling psychology, while not formally identified as such, may be subsumed under other disciplines. Thus, efforts at professional collaboration may be easily frustrated by an inability to identify international colleagues or contexts in which to develop projects of mutual interest. Fortunately, a variety of professional organizations (e.g., the International Congress of Applied Psychology and APA's divisions 52 and 17) and programs (e.g., the Fulbright Scholar program) already exist to promote mutual international interests and development via conferences, exchange programs, and professional research and journal collaboration both here and abroad. Other organizations have also worked to promote specific venues (e.g., journal issues devoted to international articles) that examine the psychological practices and perspectives of other cultures and address issues unique to international counseling psychology.

### ***Ethical Practice***

Another critical issue for the international expansion of the profession is defining what constitutes appropriate and ethical modes of practice and how best to determine culturally appropriate standards for a variety of professional helping behaviors (e.g., the appropriateness of meeting clients in their homes or cultural values related to personal space or physical touching). Many contemporary problems and adjustment issues may be ill suited to traditional treatment delivery methods (e.g., talking therapies) and will require innovative treatment strategies and flexible professionals who can develop new methodologies and modes of delivery. Attention must also be given to training and recruitment issues, both at home and abroad, to ensure that the concept of international multiculturalism extends to those who professionals train and to how they train them.

### **Social Policy and Special Interests**

Many proponents of international psychology argue that the psychopathology of the new world order often rests in extreme social conditions, and special attention should be directed to issues of social justice as they relate to the delivery of mental health services. Global conditions have a differential impact on the

psychological well-being of vulnerable groups such as women, children, displaced persons, and other marginalized minorities. New types of special populations have also been created by changes in national, economic, and technological boundaries. Populations uprooted by international conflicts and rapid economic changes require innovative strategies that offer support for victims of trauma and interpersonal violence and that provide new venues for reworking intervention efforts related to basic survival issues as well as to psychological health. Acknowledgment of the unique psychosocial forces that impact the mental health of women and children seems especially critical and includes recognition of issues such as interpersonal violence, poverty, employment conditions, child and family care responsibilities, health care, and access to educational opportunities.

### **The Necessity of Growth**

The global forces currently acting at breakneck speeds suggest that implementing a strategic plan for international counseling is not only desirable but absolutely necessary. Globalization has the potential to provoke an identity crisis of sorts not only for the profession but also for how psychological health is viewed worldwide. As traditional values are subsumed by larger world changes, there exists the potential for an absence of consensual validation for standards of "normal" behavior. Counseling psychology has been at the forefront of supporting multiculturalism through its commitment to diversity issues, and an expansion of international counseling efforts is a natural extension of this commitment. As the traditional distinctions between psychological disciplines diminish on a practical level, the question then becomes, how might the technological innovations that have created unprecedented access to a global psychological community have the potential to empower the traditional mission of counseling psychology in significant ways? A failure to move forward in a thoughtful and directed manner at this critical juncture not only incurs the risk of professional stagnation but threatens the growth and the integrity of the discipline as well as its ability to fulfill its mission in a meaningful way. A shift toward a universal multicultural international model that advances the discipline must be based on a flexible worldview that incorporates ethnic diversity as well as diverse multicultural perspectives that can validate



and expand our understanding of human growth and potential and provide us with a new way of looking at problems in “normal living.”

*Pamela Brouillard*

**See also** Conferences, Counseling Psychology (v1); Conferences in Counseling (v1); Counseling Psychology, Definition of (v1); Counseling Psychology, History of (v1); Counseling Skills Training (v2); Cross-Cultural Psychology (v3); Cross-Cultural Training (v3); International Approaches (v4); International Association for Educational and Vocational Guidance (v4); International Developments, Counseling Psychology (v1); International Test Commission (v1); Multicultural Career Assessment Models (v4); Multicultural Career Counseling Checklist (v4); Multicultural Counseling (v3); Multicultural Counseling Competence (v3); Multicultural Psychology (v3); Postdoctoral Training (v1); Translation and Adaptation of Psychological Tests (v1)

### Further Readings

- Arnett, J. J. (2002). The psychology of globalization. *American Psychologist*, 57, 774–783.
- Chung, R. C. (2005). Women, human rights, and counseling: crossing international boundaries. *Journal of Counseling and Development*, 83, 262–268.
- Gerstein, L., & Ægisdóttir, S. (2005). A trip around the world: A counseling travelogue! *Journal of Mental Health Counseling*, 27, 95–103.
- Leong, F. T. L., & Leach, M. M. (2007). Internationalising counseling psychology in the United States: A SWOT analysis. *Applied Psychology: An International Review*, 56, 165–181.
- Leong, S. A. (2003). A journey worth traveling: Globalization of counseling psychology. *The Counseling Psychologist*, 3, 412–419.
- Sabourin, M. (2001). International psychology: Is the whole greater than the sum of its parts? *Canadian Psychology*, 42, 74–81.

---

## INTERNATIONAL DEVELOPMENTS, COUNSELING PSYCHOLOGY

---

Clearly, the world is rapidly changing and becoming a global village with increased interdependence, communication, travel, migration, and trade between countries. This entry summarizes the international

developments in counseling psychology in the United States and worldwide.

### In the United States

The U.S. counseling profession has a long and distinguished history, evolving from the vocational guidance movement in the late 19th century to a strong counseling psychology specialty within the discipline of psychology in the 21st century. The specialty educates individuals through accredited training programs, generates knowledge from research, credentials members to function as professionals, and is regulated through organizations established for more than 50 years.

The profession made several early attempts to become internationalized. For example, after World War II, U.S. counseling psychologists consulted with Japanese education faculty about establishing counseling services. More systematic efforts to increase cross-cultural communication within the profession began in the mid-1960s with the creation of the *International Journal for the Advancement of Counseling*. In the 1980s, a few counseling psychologists were granted Fulbright professorships. In 1988, Bruce Fretz, then the incoming editor of *The Counseling Psychologist (TCP)*, began a new section within this journal called The International Forum, publishing articles primarily by U.S. scholars about their experiences working abroad. In 1989, the Minnesota International Counseling Institute (MICI) was created by counseling psychology faculty at the University of Minnesota, namely Thomas Skovholt, Sunny Hansen, John Romano, and Kay Thomas. The MICI is a biennial gathering of international practitioners and scholars to advance the science and practice of cross-cultural counseling. In 1991, Paul Pedersen published a landmark article proposing that culture, defined broadly, is generic to all counseling. In essence, Pedersen broadened the conceptualization of culture to expand the growing multicultural movement to include cross-cultural counseling. For the next 15 years, Pedersen provided leadership in promoting the internationalization of the profession. However, by the mid-1990s, the internationalization of the profession was not widely accepted or even well understood.

In 1997, the incoming editor of *TCP*, P. Paul Heppner, renewed the focus on international issues by (a) assigning scholars who were leaders in the international movement in counseling psychology as series coeditors (Frederick Leong and Paul Pedersen, and later Joe Ponterotto and Dave Blustein) of the



International Forum, (b) changing the review process to be more culturally sensitive for international authors submitting manuscripts, and (c) appointing the first scholar from outside the United States (S. A. Leung from Hong Kong) to serve as associate editor. Because of the work of the series coeditors, more international colleagues were encouraged to submit manuscripts, the review process was more effective, and more international scholars began to publish in *TCP* and in other counseling journals, resulting in a slow increase in communication around an international perspective in counseling psychology.

More important, between 1997 and 2003, a number of articles and books appeared by Pedersen, Leong, and other colleagues more fully articulating a strong rationale for internationalizing counseling psychology in the United States and emphasizing the pervasive role of culture in all dimensions of counseling. These publications increased awareness that culture affects behavior and thus is a very important context in which to understand the counseling process. In 2003, Louise Douce, as president of the American Psychological Association's (APA's) Division 17 (Counseling Psychology), created a forum at the annual APA convention for counseling scholars interested in international issues to discuss common goals. Two years later, Heppner, as then president of Division 17, expanded the international scholar's breakfast and reception at the APA convention to welcome international guests, promote collaborative relationships across different countries, and give scholars an opportunity to learn from each other. He also initiated, in conjunction with Lawrence H. Gerstein, an international section within Division 17.

In 2006, there was a growing awareness of the utility of cross-cultural issues in counseling, and growing numbers of international graduates were joining the ranks of counseling professionals. The infrastructure of the international counseling movement also expanded as did the availability of outlets for publication. Consequently, communication among counseling leaders worldwide has increased, and the focus on international issues within counseling psychology in the United States has accelerated.

### Around the Globe

The counseling profession is active worldwide. However, there are many differences in the identity of counseling psychologists, the credentials required to

function as such professionals, and the presence and infrastructure of associations representing this occupational group.

The profession is blossoming more in Asia than in other regions of the world. In general, counselors and counseling psychologists can be found in Taiwan, China, Japan, South Korea, Thailand, Malaysia, Hong Kong, Singapore, the Philippines, and to some extent, India and Pakistan. In only a few Asian countries is it possible for counselors (e.g., Japan) and counseling psychologists (e.g., Taiwan) to be licensed. There are, however, many organizations representing such professionals.

The counseling profession also can be found in the Southern Hemisphere. Counselors and/or counseling psychologists are available in Australia, New Zealand, and Fiji, along with several organizations.

Counseling is not as popular in the Middle East, Eurasia, southeastern Europe, and western and central Asia. Although counselors can be found in countries such as Israel, Lebanon, Saudi Arabia, Egypt, Jordan, Kuwait, the United Arab Emirates, the Palestinian territory, Turkey, and Iran, they are a recognized specialty only in Greece and can be licensed in only a few of these countries (e.g., Lebanon, Greece). A wide array of organizations is available along with a division of counseling psychology in the Hellenic Psychology Society in Greece.

The profession is growing in Africa. Counseling psychologists or counselors can be found in Uganda, South Africa, Ghana, Kenya, Nigeria, and Botswana. There are a number of organizations for such professionals. Counselors and counseling psychologists can become licensed only in South Africa.

The counseling profession has a long history in Europe. There are counselors, for instance, in Italy, the Netherlands, Sweden, Great Britain, Ukraine, Slovakia, Portugal, France, and Hungary. In Iceland and Germany, there is no counseling profession, but there are psychologists. Counselors can be licensed in Portugal but not in most other countries mentioned above. Counseling psychologists are licensed in Bulgaria and Ireland. Organizations for counselors exist in many countries. Counselors living in European countries where there is no credentialing may obtain certification from the European Association for Counselling.

Counseling psychology in Canada dates back to the 1950s. Since 1986, the profession has existed as a section of the Canadian Psychological Association (CPA). The CPA accredits doctoral programs in



counseling psychology. Various regulatory bodies recognize counseling psychology as a specialty in psychology. There is no law regulating the title of “counselor” (indicating persons with a master’s degree), but there is certification through the Canadian Counseling Association. Counseling psychologists can obtain a license.

There is little available information on the profession in South, Central, and Latin America. In El Salvador, the differences between counseling psychology and clinical psychology are not stressed. Similarly, counseling is not a separate field in Guyana. In Peru, to become a psychologist, one must complete 6 years of postsecondary education in psychology. Counseling is relatively new to the Bahamas. Only clinical psychologists are licensed.

Finally, a major development in the international recognition of counseling psychology as a specialty was the creation of Division 16 in the International Association of Applied Psychology (IAAP) in 2006. Frederick Leong was instrumental in the development of this new division. The IAAP is the oldest international organization of applied psychology. The 2006 international congress marked the first time counseling psychology had a formal voice in the IAAP.

## Conclusion

Although the inclusion of international perspectives in counseling psychology began in the 1940s, it grew relatively slowly in the U.S. until the beginning of the 21st century. Since 2000, there has been greater interest in international perspectives in counseling psychology in U.S. journals as well as changes in the infrastructure within U.S. professional associations, in the training of students in cross-cultural competencies, and in cross-national communication and collaboration to reach mutually beneficial goals. The profession is vigorously developing worldwide with differing identities, credentialing, training standards and accreditation, and a wide array of service delivery models to address various societal needs for diverse cultures. The profession is active globally and committed to strengthening collaboration among counseling professionals worldwide.

*P. Paul Heppner and Lawrence H. Gerstein*

**See also** Conferences, Counseling Psychology (v1); Conferences in Counseling (v1); Counseling Psychology, Definition of (v1); Counseling Psychology, History of (v1); Counseling Skills Training (v2); Cross-Cultural Psychology

(v3); Cross-Cultural Training (v3); International Approaches (v4); International Association for Educational and Vocational Guidance (v4); International Developments, Counseling Psychology (v1); International Test Commission (v1); Multicultural Career Assessment Models (v4); Multicultural Career Counseling Checklist (v4); Multicultural Counseling (v3); Multicultural Counseling Competence (v3); Multicultural Psychology (v3); Professional Associations, Counseling (v1)

## Further Readings

- Gerstein, L. H. (2005). Counseling psychologists as international social architects. In R. L. Toporek, L. H. Gerstein, N. A. Fouad, G. Roysircar-Sodowsky, & T. Israel (Eds.), *Handbook for social justice in counseling psychology: Leadership, vision, and action* (pp. 377–387). Thousand Oaks, CA: Sage.
- Gerstein, L. H., & Ægisdóttir, S. (Eds.). (2005). Counseling around the world [Special issue]. *Journal of Mental Health Counseling*, 27, 95–184.
- Gerstein, L. H., & Ægisdóttir, S. (Eds.). (2005). Counseling outside of the United States: Looking in and reaching out! [Special section]. *Journal of Mental Health Counseling*, 27, 221–281.
- Heppner, P. P. (2006). The benefits and challenges of becoming cross-culturally competent counseling psychologists. *The Counseling Psychologist*, 34, 147–172.
- Leong, F. T. L., & Ponterotto, J. G. (2003). A proposal for internationalizing counseling psychology in the United States: Rationale, recommendations, and challenges. *The Counseling Psychologist*, 31, 381–395.
- Pedersen, P., & Leong, F. (1997). Counseling in an international context. *The Counseling Psychologist*, 25, 117–122.

## Web Sites

- International Section of Counseling Psychology Division 17, American Psychological Association: <http://www.internationalcounselingpsychology.org>
- Society of Counseling Psychology, Division 17 of American Psychological Association: <http://www.div17.org>

---

## INTERNATIONAL TEST COMMISSION

---

Test use is an international enterprise. Tests are used widely in education, industry, government—including the military—and in other institutions to assist in decision making. The International Test Commission (ITC)



was established in 1976 to address three test-related issues at an international level: test purchase by unauthorized persons, the questionable quality of some tests, and the unethical use of tests. The ITC's primary mission is to promote an exchange of information on test development and use to improve test-related practices. The ITC works to promote this goal in various ways. First, the ITC maintains a Web site and publishes a quarterly newsletter, *Testing International*, and a scholarly journal, the *International Journal of Testing*. The ITC also promoted the exchange of information through five international conferences to address issues important to test development and use internationally. These include conferences at Oxford University on test use with children and youth; at Georgetown University in Washington, DC, on test adaptation guidelines; in Winchester, England on computer based testing and the Internet; in Williamsburg, Virginia on testing and equity; and in Brussels on psychological and educational test adaptations.

### Developing International Guidelines

Although test use is universal, test development is not. Most countries do not develop standardized tests for internal use; rather, they use tests developed in other countries. These tests typically are translated into the local language and often have unsuitable reliability, validity, and norms for subjects in the countries into which they have been imported. Therefore, under the leadership of Ronald Hambleton, the ITC developed guidelines for test adaptations. The term *test adaptations* refers to a process of altering a test originally designed for use with people who live in one culture (e.g., England) in ways that make the test appropriate for use with those who live in another culture (e.g., Hungary). The ultimate goal is to have the two tests measure the same trait in a fair, equitable, and equivalent fashion.

The ITC has also developed guidelines to encourage best practice in psychological and educational testing. The goal is to provide a common international framework from which specific local standards, codes of practice, qualifications, and user registration criteria can be developed to reflect local needs.

Finally, Internet-delivered computer-based testing is increasing. This development warrants standards for test administration, security of tests and test results, and control of the testing process. Therefore, the ITC has established international guidelines that

highlight good practice issues in computer-based testing and testing delivered over the Internet.

Thomas Oakland

*See also* Achievement, Aptitude, and Ability Tests (v4); Culture-Free Testing (v3); International Developments, Counseling (v1); International Developments, Counseling Psychology (v1); Translation and Adaptation of Psychological Tests (v1)

### Further Readings

- Bartram, D. (2001). The development of international guidelines on test use: The International Test Commission project. *International Journal of Testing*, 1, 33–54.
- Hambleton, R., Merenda, P., & Spielberger, C. (Eds.). (2005). *Adapting educational and psychological tests for cross-cultural assessment*. Mahwah, NJ: Lawrence Erlbaum.
- Oakland, T. (1995). Test use with children and youth internationally: Current status and future directions. In T. Oakland & R. Hambleton (Eds.), *International perspectives on academic assessment*. Boston: Kluwer Academic.
- Oakland, T., Poortinga, Y. H., Schlegel, J., & Hambleton, R. K. (2001). International Test Commission: Its history, current status, and future directions. *International Journal of Testing*, 1, 3–32.

---

## IVEY, ALLEN E. (1933– )

---

Both of Allen Ivey's parents were born in near poverty during a time when there was no social safety net. Ivey's father's parents had emigrated from Kernow (also known as Cornwall), Great Britain, to the United States and Canada at the turn of the century. Ivey's grandfather died when his father was 9, leaving his grandmother as the sole provider for the family. On his English mother's side, his grandfather lost his inherited local paper due to compulsive gambling. His mother grew up without money for shoes and for required books for school. From his parents' painful childhood experiences, Ivey gained a sense of economic oppression and injustice. Ivey considers himself bicultural, growing up and navigating through his English and Cornish roots, which were not always compatible in their messages with respect to education and achievement.

Ivey grew up in a small house attached to the family store in rural Mt. Vernon, Washington. He



attended a two-room school that was a mile away until he was the only person in the eighth grade. In the school environment, Ivey experienced anti-Semitic prejudice even though he had no knowledge about Jews at the time. He did not share these stories of oppression with his parents. Ivey learned to hate oppression in all forms from his rural childhood. He felt fortunate that his parents' value system of standing up alone for righteousness provided him with a foundation for understanding and supporting multicultural issues.

### Education and Professional Career

Ivey graduated from Stanford University in 1955 and received a Fulbright Scholarship to study social work for a year in Denmark at the University of Copenhagen. His experience in Denmark played a paramount role in developing his contextual approach to counseling. Ivey then attended Harvard University and received his Ed.D. in 1959. During 2 of his 3 years of study at Harvard, he was also working full-time as director of student activities and guidance instructor at Boston University.

At the age of 25, he founded the counseling center at Bucknell University and served as director of counseling. Ivey then assumed the role of director of the counseling center at Colorado State University from 1963 to 1968. In 1966, Ivey received a small grant from the Charles F. Kettering Foundation to identify specific single skills of counseling. This seed would later turn into the articulation of micro skills. Ivey began teaching at the University of Massachusetts, Amherst in 1968, where he served as a professor for more than 30 years. He authored over 35 books and over 200 articles, chapters, and monographs. His work has been translated into 18 languages. In addition to his scholarly work, Ivey founded and is the president of Microtraining Associates, an independent, educational publishing firm. Microtraining Associates has paved the way in producing videos and books related to skills training and multicultural development.

Ivey has been and still is heavily involved and active in the professional community. He served as president of the Division of Counseling Psychology (now Society for Counseling Psychology) of the American Psychological Association (APA). He is a fellow of APA and a diplomate of the American Board of Professional Psychology. In addition, he is a fellow of APA's Society for the Study of Ethnic and Minority

Psychology. Ivey also serves on the Board of Directors of the National Institute for Multicultural Competence. Ivey is a lifetime member of the American Counseling Association and he received their Professional Development award in 1992.

### Contributions

#### *Microcounseling*

Ivey established a structured approach to training therapists in discrete helping skills (micro skills) including attending behavior, open invitation to talk, reflection and summarization, paraphrasing, and interpretation. Instead of focusing only on internal variables, such as self-actualization, therapists can help clients focus on external variables that may disrupt development. The early recognition of the need to explore the cultural environment led to the realization that appropriate attending and micro skills differ from one cultural context to another.

Ivey's motivation and determination for combining his interests in skills training and cultural diversity were inspired by feedback from cross-cultural therapists and his personal values. Other cross-cultural therapists have reported that the same skills did not have the same impact on clients from different cultural backgrounds. Ivey realized that some attending behaviors may damage rapport with clients from another background because of the different cultural meanings of specific attending behaviors. This led to the concept of culture-centered skills. The fundamental key to the development of culture-centered skills is to examine a specific culture, identify concrete skills that may be used with this group, and develop a helping theory that can be tested in application.

Ivey has also infused culture into skills training. His classic text, *Intentional Interviewing and Counseling*, consistently incorporates the theme of developing cultural skills. The sixth edition suggested that the purpose of counseling is to foster client development in a multicultural society. Intentional interviewing requires awareness of racial and ethnic groups that may have patterns of expression and communication different from those of the interviewer.

#### *Developmental Counseling and Therapy*

The study of human development has had a significant impact on Ivey's ideas about culture. Ivey has



drawn from Piaget, Erickson, and Freud to apply developmental concepts directly into counseling in developing developmental counseling and therapy (DCT). In 1986, Ivey suggested that development always occurs within a cultural context, which takes into account both the therapist's and client's cultural and historical backgrounds. Later, in 1991, Ivey elaborated the cultural emphasis in developmental counseling to underline the notion of multicultural development. He proposed that therapists should facilitate clients' movement through different stages of cultural identity development. Ivey believes that therapists help clients move through stages related to conformity, dissonance, resistance and immersion, introspection, and synergistic awareness by focusing on culture in counseling. In this developmental approach, Ivey and his colleagues expanded the definition of culture to include race and ethnicity, gender, religion, economic status, nationality, physical capacity, and sexual orientation. Clients are encouraged to share their stories in ways that promote movement through different types of development. This process may result in both expanded awareness and congruent social action.

### **Multicultural Counseling**

Ivey's prolific work in operationally defining the relationship between multiculturalism and traditional theories of counseling has been influential. Ivey and colleagues concluded that most counseling theories were based on White, middle-class culture, and Ivey questioned the generalizability of these theories to other cultural contexts. Ivey's book was the first theories text to address multicultural issues directly, and it was published before culture became a popular topic in the literature. Since then, the multicultural perspective has been refined in subsequent editions of the text. According to Ivey, D'Andrea, Ivey, and Simek-Morgan, multiculturalism can be described as a meta-theory creating a framework that illustrates how different theories of counseling and psychotherapy represent different worldviews. Each theory was developed within a specific cultural context and represents the biases of that culture in trying to understand clients and facilitating change. As a result, counseling encourages therapists to view the individual in the context as well as to comprehend psychological theories within their own cultural context.

Because of Ivey's pioneering work, the centrality of culture has been widely accepted in the counseling literature. Ivey's legacy will continually impact the field of counseling psychology for generations to come.

Amy La

**See also** Counseling Skills Training (v2); Cross-Cultural Training (v3); Cultural Values (v3); Culture (v3); Developmental Counseling and Therapy (v2); Multicultural Counseling (v3); Multicultural Counseling Competence (v3); Pluralism (v3); Relationships With Clients (v2)

### **Further Readings**

- Daniels, T., & Ivey, A. (2007). *Microcounseling: Making skills training work in a multicultural world*. Springfield, IL: Charles C Thomas.
- Ivey, A. (1971). *Microcounseling: Innovations in interviewing*. Springfield, IL: Charles C Thomas.
- Ivey, A. (2000/1986). *Developmental therapy: Theory into practice*. North Amherst, MA: Microtraining.
- Ivey, A., & Authier, J. (1978). *Microcounseling: Innovations in interviewing, counseling, psychotherapy, and psychoeducation*. Springfield, IL: Charles C Thomas.
- Ivey, A., D'Andrea, M., Ivey, M., & Simek-Morgan, L. (2002). *Theories of counseling and psychotherapy: A multicultural perspective* (5th ed.). Boston: Allyn & Bacon.
- Ivey, A., Gluckstern, N., & Ivey, M. (2005). *Basic attending skills* (Book and videotapes). Framingham, MA: Microtraining Associates.
- Ivey, A., & Ivey, M. (2003). *Intentional interviewing and counseling: Facilitating development in a multicultural society* (5th ed.). Pacific Grove, CA: Brooks/Cole.
- Ivey, A., & Ivey, M. (2006). Microskills and wellness: Strength training for the future. *The Japanese Journal of Microcounseling*, 1, 2–8.
- Ivey, A., Ivey, M., Myers, J., & Sweeney, T. (2005). *Developmental counseling and therapy: Promoting wellness over the lifespan*. Boston: Lahaska/Houghton-Mifflin.
- Ivey, A., Normington, C., Miller, C., Morrill, W., & Haase, R. (1968). Microcounseling and attending behavior: An approach to pre-practicum training. *Journal of Counseling Psychology*, 16(2). (Separate monograph).
- Littrell, J. M. (2001). Allen E. Ivey: Transforming counseling theory and practice. *Journal of Counseling and Development*, 79, 105–118.





---

## KITCHENER, KAREN STROHM (1943– )

---

Karen Strohm Kitchener is recognized internationally for her contributions to the fields of counseling psychology and higher education. Among counseling psychologists, she is best known for her work in ethics. In higher education, Kitchener is best known for her research on reflective judgment, the process by which people become increasingly able to draw conclusions about problems that do not have right or wrong answers (called *ill-structured problems*). Kitchener's work spans more than 3 decades and includes over 60 refereed articles and book chapters, over 30 presentations, and over 35 invited lectures, workshops, and consultations.

Kitchener was born in Toledo, Ohio, in 1943 and spent much of her childhood moving from place to place as her father moved up in his career. Although her father's ambitions for her were limited to secretarial work, Kitchener earned a bachelor's degree in history from the University of California, Santa Barbara, a master's degree in education from Claremont Graduate School, and both master's and doctoral degrees in counseling psychology from the University of Minnesota. Kitchener noted that it was during her tenure as a junior high school teacher that she decided students needed counseling more than they needed a good teacher. This realization led her to pursue a master's degree in counseling, as she intended to serve adolescents in this capacity. However, after Kitchener received her master's degree in counseling, her husband, Richard F. Kitchener, obtained a faculty position

at Colorado State University (CSU) as a professor of philosophy, and Kitchener took a position with the CSU counseling center. This position proved to be a turning point in Kitchener's career. James C. Hurst, the director of the counseling center, encouraged her to conduct research as a part of her job. This led Kitchener to conduct studies with Hurst on how to encourage faculty to use groups more effectively in the classroom. Kitchener was also influenced by Carole Geer, a counseling center staff member, who encouraged Kitchener to earn her Ph.D.

During her time at Minnesota, Kitchener participated in a seminar focused on college student development led by her chair, Clyde A. Parker. Participation in this group was another turning point, because it sparked her interest in the cognitive development of students and introduced her to Patricia M. King, with whom she would collaborate for over 30 years. Kitchener and King's participation in this group led to the development of a model of reflective judgment (based on William Perry's model of college student development). Their model focused on the intellectual development of young adults that involved changes in epistemological assumptions and how these changes affect making judgments about ill-structured problems. Kitchener and King's reflective judgment model describes seven stages of development and provides suggestions about how to assist students' progress through these stages.

Kitchener has continued to refine the reflective judgment model with King and has also jointly developed instruments (Reflective Judgment Interview and Reasoning About Current Issues Test) to assess the development of reflective judgment. Their model and



subsequent instruments have been so successful that several universities now use them as a way to effectively enhance undergraduate curricula and to assess student development.

Clearly, Kitchener has made significant contributions to the area of intellectual development. However, she has also been one of the most influential individuals in the area of ethics in counseling psychology, which is not surprising considering that many ethical dilemmas are also ill-structured problems.

Kitchener became interested in ethics when she took her first academic position in the University of Denver's Human Development Counseling Program. After she was hired by the dean, James Davis, he asked her what she would do to improve the program. Although Kitchener thought this was a strange question to ask an assistant professor, she informed Davis that she envisioned changing it to an American Psychological Association (APA)-accredited counseling psychology program. Davis agreed that this change would be beneficial, and in Kitchener's third year she was appointed director of the program. During the process of preparing for APA accreditation, Kitchener realized that the department needed to offer an ethics course. However, her husband (who also worked in ethics) suggested that ethics was not a well-developed area in psychology. As she was unable to find any other psychologist who felt competent enough to teach an ethics course, she took it upon herself to develop a course based on *Principles of Biomedical Ethics* by Tom Beauchamp and James Childress.

Over the last 30-plus years, Kitchener has conducted research and written on a variety of topics in ethics (e.g. multiple relationships, post-therapy relationships, supervision, ethical issues when working with clients who have HIV/AIDS, student affairs). These efforts have led to numerous conference presentations and invited workshops. In addition, an entire issue of *The Counseling Psychologist*, for which Kitchener served as the guest editor, was devoted to the topic of ethics. This led to the eventual publication of Kitchener's book, *The Foundations of Ethical Practice, Research, and Teaching in Psychology*, which is now used by many departments as the textbook for their ethics courses. Finally, Kitchener served as the ethics consultant and coauthored 12 of the chapters in *Ethics in HIV-Related Psychotherapy*.

In addition to her extensive research and writing on ethical issues, Kitchener has also shaped the field through professional leadership positions she has held. As examples, Kitchener served as the chair of the Ad Hoc Task Force on Ethics for Division 17

(1984–1985), was a member of the APA Ethics Committee (1985–1988) and chaired this committee from 1987 to 1988, was a member of the Ethical Principles Revision Subcommittee for APA from 1985 to 1989, and chaired this committee from 1985 to 1986. In addition, Kitchener was a member of both the Educational and Policy Task Force on Ethics for APA and the State of Colorado Mental Health Grievance Board from 1991 to 1994. Through these appointments Kitchener was able to help shape how the fields of psychology and higher education conceptualize ethics. She helped psychologists realize they had to be able to reason through ethical dilemmas and arrive at defensible conclusions. In addition, she emphasized the importance of teaching these skills to students, noting that the field changes faster than the code can be updated and that the code cannot cover every issue that a psychologist may encounter. Kitchener's influence not only shaped the way psychologists thought about ethics but also influenced the literature on ethics. As a result of her work, many textbooks on ethics now include sections on problem solving that instruct readers on how to reason through the ambiguity that is inherent in ethical issues.

It is clear Kitchener's research on and service in intellectual development and ethics have influenced the fields of counseling psychology and higher education. She has been recognized for these many accomplishments. For example, in 1983 she received the Ralph Berdie Memorial Award for outstanding research on college student development from the American Association for Counseling and Development, and then in 1991 she received the University Lecturer Award from the University of Denver for her research. In addition, she was awarded both the Contribution to Knowledge Award (1992) and the Senior Scholar Award (1993–1998) from the American College Personnel Association for her work on ethics and reflective judgment. Kitchener was also recognized in 2006 by the Colorado Psychological Association primarily for her lifetime work on ethics. She was presented with the organization's first Lifetime Achievement Award.

Although Kitchener has significantly enhanced the field of counseling psychology through her work on both reflective judgment and ethics for more than 3 decades, her contributions are far from over. Kitchener is an emeritus faculty member at the University of Denver and is currently working with her husband on a book chapter that will explore the philosophical foundations of ethical decision making in social science research. Kitchener also lectures on what it



takes to become an ethical professional. In addition to Kitchener's continual work in ethics, she also publishes in the area of reflective judgment.

Kitchener's work has served to significantly improve the fields of counseling psychology and higher education. She has been an inspiration to many because of her groundbreaking efforts, tireless approach to research, and her passion for making a difference. When you consider these qualities, it is not surprising what she has been able to accomplish or what she will continue to accomplish as her career continues. Kitchener's persistence and commitment to excellence has enabled her to become a true pioneer and serve as a role model for many psychologists, educators, and students.

Kimberly A. Miller

**See also** Code of Ethics and Standards of Practice (v2); Counseling Skills Training (v2); Ethical Codes (v1); Ethical Decision Making (v1); Ethical Dilemmas (v1); Postdegree/Prelicensure Supervision (v1); Supervision (v1); Virtue Ethics (v1)

### Further Readings

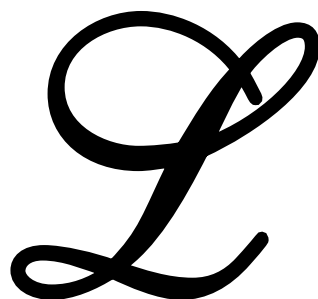
Anderson, J. R., & Barret, B. (Eds.). (2001). *Ethics in HIV-related psychotherapy: Clinical decision making in complex cases*. Washington, DC: American Psychological Association.

- Beauchamp, T., & Childress, J. (1979). *Principles of biomedical ethics* (1st ed.). New York: Oxford University Press.
- King, P. M., & Kitchener, K. S. (1986). *Developing reflective judgment: Understanding and promoting critical thinking in adolescents and adults*. San Francisco: Jossey-Bass.
- King, P. M., & Kitchener, K. S. (2002). The reflective judgment model: Twenty years of research on epistemic cognition. In B. Hofer & P. Pintrich (Eds.), *Personal epistemology: The psychology of beliefs about knowledge and knowing* (pp. 37–61). Mahwah, NJ: Lawrence Erlbaum.
- Kitchener, K. S. (1984). Ethics and counseling psychology: Distinctions and directions. *The Counseling Psychologist*, 12, 15–18.
- Kitchener, K. S. (1984). Intuition, critical evaluation, and ethical principles: The foundation for ethical decision in counseling psychology. *The Counseling Psychologist*, 12, 43–55.
- Kitchener, K. S. (1999). *The foundations of ethical practice, research, and teaching in psychology*. Mahwah, NJ: Lawrence Erlbaum.
- Kitchener, K. S., King, P. M., & DeLuca, S. (2006). Development of reflective judgment in adulthood. In C. Hoare (Ed.), *Handbook of adult development and learning* (pp. 73–98). New York: Oxford University Press.
- Kitchener, K. S., & Vasquez, M. (Eds.). (1988). Ethics in counseling: Sexual intimacy between counselors and clients [Special issue]. *Journal of Counseling and Development*, 67.









---

## LEARNING DISORDERS

---

Learning disorders (LD) refer to patterns of cognitive strengths and weaknesses in individuals that may create a risk for difficulties in learning specific skills. For example, an individual with weak verbal ability may not be efficient at remembering words, resulting in a reading problem, even though the same individual may have strong visual-spatial skills, which result in good performance in math or science. Conversely, an individual with high verbal ability may be good at reading, history, and so on, but if the same individual is weak in visual-spatial ability, he or she may have difficulties with math or map reading. Thus, LD occurs when a specific cognitive weakness creates a specific deficit in an academic learning area. Although LD was originally related to academic learning, it has now also been associated with nonschool learning (e.g., driving, sports) and social learning problems.

There are two primary reasons LD has become increasingly important to the field of counseling psychology. One relates to the secondary effects of having an LD, such as the emotional frustration of a child who can't keep up in school, and the other relates to the primary late effects of LD, such as an adolescent experiencing difficulty in college or an adult with a language problem experiencing communication problems with a spouse. Children with LD often experience frustration due to school learning problems, which may create low self-esteem, emotional difficulty, and behavior problems, which in turn may create family and parenting difficulties. It is important for counseling psychologists to understand LD in

order to be able to assist parents, the child, and the family in dealing with the consequences of LD in family interactions. Another reason counseling psychologists need to have knowledge of LD is that many vocational, social, emotional, or marital problems are related to the problems in living experienced by the adolescent or adult with an LD. For example, a husband, who may have had a language-based LD in school, may have received reading assistance and no longer has a reading disability, but may still lack efficiency in the use of language. The wife may perceive that this husband ignores her because he does not communicate with her.

Counseling psychology, as a profession, has been a strong advocate for understanding and sensitivity to individual differences as well as to group differences such as gender, ethnicity, culture, and socioeconomic level. Greater knowledge of learning disorders will allow counseling psychologists to understand cognitive differences of individuals with LD and how counseling strategies may be altered in order to take into account the individual's cognitive strengths and weaknesses. It is also important for the counseling psychologist to understand LD subtypes, because many children and adults with LD deny their disorder and need counseling in order to gain better self-awareness, so they can learn to manage and compensate for their LD.

As an example, individuals with a memory deficit LD (MemLD) may not compensate by using note reminders and a calendar if they do not have insight into their LD. Their forgetfulness will create negativism from friends, teachers, parents, and colleagues. A counseling strategy that uses cognitive strengths to overcome the memory deficit may be very helpful to



this individual. Individuals with language deficit LD (LangLD) may have a tendency to become frustrated or angry when they do not understand others and do not have insight into their LD. A counseling strategy that capitalizes on this individual's strong visual-spatial skills may help this individual process information visually through pictures and maps rather than through weaker language skills. Individuals with nonverbal learning disorders (NLD) have deficits in visual-spatial skills, and hence do not often read the nonverbal cues in human interaction such as facial expression, body language, and postures denoting certain moods. Therefore, the individual with NLD may appear insensitive or naïve to others. A counseling strategy that helps this individual to learn how to verbally interpret nonverbal social communication cues may improve the social adaptability of the client with NLD.

This entry addresses three primary types of LD (MemLD, LangLD, NLD) and provides information regarding the primary social, behavioral, and emotional characteristics of each subtype as well as the cognitive patterns found through neuropsychological assessment. It also addresses the counseling implications for each subtype at elementary age, adolescence, and college age.

## Learning Disorder Subtypes

### ***Memory Deficit Type (MemLD)***

This subtype may involve weaknesses in understanding meaningful information within context (sentences, stories), more isolated information (numbers, specific words), or verbally mediated recall even when stimulus and response are nonverbal. This deficit may be more apparent in serial-order memory tasks than in memory span tasks per se, although weaknesses in both are possible.

Assessment of memory deficits typically includes tasks that measure sequential recall (involving both visual and verbal tasks), memory for increasingly longer and more complex verbal information (sentences), and nonsequential (rote) memory across multiple trials.

The most common problem for individuals with MemLD involves short-term automatic memory weaknesses for isolated (less meaningful) information. This is often apparent in digit span recall tasks. Individuals may perform better on sentence memory tasks if they possess intact associative language skills because of the semantic-associative links embedded

within this more meaningful information. Typical daily problems might involve recalling the names of people with whom they are less familiar, phone numbers and addresses, and lengthy directions or instructions that have been verbalized to them. Early academic difficulties often involve learning the names of letters and numbers as well as letter-sound associations. Difficulty with the rapid retrieval of common, well-rehearsed information is also a common problem.

### ***Language Deficit Type (LangLD)***

This subtype can involve mixed receptive and expressive weaknesses that may vary in severity. Evaluation has to be sufficiently comprehensive not only to demonstrate receptive weaknesses but also to determine whether adequate nonverbal skills exist in order to differentiate this disorder from mental retardation and pervasive developmental disorder. LangLD individuals often have difficulty understanding and following directions and expressing themselves in both verbal and written work. These symptoms can lead to being mislabeled as attention deficit hyperactivity disorder (AD/HD) due to perceived "inattention" and "off-task" behavior.

LangLD individuals with associative weaknesses often show deficits on all associative language tests regardless of whether test items are presented visually or verbally. A few LangLD individuals with intact short-term memory skills may perform well on naming or memory tests. Most perform poorly on labeling and retrieval (memory) tests and show low scores on verbal IQ subtests and on broader indices of verbal intelligence and memory. The most common problems for individuals with less severe LangLD involve school learning (particularly language-based subjects such as reading, language arts, and written expression skills). With stronger nonverbal abilities, math is often a relative strength. Problems associated with memorizing multiplication tables and basic math facts, as well as with comprehending word problems, can also be experienced. For individuals with LangLD who exhibit more severe language deficits, in addition to more pronounced school learning difficulty, significant behavioral and emotional problems are often encountered. These symptoms likely reflect deficits in communication skills and in verbal mediation, which can impair ability to exert self-control or to self-monitor behaviors. This inability to learn and understand how



to interact with others can lead to social isolation or significant social interaction difficulties.

### ***Nonverbal Learning Disorders (NLD)***

The NLD subtype often involves deficits in visual-spatial reasoning, organizational skills, time management, motor skills, and social interaction skills secondary to social perception. Deficits are manifested in school performance difficulties resulting from lost or late assignments, poor handwriting and composition weaknesses, social acceptance issues, and difficulty understanding math concepts.

Assessment of nonverbal deficits typically involves tasks that include spatial-perceptual reasoning, perceptual-motor and fine motor skills, visual processing speed, and nonverbal (associative) categorizing skills. An appropriate evaluation should also include assessment of verbal intellectual abilities, from which a developmental discrepancy can often be seen. However, recent findings have demonstrated that symptoms of NLD can be present in the absence of a discrepancy between verbal and nonverbal IQ scores.

This subtype is often misunderstood and misdiagnosed by teachers, parents, and well-intentioned professionals. The nature of this misunderstanding arises from the assumption that individuals with capable reading ability, good communication skills, and strong language learning skills do not have a “learning” disorder. Therefore, their apparent school performance difficulties must be volitional and must be related to motivation and effort.

As a consequence, individuals with NLD are often labeled as underachievers. These individuals’ weaknesses in discerning subtle nonverbal social cues (facial expression, body language, and posturing) often cause social interaction difficulties that can result in being ostracized by peers. In a desire to be better liked or more accepted, the socially naïve NLD individuals are at increased risk for social exploitation and social isolation. Although NLD was relatively unknown twenty years ago, the considerable work by Byron Rourke and others has created improved understanding and acceptance of this disorder.

### **Social, Behavioral, and Emotional Aspects**

The relationship of cognitive strengths and weaknesses to social-emotional behaviors is a growing

field of study. Recent research has shown that there are neurocognitive patterns that place individuals at risk for specific social-emotional disorders dependent upon the interaction of the neurocognitive pattern with environmental conditions.

### ***Memory Learning Disorder (MemLD)***

The short-term memory problem of individuals with MemLD can create confusing perceptions by others such as parents, peers, teachers, or spouses. Individuals with MemLD typically have good long-term memory and associative language skills. Therefore, others perceive them as adequate or even bright in verbal language skills. So when they forget simple information, others may assume they were not listening, they did not care what the other person was saying, or they may have attention deficit disorder.

Young children with MemLD will often have symptoms that may help to identify them. They may show difficulty remembering the names of common objects, have difficulty remembering numbers and letters, and may forget even simple directions. Parents often interpret these symptoms as willful neglect or attention deficits. Children who otherwise appear cognitively alert but show these symptoms often have an undiagnosed memory disorder. There is research to show this is a relatively common condition in males and often runs in families. Although specific genetic studies have not isolated specific genes, population genetic studies have shown the male familial incidence.

Memory problems during adolescence are often attributed to bad attitude and lack of caring. When school problems first arise in adolescents, many assume this is due to willful neglect of homework. When adolescents do not follow directions of parents, it is often assumed this is due to rebellion. However, it is important to first rule out a short-term memory deficit before making these assumptions. Often the adolescent with MemLD has been able to “get by” in school due to good language skills; however, as the amount of content to be studied increases in junior high or high school, there is a greater load on memory, and difficulties arise. Also, many adolescents would rather appear to have a motivational problem than be identified as having a learning problem. Research has shown that most attention deficits are identified prior to adolescence, so if an adolescent suddenly shows signs of attention deficit disorder, the counseling psychologist should be alert for a possible memory deficit.



College students who have never shown previous difficulty in learning and then begin to struggle academically often have a memory deficit. Individuals with MemLD usually learn to read, especially if they have received strong early phonics instruction. However, they usually read at a slower rate than average as they attempt to comprehend and remember what they have read. The increased reading demands in college often expose this slow reading rate and the student is not able to keep up. Also, the memory deficit will make it difficult for the college student to listen and remember multiple lectures throughout the day. As they try to take notes, they cannot remember what the instructor is saying. These symptoms should alert the counselor to the possibility of a memory-based learning disorder.

### **Language Learning Disorder (LangLD)**

There is some disagreement in the literature regarding how to classify the various types of language disorders. Some consider the memory disorder discussed in the previous section as a form of an expressive or verbal language disorder. In this section, the discussion will be limited to an associative language disorder that is referred to by some as a *receptive language disorder* or a *comprehension language disorder*. There is considerable evidence that children with language disorder are at risk for behavioral and emotional disorders.

The primary problem for the individual with an associative language disorder is a deficiency in efficient verbal mediation skills necessary for verbal abstract reasoning and the self-verbal guidance needed for self-control and maintenance of attention and behavior. This may result in comprehension deficits in academic learning, inability to form the verbal abstraction necessary to develop complex interpersonal relationships, and difficulty in governing externalization of thoughts, feelings, and behavior.

Young children with a language disorder may experience chronic school failure, social rejection, and low self-esteem. They may not have the verbal flexibility to engage in social or teasing banter often seen in young children, and, therefore, they may be ostracized from playgroups. They do not have the verbal fluency to rapidly answer a question in class, so the teacher may cease to call on them. They often perform poorly on tests that tax their verbal comprehension ability. The response to this constellation of

problems is social withdrawal, dislike of school, and sometimes acting out behavior due to frustration. These children are often seen as having a primary behavior disorder and are punished, or they are seen as having AD/HD and are medicated.

During adolescence, youth with LangLD often begin to become so frustrated due to school failure and lack of positive peer groups they are at risk for bullying or joining unsavory peer groups. Because they do not have efficient verbal abstract reasoning skills, they are vulnerable to the influence of others and are often set up by other behavior-disordered peers to be the scapegoat for group problem behaviors. As academic functioning becomes more abstract, they may drop out of school or attend alternative school for behavior disorders. There is a critical period for language development change with early language therapy success, but not at this age. At this point, recognition of the LangLD can at least lead to functional educational intervention, vocational rehabilitation training, and counseling strategies, which all rely more on visual and active interventions rather than verbal strategies.

Individuals with LangLD rarely succeed academically at a level that will be found in traditional universities. However, they may be attending junior college, vocational schools, or colleges for students with LD.

### **Nonverbal Learning Disorders (NLD)**

The primary characteristic of the individual with (NLD) is difficulty processing visual-spatial information despite good verbal reasoning and verbal memory functions. The cognitive aspects of this problem lead to difficulty with schoolwork involving written work, worksheets, map reading, note taking, and other visual integration tasks. Difficulty in visual abstract reasoning also may result in problems with conceptual elements of time management and organization. A further problem for many individuals with NLD relates to social interaction skills. Individuals with NLD often have difficulty interpreting the nonverbal aspects of human interaction. They have difficulty with reading body language, facial expression, and tone of voice, for example, anger versus joy.

The younger child with NLD usually shows both school and social difficulties. Due to delay in development of visual-spatial and visual-motor skills, they may have school difficulty such as messy worksheets and handwriting problems. The primary academic



difficulty is usually in math because of the visual-spatial aspects of mathematical thinking. However, because individuals with NLD usually have good verbal skills, they are often successful in most academic areas. One difficulty often encountered is that teachers and parents may think that these children are not trying on written work or in math because they do so well in other subjects. It is important for the counselor to recognize that the combined symptoms of math problems, messy schoolwork, and social perception concerns may indicate a NLD.

Adolescents with NLD often show organizational difficulties characterized by unfinished or lost schoolwork, decline in scores on long standardized tests, and math difficulties. Also adolescents with NLD may begin to become involved with problem peer groups as an attempt to find social interaction, because they are often ostracized from mainstream peer groups. As some adolescents with NLD begin to act out due to social frustration, they are often misdiagnosed as having AD/HD or behavior disorders. However, careful examination of the etiology of these behaviors often reveals a frustrated, lonely adolescent who lacks the social skills necessary for positive social interaction.

College students with NLD are at particular risk for emotional difficulties. They have often been successful academically, so they may not have experienced particular problems if they have been protected from social difficulty by parents and family. However, when they leave home, there is increased pressure to develop independent social functioning, and their social perception concerns may impair their ability to have positive peer groups or social interactions. This may lead to serious feelings of social isolation, and due to their good verbal abstract reasoning skills, they are also at risk for the loneliness of existential self-questioning. College counselors need to recognize the symptoms of NLD in the students they encounter, because there are academic modifications that can be made and therapeutic approaches to address the self-insight needed to overcome NLD.

### **Counselor Implications**

When working with individuals with LD, counseling psychologists may need to use techniques that fit with the individual's cognitive strengths and focus on certain types of behaviors that relate to the LD. As with any intervention, these techniques will be different for different age groups.

### ***Elementary Age***

Counseling psychologists will often be working with parents as much as children in this age group. Strategies that are concrete and do not involve abstract thinking are often needed when working with elementary age children.

#### **Memory Learning Disorder (MemLD)**

Teaching elementary age children specific memory strategies, such as mnemonic devices, acronyms, and verbal cumulative rehearsal, can be helpful. In addition, instructing parents on adding external memory devices, such as using lists and bulletin boards, may be a good strategy.

#### **Language Learning Disorder (LangLD)**

Children with LangLD may have a difficult time expressing themselves verbally, so behavioral techniques or strategies that allow them to express themselves through play, pictures, or music may be helpful.

#### **Nonverbal Learning Disorder (NLD)**

Social skills training is often needed with elementary age children with NLD. This training should be very explicit and outline specific steps in social interaction and nonverbal communication. Modeling and role-playing is often beneficial. Elementary age children with NLD often do not intuitively pick up social skills, so explicit instruction is helpful.

### ***Adolescent Age***

In adolescence, more individual work with the adolescent and less involvement with the parent begins to take place, and new strategies may be needed. At this age, helping to determine what impact (if any) the LD is having in the adolescent's life may be a focus of counseling. In addition, addressing some of the specific social, behavioral, and emotional aspects of the adolescent's LD may be necessary.

#### **Memory Learning Disorder (MemLD)**

As with elementary age children, teaching specific memory strategies would continue to be helpful, with the adolescents beginning to use external memory devices themselves. At this age, individuals can learn



more abstract memory strategies, such as using associations and stories during counseling.

### Language Learning Disorder (LangLD)

Incorporating visual and active strategies can be helpful for adolescents with LangLD. Helping them recognize the impact of the LangLD in their social relationships and everyday life and teaching coping strategies may be a focus of counseling. It may also be helpful to involve parents in counseling, so that they may also learn how to better communicate with their adolescent.

### Nonverbal Learning Disorder (NLD)

Social skills training will likely continue to be a key component in counseling for adolescents with NLD. As with elementary age students, teaching these skills explicitly is ideal. Adolescents may also need help with general organization strategies.

### College Age

College age individuals are working on transitioning to being independent and responsible for everyday life. They will likely participate in counseling by themselves and have minimal parental support.

### Memory Learning Disorder (MemLD)

Teaching memory strategies will continue to be important at this age, again focusing on external memory devices. If students have good associative skills, teaching them how to make associations and use stories can be a useful strategy.

### Language Learning Disorder (LangLD)

As with other age groups, college age individuals with LangLD would benefit from using visual and active techniques in counseling. Traditional talking strategies may be difficult and cause frustration for individuals with LangLD. A focus of counseling should include how their LD has an impact on relationships with significant others and strategies to improve all types of communication, both verbal and nonverbal.

### Nonverbal Learning Disorder (NLD)

Again, social interaction difficulties are prominent with college age individuals with NLD. In addition to

social skills training, counseling may need to focus more on relationships rather than just skills. Counseling psychologists may also need to help the college age individual with NLD explore the impact NLD has on his or her daily life, including academic and social areas.

*Lynn C. Richman, Kevin Wood,  
and Tammy Wilgenbusch*

**See also** Academic Achievement (v2); Attention Deficit/Hyperactivity Disorder (v1); Developmental Disorders (v1); Intelligence (v2); Memory, Assessment of (v2); Mental Health Issues in the Schools (v1); School Counseling (v1); School Psychology (v1)

### Further Readings

- Cantwell, D. P., & Baker, L. (1991). *Psychiatric and developmental disorders in children with communication disorder*. Washington, DC: American Psychiatric Press.
- Gaddes, W. H., & Edgell, D. (1994). *Learning disabilities and brain function* (3rd ed.). New York: Springer-Verlag.
- Hooper, S. R., & Willis, W. G. (1989). *Learning disability subtyping*. New York: Springer-Verlag.
- Kail, R. (1984). *The development of memory in children* (2nd ed.). New York: W. H. Freeman.
- Lyon, G. R., Gray, D. B., Kavanagh, J. F., & Krasnegor, N. A. (Eds.). (1993). *Better understanding learning disabilities*. Baltimore: Paul H. Brooks.
- Lyon, G. R., & Krasnegor, N. A. (Eds.). (1996). *Attention, memory, and executive function*. Baltimore: Paul H. Brooks.
- Richman, L. C., & Wood, K. M. (1999). Psychological assessment and treatment of communication disorders: Childhood language subtypes. In S. Netherton, D. Holmes, & C. E. Walker (Eds.), *Child and adolescent psychological disorders* (pp. 51–75). New York: Oxford University Press.
- Rourke, B. P. (Ed.). (1995). *Syndrome of nonverbal learning disabilities*. New York: Guilford Press.
- Shaywitz, S. (2003). *Overcoming dyslexia*. New York: Alfred A. Knopf.

---

## LEGAL ISSUES IN PARENTING

---

The legal issues regarding parenting can be, and often are, highly complicated and controversial issues, needing to be addressed within the following categories: custody, adoption, parenting by unmarried couples, and rights and responsibilities of parents.



Understanding how these variables interact is important, because many individuals experiencing problems in their relationships will seek help through counseling. If mental health professionals continue using the same therapeutic tools common in the past, then it is possible that the counselor may harm the client; for example, what an unmarried, heterosexual couple faces is likely to be different from what an unmarried, same-sex couple might experience.

## Custody

When a couple becomes divorced and children are involved, custody is an inevitable issue. There are two kinds of custody: legal custody and physical custody. *Legal custody* refers to the fact that all major decisions are made by the individual(s) with legal authority to decide, based on the best interests of the child. Within legal custody, there are two types: sole legal custody and joint legal custody. Sole legal custody states that only one parent possesses the legal authority to make major decisions on behalf of the children. These resolutions are focused upon education, religion, and health care. On the other hand, joint legal custody refers to the fact that both parents possess the same legal authority to make decisions on behalf of the children. These decisions may include the type of education the children receive, type(s) of religion (or lack thereof) the children will be raised within, nonemergency medical decisions, etc.

*Physical custody* refers to a legally binding decision as to where the children reside for the majority of the time. Again, within this custody are three categories: sole physical custody, joint physical custody, and bird's nest custody. *Sole physical custody* means the children live with one parent at one physical location most of the time. Generally, the noncustodial parent follows a *visitation schedule* (in some states, the term is *parenting time*, *alternative placement*, or a *parenting schedule*) allowing for generous visitation rights; that is, the children may sleep over at the noncustodial parent's house. *Joint physical custody* is also called *shared custody*, *shared parenting*, or *dual residence*. With joint physical custody, each parent lives with the children for a specific part of the week, month, or year—the times and the length depending upon parental agreement. Normally, the children spend approximately the same amount of time with each parent. *Bird's nest custody* means the children reside at one central location, with the parents taking turns to move in and

out of the children's residence on a previously agreed schedule.

Almost all divorcing parents choose shared parenting (joint physical custody), because it is the closest facsimile to the original parent-child family structure. Meanwhile, the law considers either joint legal custody or joint physical custody as the best custody option when both parents are deemed fit to raise the children. Another primary reason for the attractiveness of joint custody is that any major decision affecting the child is made by both parents—both parents must agree to any action involving the children.

Empirical studies support shared parenting as the most suitable arrangement, because it has the most positive impact on the children. For instance, children in joint custody are less likely to have behavioral or emotional problems and appear to have higher levels of self-esteem, better family relations, and better academic performance when compared to children in sole custody arrangements. In fact, the concept of shared parenting or joint custody was first developed in 1970 for the primary purpose of helping both parents be equally involved in raising their children. Courts have preferred joint custody since it was first used in Indiana in 1973. However, some studies argue against shared parenting, stating it is the reflection of a predivorce family structure; thus, there should be caution against an uncritical acceptance of the idea that the husband and wife make identical contributions to parenting.

Another issue seldom involved in custody agreements is the payment of child support. The law treats child support and visitation as separate issues. In other words, even if a parent fails to pay child support, he or she may not lose visitation rights.

## Adoption

There are four major types of adoption proceedings:

1. *Individual adoption* refers to a single person making a decision to adopt a child, once a child's biological parents have terminated their parental rights by their free will. The adoption decision is made based on the best interests of the child. Thus, prior to approving the adoption, a home study is conducted. During this period, scores are given to the potential adopting parent based on several factors, such as parenting skills, income, physical and mental health, and so on.



2. *Joint adoption* refers to a child being adopted by both parents who have had no previous biological or adoptive relationships with the child. The procedure is similar to individual adoption, i.e., a home study is conducted to assess whether adoption is in the best interests of the child. Most states do not approve of adoptions if both parents are of the same sex. However, exceptions do exist, such as Pennsylvania and Iowa.

3. *Second-parent adoption* allows a same-sex partner in a relationship to adopt the legal child (biological or adoptive) of his or her partner. For gays and lesbians, second-parent adoption is the only legal method that ensures their legal rights and responsibilities with respect to their partner's child. Moreover, second-parent adoptions protect children in lesbian and gay families by giving them the security of two legal parents.

This is not to say, however, that the child's other biological parent "disappears"; rather, second-parent adoption is only viable if the second biological parent agrees to terminate his or her parental rights. If no consent for termination is given, then any adoption is considered illegal and subject to both civil and criminal law. Sperm donors usually terminate any and all parental rights to any children conceived once their sperm has been donated.

The following conditions are created in second-parent adoption: (a) If the biological parent dies, the second-parent's custody right is guaranteed; (b) the child becomes the recognized heir to the second parent; and (c) the child is eligible for the second parent's health benefits as well as other benefits, such as social security survivor benefits when the second parent dies.

4. *International adoption* refers to individuals or couples adopting children outside their own nation. When an American or an American couple decides to adopt a child from another country, the adoptive parents have to comply with American adoption laws (federal and state) as well as the law of the child's birth country. Adoption laws in most foreign countries do not allow gay/lesbian or unmarried couples to adopt children.

### Parenting Issues for Unmarried Couples

When unmarried heterosexual couples have children, it is essential that both parents be recognized as the child's legal parents, because it bestows upon the

child certain rights, for example, rights of inheritance, social security benefits, child support, health coverage, etc. In addition, lawyers recommend that both parents make a formal, written contract stating their intention to continue coparenting, even if their relationship with one another is terminated.

For unmarried couples, only one parent can claim the child as a dependent for tax purposes. With regard to medical care, when biological parents share custody of a child, they are the only people vested with the legal authority to make medical decisions for the child. On the other hand, if one biological parent is not involved, then the partner of the other biological parent may be listed as the emergency contact person for the child; however, the involved biological parent has the first choice in making any medical decisions.

### Rights and Responsibilities of Parents

By law, parents are legally responsible for their children until the children reach the age of majority, and in most countries, this occurs when the child reaches 18. Meanwhile, the law allows parents certain rights with respect to important decisions regarding different aspects of their children's lives, such as education, religion, and so on. Most of the time, the law does not interfere in parents' decisions unless the child's life is threatened or in extreme situations, for example, if the parents ignore their children's needs for medical care. In fact, parental prosecution has occurred in cases where parents, following their religious beliefs, refused to allow their seriously ill children access to appropriate medical treatment.

The law also requires parents to restrain their children's behavior. For example, if a child damages someone else's property, the parents are responsible. In addition, if a parent is deemed incompetent in terms of controlling his or her child's behavior and the child's behavior is seriously out of control, the law has the right to intervene, that is, to take custody away from the parents until the situation has improved.

*Cary Stacy Smith, Li-Ching Hung,  
and Cindy Tidwell*

*See also* Child Maltreatment (v1); Couple and Marital Counseling (v1); Custody Evaluations (v1); Family Counseling (v1); Parenting (v1); Teenage Parents (v1); Transracial Adoption (v3)



### Further Readings

- American Civil Liberties Union Lesbian and Gay Rights Project. (2002). *Too high a price: The case against restricting gay parenting*. New York: American Civil Liberties Union.
- Appell, A. R. (2003). Recent developments in lesbian and gay adoption law. *Adoption Quarterly*, 7, 73–84.
- Bauserman, R. (2000). Child adjustment in joint-custody versus sole-custody arrangements: A meta-analytic review. *Journal of Family Psychology*, 16, 91–102.
- Falk, P. J. (1989). Lesbian mothers: Psychosocial assumptions in family law. *American Psychologist*, 44, 941–947.
- Kruk, E. (1993). Promoting cooperative parenting after a therapeutic/interventionist model of family medication. *Journal of Family Therapy*, 15, 235–261.

---

## LOW-INCIDENCE DISABILITIES

---

Definitions of disabilities categorized as low-incidence vary in scope. Broadly defined, low-incidence disabilities refer to a visual impairment or hearing loss, deaf-blindness, and significant cognitive impairment. For children, the definition extends to any impairment that requires individualized intervention services provided by professionals with highly specialized skills and knowledge in order for the child to benefit from his or her education. Thus, this definition includes individuals with autism, traumatic brain injuries, orthopedic impairments, or multiple disabilities. Although these classifications may be useful for data collection or communicating potential needs of clients with a particular disability, individuals within each disability category may be more different than they are alike and will likely require highly individualized services.

Even when a very broad definition is used, individuals with low-incidence disabilities compose a small percentage of the population. Nevertheless, it is likely that counselors will encounter clients with low-incidence disabilities in their practice. Individuals with disabilities, like all individuals, may present with a variety of physical, social, and psychological needs that may warrant professional intervention. In keeping with ethical standards, professionals should practice within the scope of their training and recognize when it may be more appropriate to refer to a practitioner with specialized training in the area of the client's disability.

This entry focuses primarily on issues related to providing services to individuals with visual impairments, deaf-blindness, and hearing loss.

### Understanding Low-Incidence Disabilities

#### *Deaf/Hard of Hearing*

Within the medical field, hearing loss is typically defined by one's ability to perceive sounds of different frequencies and at different intensities. Hearing loss is classified as normal (0–15 decibel [dB] loss), mild (26–40 dB loss), moderate (41–70 dB), severe (71–90 dB), or profound (91 dB or greater). In addition, hearing losses may be classified as conductive, sensorineural, mixed, or central auditory processing disorders. Hearing loss can also be defined by functional ability. For example, individuals who are able to communicate using the telephone are often considered "hard of hearing," while those who primarily receive information visually rather than through auditory pathways are considered "deaf." These medical and functional definitions do not necessarily correspond with an individual's cultural identity. Some clients who have a hearing loss may consider themselves culturally Deaf (indicated with the capital *D*), reflecting their pride in belonging to a community of individuals that share common experiences, a rich cultural heritage, and a shared language—sign language.

The deaf and hard of hearing population is heterogeneous. Factors to consider when working with an individual who is deaf or hard of hearing include the cause, type, severity, and stability of hearing loss; age of onset; type of amplification preferred; preferred communication modality; presence of any additional disabilities; and cultural affiliation. The unique interplay of these factors differentially impacts the individual's language development, speech intelligibility, academic performance, self-concept, identity, behavior, and social and emotional development.

#### *Visual Impairment/Blindness*

Definitions of visual impairment vary but often refer to levels of visual acuity or functioning. Clarity of vision is typically defined in terms of visual acuity, measured on a scale comparing the person's vision at 20 feet with that of someone who has full acuity. Visual acuity ranges from normal vision (20/20



acuity) to profound low vision acuity (lower than 20/400). Visual acuity that approximates total blindness may also be designated by functional descriptions such as the ability to detect light. The term *blindness* typically refers to total vision loss, including no light perception, or significant impairment in sight, making it necessary for the individual to rely primarily on senses other than vision to interact with the environment. *Legal blindness* does not necessarily imply total blindness, and it is defined as corrected distance visual acuity of less than 20/200 or a visual field of 20 degrees or less in the better eye. Individuals with visual impairments demonstrate a wide range of vision functioning that may fluctuate on a daily basis due to a variety of factors.

Factors contributing to the uniqueness of each individual with a vision loss include the type, severity, etiology, age of onset, and stability of the vision impairment as well as the presence of one or more developmental disabilities.

### **Deaf-Blind**

Individuals who are considered deaf-blind have co-occurring vision and hearing losses. The vision and hearing loss both may have been present from birth, or one may precede the other. Often, vision and/or hearing may decline throughout the individual's lifetime. Clients fitting this classification likely have significant impairments in vision and hearing, requiring specialized services that are not adequately defined by typical services for individuals who are either deaf or blind. Vision and hearing functioning vary considerably within this population, resulting in varied communication preferences and use of assistive devices. Thus, factors contributing to the uniqueness of individuals who are deaf-blind include the etiology, age of onset, severity of visual and hearing impairment, communication preferences, and presence of comorbid disabilities.

## **Counseling Considerations**

### **Cultural Perspective**

The mental health needs of individuals with low-incidence disabilities have been traditionally underserved. Historically, counselors' misunderstandings about individuals with disabilities often led to erroneous assumptions that clients with significant hearing and/or vision loss lacked the language and

cognitive skills necessary to benefit from therapy. Clients with disabilities who continually encounter bias in their everyday lives may be resistant to or distrustful of counselors who they do not feel relate to their experience. Furthermore, limited accessibility to services continues to be influenced by the shortage of professionals trained to meet the unique needs of these clients. In particular, there is a scarcity of practitioners who can communicate directly with clients using sign language.

### **Communication**

Because of the importance of communication in therapy, it is critical for counselors to attempt to match the client's preferred mode of communication. Clients who are deaf, hard of hearing, or deaf-blind may prefer to communicate using speech, American Sign Language or other sign language systems, cued speech, gestures, pantomime, body language and facial expressions, writing, or combinations of the above. Communicating directly with clients in their preferred mode of communication is preferable to facilitate the therapeutic process. However, when direct communication is not possible, counselors may have to rely on using interpreters. Counselors should be aware of the impact of indirect communication on the therapeutic relationship with their client, including the client's level of trust and confidence in the counselor, the increased likelihood of miscommunication, and challenges in effectively assessing the client's language level and thought process. When interpreters must be used, it is preferable to use a consistent, certified interpreter.

### **Developmental Perspective**

A developmental perspective is also important when working with clients with low-incidence disabilities. For example, young children with visual impairments will need support to learn how to explore and function independently within their environment. Severe visual impairment may affect children's social skills. They may need to be directly taught skills for using meaningful gestures and appropriate facial expressions, joining in sports and other social activities, assertiveness, and self-advocacy. Children with congenital blindness may also demonstrate behaviors that appear to be autistic (e.g., echolalia, stereotypic behaviors), which may also interfere with socialization.

Language delays associated with hearing loss may also significantly affect one's behavioral regulation and



social skills throughout the life span. Children with hearing loss may feel isolated from peers who do not use the same communication modality. Adapting to their hearing and/or vision loss may have a significant impact on individuals' developing sense of identity and willingness to assert their independence. Individuals coping with sudden or progressive vision and/or hearing loss may benefit from counseling as they adjust to resulting changes. Even those who have seemingly adjusted to the impact of their vision loss may re-experience social and emotional adjustment difficulties when faced with particular developmental milestones impacted by their visual impairment, such as getting a driver's license or transitioning to college or the workplace.

### ***Ecological Perspective***

When working with clients with low-incidence disabilities, it is important for counselors to consider the match between the client and his or her environment, given each client's unique characteristics and needs. It may be particularly important to include families in counseling. Much like individuals reacting to progressive vision or hearing loss, parents go through a process similar to grieving in reaction to their child's diagnosis. Particularly when the diagnosis is made during early childhood, parents' attachment and parenting skills may be affected. The overwhelming majority of children who are deaf are born to hearing parents. This results in a unique situation in which the child may communicate using a language that differs from his or her parents' language and may identify with a culture that differs from his or her parents' hearing culture. Furthermore, an individual's declining vision and/or hearing functioning also likely has an impact on the family. It may be beneficial to include other family members in treatment to address changes in roles and responsibilities and associated stress on the family unit.

### ***Role of the Counselor***

Counselors fill a variety of roles working with clients with low-incidence disabilities. Rehabilitation counselors evaluate and address clients' independent living skills, use of assistive devices, social interaction skills, academic or career skills, and recreation and leisure skills. An assessment of language and communication functioning or orientation and mobility skills may also be warranted.

Professionals conducting assessments with individuals with low-incidence disabilities should refer to

professional guidelines regarding appropriate assessment procedures. Assessment tools must be selected carefully with the understanding that few instruments allow comparisons with other individuals demonstrating similar disabilities. When working with clients with visual impairments, clinicians should avoid tasks that place heavy demands on vision, including verbal tasks with a corresponding visual component, unless the purpose of the assessment is to measure vision. Conversely, when working with clients with hearing loss, nonverbal, performance-based tasks may yield the best estimate of functioning. It may be appropriate to provide accommodations during the assessment that facilitate the client's access to the tasks without significantly altering the construct intended to be measured. One should also take into consideration whether the assessment reflects experiences that may be outside of the client's repertoire due to the impact of the vision or hearing loss. Finally, the impact of vision or hearing loss on processing speed, concentration, attention, and fatigue should be carefully considered when interpreting results.

*Deborah E. Witsken*

**See also** Autism/Asperger's Syndrome (v1); Chronic Illness (v1); Developmental Disorders (v1); Individuals with Disabilities Education Act (v1); Mental Retardation and Developmental Disabilities (v1); Neuropsychological Functioning (v2); Persons with Disabilities (v4); Traumatic Brain Injury and Rehabilitation (v1)

### **Further Readings**

- Glickman, N. S., & Gulati, S. (Eds.). (2003). *Mental health care of deaf people: A culturally affirmative approach*. Mahwah, NJ: Lawrence Erlbaum.
- Ingraham, C. L., Carey, A., Vernon, M., & Berry, P. (1994). Deaf-blind clients and vocational rehabilitation: Practical guidelines for counselors. *Journal of Visual Impairment and Blindness*, 88(2), 117-127.
- Leigh, I. W. (Ed.). (1999). *Psychotherapy with deaf clients from diverse groups*. Washington, DC: Gallaudet University Press.
- Moore, J. E., Graves, W. H., & Patterson, J. B. (Eds.). (1997). *Foundations of rehabilitation counseling with persons who are blind or visually impaired*. New York: AFB.

### **Web Sites**

- The National Center on Low-Incidence Disabilities:  
<http://nclid.unco.edu>









---

## MEDIATION

---

Mediation is a type of intervention meant to reduce or eliminate conflict among persons or parties who have opposing desires in a situation. For example, a family mediator may assist a couple going through a divorce to reach an agreement on the terms of the divorce in areas such as custody of children, settlement of property, and so on. More technically, mediation is the intervention by a third party who is acceptable to the disagreeing parties, who is impartial, and who is neutral (having no relationship with the disagreeing parties). Neutrality also means that the mediator will not gain personal favors or benefits from one of the parties for assisting with mediation.

By definition, mediation is part of *negotiation*. That means that mediation occurs during a process in which two or more people or parties are discussing their differences and attempting to reach a solution on one or more areas of disagreement. Mediation, therefore, is an extension of negotiation with the addition of a third, neutral party in the negotiation discussions. The assumption behind the addition of the mediator is that the third party will be able to influence the relationship between the two disagreeing parties in such a way as to help them settle the disagreement. The mediator might, for example, balance a power differential, influence the behavior of one of the parties, create a more effective problem-solving process, or create a more facilitative atmosphere during the discussions.

The mediator does not have the power to make a final decision in the disagreement. A judge or an arbitrator may be designated by law or procedure to make

a final decision in favor of one or the other party or partially favoring both. In contrast, a mediator assists the parties in arriving at a mutually acceptable solution that maximizes each party's interest.

Mediation has gained favor in recent years as a method of conflict resolution, because it offers several benefits. When compared to litigation, mediation can result in quicker and less expensive decisions. If completed successfully, mediation, by definition, results in a decision that maximizes each party's interest and thus should be more satisfactory to both parties than a decision arrived at by a judge or arbitrator. Mediation can consider a variety of issues between parties, including ones not typically considered in courts. Last, and of interest to counselors, mediation can teach the parties more effective skills of negotiation and problem solving, which can be applied in future disputes.

Mediation proceeds along a series of stages. These stages begin with initial contacts with the parties to the dispute and continue through assisting the parties in selecting a strategy to work with during mediation, collecting background information, defining the issues and setting the agenda, generating options for the agreement, conducting final negotiations, and achieving a settlement. Within each of these stages are various tasks for mediators and parties. For example, during initial contacts with the parties, the mediator will be working to prepare the parties to work together cooperatively, defusing negative emotions resulting from previously unsuccessful negotiations, building trust, clarifying expectations, and ensuring clear communication.

There are three terms that are central concepts for mediation: issues, interests, and positions. *Issues* are the topics or problems that the mediator and the



parties will focus on during their discussion. For example, divorcing parents may identify issues of child support, custody, and spousal relocation. A community that is divided over location of low-income housing may identify issues of distribution versus proximity, distribution among schools, and closeness to appropriate services.

*Interests* are the needs that each party wishes to satisfy and thus are much less easily communicated than issues. For example, in a divorce case, a husband may have a need to have continuing communication with his children even though his wife may be awarded custody. Other interests, such as having one's point of view heard fully, achieving a cooperative solution, avoiding emotional blow-ups that endanger future relations, and feeling respected during the negotiation process, are ones that each party may feel comfortable discussing with the mediator but not with the opposing party. However, the mediation must meet these needs in order to be successful.

*Positions* are proposals or ideas of solutions that either party is putting forward to meet their interests and needs. For example, with divorcing parents, a position is "I want joint custody." Another position is "I want the children all summer, because you will be the primary custodial parent." In a community struggling over low-income housing location, one position might be "We want all this housing to be located in one area, because distributing such housing around town will lower property values." Another position might be "Our community is a caring community, and every neighborhood should have a certain number of low-income housing units." Because positions are framed from each party's view, they are usually going to be one-sided and favor one party over the other.

The mediator's task, therefore, is to reframe positions so that both parties move from bargaining over positions to discussing interests. As an example, a mediator might ask why a certain position (e.g., joint custody) is important for the party. Redefining the problem as one in which the solution needs to satisfy the interests of both parties, rather than the positions, is another way for the mediator to move from positional bargaining to mediation. Reframing the mediation process from arguing over positions to discussing and considering needs and interests is critical to the success of the mediation. Most likely, the previous negotiations have already exhausted the discussion of the positions, and thus the mediator needs to exercise certain skills to move the parties' discussions into new ground.

At the conclusion of the mediation, the mediator plays a critical role. Once settlement options have been discussed, the mediator will carry out many tasks. One task is that of testing reality for both parties: Will this settlement meet your needs and interests? Another task is helping both parties consider long-term as well as short-term impacts of the settlement options. A third task is for mediators to assist the parties in comparing settlement options to other alternatives.

Mediators typically have received specialized training. Counselors might consider whether learning mediation skills and adding mediation to their skill set is a way of expanding their practice and invigorating their typical work. Many of the microskills that a counselor is already effectively using—empathic communication, recognizing feelings, relabeling, reframing, containing difficult client emotion—are ones that are essential to successful mediation.

*Elizabeth M. Altmaier*

*See also* Community-Based Action Research (v1); Counseling, Definition of (v1); Couple and Marital Counseling (v1); Custody Evaluations (v1); Family Counseling (v1); Legal Issues in Parenting (v1); Parent-Adolescent Relations (v1)

### Further Readings

- Coltri, L. S. (2004). *Conflict diagnosis and alternative dispute resolution*. Upper Saddle River, NJ: Prentice Hall.
- Moore, C. W. (1996). *The mediation process: Practical strategies for resolving conflict* (2nd ed.). San Francisco: Jossey-Bass.
- Roberts, M. (2007). *Developing the craft of mediation*. Philadelphia, PA: Kingsley.

---

## MEDICATION ADHERENCE

---

The phrase *medication adherence* refers to the extent to which persons given a pharmacologic treatment actually use it in the way the prescribing clinician intends, for example, taking an antibiotic twice every day with a 12-hour interval between doses. Medication adherence is a complex phenomenon related to characteristics of the person using the medication, his or her beliefs about it and its effectiveness, the milieu in which he or she lives, the characteristics of the treatment



(frequency of doses, presence of side effects), and external mechanisms used to remember to take medication, such as pill boxes or automatic reminder devices. Park has argued for the integration of these areas in a broader model for understanding medication adherence.

### **Person Characteristics**

Several characteristics of the person prescribed a medication may affect his or her adherence to its use. Cognitive function, mood, age, socioeconomic status, and cultural background are all related to medication adherence. Poorer cognitive function has been related to lower levels of adherence, and more complex cognitive functions such as executive abilities may be related to more complex adherence behaviors. Depression has a negative effect on adherence. Although increasing age is commonly thought to be associated with poorer adherence, several studies have shown that older adults actually have better adherence than their younger counterparts. African Americans have been shown to have poorer adherence to some medications even after controlling for factors such as access to care and socioeconomic status.

### **Person Beliefs**

Individuals' beliefs about the medication, including the extent to which it is useful for the condition for which it is given, have important effects on adherence. Several theories have been proposed to explain the relation between beliefs and behavior, including Janz and Becker's health belief model and Ajzen's theory of planned behavior as well as others. In addition to beliefs about effectiveness, beliefs about the seriousness of the treated condition can affect adherence. Adherence to a medication believed to be ineffective or prescribed for a condition that is viewed as not very serious (e.g., a medication for mild insomnia) is likely to be lower than for an effective medication given for a life-threatening condition.

### **Treatment Characteristics**

Characteristics of the treatment regimen may also affect adherence. Regimen complexity (number of medications, number of doses, whether doses must be taken a certain time before meals or should be taken with food) plays a role in adherence. In some health

conditions, such as HIV-related diseases, regimen complexity may interact with cognitive status. The presence or absence and severity of adverse effects (side effects) have an important negative impact on medication adherence.

### **Social Environment**

Beliefs of caregivers, significant others, or family members about the medication's effectiveness and the condition for which it is prescribed are likely to affect adherence. Caregiver or family beliefs may be especially important for conditions that affect cognitive or functional status and thus require external information or caregiver interventions (e.g., Alzheimer's disease, congestive heart failure, HIV-related dementia).

### **External Supports**

Individuals' medication adherence is a complex behavior that must occur over long periods of time. Maintenance of the behavior consistently over such intervals can be supported by mechanical devices such as pill boxes that can be filled a week or month at a time and thus provide passive prompts to the treated individual on a daily basis. Active prompts can be provided via alarm clock-based timers, computer-based automated reminding via home telephones or pagers, and in-home checks and reminders by home healthcare workers.

### **Importance**

Medication adherence is vitally important in the treatment of disease. To the extent that a condition is affected by medication, adherence to the regimen may be critical and even life sustaining. An example of the critical importance of adherence is provided by the effects of adherence on antiretroviral treatments for HIV infection. High levels of adherence are required for successful suppression of viral replication and improved immune system functioning. Importantly, intermittent or low levels of adherence may result in the creation of medication-resistant viral strains. Adherence is related to likelihood of hospitalization in some conditions, such as congestive heart failure, where close adherence to treatment can affect the status of the cardiovascular system. Medication adherence has been related to various healthcare outcomes, including medication adverse events, hospitalization, and healthcare costs.



Perhaps most interestingly, high levels of adherence are related to healthcare outcomes independent of other treatment interventions. Studies show that high levels of adherence even to placebo may be associated with better health outcomes than intermittent adherence to active medication. A review of these studies has led some to propose a “good adherer” type that may be associated with a variety of healthcare behaviors such as diet and exercise. According to Joynt and colleagues, it is likely that medication adherence and other behaviors interact with physical disease factors to produce good or poor healthcare outcomes.

### Interventions to Improve Adherence

Each of the areas associated with medication adherence has been the target of interventions to improve adherence. Interventions that target persons’ beliefs about medication effectiveness and condition seriousness have been useful in improving adherence, especially when the messages are made personally relevant to the person taking the medication. Family or social milieu interventions may also be effective in improving adherence. Changes in treatment characteristics, such as minimizing regimen complexity and reducing the impact of adverse medication effects, can improve adherence. External supports or reminders, whether passive or active, are also effective in improving medication adherence. Computer-based interventions may become increasingly important in improving medication adherence, because they can make labor-intensive interventions, such as providing individually tailored information, economically feasible.

*Raymond L. Ownby*

**See also** Chronic Illness (v1); Chronic Pain (v1); Community-Based Health Promotion (v1); Health Belief Model (v1); HIV/AIDS (v1); Physical Health (v2); Technology and Treatment (v1); Treatment Compliance (v1)

### Further Readings

- Ajzen, I. (1991). The theory of planned behavior. *Organizational Behavior and Human Decision Processes*, 50, 178–211.
- Bosworth, H. B., Dudley, T., Olsen, M. K., Voils, C. I., Powers, B., Goldstein, M. K., et al. (2006). Racial differences in blood pressure control: Potential explanatory factors. *American Journal of Medicine*, 119, 70.e9–70.e15.
- DiMatteo, M. R., Giordani, P. J., Lepper, H. S., & Croghan, T. W. (2002). Patient adherence and medical treatment outcomes: A meta-analysis. *Medical Care*, 40, 794–811.
- DiMatteo, M. R., Lepper, H. S., & Croghan, T. W. (2000). Depression is a risk factor for noncompliance with medical treatment: A meta-analysis of the effects of anxiety and depression on patient adherence. *Archives of Internal Medicine*, 160, 2101–2107.
- Hinkin, C. H., Castellon, S. A., Durvasula, R. S., Hardy, D. J., Lam, M. N., Mason, K. I., et al. (2002). Medication adherence among HIV+ adults: Effects of cognitive dysfunction and regimen complexity. *Neurology*, 59, 1944–1950.
- Janz, N. K., & Becker, M. H. (1984). The health belief model: A decade later. *Health Education Monographs*, 2, 409–419.
- Leventhal, E. A., Leventhal, H., Robitaille, C., & Brownlee, S. (1999). Psychosocial factors in medication adherence: A model of the modeler. In D. C. Park, R. W. Morrell, & K. Shifren (Eds.), *Processing of medical information in aging patients* (pp. 145–165). Mahwah, NJ: Lawrence Erlbaum.
- Ownby, R. L., Hertzog, C., Crocco, E., & Duara, R. (2006). Factors related to medication adherence in memory disorder clinic patients. *Aging and Mental Health*, 10, 378–385.
- Park, D. C., & Jones, T. R. (1997). Medication adherence and aging. In A. D. Fisk & W. A. Rogers (Eds.), *Handbook of human factors and the older adult* (pp. 257–287). New York: Academic Press.
- Rimer, B. K., Conaway, M., Lyna, P., Glassman, B., Yarnall, K. S., Lipkus, I., et al. (1999). The impact of tailored interventions on a community health center population. *Patient Education and Counseling*, 37, 125–140.
- Simpson, S. H., Eurich, D. T., Majumdar, S. R., Padwal, R. S., Tsuyuki, R. T., Varney, J., et al. (2006). A meta-analysis of the association between adherence to drug therapy and mortality. *British Medical Journal*, 333, 15–19.

---

## MENTAL HEALTH ISSUES IN THE SCHOOLS

---

School mental health programs and services in the United States have grown rapidly, facilitated by the recommendations of important initiatives such as the U.S. Public Health Service, 2000; the President’s New Freedom Commission on Mental Health, 2003; and the American Academy of Pediatrics Committee



on School Health, 2004. Schools offer access as a point of engagement with youth to address their academic and mental health needs; school mental health programs and services offer potential for reduced stigma for help seeking, increased generalization and maintenance of treatment gains, enhanced capacity for prevention and mental health promotion efforts, and ecologically grounded roles for clinicians.

School mental health is an emerging field with challenges confronted at many levels. Figure 1, an adaptation of a template proposed by Weist, Paternite, and Adelsheim and first published by Flaspohler, Anderson-Butcher, Paternite, Weist, and Wandersman, presents interrelated actions to support policies, infrastructures, resources, and practices to strengthen effective school mental health. Desired outcomes include student emotional and behavioral well-being and school success as well as enhanced family, school, and community systematic functioning. To achieve these outcomes, effective mental health promotion, primary and secondary prevention, assessment and early intervention, and intensive treatment programs and services are needed.

Undertaking a critical quality assessment and improvement agenda, in which delivery of culturally competent evidence-based practices are reflective of strong family and community engagement, helps to ensure effective school mental health practices. Service delivery infrastructures that reflect effective communication, strong collaboration, and meaningful training underpin the successful development and implementation of such programs and services. Policies that are based on a clear understanding of the current status and needs of the field promote effective school mental health practices and inform strategic planning. Judiciously allocated resources support well-coordinated, nonduplicative school mental health programs and services that reflect a common agenda for families and other stakeholders in child-serving systems (education, mental health, health, child welfare, and juvenile justice).

This entry presents several key themes for the advancement of school mental health. These include the importance of and challenges associated with achieving conceptual clarity about school mental health, the need to prioritize preventive services and mental health promotion, the move toward mental health and education systems integration, the need to strengthen the research base of the field, and future directions of school mental health.

## **Achieving Conceptual Clarity About School Mental Health**

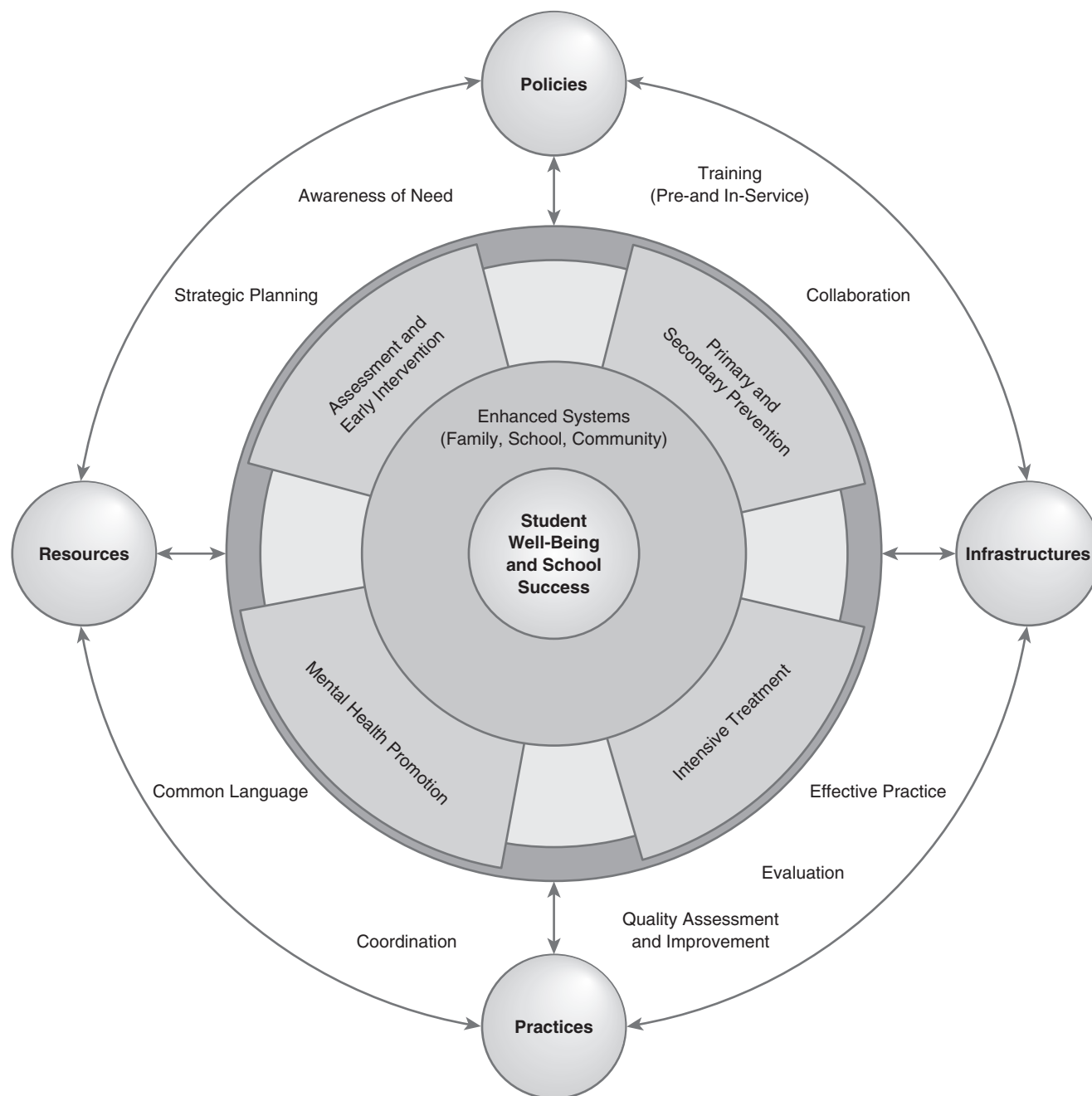
School mental health services have been delivered in a variety of forms, and there is not an explicit best practice model. However, the term *expanded school mental health* describes programs and services that incorporate key elements reflected in the recommendations of the President's New Freedom Commission on Mental Health, 2003 and other important initiatives referred to above. These elements include the following: (a) family-school-community agency partnerships; (b) commitment to a continuum of mental health education, promotion, assessment, problem prevention, early intervention, and treatment; and (c) services for youth in general and special education.

*Expanded* conveys building on programs and services that exist in most schools, including the work of school-employed staff (e.g., school psychologists, social workers, counselors, school nurses, and teachers with behavioral expertise). The emphasis on effective collaboration between schools and community entities (e.g., mental health centers, health departments, university-affiliated centers) is based on the realization that schools cannot do all the work alone. Often, schools are overburdened with demands that could be addressed by other community systems. A strong connection between schools and community organizations also helps a community move toward a system of care. Expanded school mental health is a framework within which other critical elements are essential, including interdisciplinary collaboration, family and other stakeholder engagement, ongoing quality assessment and improvement, culturally competent services, and empirically supported practice.

## **Prioritizing Preventive Services and Population- Focused Mental Health Promotion**

An essential intent of expanded school mental health is to contribute to the creation of a comprehensive and integrated system of support and care for youth, which necessitates attention to the promotion of healthy development and to primary-through-tertiary prevention of problems in their own right and as significant barriers to school success. One of the realities of delivering mental health services in schools is that providers find it hard to remain committed to a full spectrum of





**Figure 1** Conceptual framework for action to advance school-based mental health

*Source:* Adapted from Flaspohler, Anderson-Butcher, Paternite, Weist, and Wandersman (2006).

activity. Without diligence about preventive and mental health promotion efforts, drift can occur easily toward primarily individual services for students with severe or chronic problems. In part, this is due to a fundamental bias that undergirds how “mental health” is approached in the United States. Training, service delivery

approaches, and fee-for-service funding are focused primarily on treating disorders that are presumed to exist within individuals, and school staff contend with a flood of referrals for students with serious problems and crises, making the implementation of preventive and health-promoting services difficult. For school



mental health in everyday practice in the United States, the World Health Organization model of health-promoting schools, emphasizing population-based health promotion at the base and treatment for youth with serious problems at the apex, essentially is inverted.

Advocates for school mental health services emphasize the importance of prioritizing prevention and mental health promotion. For example, Atkins and colleagues have documented effective strategies for adapting school mental health programs to the needs and competencies of teachers, parents, and students to capitalize on schools' unique opportunities to provide mental health-promoting activities. Clearly though, there is need for individual intervention in a school mental health program; however, that place should be circumscribed and informed by the evidence in support of its use.

In embracing the shift necessary to move toward enhanced preventive services and mental health promotion, examples from other countries are instructive. Australia, Cuba, and many Western European nations are prioritizing mental health promotion strategies for all youth in schools. In addition, important international groups are advancing the dialogue about school mental health promotion, such as the Clifford Beers Foundation, the World Federation for Mental Health, the International Union for Health Promotion and Education, the Society for Prevention Research, and the International Alliance for Child and Adolescent Mental Health and Schools.

### **Promoting the Integration of Mental Health and Education Systems**

Historically, school mental health programs and staff (e.g., social workers, psychologists, counselors) often have been considered by educators to be "add ons." The seeming incompatibility between the "nonacademic" interests of mental health providers and the "academic" interests of educators has resulted, at best, in uneasy cooperation. Adelman and Taylor and others have suggested that the mental health and education systems move beyond program cooperation and strive for program integration—with mental health staff and educators working together closely based on shared values and goals.

Several strategies promote the integration of mental health and education systems, including the following: (a) ensuring strong collaboration among families, school leaders, and mental health leaders in

program planning; (b) ensuring that school mental health providers understand school cultures and how to work as collaborative partners and that they are well trained, closely supervised, and interpersonally skilled; (c) ensuring that school mental health practices are of high quality and are empirically supported; (d) emphasizing school mental health services as effective means for reducing barriers to learning and promoting school success; and (e) documenting that services lead to outcomes valued by youth, families, and schools. Much of this work addresses the need to achieve in-depth understanding of schools—the people who live and work in them (especially teachers)—from multiple perspectives.

Although schools cannot be held responsible for meeting every need of every student, most educators endorse an educational agenda that involves enhancing academic skills and physical, social, emotional, and character development. In addition, many professionals advocate that schools address student needs that directly affect learning and school success. There is compelling evidence that emotional and behavioral health problems are significant barriers to learning and that there are strong positive associations between mental health and academic success.

If schools do not have expanded school mental health services and programs, linkages to community-based services can be employed, but these linkages generally are quite poor or nonexistent. In addition, in the absence of the expanded approach, there often is "tier drift" into special education, with excessive referrals in order to give students access to mental health services. This practice results in increased burdens to special education systems, often for services of questionable value for youth who might not truly have learning impairments. Alternatively, if schools embrace movement toward expanding mental health services, the challenge of enhancing integration of mental health and education systems is complex. There are many issues to be addressed, such as the following:

1. Who will the community partners be and how will their work be integrated with the efforts of school-employed mental health and educational staff?
2. How will broad stakeholder perspective be incorporated into the program model?
3. How will a full continuum of services be guaranteed?



4. How will ongoing training needs of personnel be addressed to ensure that they have the competencies needed to collaborate successfully and to deliver effective services?
5. How will the quality of service delivery be assessed along dimensions meaningful for all stakeholders, and what strategies will be used for promoting empirically supported practices?

### Strengthening the Research Base

In spite of strong momentum to promote enhanced mental health practices in schools, the research base for school mental health is quite limited. Much current research is focused on development and delivery of evidence-based child mental health services. However, the impact of this research on everyday practice in community settings, and in schools, is restricted.

The promotion of effective mental health practices in schools involves more than simply trumpeting the selection of evidence-based approaches, most of which have not been examined for their effectiveness, palatability, durability, affordability, sustainability, and transportability in and to real world school or clinic settings. In addition, the dearth of research on diffusion, dissemination, and the processes of change in movement toward effective mental health practices all contribute to the continuing gulf between evidence-based and current, everyday practice. The literature on evidence-based practices in children's mental health does not typically attend to features of the school context that influence intervention delivery.

The community science model proposed by Wandersman and the deployment-focused model of intervention development and testing proposed by Weisz and colleagues both emphasize that practice-based evidence is an untapped resource in the development and delivery of effective school (and community-based) mental health services. Both models highlight the significance of and variability across everyday clinical practice conditions.

Wandersman proposed a "community science," a multidisciplinary field that attempts to strengthen community functioning by investigating how to improve the quality of common approaches (health promotion, education, prevention, treatment) implemented in real world settings. Community science emphasizes community-centered models to complement

the research-to-practice model that serves as the dominant paradigm for the development of best practice programs. Community-centered models focus attention on local needs, see best practice as process rather than magic bullet programs, and emphasize control by practitioner, client, or community. Key attributes of community-centered models also include emphasis on local evaluation and self-monitoring and on a research agenda that focuses on tailoring interventions to fit local needs and contexts.

In short, community science promotes local participation oriented toward accountability in the community delivery *process* (rather than just proven intervention content delivered with fidelity). Engaging practitioners in planning, implementing, evaluating, sustaining, and continuously improving prevention, risk reduction, and treatment efforts based on locally determined needs builds local capacity to improve the quality of practice and achieve positive health outcomes.

Even with evidence-based school mental health practices that have been shaped along dimensions noted above, successful implementation depends on many systemic factors, such as the support of school staff, negotiation of obstacles such as time in the curriculum, and school day and space. Efforts to promote evidence-based school mental health must be imbedded in a broader, ongoing commitment to quality assessment and improvement. However, systematic research and practice on quality assurance have been limited in school mental health. Currently, Weisz and colleagues are studying school mental health quality assessment and improvement (QAI) programming at sites in three states. For the study, they developed the School Mental Health Quality Assessment Questionnaire, which assesses 10 principles for best practice in school mental health (see Table 1). An important goal of the study is to promote evidence-based structuring of the school mental health "independent variable," which has important implications for developing a credible services (practice-based) research agenda for the school mental health field.

### Future Directions

With progressive development over the past two decades and significant recent support from federal initiatives, school mental health is becoming a force in the United States. Increasingly, communities are turning to school mental health to improve inaccessible



**Table 1** Ten principles for best practice in school-based mental health

1. All youth and families are able to access appropriate care regardless of their ability to pay.
2. Programs are implemented to address needs and strengthen assets for students, families, schools, and communities.
3. Programs and services focus on reducing barriers to development and learning, are student and family friendly, and are based on evidence of positive impact.
4. Students, families, teachers, and other important groups are actively involved in the program's development, oversight, evaluation, and continuous improvement.
5. Quality assessment and improvement activities continually guide and provide feedback to the program.
6. A continuum of care is provided, including schoolwide mental health promotion, early intervention, and treatment.
7. Staff hold to high ethical standards; are committed to children, adolescents, and families; and display an energetic, flexible, responsive, and proactive style in delivering services.
8. Staff are respectful of and competently address developmental, cultural, and personal differences among students, families, and staff.
9. Staff build and maintain strong relationships with other mental health and healthcare providers and with other educators in the school, and a theme of interdisciplinary collaboration characterizes all efforts.
10. Mental health programs in the school are coordinated with related programs in other community settings.

and ineffective youth mental health systems and to assist families and schools in addressing youth mental health, which is inexorably linked to academic success. However, school mental health is an emerging field, and an integrated strategy is needed to advance policy, increase resources, improve training and support to programs and staff, emphasize quality and evidence-based practices, and document outcomes—in promotion of a true public mental health agenda.

Related to federalism (states' rights, local control), limited focus on health promotion and problem prevention, and inadequate access to care, the United States has not embraced a public health promotion agenda for any health condition, including emotional and behavioral health of children and adolescents. However, the President's New Freedom Commission on Mental Health, the first presidential initiative addressing mental health in 30 years, provides an historic opportunity for the advancement of a public mental health promotion agenda, with school mental health a cornerstone. The final report of the commission focused on transforming mental health care in America and emphasized a specific recommendation to "expand and improve school mental health programs." This recommendation, based on consensus of diverse national experts, provides sanction and credibility for federal- and state-supported and

locally driven efforts to bring effective mental health promotion to youth where they are.

*Carl E. Paternite, Mark D. Weist,  
Robert Burke, and Paul Flaspohler*

*See also* Attention Deficit/Hyperactivity Disorder (v1); Community-Based Health Promotion (v1); Externalizing Problems of Childhood (v1); Internalizing Problems of Childhood (v1); Learning Disorders (v1); School Counseling (v1)

### Further Readings

- Atkins, M. S., Frazier, S. L., Adil, J. A., & Talbott, E. (2003). School-based mental health services in urban communities. In M. Weist, S. Evans, & N. Tashman (Eds.), *Handbook of school mental health: Advancing practice and research* (pp. 165–178). New York: Kluwer Academic/Plenum.
- Evans, S. W., Serpell, Z., & Weist, M. D. (in press). *Advances in school-based mental health, Volume 2*. Kingston, NJ: Civic Research Institute.
- Evans, S. W., & Weist, M. D. (2004). Implementing empirically supported treatments in the schools: What are we asking? *Clinical Child and Family Psychology Review*, 7, 263–267.
- Flaherty, L. T., & Osher, D. (2003). History of school-based mental health services. In M. D. Weist, S. W. Evans, &



- N. A. Lever (Eds.), *Handbook of school mental health: Advancing practice and research* (pp. 11–22). New York: Kluwer Academic/Plenum.
- Flaspohler, P. D., Anderson-Butcher, D., Paternite, C. E., Weist, M. D., & Wandersman, A. (2006). Community science and expanded school mental health: Bridging the research to practice gap to promote child well being and academic success. *Educational and Child Psychology*, 23(1), 27–41.
- Ghuman, H. S., Weist, M. D., & Sarles, R. M. (2002). *Providing mental health services to youth where they are: School- and community-based approaches*. New York: Brunner-Routledge.
- Greenberg, M. T., Weissberg, R. P., O'Brien, M. U., Zins, J. E., Fredericks, L., Resnik, H., et al. (2003). Enhancing school-based prevention and youth development through coordinated social, emotional, and academic learning. *American Psychologist*, 58, 466–474.
- McNeely, C., & Falci, C. (2004). School connectedness and the transition into and out of health-risk behavior among adolescents: A comparison of social belonging and teacher support. *Journal of School Health*, 74, 284–292.
- Paternite, C. E., & Johnston, T. C. (2005). Rationale and strategies for central involvement of educators in effective school-based mental health programs. *Journal of Youth and Adolescence*, 34, 41–49.
- President's New Freedom Commission on Mental Health. (2003). *Achieving the promise: Transforming mental health care in America*. Final report (SMA Publication No. 03-3832). Rockville, MD: Author.
- Robinson, K. E. (2004). *Advances in school-based mental health interventions: Best practices and program models*. Kingston, NJ: Civic Research Institute.
- Wandersman, A. (2003). Community science: Bridging the gap between science and practice with community-centered models. *American Journal of Community Psychology*, 31, 227–242.
- Weist, M. D., Evans, S. W., & Lever, N. A. (2003). *Handbook of school mental health: Advancing practice and research*. New York: Kluwer Academic/Plenum.
- Weist, M. D., Sander, M. A., Walrath, C., Link, B., Nabors, L., Adelsheim, S., et al. (2005). Developing principles for best practice in expanded school mental health. *Journal of Youth and Adolescence*, 34, 7–13.

delay in reaching certain developmental milestones that typify the normally developing person. Mental retardation (MR) is a developmental disability that is exemplified by the presence of deficits in both *cognitive* and *adaptive* functioning. Individuals with MR have significantly limited patterns of personal functioning, though these patterns will vary from person to person, depending on the severity and type of deficits. As with any developmental disability, the limits in functioning of an MR individual are manifest by infancy or early childhood and are lifelong in nature.

## The Nature of Mental Retardation and Developmental Disabilities

### Diagnostic Criteria

The diagnostic criteria for MR are listed in the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR)* under the heading of “Disorders Usually First Diagnosed in Infancy, Childhood, and Adolescence” and can also be found in the American Association on Mental Retardation's (AAMR) *Mental Retardation: Definition, Classification, and Systems of Supports, Tenth Edition*. (Note: The AAMR has changed its name to the American Association on Intellectual and Developmental Disabilities.)

To warrant a diagnosis of MR, both of the following symptoms must be present in an individual prior to age 18: below average intellectual functioning and impairment in at least two areas of adaptive functioning.

Intellectual functioning is assessed using standardized instruments that measure an individual's intelligence quotient (IQ), such as the Wechsler Adult Intelligence Scale—Third Edition and the Stanford-Binet Intelligence Scales, Fifth Edition. Standardized IQ scores exist along a normal continuum, where a mean IQ score of 100 (standard deviation of 15) reflects an individual with average intelligence. To be considered for an MR diagnosis, individuals must have an IQ score approximately two standard deviations below the mean. This means that an IQ score of approximately 70 or below is needed to demonstrate significantly subpar intellectual functioning. Moreover, intellectual functioning is also coded to reflect the severity of impairment: mild (50–55 to approximately 70), moderate (35–40 to 50–55), severe (20–25 to 35–40), and profound (20–25 or below). Unspecified is the code given when there is a strong suspicion of MR, but actual IQ scores cannot be determined due to

---

## MENTAL RETARDATION AND DEVELOPMENTAL DISABILITIES

---

*Developmental disability* is an umbrella term that broadly refers to a set of severe and chronic physical or mental impairments characterized by an absence or



factors that interfere with IQ testing, such as uncooperativeness or extremely impaired functioning.

*Adaptive functioning* refers to activities needed to successfully navigate day-to-day demands of life. When individuals exhibit adaptive functioning deficits, they display consistent ineffectiveness in completing these daily activities. Levels of adaptive functioning are considered in light of the chronological age of an individual and are measured using standardized assessment instruments, such as the Vineland Adaptive Behavior Scales, Second Edition and the AAMR Adaptive Behavior Scale, Second Edition. The broad areas of adaptive functioning considered for an MR diagnosis include daily living skills, communication skills, and social and interpersonal skills. *Daily living skills* refer to a set of behaviors that center on self-care, household chores, work or academic involvement, and the ability to access community resources. *Communication skills* involve the ability to accurately understand others and express oneself. Social and interpersonal skills are the set of skills needed to successfully interact with others, cope with daily stressors, and make use of free time. In addition to these three areas, deficits in fine and gross motor skills, such as toilet training and walking, may also be assessed in children.

In addition to intellectual functioning and adaptive functioning, the AAMR definition of MR goes a step further and integrates a skills-based component to shift the focus away from the solely limitations-based definition given by the *DSM-IV-TR*. For example, the AAMR definition of MR addresses the context of the individual's limitations, strengths, and available environmental supports. Both the *DSM-IV-TR* and the AAMR suggest that before a diagnosis of MR is rendered, it is imperative to rule out medical conditions, cultural and language considerations, and physical limitations (e.g., hearing or visual impairments) that may interfere with normal development or current functioning. In addition, developmental issues should be taken into account when assessing adaptive functioning; for example, it would be inappropriate to measure occupational performance when assessing the adaptive functioning of a child.

## Causes

A variety of genetic, chromosomal, and environmental causal sources have been linked to MR. Genetic and chromosomal disorders are thought to account for approximately half of MR cases, with the other half due to environmental or unknown causes. Examples of

genetic and chromosomal types of disorders include the following: metabolic disorders (e.g., phenylketonuria, galactosemia) and chromosomal abnormalities (Down syndrome, Klinefelter's syndrome, fragile X). Environmental causes include chronic and severe neglect of basic needs (e.g., food, affection), teratogen exposure in utero (e.g., fetal alcohol syndrome, Food and Drug Administration pregnancy category D- and X-classed drugs), fetal and infant malnutrition, and birth complications (e.g., hypoxia, premature delivery).

## Morbidity

Most reliable sources, such as the Centers for Disease Control and Prevention and the AAMR, put the prevalence rate of MR at about 1% to 3% of the general population. The incidences of MR caused by genetic and chromosomal factors occur similarly across different socioeconomic categories. Environmental causes (e.g., lead poisoning and malnutrition) appear to occur more commonly in individuals of lower socioeconomic status. In addition, MR seems to occur at a higher frequency in males (1.5 males to 1 female). Mild MR is more common, representing approximately 85% of all individuals in this group. Moderate MR occurs at 10%, severe MR corresponds to approximately 3% of all MR cases, and profound MR occurs in approximately 1% of such individuals. In general, people with MR have the same rates of chronic physical and mental health disorders as the general population. The exceptions are due to the problematic symptoms specific to certain disorders, such as metabolic disorders, and with the neurological abnormalities and physical limitations present in individuals with profound MR.

## Changes and Challenges

### Treatment Interventions

Interventions for MR individuals directly target adaptive living skills and take into account both the limitations and strengths of the individual. Interventions typically address increasing self-determination, targeting problematic behaviors, increasing social skills, and assisting caregivers, families, and employers in modifying the individual's environment to maximize success. This is best accomplished by coordinating several services, such as therapy, vocational rehabilitation, social services, schools, and caregivers. Interventions are highly dependent on the individual's level of disability; for instance, a treatment plan for an individual with mild



MR will be different from that for an individual with more extensive limitations. A typical example of an individual with mild MR might be a day school program that places academic lessons in the context of daily living, such as focusing on social skills, reading bus schedules, calculating a simple budget, cooking, and household upkeep. Vocational training is also a recommended treatment consideration and should be based on the individual's strengths.

In addition, healthcare providers are increasingly aware that psychological disorders occur at a much higher rate in the MR population than previously thought and warrant psychological services. Rates of depression, anxiety, conduct problems, or impulse control issues are common, and, consistent with the symptomatology of these disorders, injurious behaviors are sometimes present. Interventions targeting these behaviors are important, as is teaching beneficial coping mechanisms (e.g., time-out/taking a break, redirecting attention). Likewise, the appropriate use of psychotropic medication can be a viable treatment avenue. Insight-oriented therapy may have some utility with individuals with mild MR. Therapeutic interventions should focus on modeling healthy emotional expression, managing interpersonal and professional relationships, and managing stressful situations.

### Caregiver Issues

According to the AAMR, trends indicate a four-fold decrease in the number of MR individuals in state institutions over the past 30 years. This transition out of institutions into residential settings has been beneficial for many MR individuals, as it promotes self-determination, yet this trend has increased stresses for caregivers and families in several ways. The additional emotional and social supports needed to care for MR individuals can be difficult to understand by all members of the family, particularly for siblings. Financial hardship induced by the unique needs of MR individuals can be taxing. Though many MR individuals are recipients of Medicaid benefits that decrease the financial burden of health care, there is often difficulty finding physicians who will take Medicaid patients, because reimbursement rates are lower than those provided by other types of health insurance. Physical demands are placed on caregivers and families. Activities such as lifting or transporting the person with MR or dealing with injurious or other challenging behaviors can increase stress and fatigue. Nonprofit

organizations that assist families with these demands are invaluable, as they help with issues such as finding community resources, transportation, and respite care. Many of these organizations, however, have extensive waiting lists. Paid caregivers are typically reimbursed for their services at a low rate, generating high turnover and poor continuity of care. In general, stress and fatigue can prompt an increase in abusive and neglectful behaviors among caregivers. Such behaviors can be either passive (e.g., failure to respond to basic needs) or active (e.g., physical violence, verbal abuse). Regardless, attending to the psychological needs of the caregivers of MR individuals and providing social supports are important intervention considerations.

*Julie A. Kellaway and Lee A. Rosén*

**See also** Autism/Asperger's Syndrome (v1); Caregiver Burden (v1); Caregiving (v1); Developmental Disorders (v1); *Diagnostic and Statistical Manual of Mental Disorders (DSM)* (v2); Intelligence (v2); Low-Incidence Disabilities (v1); Mental Status Examination (v2); Neuropsychological Functioning (v2); Traumatic Brain Injury and Rehabilitation (v1)

### Further Readings

- American Association on Mental Retardation. (2002). *Mental retardation: Definition, classification, and systems of supports* (10th ed.). Washington, DC: Author.
- American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed., Text rev.). Washington, DC: Author.
- American Psychological Association. (2005). *Guidelines on effective behavioral treatment for persons with mental retardation and developmental disabilities*. A resolution by APA Division 33. Retrieved from <http://www.apa.org/divisions/div33/effectivetreatment.html>
- Centers for Disease Control and Prevention. (2005, October 25). *Developmental disabilities: Mental retardation*. Retrieved from <http://www.cdc.gov/ncbddd/dd/ddmr.htm>

---

## MENTORING

---

Mentoring is an activity or relationship that occurs between two or more persons interested in advancing their knowledge, skills or position via a helping relationship. A *mentoring relationship* is one in which a more skilled or knowledgeable person assists another



who possesses less knowledge and/or skill in a particular area. These relationships typically last beyond a single encounter and can be either formal, informal, or some combination of the two. By definition, mentoring begins as a hierarchical relationship in which the mentor and protégé engage in a variety of roles and functions to support the protégé's learning and development. Most mentoring relationships follow a predictable path and over time develop into a more collegial relationship that allows for reciprocity and mutuality between the mentor and protégé. Although, the concept of mentoring can be traced back to Greek mythology, no systematic studies of mentoring were conducted until the early 1970s.

### A Brief History of Mentoring

Mentoring relationships have been documented in the literature since antiquity. The first use of the term *mentor* is credited to Homer in his third book of the *Odyssey*. In this Greek myth, Odysseus, a great royal warrior, calls upon his friend Mentor to serve as a guide and advisor to the entire royal household when Odysseus leaves to fight the Trojan wars. Athena, the goddess of wisdom, takes the form of Mentor and accompanies and guides Telemachus, Odysseus's son, on a journey in search of his father. During this journey, Telemachus strives for and develops a new and fuller identity, hence the parallels between Telemachus's journey and that of the modern day protégé.

Mentor-apprentice relationships have also been documented through the development of artisans' guilds as a means to pass on particular skills and ways of being. In these settings, a more experienced and typically older adult educated, challenged, and supported the younger adult or protégé. The protégé remained in the mentoring relationship until he or she learned and could demonstrate the knowledge and practices of that particular craft. The practice of mentoring allowed members of guilds or professions an agreed-upon process through which they could transmit the specific technical and intellectual heritage of their discipline to selected individuals. Thus, mentoring served as means for selection, education, and continuity within professions.

### The Nature of Mentoring

Mentoring occurs along a continuum, from formal mentoring at one end to informal mentoring at the other end. The distinguishing characteristics of a

formal mentoring relationship describe the nature, purpose, duration, and quality of the contact. In a formal mentoring relationship, the mentor and protégé are typically assigned to work with each other, by a third person or group, in order to complete a specific purpose, training, or task. The mentor is clearly in charge and responsible for the work of the protégé. The mentor directs the activities without much expectation of a reciprocal relationship from the protégé. The relationship remains hierarchical, and the interactions formal. Mentoring ends when the protégé has acquired the desired skills or accomplished the specific task. Because the contact is more formal, task-focused, and shorter in duration, mentors and protégés typically do not report much interpersonal support or relational progression.

In contrast, informal mentoring relationships focus less on specific behaviors or tasks of the mentor and protégé and more on the nature, quality, and process of interpersonal and professional relationship. Informal mentoring relationships are typically initiated by the protégé for the purpose of longer-term personal and professional development. The mentoring relationship is expected to last over time and may or may not have an explicit end. The relationship begins in a somewhat formalized and hierarchical manner and progresses through identifiable stages. In informal mentoring relationships, the mentor and protégé experience intensity within the relationship that provides for reciprocity, interpersonal regard, comprehensiveness, appreciation, and gratitude.

### Stages of a Mentoring Relationship

Numerous researchers have examined the nature and process of mentoring. Kram has researched mentoring since the early 1980s. She identified four stages of a mentoring relationship that appear to be sequential and developmental. It should be noted that the stage model presented here is one of many in the literature, and there is a lack of agreement among researchers as to what defines a stage, what the duration of a stage is, and what constitutes movement within and between stages. The four stages are initiation, cultivation, separation, and individuality. The stages occur more frequently in informal mentoring relationships.

In the initiation stage, the mentor is idealized by the protégé and viewed as all-knowing. In the second stage, cultivation, the mentor provides vocational guidance and personal support. During the separation



stage, the protégé has become more competent and independent and is able to offer more to the mentor. It is also in this third stage that the mentor is more likely to experience mutuality and reciprocity with the protégé. The final stage, individuality, is defined by a sense of dichotomy. That is, the mentor and protégé either develop a mutually supportive friendship or they separate feeling used and bitter.

### Mentor Roles and Functions

Researchers have suggested that mentors engage protégés from a variety of roles and provide a number of functions. The terms *roles* and *functions* are often used interchangeably, yet scholars in the area of mentoring distinguished them as follows. Roles are a series of expected attitudes, dispositions, behaviors, and obligations organized around a specific vocation. Functions are specific behaviors or actions that emanate from specific roles.

A skilled mentor moves in and out of his or her roles effortlessly. The role adopted by a mentor is determined by the stage of the mentoring relationship and often is a blend of several roles. The adoption of a role or roles is subtle and nuanced. The mentor role is related to the perceived, identified, or expressed need(s) of the protégé. Mentor roles include: teacher, sponsor, advocate, role model, advisor, evaluator, coach, and supervisor. Knowledge, responsibility, accountability, maturity, and ethical behavior are inherent in the roles of a mentor.

In the early to mid-1980s, Kram and other researchers identified two categories of mentor functions, psychosocial and career. Psychosocial functions are personal in nature and focused on the relationship. The mentor provides acceptance, support, encouragement, advice, guidance, and challenge to the protégé. Psychosocial functions provide the foundation for the personal and sometimes intense nature of the mentoring relationship. The career or vocational functions provided by mentors provide the protégé opportunities, “plum assignments,” coaching, protection, role modeling, social status, reflected credit, sponsorship, advocacy, visibility and exposure. These functions are provided with the protégé’s career goals in mind and are related to the institution or profession in which both are currently engaged. Thus a mentor may introduce a protégé to selected influential colleagues at a conference (sponsorship and reflected credit) and encourage them to attend the protégé’s presentation (visibility and exposure). This interaction provides the protégé a role model of one engaging with professional peers and

may, in the long term, enhance the social status of the protégé. Mentor functions, like mentor role models, are complex and dynamic interactions that occur as a result of the quality and strength of the relationship.

### Benefits and Costs of Mentoring

Mentoring relationships are widely recognized as vital personal and career resources in many disciplines. Mentoring has been an essential element in the training of business professionals, nurses, psychologists, counselors, and educators. There are numerous and detailed accounts of the benefits to the institution, the mentor, and the protégé. For the institution, particularly in higher education, researchers report the benefits to be stable, enthusiastic, and productive employees; less employee attrition, lower training cost, and greater scholarly productivity. The benefits to the mentor include the development of a dependable peer-in-training; generativity or giving back to one’s profession; rejuvenation and enrichment of one’s energies, career, and research interests; and working with a person that has the potential to carry on the mentor’s legacy. Protégés benefit from greater socialization into their vocation, improved career and personal performance, higher salaries, and more frequent promotions. In settings such as higher education, protégés have reported that they experienced greater satisfaction with their graduate education, improved postgraduate scholarly productivity, and more ease achieving tenure and promotion once employed in the academy.

Despite the many benefits of mentoring, there are also some barriers or costs related to this process. Researchers have reported that institutions tend to expect professionals to accept preselected protégés without the professional’s input or to provide mentoring to junior colleagues or students without any additional release time, compensation, or resources. The lack of personal involvement and support can lead to professionals feeling confused and burdened, while protégés may be left feeling disregarded. Protégés have reported that mentoring relationships can be confusing or detrimental when the mentor engages in unethical behavior by violating either academic or personal standards of appropriateness.

*Linda L. Black and Ernie Zullo*

*See also* Counseling Skills Training (v2); Counselors and Therapists (v2); Postdegree/Prelicensure Supervision (v1); Postdoctoral Training (v1); School Counseling (v1); Supervision (v1)



### Further Readings

- Black, L. L., Suarez, E. C., & Medina, S. (2004). Helping students help themselves: Strategies for successful mentoring relationships. *Counselor Education and Supervision, 44*, 44–56.
- Green, S. G., & Bauer, T. N. (1995). Supervisory mentoring by advisers: Relationships with doctoral student potential, productivity, and commitment. *Personnel Psychology, 48*, 537–561.
- Johnson, W. B., & Huwe, J. M. (2003). *Getting mentored in graduate school*. Washington, DC: American Psychological Association.
- Schwiebert, V. (2000). *Mentoring: Creating connected, empowered relationships*. Alexandria, VA: American Counseling Association.

---

## MINDFULNESS

---

Mindfulness refers to a meditative practice most commonly associated with Buddhism that dates back to 25 centuries ago as part of the Buddha's teachings. It has become increasingly popular in the Western world over the past 2 decades. Mindfulness meditation involves the practice of becoming fully aware of the present moment and all that is happening in the moment. Observations of the present moment are made without judgment, without categorization or opinion. Rather, the idea is to observe what is actually there in the moment.

Becoming fully aware of the present moment through the practice of mindfulness meditation is thought to make it possible for people to truly experience life, because life can only be found in the present moment. The premise is that individuals often spend much time thinking about the past, the future, or places other than where they actually are. Our attention is given to things that take away from our ability to accurately perceive and experience the present. Living out of the moment separates us from our experiences and makes it more difficult to deal with life in an effective and mindful fashion. Our minds are occupied by thinking, judging, worry, or other distractions, with the result that we are not being fully aware of the present. The belief is that if we are not really there (or fully present), it is difficult to see things deeply and clearly. Instead, we perceive events in a vague fashion without deep understanding. Further, by living so much out of the moment or in a mindless fashion, we are not truly ourselves. That is, by functioning with our minds elsewhere, in the past or in the future, our

body and mind are separated from each other. By practicing mindfulness in a concentrated fashion, our body and mind become one or are reunified and we become our true selves.

The ability to practice mindfulness must be learned and developed through regular practice. Certain methods are taught to develop the capacity for mindfulness, with attention to the breath being one of the most important. For example, one might pay attention to inhaling and exhaling by saying such things as, "Breathing in I know that this is my in-breath, and breathing out I know that this is my out-breath." By paying attention to breathing in and out, the individual is brought to the present moment. Distracting thoughts and emotions that divide one's attention and interfere with clear thinking and perception are removed. In a sense, everything stops, and what is left is the present moment with all of its contents. The practice of mindfulness (being in the present moment) can be done in a fashion that is traditionally associated with meditative practice. For example, it may be practiced in a quiet setting set aside as a place for meditation using specific steps designed to develop the capacity for mindfulness in an optimal fashion. However, expert practitioners of mindfulness make it clear that the practice can also be done in any daily activity such as washing dishes, driving a car, or walking.

By engaging in the practice of mindfulness, one is more prepared to deal with life's challenges. For example, if one's anger is triggered, the practice of mindfulness might be to return to breathing and say something like, "Breathing in I know that I am angry; breathing out I know that I am angry." The anger is not suppressed or avoided. Rather, it is noted or observed. There is no judgment about whether or not one should be angry, but rather, one simply notes that one is angry. Even though the anger is still there, it has already become different. The person is taking appropriate care of his or her anger by acknowledging it and looking deeply into it. This practice is thought to bring about a transformation by creating the ability to look deeply into the anger and to see the roots of it through deep awareness so that it can be released. Suffering is released through awareness and understanding. The same process is applied to other difficulties such as depression, anxiety, or other forms of suffering. Also, the practice of mindfulness is thought to allow people to realize that they are more than their sickness, more than their sorrow, more than their suffering.

Practitioners say that when fully developed, mindfulness permits people to keep themselves free of



mental barriers, to achieve liberation from their suffering, and to be less vulnerable to the ups and downs of living. The sort of deep observation produced through mindfulness is said to lead to the complete absence of confusion. Also, practitioners of mindfulness note that while peace is important, the capacity to enjoy peace is important too, and the practice of mindfulness cultivates the capacity to enjoy peace as well. Peace, happiness, and joy are said to be available in the present moment if one has the capacity to experience them.

### Current Applications to Counseling and Health

Mindfulness meditation is being used with increasing frequency in areas related to mental health. For example, Marsha Linehan has incorporated the practice of mindfulness meditation into her treatment approach, termed dialectical behavior therapy (DBT), for borderline personality disorder. Part of the approach includes what she has called “core mindfulness skills,” which are essentially techniques that make it possible for the client to become more fully aware of his or her experiences and to develop the capacity to stay with the experience in the present moment, rather than being overwhelmed or distracted by thoughts and feelings that might otherwise block progress. Mindfulness meditation is also being used in some cognitive treatments for depression.

Also, the Center for Mindfulness in Medicine, Health Care, and Society at the University of Massachusetts Medical School was established in 1995. The center has a mindfulness based stress reduction (MBSR) program, which is one of a number of successful initiatives developed to assist people through the use of mindfulness meditation. Further, The National Center for Complementary and Alternative Medicine has been funding research on the practice of mindfulness.

### Other Applications

Several other examples of the growing popularity of mindfulness meditation can be found. A number of prominent law schools are using mindfulness meditation to improve the ability to listen and function more skillfully. A notable example can be found at the University of Missouri School of Law, which has established the Initiative on Mindfulness in Law and

Dispute Resolution, which involves research, teaching in law school courses, and public service using the practice of mindfulness meditation. The practice is used to help lawyers, litigants, mediators, and others listen better, improve self-awareness and understanding of others, manage stress more effectively, and function better in general. Mindfulness meditation is also being used by some professional sports teams and some corporations.

David Gonzalez

*See also* Dialectical Behavioral Therapy (v2); Exercise and Sport Psychology (v1); Eye Movement Desensitization and Reprocessing (v1); Health Belief Model (v1); Hypnosis (v1); Quality of Life (v2); Stress Management (v2); Stress-Related Disorders (v1); Work Stress (v4)

### Further Readings

- Baer, R. A. (2005). *Mindfulness-based treatment approaches: Clinician's guide to evidence base and applications*. Amsterdam: Elsevier; Boston: Academic Press.
- Gunaratana, B. H. (2002). *Mindfulness in plain English*. Boston: Wisdom.
- Kabat-Zinn, J. (1990). *Full catastrophe living: Using the wisdom of your body and mind to face stress, pain, and illness*. New York: Delacorte.
- Langer, E. J. (1989). *Mindfulness*. Reading, MA: Addison-Wesley.
- Linehan, M. (1993). *Cognitive-behavioral treatment of borderline personality disorder*. New York: Guilford Press.
- Nhat Hanh, T. (1991). *Peace is every step: The path of mindfulness in everyday life*. New York: Bantam Books.
- Sothers, K., & Anchor, K. N. (1989). Prevention and treatment of essential hypertension with meditation-relaxation methods. *Medical Psychotherapy: An International Journal*, 2, 137–156.
- Teasdale, J., Segal, Z., Williams, J., & Mark, G. (1995). How does cognitive therapy prevent depressive relapse and why should attentional control (mindfulness) training help? *Behavior Research and Therapy*, 33, 25–39.

---

## MIXED METHODOLOGY RESEARCH

---

Mixed methodology research incorporates both qualitative and quantitative research methods. Qualitative research methods provide detailed descriptions about



phenomena and may include interviews, observations, and analyses of documents, records, artifacts, photos, and film. Researchers choose this methodology when they are interested in a rich narrative description with an abundance of deep detail. Quantitative research methods, on the other hand, include randomized experimental and quasi-experimental designs, surveys, written or oral assessments, and other standardized instruments with which responses can be measured on a numerical scale. Statistical procedures are then used to analyze the numerical responses. In mixed methods research, both qualitative and quantitative methods are used in data collection or data analysis in the same study. Mixed methodologists believe that this developing paradigm will be the dominant form of research during the 21st century.

## Paradigms

The type of methodology researchers use depends on their research perspective or paradigm. Scholarly conversations in this area have been highly developed for both the quantitative and qualitative paradigms. Over the last decade, mixed methodologists have begun to add to this debate.

### Quantitative

Purely quantitative researchers generally work from the *positivist-postpositivist* paradigm. They believe that phenomena can best be measured and explained using the scientific method, which has been the dominant paradigm throughout the history of social science research. Quantitative researchers use *experimental* designs in which participants are randomly assigned to a *treatment group*, the group receiving the specific treatment, or the *control group*, which is the group not receiving the treatment. For example, in drug studies, some subjects will be randomly assigned to receive a drug and some subjects, assigned to the control group, will receive a placebo. The researchers then may administer a standardized instrument (an assessment that measures the results of the study) to both groups. Statistical analysis is conducted to compare the results.

A second type of design quantitative researchers use is the *quasi-experimental* design, which includes both treatment and control groups, but subjects are not randomly assigned to either group. Quasi-experimental designs are often used when dealing with intact

groups where random assignment is not feasible, such as classrooms of students.

A third design quantitative researchers use is the *causal comparative* design. In causal comparative studies, the researcher does not impose a treatment. Instead research is done after the fact, or *ex post facto*. The researcher looks for cause and effect relationships based on group differences. For example, the researcher might investigate how familial support among new mothers is related to their postpartum depression levels.

### Qualitative

Purely qualitative researchers work from the *interpretive-constructivist* paradigm. They believe that the way to understand phenomena is through exploring people's interpretations. Qualitative researchers use designs such as case study, ethnography, phenomenology, grounded theory, and narrative inquiry. Data collection is carried out as naturalistically as possible in the research context through the use of observations, interviews, and collection of documents and records. Some examples of qualitative research include a case study of counseling techniques at a clinic, an ethnography of a school counselor's day-to-day practice over an extended period of time, and an examination of counselors' use of intuition in a phenomenological study. While there are many detailed approaches to qualitative analysis, qualitative research is analyzed categorically or thematically; the researcher reads the data to identify similarities and dissimilarities.

### Mixed Methods

In mixed methods research, the researcher's paradigm is often *pragmatism*. Pragmatists believe not only that it is acceptable to use multiple paradigms in the same research study but that qualitative and quantitative methods can be complementary. For a mixed methodologist, "what works" becomes the driving factor. Pragmatists value both the subjective and the objective; they believe that the research question is the most important issue. The research question, not the framework, should drive the method. By combining qualitative and quantitative methods, researchers are able to discover issues that might otherwise go undetected. However, critics of pragmatism have dismissed this paradigm as naïve, simplistic, and overly applied. A mixed methodologist would contend that an undue focus on theory and paradigms has detracted



from the need to focus on the point of research: the research question. The focus on the problem and not theory is one of the reasons mixed methodology has emerged as a field that is demanding respect.

## History

Mixed methodology research has been called the third methodological movement. Mixed methods research has not always been and is not currently accepted by all research methodologists. Though it is a “new” methodology, mixed methods research has been conducted throughout the 20th century. From the late 1950s through the late 1970s, mixed methods research was in a formative stage. During this time, researchers were beginning to combine surveys and interviews as well as using qualitative and quantitative data results to support each other. Some researchers viewed this mixing of methods as a mixing of mutually exclusive paradigms. The issue of paradigm conflicts was and remains difficult for some researchers to overcome. Therefore, the 1980s and early 1990s were characterized by this paradigm debate. Purists, those who believed strongly in either qualitative or quantitative methods, did not believe it was appropriate to combine the paradigms. For example, quantitative researchers have contested the use of qualitative methods in scientifically based experimental research designs on the grounds that the designs have a methodological hierarchy in which quantitative methods are preferred and qualitative methods are consigned to a supplementary role.

Though this debate continues for many researchers, by the end of the 20th century, some researchers began to identify their methodology as a mix or blend of qualitative and quantitative research. From the mid-1990s to the present, these researchers have been attempting to further develop mixed methods research procedures. They have worked on definitions, notation, and a classification system for the different combinations of mixed methods research. The millennium brought about a call to make mixed methods research its own separate paradigm.

## Purpose

The main purpose for using mixed methods research is to balance the weakness of single methodologies. Both qualitative and quantitative research methodologies have weaknesses when used alone. One weakness in qualitative research is that small sample sizes are used. Consequently, qualitative researchers are unable to

statistically generalize the results to large groups of people. Mixing methods allows the researcher to study both small and large sample sizes in one study. Another perceived weakness of the qualitative approach is that researchers include their own interpretations and biases in the research.

Likewise, quantitative research has weaknesses. Usually the context of the study, the surroundings, and the environment are controlled and therefore not completely understood. Individual voices are not heard in a quantitative study. The researcher's biases are not usually explicitly addressed in quantitative research. Mixing qualitative and quantitative research results in a more comprehensive and therefore stronger study.

Besides strengthening the design and interpretation, mixed methods research allows researchers to answer questions otherwise unanswerable using only one approach. For example, a counselor may want to find out which coping skills are used and how widely those skills are used within certain ethnic groups dealing with the emotional aspects of diabetes. The counselor may use interviews or focus groups to identify emotional themes and coping skills used by each ethnic group. The researcher may then use a survey, developed from those themes, to determine the extent of use of those coping skills discovered using interviews. Without the first qualitative approach, the researcher may not be sure that the relevant emotional themes and coping skills used by each ethnic group had been identified. Without the second quantitative approach, the researcher may not be sure that the relevant emotional themes and coping skills identified in the smaller sample would hold true in a larger group of subjects from each ethnic group.

Though it is not a purpose of mixed methods research, one advantage of this method is that it promotes collaboration between qualitative and quantitative researchers. Because it is not common that a single researcher is adept in both types of research, experts in each methodology often form a research team. This collaboration encourages multiple worldviews. This paradigm is practical in that all types of data collection and analysis techniques are available to mixed methods researchers. It allows words and numbers to be combined to help understand complex systems.

## Procedures

There are four common types of designs in mixed methods research: *triangulation*, *embedded*, *explanatory*, and *exploratory*. Each has a different purpose.



### ***Triangulation Design***

In the triangulation design, the purpose is to use the strengths of both qualitative and quantitative research to support each other with the goal of comparing and contrasting the results of the qualitative and quantitative approaches in order to identify where the results agree or converge. When the results agree, this strengthens the validity of the study. The qualitative and quantitative portions of the triangulation design are usually done in the same time frame and are given equal weight. For example, a counselor may study the effects of suicide using both a quantitative standardized instrument and an in-depth interview. The results of both would then be merged into one overall conclusion.

### ***Embedded Design***

In an embedded design, the primary focus is on either the qualitative or the quantitative piece with the other type having a secondary role. A typical use of this design is in an experimental study that is primarily quantitative, in which one group is given a treatment and then compared to a control group or a group with no treatment. Quantitative methods such as the use of a standardized instrument are used to determine whether the treatment worked. However, a qualitative portion can be embedded in the design, which may include an in-depth interview of the participants before, during, or after the treatment. In this way the qualitative methods inform the overall quantitative study.

### ***Explanatory Design***

The explanatory design is a *sequential* design in which one type of research is followed by the other for purposes of further explaining what was found in the first portion. For example, a quantitative study may reveal that certain mental health clinics are outperforming others. A qualitative follow-up study would be conducted to try to understand, or explain, what those high-performing clinics were doing. The qualitative piece would involve interviews and a site visit to observe the effective practices.

### ***Exploratory Design***

The exploratory design is also a sequential design in which one type of research is followed by the other. However, the purpose in an exploratory design is to build on the results from the first type of research to a second phase of the research. A commonly used

exploratory design is to use qualitative methods to discover themes regarding an issue, and then use those themes to develop and administer an instrument that will generate data that will be analyzed quantitatively.

## **Data Analysis**

Data analysis depends on whether the design is concurrent or sequential. In a concurrent design, the qualitative data are organized and then analyzed separately from the quantitative data. Then the two results are combined for another round of data analysis. In a sequential design, a first methodology informs the second. Therefore, the analysis of the first portion is completed before beginning the analysis of the second portion.

### ***Data Analysis in Concurrent Design***

#### **Qualitative Data Analysis**

Qualitative data analysis begins with preparing the data, which means organizing the data, documents, field notes, or other visual data. Taped interviews are transcribed. Exploring the qualitative data is next and involves making notes about early observations as well as developing codes. *Codes* are words, phrases, or even sentences that are assigned to chunks of qualitative data that allow researchers to categorize the data into themes. Data analysis then involves the researcher coding the data by reading the raw data (field notes, interview transcripts, researcher observations, etc.) and assigning codes to small portions of the text. Codes are then grouped together to form themes. Themes can be grouped together to form more themes. Software packages are available to help develop themes in qualitative data.

The findings from the qualitative portion are then represented using rich descriptive narratives, discussions of the themes, and tables, figures, diagrams, or visual models. The qualitative data analysis is then combined with the quantitative data analysis for another round of analysis.

#### **Quantitative Data Analysis**

In the quantitative portion of data analysis in the concurrent design, the quantitative data also must be prepared for analysis. Numeric values are assigned to the data using a predetermined coding scheme. The data are entered into a computer software package. The data are “cleaned,” which means that the



researcher uses visual inspection and basic descriptive statistical procedures to identify and fix data entry errors. As in qualitative data analysis, exploring the quantitative data is next. This involves using descriptive statistics (e.g. measures of central tendency, measures of variation, and graphical representations) to check for patterns or trends in the data. The researcher chooses an appropriate statistical test to conduct the actual data analysis using inferential statistics.

Three types of inferential statistics techniques are commonly used; the choice of which will depend on the research question. The researcher may find and report a confidence interval, which is an estimate of a population parameter. The second type of inferential statistics commonly used is the hypothesis test. In hypothesis testing, a theory, belief, or hypothesis is tested using the data collected along with rules of probability. The third type of inferential statistics commonly used is regression. The goal in regression is to develop a mathematical model that describes the relationship between variables. For example, regression helps to describe what happens to one variable as another decreases or how much of the change in one variable can be attributed to the other variable changing.

### **Qualitative and Quantitative Analyses Combined**

In a concurrent mixed methods design, the qualitative and quantitative data analysis portions are completed separately and independently of one another. Once completed, the two data sets are merged. Three techniques for merging are typically used.

One technique is to transform one type of data into the other type. For example, qualitative data can be converted to quantitative data by counting the number of times certain codes or themes appear. Quantitative data can be converted to qualitative data by conducting a factor analysis, which is a statistical procedure that allows researchers to categorize quantitative data into themes; these themes can be considered qualitative.

A second technique for merging the two data sets is to use a *matrix*, which is a table in which the qualitative themes are arrayed along the top of the table and the quantitative results appear on the side of the table. The cells within the table are the conclusions about each category of results.

A third technique for merging the two data sets is to write a narrative discussion. The discussion could be used in conjunction with the matrix or stand alone.

In the discussion, the researcher compares and contrasts the results of both types of analysis and discusses how results converge.

### ***Data Analysis in Sequential Design***

Sequential designs are used with explanatory or exploratory designs and some embedded designs. The idea of sequential designs is that one type of data collection and analysis is used to inform the other type of data collection and analysis. If the qualitative portion is first in the design, then the data are collected and analyzed qualitatively first before starting the quantitative portion. The themes that emerge from the qualitative portion are commonly used to inform the quantitative portion in the form of the development of a quantitative instrument. If the quantitative portion is first in the design, then the data are collected and analyzed quantitatively first before starting the qualitative portion. An example of this type of study would be to use the quantitative results to help identify specific cases that can be investigated further using qualitative techniques, such as in the scenario above of following up on high-performing clinics.

### **Validity and Reliability**

Efforts to maximize the validity and reliability of research are standard practice in all paradigms. Validity assumes that what is being studied is in fact being studied. Reliability refers to the idea of repeatability or replicability. Would the study, if conducted again, yield similar results? Mixed methodology researchers need to maximize validity and reliability by using established methods to enhance validity and reliability in both qualitative and quantitative research. The exact methods used will vary depending on the research design. With the qualitative data, the methods may include triangulation, member or peer checks, and rich, detailed descriptions and salient quotes regarding the data. With the quantitative data, the researcher may discuss the previously established validity and reliability of the instruments used and identify threats to internal validity.

### **Future**

Mixed methodologists believe there are encouraging signs that this methodology is beginning to develop into a legitimate paradigm. For example, a journal has emerged recently that publishes only studies that use



mixed methodology designs. Also, basic research textbooks are starting to include sections on mixed methodology. Mixed methodologists believe that this third paradigm will increase the ability of researchers to draw from the strengths of quantitative and qualitative methodologies without having to sacrifice the strengths of one methodology for the weaknesses of the other. The future of mixed methodology will be fueled by the advantages discovered through the more comprehensive picture created by combining qualitative and quantitative techniques.

*Monica R. Geist and Maria K. E. Lahman*

*See also* Achievement, Aptitude, and Ability Tests (v4); Behavioral Observation Methods, Assessment (v1); Behavior Rating Scales (v1); Biodata (v4); Clinical Interview as an Assessment Technique (v2); Psychometric Properties (v2); Qualitative Methodologies (v1); Quantitative Methodologies (v1)

### Further Readings

- Creswell, J. W., & Plano Clark, V. L. (2007). *Designing and conducting mixed methods research*. Thousand Oaks, CA: Sage.
- Greene, J. C., & Caracelli, V. J. (Eds.). (1997). Advances in mixed-method evaluation: The challenges and benefits of integrating diverse paradigms. *New Directions for Evaluation*, 74. San Francisco: Jossey-Bass.
- Hanson, W. E., Creswell, J. W., Plano Clark, V. L., Petska, K. S., & Creswell, J. D. (2005). Mixed methods research designs in counseling psychology. *Journal of Counseling Psychology*, 52(2), 224–235.
- Johnson, R. B., & Onwuegbuzie, A. J. (2004). Mixed methods research: A research paradigm whose time has come. *Educational Researcher*, 33(7), 14–26.
- Morgan, D. L. (2007). Paradigms lost and pragmatism regained: Methodological implications of combining qualitative and quantitative methods. *Journal of Mixed Methods Research*, 1(1), 48–76.
- Tashakkori, A., & Teddlie, C. (Eds.). (2003). *Handbook of mixed methods in social and behavioral research*. Thousand Oaks, CA: Sage.

without it. Music is a part of many social activities and is present in much of our environment. People may use music to communicate with others and often respond emotionally to music. Music has been a part of all cultures, and people report listening to music more than any other activity over a wide variety of contexts.

Music affects people emotionally, physically, and aesthetically, and these responses provide the basis for the use of music in therapy. Emotional responses may include nostalgia at hearing a song, sadness evoked by a piece of music, or joy and exhilaration while dancing to music. Music influences physiological responses such as changes in heart rate, electrical skin conductance, and breathing, and it also affects physical and brain responses. Aesthetic responses reflect one's experience of the beauty and art of music.

Music and healing have been tied together throughout history. Shamans have used music in healing since primitive times. The Greek philosophers Plato and Aristotle wrote of how to use music to affect health and behavior, and music continued to be tied to healing throughout the Middle Ages and later. Music has been used to treat physical and mental problems in the United States for the last century and a half.

Formal music therapy in the United States stems from the period during World War II, when musicians played their instruments for veterans with physical and emotional trauma in Veterans Health Administration hospitals. Their music often had a positive effect on the hospitalized veterans, and the medical personnel began to request that hospitals hire the musicians. It became clear that the hospital musicians needed some training before working in the facilities, and the demand grew for a college curriculum. The first music therapy degree program in the world began in 1944, followed by the first music therapy association in 1950. The American Music Therapy Association (AMTA), the current U.S. association, was founded in 1998 through the unification of older music therapy organizations.

AMTA establishes standards and oversees music therapy education and training in the United States. Music therapy training is offered at the bachelor's level or higher at over 70 educational institutions approved to offer music therapy degrees. Bachelor's level training leads to entry level competencies in musical, clinical, and music therapy foundations and principles; these are acquired through academic coursework and 1200 hours of clinical training that includes a supervised internship. Many universities offer master's and doctoral degrees in music therapy.

---

## MUSIC THERAPY

---

Music is such an important part of life that some find it difficult to imagine what the world would be like



Music therapists also may obtain graduate degrees in music therapy or a related field such as special education, social work, or gerontology. The Certification Board for Music Therapists (CBMT) establishes competencies for music therapists to become Board Certified Music Therapists (MT-BC), the credential necessary to practice music therapy, and requires continuing education to ensure that music therapists' skills are up to date.

Music therapy is well established in many parts of the world, and many countries in addition to the United States have standards for educating and training music therapists, governmental regulations for music therapy, and active music therapy associations. The World Federation for Music Therapy (WFMT) is dedicated to the promotion and development of music therapy worldwide. *Voices: A World Forum for Music Therapy* is a regular online publication that presents information and opinions on music therapy from around the world. *Music Therapy World* publishes articles, online databases, and additional information about music therapy. These Web sites provide international networking opportunities for music therapists and others interested in music therapy and increase international awareness and communication.

### Definition and Scope

Music therapy is defined by AMTA as "the clinical and evidence-based use of music interventions to accomplish individualized goals within a therapeutic relationship by a credentialed professional who has completed an approved music therapy program." Music therapists use the unique qualities of music and a relationship with a therapist to access emotions and memories, structure behavior, and provide social experiences in order to address clinical goals.

Music therapy may be used with children or adults with physical or emotional problems or with healthy people to achieve higher levels of awareness. Music therapists work with clients with a range of diagnoses. The client groups listed below, arranged from more to less frequently served, are those served most frequently by music therapists as reported by AMTA in 2006, but they are only some of the many client groups that music therapists see. They include clients who are developmentally disabled, those with autism spectrum, the school-age population, clients with behavioral disorder, clients with mental health issues, multiply disabled individuals, elderly persons, physically disabled

individuals, clients with Alzheimer's disease or some other form of dementia, speech impaired clients, emotionally disturbed clients, learning disabled clients, clients in early childhood, neurologically impaired clients, visually impaired clients, individuals with dual diagnoses, stroke victims, and hearing impaired clients.

Music therapy methods may be both active and receptive. Active methods involve the client *doing* something with the music; with receptive methods, the client is *receiving* the music, generally through some form of listening. All may include verbal processing of feelings and experiences, particularly with adults.

Bruscia divides uses of music in therapy into four methods: improvising, performing or re-creating, composing, and listening experiences. Improvising occurs when the client makes up music using any medium, individually or with others. Performing or re-creating takes place when the client learns or performs precomposed music. Composing experiences involve the client writing songs, lyrics, or instrumental pieces with the assistance of the therapist. In listening experiences, the client listens to music of any type and responds silently, verbally, or in another modality.

Music therapy as psychotherapy may occur at three levels. In *supportive, activity-oriented* music therapy, goals are achieved through the use of therapeutic activities (including verbalization when appropriate), but understanding why a behavior occurs is not important. In *re-educative, insight- and process-oriented* music therapy, the focus is on feelings, the exposition and discussion of which lead to insight that results in improved functioning. Music may be used to elicit emotional or cognitive reactions necessary for the therapy. In *reconstructive, analytically, and catharsis-oriented* music therapy, the music helps to elicit unconscious material, which is then worked with in an effort to promote reorganization of the personality. Music therapists may work at one or more of these levels depending upon the needs of the client and the skills of the therapist, with more advanced training required at each level.

### Clinical Examples of Music Therapy

Music therapy can be used in numerous ways, as suggested by the methods and levels described above. Client needs, abilities, and interests are primary considerations in determining music therapy techniques.



A few examples of music therapy, selected to illustrate a variety of clients and approaches, are given below.

### ***Children With Developmental Disabilities***

Music therapy is effective for treating a wide range of problems of children with developmental disabilities and with multiple disabilities. Lisa began music therapy when she was 9 years old and received individual music therapy that was written into her individualized education program (IEP). She had multiple severe disabilities and was nonverbal, although she occasionally made some sounds. Goals for her music therapy were to increase eye focus to task, improve responses to commands, increase frequency of vocalizations, and improve bilateral use of her hands. Music therapy techniques included encouraging Lisa to play simple rhythm instruments, sometimes in response to directions from the therapist; playing songs that encouraged her to respond vocally; and having her do structured movement to music, often to directions given in the song and encouraged by the therapist. She improved in all areas, including some instances in which she said words that were distinguishable. After 2 years (82 sessions), Lisa began music therapy with the same music therapist in her school so that she could work on social skills with her peers. Sessions were held for the next 2 years in the school, with goals including increasing use of her voice, cooperating with others and increasing interpersonal relatedness, following simple directions, and increasing two-handed use of objects. Lisa continued to make progress toward many of the goals, although her responses were inconsistent.

### ***Medical Settings***

Music therapy is effective in medical settings with adults and children. Barbara L. Wheeler has worked in several medical settings, and her work with one young man will serve as an example.

Steven was 19 and hospitalized for a brain tumor. Optic glioma, diagnosed when he was 5, had now progressed so that he could not see and was confined to his hospital bed on the intensive care unit. He had other problems, including muscular dystrophy and hydrocephalus. Because he was hospitalized for an extended period of time, Steven had eight music therapy sessions. Goals were to decrease isolation, provide an opportunity for emotional expression, and increase stimulation. The music therapist usually sang

songs of Steven's choice and encouraged him to tap on a tambourine as a way of participating. He found the sessions useful and usually expressed his enjoyment by smiling, playing the instrument, and speaking of his pleasure. On one occasion, a familiar melody ("You Are My Sunshine") provided the outline for a song about what he had done that day. He was responsible for choosing the words to insert in the blanks when words were left out of the song. The song went, "Today I lay in bed, and I had pancakes. My mom was here and she loves me." Steven was gratified by this creative endeavor, and his mother cried with emotion at Steven's creation. Steven was transferred to a long-term facility and passed away within a few months.

### ***Adults With Psychiatric Disorders***

Working with people with psychiatric disorders, or in the mental health area, is a common focus of music therapists' work, and music therapy has been found to be successful with this population. Additional evidence of the usefulness of music to address the problems of adults with psychiatric disorders is provided by research on aspects of music therapy used with these problems, including those related to depression. Two types of in-depth work are described.

Diane Austin uses vocal improvisation in analytically oriented music therapy. Vocal psychotherapy uses the voice, vocal improvisation, song, and dialogue to promote intrapsychic and interpersonal change within a client-therapist relationship. Austin uses the voice because she finds that singing connects people to their breath, their bodies, and their emotional lives. She uses techniques such as "vocal holding," involving the client and therapist singing together over two consistent chords in unison; harmony; and mirroring to provide a reparative experience and work through developmental arrests.

The Bonny method of guided imagery and music (BMGIM) is an important way of using music as therapy. This method, developed by Helen Bonny beginning in the 1970s and described by Bonny in 2002, is usually done in an individual session with a trained therapist serving as the guide. The client, in an internally focused state, listens to specially programmed classical music that may evoke emotions, memories, imagery, moments of healing and transformation, and spiritual experiences. The client's imagery comes from the client's experience of the music and is not directed by the therapist. The development and theory



of BMGIM, plus numerous instances of deep and transformational experiences with this method, are documented in the literature.

*Barbara L. Wheeler*

**See also** Art Therapy (v1); Autism/Asperger's Syndrome (v1); Developmental Disorders (v1); Health Belief Model (v1); Indigenous Healing (v3); Mental Health Issues in the Schools (v1); Mental Retardation and Developmental Disabilities (v1)

### Further Readings

- Austin, D. (2006). Songs of the self: Vocal psychotherapy for adults traumatized as children. In L. Carey (Ed.), *Expressive and creative arts methods for trauma survivors* (pp. 133–151). Philadelphia: Jessica Kingsley.
- Bonny, H. (2002). *Music and consciousness: The evolution of guided imagery and music* (L. Summer, Ed.). Gilsum, NH: Barcelona.
- Bruscia, K. E. (1998). *Defining music therapy* (2nd ed.). Gilsum, NH: Barcelona.
- Dileo, C., & Bradt, J. (2005). *Medical music therapy: A meta-analysis and agenda for future research*. Cherry Hill, NJ: Jeffrey Books.
- Gold, C., Heldal, T. O., Dahle, T., & Wigram, T. (2005). Music therapy for schizophrenia or schizophrenia-like illnesses. *Cochrane Database of Systematic Reviews* (4), CD004025.
- Houghton, B. A., Scovel, M. A., Smeltekop, R. A., Thaut, M. H., Unkefer, R. F., & Wilson, B. L. (2002). Taxonomy of clinical music therapy programs and techniques. In R. F. Unkefer & M. H. Thaut (Eds.), *Music therapy in the treatment of adults with mental disorders* (2nd ed.; pp. 181–184). Gilsum, NH: Barcelona.
- Standley, J. M. (2000). Music research in medical treatment. In M. S. Adamek, P. A. Coddington, A. Darrow, A. Gervin, & K. Gfeller (Eds.), *Effectiveness of music therapy procedures: Documentation of research and clinical practice* (pp. 1–64). Silver Spring, MD: AMTA.
- Wheeler, B. L. (1983). A psychotherapeutic classification of music therapy practices: A continuum of procedures. *Music Therapy Perspectives*, 1(2), 8–12.
- Wheeler, B. L. (1999). Lisa: The experience of a child with multiple disabilities. In J. Hibbin (Ed.), *Music therapy: From a client's perspective* (pp. 237–246). Gilsum, NH: Barcelona.

### Web Sites

- American Music Therapy Association: <http://www.musictherapy.org>
- Certification Board for Music Therapists: <http://www.cbmt.org>
- World Federation for Music Therapy: <http://www.musictherapyworld.net>
- Voices: A World Forum for Music Therapy: <http://www.voices.no>
- Music Therapy World: <http://www.musictherapyworld.net>





---

## NORCROSS, JOHN C. (1957– )

---

John C. Norcross is a professor of psychology and distinguished university fellow at the University of Scranton and an internationally recognized authority on behavior change and psychotherapy. Norcross received his B.A. degree in psychology at Rutgers University (1980) *magna cum laude*, and his M.A. (1981) and Ph.D. (1984) degrees in clinical psychology from the University of Rhode Island. Norcross is a licensed psychologist in the Commonwealth of Pennsylvania and is board certified by the American Board of Professional Psychology in clinical psychology. He and his wife, Nancy, have two children, Jonathon and Rebecca.

Expertise in a field can result in a singular focus on a circumscribed topic in one or two publications. Norcross has opted for the opposite: a wide focus on several topics of critical import to counselors and psychotherapists. As an educator and trainer, Norcross is among those in the psychology profession who have published across the spectrum and in many very prestigious publications. His extensive contributions to psychological science, training, and practice are in areas such as psychotherapy integration, therapeutic relationships, evidence-based practices, psychotherapist self-care, and practice resources. Norcross has cowritten or edited 15 books, authored 50 book chapters and 250 journal articles, and delivered over 350 professional presentations and workshops in these areas of expertise in 24 countries. The impact of his contribution is found not only in the number of publications but also in their breadth and practicality. He has published in many different domains of psychology, including

teaching journals; clinical, school, and counseling journals; integration and eclectic journals; common factors and alliance research journals; and key publications based in social work, education, and psychiatry.

Recognition for his work has included the 1992 Krasner Early Career Award from the American Psychological Association (APA) Division of Psychotherapy, the 1992 Pennsylvania Professor of the Year from the Carnegie Foundation, the bestowing of fellow status from the American Psychological Association in 1996, the 2003 Rosalee G. Weiss Award from the American Psychological Foundation, the 2004 Distinguished Psychologist Award from the APA Division of Psychotherapy, and most recently the APA 2005 Distinguished Contributions to Education and Training Award.

In addition to the honors and awards, Norcross has served in prestigious leadership positions in the profession. He is council representative of the APA Division of Psychotherapy, member of the APA Policy and Planning Committee, and a member of the Board of Directors of the National Register of Health Services Providers in Psychology. He is past president of the International Society of Clinical Psychology and the APA Division of Psychotherapy and was a member of the APA Presidential Task Force on Evidence-Based Practices in Psychology.

### **Contributions to Education and Training**

Norcross's influence on clinical training traverses all levels of higher education, from the undergraduate level through professional development to continuing



education. At the undergraduate level, his coauthored *Insider's Guide to Graduate Studies in Clinical and Counseling Psychology* is revised every two years and more than 75,000 copies have been sold to potential graduate students. At the graduate level, the Prochaska and Norcross *Systems of Psychotherapy* is now in its sixth edition and its third decade of educating students. It was one of the earliest texts to advocate comparative analysis and an integrative, evidence-based perspective. His recent *Psychotherapy Relationships That Work*, similarly, introduces evidence-based training in customizing the therapeutic relationship to the individual client.

At the professional level, Norcross and his colleagues have promoted training through publications on self-help and self-change and on psychotherapy integration, and he has also produced numerous psychotherapy videotapes. Practical teaching tools for all three include the *Authoritative Guide to Self-Help Resources in Mental Health*, which describes the most effective self-help books, films, autobiographies, and Internet sites based on eight national studies involving over 3,500 clinical and counseling psychologists. With several colleagues, Norcross coordinated 12 videotapes on systems of psychotherapy (Series I) and 12 additional videotapes on psychotherapies for specific problems and populations.

### Contributions to Research and Theory

Early in his career, Norcross began writing on the common factors, psychotherapy integration, and treatment-relationship matching. His influence on theory development is evidenced through the aforementioned text, *Systems of Psychotherapy: A Translational Analysis*, which highlights the stages of change and change processes. He has advanced research on the theoretical concepts developed in his models. These studies focus on therapeutic commonalities, exploring paths toward integration, obstacles to psychotherapy integration, supervision of integrative psychotherapy, prescriptive matching, and delineation of empirically based principles in psychotherapy. His coedited text, *Handbook of Psychotherapy Integration*, continues to have an impact on how trainers, researchers, and practitioners think about the evolution of psychotherapy.

From 1999 through 2002, Norcross chaired the APA Division 29 Task Force on Empirically Supported Therapy Relationships. From the work of this task force came his edited text *Psychotherapy Relationships*

*That Work*, which he considers “the most exciting of my career and potentially the most significant.” The book represents the first time that the research evidence on clinical attempts to individualize the therapy relationship has been aggregated in a single source. Because of his expertise in elements of the therapeutic relationship, Norcross was appointed in 2005 to the APA Presidential Task Force on Evidence-Based Practices in Psychology. The document produced by the task force has set the course for defining the profession’s response to the juggernaut of evidence-based practice in mental health. Subsequently, in 2006, he coedited *Evidence-Based Practices in Mental Health: Debate and Dialogue on the Fundamental Questions*, a book that highlights critical points of convergence and remaining points of contention.

Norcross serves the profession through his editorial appointments to over 15 journals. He is the editor of the *Journal of Clinical Psychology: In Session* and currently serves on the editorial boards of the *American Journal of Psychotherapy*, *Professional Psychology*, *Psychotherapy*, *Clinical Psychology & Psychotherapy*, *Pragmatic Case Studies in Psychotherapy*, the *Oxford University Press Textbooks in Clinical Psychology*, and the *Journal of Clinical Psychology*. He has served as the editor of the Brunner/Mazel Integrative Psychotherapy book series and as associate editor of the *Journal of Psychotherapy Integration* for 10 years.

His ongoing research into graduate education and graduate admissions has advanced the field through publication of many articles on such subjects as evaluating clinical training, evaluation activity in training clinics, training integrative psychotherapists, and evaluation of internship training.

### Contributions to Practice

Norcross is roundly recognized by practitioners for his application of clinical experience and research evidence to the practice of psychology. He is viewed by clinicians as an educator and training professional whose writings bring a scientific framework to the practice of psychology. He has written eloquently and effectively for the practice audience in several areas. Some of these publications include texts such as *The Psychologists' Desk Reference*, *Casebook of Eclectic Psychotherapy*, *Handbook of Psychotherapy Integration*, and *The Authoritative Guide to Self-Help Resources*.

It is evident in his publications and his presentations that Norcross values both research and practice



and is among those who find commonalities rather than differences. He has delivered many workshops and presentations on the continuing convergence and contention between these domains and has written most effectively on the subject.

The development of the psychotherapist as a person is an important focus of both writing and training for Norcross. He has devoted two coedited books to this subject—*The Psychotherapist's Own Psychotherapy* and *Leaving it at the Office: Psychotherapist Self-Care*—as well as numerous articles and chapters that chronicle his observations and expertise in the area. In addition, Norcross has published many articles that identify the importance of professional development in terms of self and one's larger identity with the profession. His publications exemplify this concern: Consider, for example, his research on clinicians' theoretical orientations, national surveys of mental health professionals, dimensions of psychotherapeutic skills and techniques, self-change in psychological distress, values in psychotherapy, and conducting psychotherapy with psychotherapists.

In concert with his students, Norcross has conducted multiple national surveys that chronicle the evolution of the profession over the past 25 years. Further, he has conducted presentations and workshops in advancing the discussion of the future of psychology and psychotherapy. Among these contributions are Delphi polls on the future of psychotherapy every 10 years, roundtables on psychotherapy breakthroughs, and lifelong lessons on and studies of the great books of psychology.

*Linda F. Campbell*

**See also** Common Factors Model (v2); Counseling Theories and Therapies (v2); Evidence-Based Treatments (v2);

Integrative/Eclectic Therapy (v2); Psychological Well Being, Dimensions of (v2); Scientist–Practitioner Model of Training (v1); Working Alliance (v2)

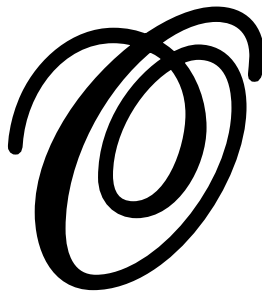
### Further Readings

- Geller, J. D., Norcross, J. C., & Orlinsky, D. E. (Eds.). (2005). *The psychotherapist's own psychotherapy: Patient and clinician perspectives*. New York: Oxford University Press.
- Koocher, G. P., Norcross, J. C., & Hill, S. S. (Eds.). (2005). *Psychologists' desk reference* (2nd ed.). New York: Oxford University Press.
- Norcross, J. C. (Ed.). (1987). *Casebook of eclectic psychotherapy*. New York: Brunner/Mazel.
- Norcross, J. C. (Ed.). (2002). *Psychotherapy relationships that work*. New York: Oxford University Press.
- Norcross, J. C., Beutler, L. E., & Levant, R. F. (Eds.). (2006). *Evidence-based practices in mental health: Debate and dialogue on the fundamental questions*. Washington, DC: American Psychological Association.
- Norcross, J. C., & Goldfried, M. R. (Eds.). (2005). *Handbook of psychotherapy integration* (2nd ed.). New York: Oxford University Press.
- Norcross, J. C., & Guy, J. D. (2007). *Leaving it at the office: Psychotherapist self-care*. New York: Guilford Press.
- Norcross, J. C., Santrock, J. W., Campbell, L. F., Smith, T. P., Sommer, R., & Zuckerman, E. L. (2003). *Authoritative guide to self-help resources in mental health* (2nd ed.). New York: Guilford Press.
- Norcross, J. C., Sayette, M. A., & Mayne, T. J. (2002). *Insider's guide to graduate programs in clinical and counseling psychology* [2002–2003 ed.]. New York: Guilford Press.
- Prochaska, J. O., & Norcross, J. C. (2007). *Systems of psychotherapy: A transtheoretical analysis* (6th ed.). Pacific Grove, CA: Brooks/Cole.









---

## OCCUPATIONAL STRESS

---

Occupational stress is a broad concept that has been defined in a variety of ways in the popular and professional literature. It is generally agreed that occupational stress consists of the harmful physical and psychological consequences to individuals that result when an imbalance exists between demands of the work environment and individual needs, abilities, and resources. Most people experience some level of occupational stress on occasion, and it is generally believed that such short-lived, episodic experiences do not pose serious or lasting harm to the individual. However, when a significant level of occupational stress persists for an extended period of time, potentially serious physical and psychological harm may occur. Although occupational stress is most often considered to be undesirable, the notion of *good stress*, also referred to as *eustress*, has been used to describe stress that motivates and energizes the worker to learn new skills and perform more effectively, without the debilitating impact typically associated with occupational stress. In the case of good stress, the result of having successfully mastered the challenge posed by the stressful condition is a sense of personal satisfaction and achievement.

Occupational stress in the American workplace is widespread and appears to be growing. When asked about primary sources of stress in their lives, a substantial number of people point to conditions in their work environments such as long hours, workload, poor communication, management problems, and lack of support, to name several examples. Recent surveys of workers suggest that as many as 80% of workers

experience stress in their work, and 40% of respondents find their work to be *very* or *extremely* stressful. Occupational stress poses a very real threat to the quality of life for employees within an organization as well as a serious threat to the productivity and profitability of the organization itself.

### Individual and Organizational Perspectives

Efforts to explore the origin of occupational stress have approached the question from the perspectives of both the individual and the workplace environment. Obviously, characteristics of the individual and the work environment interact to produce the various individual and organizational outcomes observed in studies of occupational stress.

#### *Individual Perspective*

When individuals experience stress, the brain mobilizes the body's systems for defensive action in what is commonly known as the fight-or-flight response. This response is characterized by an increase in various bodily hormones that stimulate an increase in several vital functions such as heart rate, respiration, blood pressure, and muscle tension. This fight-or-flight response plays a key role in humans' ability to protect themselves when in potentially dangerous situations, either by fleeing or fighting. However, if the stressful situation persists unresolved, the prolonged arousal of vital functions may eventually deplete the body's resources, contributing to injury or disease.



### Symptoms

According to the National Institute for Occupational Safety and Health (NIOSH), a federal agency responsible for research and policy on matters of work-related illness and injury, several symptoms have been identified as early warning signs of occupational stress. These symptoms may include headaches, difficulty concentrating, sleep disturbances, upset stomach, mood disturbances, job dissatisfaction, and disturbed relationships. These early warning signs are fairly easy to recognize. Of greater concern, however, is the fact that prolonged occupational stress can contribute, in concert with other factors, to more serious physical and mental health problems that are chronic in nature and potentially life threatening. NIOSH has identified three broad categories of health problems believed to be associated with prolonged stress that include cardiovascular disease (e.g., heart disease, high blood pressure), musculoskeletal disorders (e.g., tendonitis, lower back pain), and psychological disorders (e.g., anxiety, depression).

In addition to physical and psychological difficulties, it has also been shown that individuals experience stress as a result of competing work and family roles, that is, work–family conflict. With the increase in the number of women in the workforce, the growing number of dual-worker families, and the changing nature of men's and women's roles in American society, it is not surprising that a significant number of people report difficulties managing the often competing demands associated with their work and family roles. Many employees with families report feeling torn between expectations of them in the workplace and their responsibilities as spouses and parents. This conflict can further contribute to the level of stress experienced.

### Influencing Factors

It has been well established that individual characteristics have a significant impact on an individual's perception, experience, and management of stress. Two individuals employed in the same work setting may provide very different reports of their own occupational stress as a result of their unique perspectives, preferences, needs, values, abilities, and experience. Perspectives may be so divergent that one person experiences stress as a positive phenomenon, serving to arouse and motivate strong performance or signify the need for a change in work or lifestyle. Another person may experience stress as negative and

disruptive of performance. Often, both perspectives prove true; that is, stress may be viewed as positive and functional in the short term, but, over time, prolonged stress becomes deleterious to the individual as it weakens, erodes, and undermines psychological and physical health.

The nature and extent of occupational stress experienced, as well as one's response to it, appears to be influenced by several different personality characteristics. Not surprisingly, individuals who are highly idealistic, set unrealistic goals, overidentify with others, and have a high need for self-affirmation tend to demonstrate greater vulnerability to occupational stress. Individuals who have an *internal locus of control* (tend to attribute outcomes to their own efforts rather than to factors outside of their control such as luck or chance) tend to be somewhat less susceptible to occupational stress than those with an *external locus of control*. Self-efficacy, the belief that one has the ability to respond effectively to the demands of the work situation, appears to buffer against the negative impact of stress. Finally, an active coping style, or one in which the individual faces challenges directly and proactively, has been associated with lower levels of occupational stress as well as with more effective response strategies for managing existing stress.

### Intervention

When the focus of occupational stress is the individual, the emphasis of intervention is on helping the individual to manage the stress being experienced in a way that minimizes or eliminates the negative impact of stress on work performance and the individual's health. Many companies provide stress management assistance to their employees as a benefit of employment. This assistance might include psychoeducational programs designed to teach workers about occupational stress and its potential effects on life and health as well as strategies for reducing work-related stress. Such strategies might also include training in specific behavioral management techniques such as time management and relaxation, for example. Employee assistance programs (EAPs) are another form of help that is frequently provided on-site by employing organizations. EAPs are typically staffed by professionals with training in mental health service delivery and offer individual counseling for both work-related and personal problems. According to NIOSH, although interventions focused on stress



management are often relatively inexpensive and effective in reducing symptoms of occupational stress, the benefits are often short-lived. Furthermore, because the problem of occupational stress is so widespread, interventions that target employees more broadly have the potential for greater impact. Finally, interventions focusing on the individual often ignore or overlook the real sources of the problem that exist in the work environment. For these reasons, interventions that are targeted at the work environment are often preferable.

### ***Organizational Perspective***

Organizations are complex systems structured to accomplish specific tasks (e.g., manufacture a product, provide a service) and to provide control and accountability. Although modern theories regarding organizations tend to discourage rigid, hierarchical, bureaucratic designs, these characteristics are true of most current organizations, at least to some degree. Many of these features of organizations, as well as the environments within which they operate, are sources of stress for employees who work in them. The symptoms of occupational stress may be found in the behavior of employees or in patterns within the organization's structure.

### **Symptoms**

Many different symptoms point to stress in the work environment. High levels of job dissatisfaction and related concerns are almost certain to arise eventually in stressful environments. Chronic absenteeism and tardiness are often common in highly stressful work environments, too. An unusually high turnover rate among employees is another common symptom of occupational stress that can be quite costly to the organization in terms of the time and resources required to train new people. Negative social behaviors, such as aggression, may occur more frequently in highly stressful environments. The term *going postal*, coined after several incidents in which disgruntled postal employees shot and killed fellow workers, has come into popular use to refer to workplace anger and violence. Increasing frequencies of stress-related physical and psychological problems among employees contribute to substantial increases in health-care costs. Declines in productivity and the quality of workmanship are also common manifestations of a

highly stressful work environment. Left unresolved, these symptoms can have devastating effects on the organization and the people employed there.

### **Influencing Factors**

It is generally agreed that work environments have become increasingly more stressful over time. Downsizing (cutting positions or services to save costs), outsourcing (delegating jobs or services to external specialists to cut costs), and the growth of non-permanent employment contracts are examples of changes that have contributed substantially to making employees' work lives more stressful. Many workers believe their jobs are less secure than before and feel as though they have less control over their work lives. One of the most prominent theories of job stress hypothesizes that job demands interact with control to influence the amount of stress likely to be experienced. For example, high job demands are likely to be experienced as more stressful when employees have less control over their work than when they have more control.

Organizations are often described as complex human systems, composed of several important subsystems that are highly interdependent. These subsystems, although referred to by various names, exist within all organizations and compose the organization's structure. Three commonly identified subsystems include the operational (includes communication, roles, authority, power, norms, reward systems), purposive (includes goals, objectives, mission, core values), and methodological (includes technology, procedures, materials used) subsystems. Not surprisingly, different types and sizes of organizations operate most effectively with different types of structures. When given elements of an organization's structure are poorly designed or managed, the result can be considerable workplace stress. For example, expectations for employees with specialized skills to serve in multiple roles may result in excessively heavy workloads and long hours for those individuals. Likewise, excessive noise or overcrowding in the workplace may occur as a result of specific technology or procedures being used. Both of these examples illustrate how structural elements of the organization can produce stressful conditions for workers. If such conditions are permitted to persist over time, it is likely that symptoms of stress will eventually emerge both in the work environment (e.g., through reduced productivity) and in the physical and psychological health of employees.



Leadership style is a very important element of organizational structure that can greatly impact workplace stress. Leaders can influence the nature and quality of the work environment in several important ways. For example, leaders can either encourage or discourage open communication across individuals and groups within the organization. Rigid, bureaucratic leaders typically tend to discourage employees from communicating effectively with one another (horizontally) and with the leaders themselves (vertically). Poor communication may inhibit the quantity and quality of information that is available and considered in decision making within the organization. Potentially negative outcomes from poorly informed decisions may further contribute to workplace stress.

### Intervention

Given the magnitude and breadth of the problem of occupational stress, it is generally believed that interventions that focus on changing the structure of the organization (work environment) will produce more effective and more enduring outcomes than interventions focusing on individual employees. In light of the fact that so much of work-related stress can be attributed to problems in organizational structure, it makes good sense to design organizations in ways that facilitate strong work performance while minimizing the stress experienced by employees of the organization. In the past, it was largely assumed that stress was an inevitable companion to organizational productivity. However, considerable evidence has emerged to suggest that the opposite is true; that is, productivity and worker satisfaction will be higher in organizational environments that optimize the health and welfare of employees.

Remedial approaches that focus on treating individual casualties of the stress produced in work environments will always be necessary and appropriate. Thus, there will be a continuing place for procedures designed to foster more effective management of stress at the individual level. However, the most desirable approach is one that is preventive in nature. Such an approach will require creating and maintaining work environments that are highly sensitive and responsive to the needs of workers. In reality, the most successful efforts to addressing workplace stress will likely incorporate both individual and organizational interventions.

There are many different models for facilitating organizational change, but they tend to share several

common elements. For example, those to be affected by future change(s) ought to be included in all aspects of the change process. This kind of inclusion fosters ownership of the change, increases the likelihood that the change will meet the needs of those affected by it, and reduces the likelihood of resistance due to perceptions that change is being imposed. Collaboration among affected parties in identifying problems and designing and implementing changes will increase the likelihood that plans are based upon sound information and diverse perspectives. The feelings and preferences of individuals must be considered along with factual data. Finally, the worth and dignity of the individual is of paramount importance.

*Jody L. Newman and Dale R. Fuqua*

*See also* Job Satisfaction and General Well-Being (v4); Physical Health (v2); Psychological Well-Being, Dimensions of (v2); Stress (v2); Stress Management (v2); Stress-Related Disorders (v1); Work-Family Balance (v4); Work Stress (v4)

### Further Readings

- Addley, K. (1997). *Occupational stress: A practical approach*. Boston: Butterworth-Heinemann.
- Hancock, P. A., & Desmond, P. A. (2001). *Stress, workload, and fatigue*. Mahwah, NJ: Lawrence Erlbaum.
- Helpguide. (n.d.). *Job stress management*. Retrieved from [http://www.helpguide.org/mental/work\\_stress\\_management.htm](http://www.helpguide.org/mental/work_stress_management.htm)
- Jex, S. M. (1998). *Stress and job performance: Theory, research, and implications for managerial practice*. Thousand Oaks, CA: Sage.
- Levenstein, C., & Wooding, J. (1997). *Work, health, and environment: Old problems, new solutions*. New York: Guilford Press.
- National Institute for Occupational Safety and Health. (n.d.). *Stress at work*. DHHS (NIOSH) Publication No. 99-101. Retrieved from <http://www.cdc.gov/niosh/stresswk.html>
- Nelson, D. L., & Burke, R. J. (2002). *Gender, work stress, and health*. Washington, DC: American Psychological Association.
- O'Donnell, M. P., & Harris, J. S. (1994). *Health promotion in the workplace*. Albany, NY: Delmar.
- Quick, J. C., & Tetrick, L. E. (2003). *Handbook of occupational health psychology*. Washington, DC: American Psychological Association.
- Zalaquett, C. P., & Wood, R. J. (1997). *Evaluating stress: A book of resources*. Lanham, MD: Scarecrow Press.



---

## OPPOSITIONAL DEFIANT DISORDER

---

Oppositional defiant disorder (ODD) is a condition prevalent in a significant percentage of children that adversely impacts the individual and also affects the family, school, community, and society. Early awareness of and intervention in ODD is crucial in stopping a potentially dangerous and destructive progression to a more serious disorder. However, as oppositional behavior is a normal part of development for young children and early adolescents, clinicians need to exercise caution when assessing and diagnosing ODD in order to avoid misdiagnosis.

### Definition

The American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV)* defines ODD as a childhood disorder characterized by an ongoing and persistent pattern of hostile, noncompliant, and resistant behaviors manifested toward authority figures. In order to attain a diagnosis of ODD, behaviors must consistently occur for at least 6 months. Individuals with ODD are often described as stubborn, easily angered, argumentative, verbally aggressive, quickly annoyed by others, externally blameful for personal mistakes, deliberately annoying, and physically aggressive. In addition, such children easily lose their temper on a consistent basis and may demonstrate vindictive behavior. Often, children with ODD possess a low frustration tolerance and have difficulty controlling impulses. Last, individuals with ODD typically procrastinate and dawdle when expected to comply with a command. They commonly lack insight into their behavior and view their noncompliant behavior as an acceptable response to overdemanding situations.

ODD can cause significant difficulties in many areas of a child's life, including the family and school environment. Typically children with ODD have a difficult time getting along with family members (i.e., siblings, parents) and may find it hard to initiate or maintain peer relationships. Although children with ODD often have difficulty forming positive relationships with individuals of authority (i.e., teachers, coaches), defiant behaviors are sometimes solely present with individuals with whom the child has a close relationship.

### Prevalence and Onset of Symptoms

Although studies differ in reported statistics, an estimate of the prevalence rate for ODD ranges from 2% to 16%. In addition, the *DSM-IV* states that ODD tends to be more common in males prior to puberty, but prevalence rates even out between males and females following puberty. ODD is typically noticeable before the age of 8 and is not commonly evident soon after adolescence commences. Onset of symptoms is not sudden, and behaviors tend to slowly manifest over the course of several months or years. As younger children develop more sophisticated verbal capabilities, defiance may advance from simple refusals to more sophisticated oppositionality (i.e., negotiations).

### Associated Difficulties

Problems commonly associated with ODD include low self-esteem, substance use or abuse, and frequent mood fluctuations. In addition, ODD may be an early indicator of a more severe psychopathology but does not necessarily precede a more severe condition. In some cases, ODD may progress into conduct disorder (CD), a disorder characterized by socially inappropriate (i.e., law breaking) and destructive behaviors. Children with ODD were 4 times more likely to develop CD than were children without ODD, although the risk of development from ODD to CD in females is somewhat unclear. Longitudinal research conducted by Hinshaw, Lahey, and Hart has shown that half of children with ODD progress to CD, 25% maintain the ODD diagnosis, and 25% eventually discontinue showing clinically significant levels of externalizing behavior. Last, attention deficit hyperactivity disorder (AD/HD), learning disabilities, and mood disorders commonly coexist with ODD, and interventions targeting these conditions may reduce oppositional behavior.

### Assessment

In order to obtain a comprehensive assessment of ODD, a clinician should adopt a multifaceted approach in which a variety of domains are explored. In addition, the assessment should employ a number of ways to gather information from multiple individuals in the child's life.

Often when assessing for ODD, clinicians engage in a structured diagnostic or clinical interview with



both the child and the parent(s). A structured interview is a diagnostic assessment with pre-established questions that can be scored in an objective fashion. A clinical interview is important in order to assess the frequency of behaviors, level of impairment for the child and family, and antecedents (e.g., a request from a parent or teacher) and consequences (e.g., time-out) that surround the oppositional behavior. In addition, both structured and clinical interviews are helpful in determining the presence of other psychiatric conditions. Last, interviews with the child are helpful aids to parent interviews.

In addition to interviewing the child and other authority figures in the child's life, clinicians also administer self-report behavioral rating scales, such as the Child Behavior Checklist (CBCL), to the child, parents, and teachers. These assessments are useful in gathering a broad range of information as well as information about specific behaviors. Also, like the interview, some rating scales provide data that may be helpful to guide diagnostic decisions.

Last, in order to corroborate information gathered in both the interview and the self-report measures, behavioral observations are often conducted. McMahon and Wells point out that behavioral observation is crucial in the assessment process in that it allows a clinician to observe parent-child or teacher-child interaction patterns and to assess change in the communication patterns as treatment progresses.

## Treatment

### *Psychosocial Intervention*

Treatments for ODD are eclectic and may include individual therapy, family therapy, and behavioral modification plans. Although psychodynamic and humanistic approaches to treatment are available, treatment typically focuses on cognitive-behavioral approaches, as they have received the most empirical support. Behavioral parent training programs are based on social learning principles that suggest children learn noncompliance through a process of modeling and reinforcement for externalizing behaviors from individuals in their environment, particularly parents. Therefore, parents are taught to recognize and change their parenting behaviors in order to enhance their child's prosocial behaviors and decrease inappropriate behaviors.

Behavioral parent training programs also focus on relationship building and teaching effective discipline techniques. In the relationship component, parents are

taught skills to enhance communication patterns and to foster a stronger parent-child bond. During this component, parents are taught to follow the child's lead during a play situation, to recognize and praise positive behaviors, and to systematically ignore minor inappropriate behaviors (e.g., differential attention). The discipline portion of behavioral parent training focuses on teaching parents how to give effective commands, to consistently praise compliant behavior, and to effectively implement a time-out contingent upon noncompliant behavior. Behavioral parent training programs employ a variety of methods to teach behavior modification techniques, including didactic instruction, role-play, modeling, live coaching, and practicing in both the clinic and home environment.

### *Psychopharmacological Intervention*

Although some pharmacological interventions have shown promise in reducing oppositional defiant behavior, the literature continues to assert that psychosocial treatment is the gold standard in treating this disorder. Few randomized clinical trials have investigated the effects of medication on ODD in isolation. However, Newcorn, Spencer, Biederman, Milton, and Michelson examined the effect of psychopharmacological agents on ODD when the disorder is an adjunct to AD/HD and have found positive results. Although research suggests that certain psychopharmacological agents may be a well-tolerated and effective treatment for ODD, further investigation is warranted in this area.

## Clinical Considerations

### *Assessing Age-Appropriate Behavior*

One factor that needs to be considered in making a diagnosis of ODD is whether the frequency and intensity of behavior problems occur outside of the expected range for a child's mental age and developmental level. An individual with ODD tends to show a recurrent pattern of negativistic behavior as opposed to episodes of transient temper tantrums and disobedience that do not greatly impair daily functioning. It is developmentally appropriate for young children to occasionally act out and refuse to obey commands. For example, normally developing 2- or 3-year-old children typically begin to seek more autonomy from their parents, and with this independence come more occasions for parent-child disagreements. In addition,



beginning school can be a difficult endeavor for any young child and may set the stage for mild disagreements with peers. Typically, peer-related arguments and disagreements quickly diminish as children learn more positive ways to interact. For this reason, a clinician must separate behavior that is developmentally appropriate from that which occurs more frequently and with more severity.

### **Differential Diagnosis**

As externalizing behaviors exist on a spectrum, it is important to differentiate ODD from other behavior disorders such as conduct disorder. The chief factor separating ODD from CD is that children with ODD do not engage in behaviors that violate the basic rights of others or break age-appropriate societal norms. Children with ODD tend to manifest overt, nondestructive behaviors that are typically easy to detect. On the other hand, children with CD typically demonstrate more destructive, aggressive behaviors (overt and covert) that may endanger the safety of themselves or others. For example, an individual with CD may cause harm to animals, set fires, vandalize, or run away from home for long periods of time. It is worth noting that most individuals with CD meet diagnostic criteria for ODD, but a diagnosis of CD is made when both diagnoses can be given.

### **Case Example**

Daniel, age 5, was referred to the clinic due to his oppositional and verbally aggressive behaviors at home and at school. At home, Daniel often refused to listen to his parents and would lash out at his little sister. On more than one occasion, Daniel's parents felt unsafe around him during his meltdowns. Daniel's parents stated that they felt like they were constantly walking on eggshells at home, and even the smallest incident would set him off. They described Daniel as a "difficult" baby and said they felt like he had never progressed beyond 2 years of age. Daniel often would scream, "I hate you" to his parents when they asked him to do even the simplest task. In addition, Daniel constantly blamed his little sister for incidents that he was clearly responsible for.

At school, Daniel was constantly getting in trouble for his behavior. He frequently yelled at his teacher and rarely listened to instructions. On occasion, Daniel would run out of the classroom without permission and disrupt other children in the hallway. Daniel's teachers said that he was constantly teasing other children for

"no reason whatsoever" and often held grudges against other children. For his bad behavior, Daniel consistently received "red lights" from his teacher and missed recess at least 3 times a week. Daniel had seldom been physically aggressive with others and did not engage in more dangerous behaviors such as fire-setting, maliciously lying, or displaying developmentally inappropriate sexual behavior.

Daniel's parents stated that they had "tried everything," and nothing seemed to work with Daniel. They reported that he was constantly in time-out but that it did little to diminish his bad behavior. Also, they said that they took everything away from Daniel when he acted out until they had no privileges left to take away. Daniel's parents were concerned that his quick temper and lack of flexibility would lead to a larger problem in the future and negatively affect his relationships with them, his sister, and his peers.

In order to reduce Daniel's oppositional behavior and improve the quality of life at both home and school, the therapist recommended behavioral parent training and had Daniel's parents commit to six sessions. During treatment, Daniel's parents learned ways to effectively communicate with Daniel. For example, Daniel's parents learned the importance of social reinforcement and that praising Daniel for a specific behavior would increase the likelihood of that behavior occurring again. Also, Daniel's parents learned how to remove their attention for negative behaviors. Last, his parents learned effective ways to give instructions to Daniel and to administer appropriate consequences to Daniel's responses. After eight sessions, Daniel's oppositional behavior diminished at both home and school, and he not only began to receive fewer "red lights" but also began to bring home "green lights" for good behavior.

*Joshua J. Masse and Cheryl B. McNeil*

*See also* Attention Deficit/Hyperactivity Disorder (v1); Conduct Disorder (v1); *Diagnostic and Statistical Manual of Mental Disorders (DSM)* (v2); Externalizing Problems of Childhood (v1); Learning Disorders (v1); Parent-Adolescent Relations (v1); Parenting (v1); Psychopharmacology, Human Behavioral (v2)

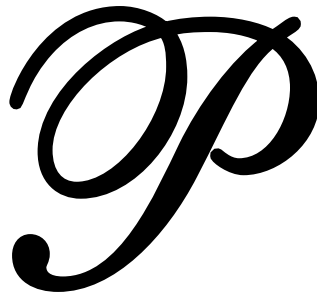
### **Further Readings**

Brestan, E. V., & Eyberg, S. M. (1998). Effective psychosocial treatments of conduct-disordered children and adolescents: 29 years, 82 studies, and 5,272 kids. *Journal of Clinical Child Psychology*, 27, 180-189.



- Burke, J. D., Loeber, R., & Birmaher, B. (2002). Oppositional defiant disorder and conduct disorder: A review of the past 10 years, part II. *Journal of the American Academy of Child & Adolescent Psychiatry*, 41, 1275–1293.
- Hembree-Kigin, T. L., & McNeil, C. B. (1995). *Parent-child interaction therapy*. New York: Plenum Press.
- McMahon, R. J., & Forehand, R. L. (2003). *Helping the noncompliant child: Family-based treatment for oppositional behavior* (2nd ed.). New York: Guilford Press.
- McNeil, C., Eyberg, S., Eisenstadt, T., Newcomb, K., & Funderburk, B. (1991). Parent-child interaction therapy with behavior problem children: Generalization of treatment effects to the school setting. *Journal of Clinical Child Psychology*, 20, 140–151.
- Spencer, T. J., Abikoff, H. B., Connor, D. F., Biederman, J., Pliszka, S. R., Boellner, S., et al. (2006). Efficacy and safety of mixed amphetamine salts extended release (Adderall XR) in the management of oppositional defiant disorder with or without comorbid attention-deficit/hyperactivity disorder in school-aged children and adolescents. *Clinical Therapeutics*, 28, 402–418.





---

## PARENT–ADOLESCENT RELATIONS

---

Parents and their children relate, or interact, on a number of different levels: as playmates, as teacher and student, as healer and patient, as disciplinarian and offender. Interactions between parents and their children that are characterized by warmth, consistency, reciprocity, supportiveness, and openness have consistently been shown to be related to a range of positive outcomes. For example, children who report having a positive relationship with their parents tend to have higher self-esteem, have more positive peer relationships, do better in school, and avoid behaviors such as substance use and delinquency. In fact, the relationship between a parent and his or her child may be one of the most crucial factors in the personality growth of the child, and the quality of that relationship may determine how susceptible the child is to deviations in normal development. Moreover, despite the popular notion that parents become increasingly irrelevant during adolescence, there is a growing body of evidence that suggests parents remain a constant, meaningful influence on their teen's attitudes and behaviors well through the adolescent years.

As children grow, the balance of the components of a successful parent–child relationship modifies to account for changing physical, socioemotional, and cognitive needs of both the child and the parent. Indeed, an interactional style successfully used by a parent and a 5-year-old may be perceived quite differently if used by a parent and a 15-year-old. Although the nature of the parent–child relationship changes with time and development, there are several static but key essentials to a healthy and protective relationship from

childhood through adolescence. Two of these critical components are attachment and communication.

### Attachment

#### *Historical Perspective*

Attachment, simply defined, is the inclination for one individual to seek closeness with another individual (e.g., parents, romantic partner), to feel safe when that person is present, and to feel anxious in his or her absence. From the time they are born, children begin to form an attachment with their caregivers. Early in development, children learn what to expect from their parents: “If I cry, I will be comforted (or I will not be comforted),” or “if I am hungry, I will be fed (or I will not be fed),” or “if I smile, I will be smiled at.” Based on their experiences and interactions, according to attachment theory, the child will create a “map” (i.e., a “working model of attachment”) of what to expect when interacting with the parent. This map will then help guide future interactions between parent and child.

John Bowlby and his colleagues believed that children could be classified into one of four categories of attachment based on the working models the child created regarding his or her interaction with the parent: (1) secure, (2) anxious-ambivalent, (3) anxious-avoidant, and (4) disorganized. Each of the four types of attachment were thought to reflect certain strategies the child would use either to draw a caregiver closer or to dismiss or devalue the importance of the caregiver. There is strong evidence that secure attachment with a parental figure in childhood leads to greater emotional regulation, less personal distress, higher levels of social support, and better overall psychological



adjustment in adolescence. Conversely, insecurely attached children (i.e., those classified as anxious-ambivalent, anxious-avoidant, or disorganized) tend to have greater difficulty regulating negative affect, have poorer peer relationships, and exhibit greater levels of psychopathology.

Whereas many perceive attachment to be a static phenomenon established in infancy and maintained throughout childhood, research suggests otherwise. Attachment is a dynamic, interactive aspect of parent–child relations that is constantly adjusting and shifting throughout the life course. Indeed, attachment is not simply the product of a child’s perceptions of his or her caregiver’s early behavior; parent behavior toward the child is, in part, influenced by the child’s own behavior. As such, attachment is a product of ongoing interaction; children update their working models of attachment—and subsequently their behavior toward their parents—based on the quality and nature of the interactions. Parents, in turn, adjust their behavior toward their children based on the quality and nature of the interaction with their children.

### ***Parent–Child Attachment in Adolescence***

Historically, parent–child attachment has been discussed in the context of infancy and toddlerhood; however, attachment is an equally important dimension of the parent–adolescent relationship. As is the case in childhood, secure attachment to parents during adolescence is related to fewer mental health problems, less involvement in risky behaviors, better relationships with peers and romantic partners, and better strategies for coping with difficulties. Nevertheless, how attachment works in adolescence is less straightforward than in infancy and childhood.

Adolescents face many critical developmental tasks, including seeking autonomy from parents while increasing reliance on peers. Common sense might suggest that such a developmental task is incompatible with maintaining a secure attachment with parents. Contrary to this view, adolescents who successfully navigate this task are often keenly attentive to the importance of an ongoing relationship with their parents and to how that relationship may provide a critical bridge between dependence and autonomy. So how do adolescents achieve secure attachments with parents while simultaneously seeking autonomy?

One way is by walking a fine line between achieving their own agenda of obtaining autonomy and

maintaining certain objectives within their relationships with their parents. Within this so-called goal-corrected partnership, secure adolescents seek autonomy yet are still attentive to the need to maintain a stable, trusting relationship with parents. When there is a disruption within the parent–adolescent relationship, such as high conflict or a breach of trust, the adolescent makes corrections in order to reestablish the relationship. The result, therefore, is limited negative interactions, greater support within the parent–adolescent relationship, and greater levels of trust. This family environment allows the adolescent more opportunities to seek and establish meaningful, positive peer relationships in two ways. First, secure attachment with parents serves as a model for other relationships; this often translates into having secure peer and romantic partner relationships. Second, adolescents who have the trust and support of their parents are afforded more opportunities to engage in appropriate peer relationships, social activities, and environments outside of the home that promote autonomy.

### **Parent–Child Communication**

Another key element underlying strong and protective parent–child relations throughout the course of childhood and adolescence is the extent to which parents and adolescents talk openly and honestly with one another. Both the quality and the content of parent–adolescent communication serves as the framework upon which values and expectations are shared, information seeking and monitoring are influenced, and explanations and deeper understanding of behavior are obtained. Related to the attachment process, this communication framework is built from the beginnings of life and transforms with time.

Being able to discuss one’s intentions, plans, and activities without being criticized or punished promotes greater understanding for both the parent and adolescent roles. The sharing of values and expectations decreases the possibility of conflict in the relationship by increasing mutual understanding and eliminating confusion around established rules and roles within the family. As a result, parents may be more comfortable and efficient in situations where they can grant moderated independence, while adolescents are more likely to abstain from behaviors perceived to drift away from the parents’ values and expectations.

Communication also provides protection in terms of collecting increased amounts of information about the



adolescent's current activities, peers, and locations. Parents use varied approaches for increasing their awareness of their children's activities, yet one of the most effective means of increasing parent awareness is by collecting information directly from the adolescent (self-disclosure). Warm relationships and open communication between parents and their children are integral to increasing the likelihood that adolescents will feel comfortable enough to self-disclose information about their plans and activities to their parents.

Finally, there is a natural tendency for parents and adolescents to investigate situations in which they perceive most others to engage. Parents may investigate monitoring or parenting behaviors that may seem off center with their current relationship with their adolescent. Likewise, adolescents may find themselves in situations of which their parents disapprove. In both instances, the establishment of open communication increases the opportunity for each to discuss their behaviors. Understanding why someone engages in an activity decreases perceptions that the behavior was done in malice toward the other or as a result of the lack of trust or sense of privacy. Likewise, while challenging the warm and open parent-adolescent relationship, these situations require parents and adolescents to build from their relationship to react and communicate with one another effectively. A breakdown in communication in reaction to a challenging situation could alter all of the remaining protective processes (e.g., monitoring) that depend on an open communication between parents and adolescents.

Additional prevention against adolescent risk involvement or problematic parent reactions has been found in parent and adolescent discussions of particular issues. Conversations about sensitive topics such as community drug use or teenage pregnancy have been shown to decrease adolescents' drug use or sexual involvement. While most effective if started in a natural conversation while engaging in a different activity rather than being premeditated, these conversations have been shown to increase parent and adolescent awareness of these issues, to directly align parent and adolescent values with regard to participation in these behaviors, and to identify successful ways to avoid these behaviors in the future.

### Critical Factors

The strength and quality of parent-child relations can provide powerful protection against a range of

negative outcomes for adolescents. Whereas peers become increasingly relevant over the course of adolescence, parents continue to have a significant amount of influence on the attitudes and behaviors of their children. The key to this relationship is for parents and adolescents to be aware of the necessity to build and maintain strong, secure attachments and to communicate thoughts, plans, and experiences on a consistent basis. Moreover, both the parent and the adolescent must be aware that the bidirectional nature of the parent-adolescent relationship requires consistent appraisal and alteration to allow for the changing developmental needs of both parties. Finally, parents and adolescents should be aware that maintaining secure attachments and positive communication between parents and children during the adolescent years is not incompatible with the goal of achieving autonomy from parents; rather these may be critical factors leading to the successful attainment of that goal.

*Steven A. Branstetter and Lesley Cottrell*

*See also* Attachment Theory (v4); Conduct Disorder (v1); Family Counseling (v1); Externalizing Problems of Childhood (v1); Internalizing Problems of Childhood (v1); Legal Issues in Parenting (v1); Parenting (v1); Parenting Stress Index (v1); Teenage Parents (v1); Work-Family Balance (v4)

### Further Readings

- Bowlby, J. (1969). *Attachment and loss. Vol. 1, Attachment*. Harmondsworth, UK: Penguin.
- Bowlby, J. (1988). *A secure base: Parent-child attachment and healthy human development*. New York: Basic Books.
- Bronfenbrenner, U. (1979). *The ecology of human development*. Cambridge, MA: Harvard University Press.
- Capaldi, D. M. (2003). Parental monitoring: A person-environment interaction perspective on this key parenting skill. In A. C. Crouter & A. Booth (Eds.), *Children's influence on family dynamics: The neglected side of family relationships* (pp. 171-179). Mahwah, NJ: Lawrence Erlbaum.
- Crittenden, P. M., & Claussen, A. H. (2000). *Maturation, culture, and context: The organization of attachment relationships*. New York: Cambridge University Press.
- Crouter A. C., Bumpus, M. F., Davis K. D., & McHale, S. M. (2005). How do parents learn about adolescents' experiences? Implications for parental knowledge and adolescent risky behavior. *Child Development*, 76(4), 869-882.



Ginott, H. G., Ginott, A., & Goodard, H. W. (2003). *Between parent and child: The bestselling classic that revolutionized parent-child communication*. New York: Three Rivers.

---

## PARENTING

---

The term *parenting* refers to the process of raising a child, usually from birth up until adulthood. A child's biological parents typically assume the parenting role and the majority of responsibility associated with raising a child. However, other individuals including stepparents, grandparents, foster parents, older siblings, adoptive parents, and other relatives may also be involved or even assume the primary role in parenting. The process of parenting involves providing education to children to teach them right from wrong and to foster their growth and maturation.

Parenting has been a topic of interest to researchers for decades. In particular, researchers who study child development have examined the relationship between parenting and child behavior. Many of these researchers have determined that it is more helpful to look at overall parenting styles than individual behaviors such as yelling as a form of discipline or playing games with their children. Parenting styles refer to a set of similar practices and strategies that parents use when attending to and disciplining their child. These styles incorporate two important components, responsiveness and demandingness. Parental responsiveness, also known as parental warmth, refers to how parents nurture and support their child's growth, individuality, and specific needs. Parental demandingness, which can also be referred to as behavioral control, describes the nature of the responsibilities that parents place on their child. For instance, some parents set high standards and expectations for their children, while other parents have few standards and expectations.

The manner in which parents help their child develop is predictive of child behavior and emotional functioning. In particular, the four parenting styles of authoritative, authoritarian, permissive, and uninvolved have been found to be related to specific outcomes in children. Therefore, numerous parent-training programs have been developed for diverse populations to target parenting styles. Research demonstrates that these programs are effective at improving parenting and reducing child behavior problems. As a result,

parent-training programs are becoming more widely available and are used for prevention as well as early intervention in and treatment of child mental health problems.

## Parenting Styles

Diana Baumrind conducted research on parenting styles by watching parents interact with their preschool-age children. Based on these observations, she identified three different parenting styles that describe and categorize parents based on both parental responsiveness and demandingness. She referred to these styles as authoritative, authoritarian, and permissive. Later Eleanor Maccoby and John Martin developed a fourth style, uninvolved or neglectful parenting. All of these styles are based on the assumption that parents' main responsibilities are to influence, teach, and manage their children. It is also important to note that all four styles are used to describe typical differences in all types of parenting and are not generally used to describe abusive parenting.

### *Authoritative Parents*

According to Baumrind's description, an authoritative or democratic parent is both responsive and demanding. Specifically, an authoritative parent is firm when necessary to enforce rules, but does so in the context of a warm and loving environment. These parents are able to recognize their child's individual needs, opinions, personality traits, and interests. Therefore, although authoritative parents monitor their children and have very clear rules and expectations, they are not overly intrusive or restrictive. They typically make reasonable demands on their child, given their child's age and developmental level. For instance, authoritative parents would encourage family discussions and value their child's point of view.

### *Authoritarian Parents*

Baumrind used the term *authoritarian* to describe parents who use a lot of behavioral control. However, this type of parent uses this control without the warmth characteristic of an authoritative parent. Authoritarian parents are similar to dictators in that they value and demand complete obedience in their children and believe that children should be kept in their place. This type of parent places many responsibilities on their



child and does not allow the child to make individual choices or decisions. Furthermore, an authoritarian parent may restrict discussions because of the belief that children should accept whatever their parents tell them.

### ***Permissive Parents***

According to Baumrind, a permissive, or indulgent parent, describes a parent who is warm but does not use behavioral control. Permissive parents are considered lenient because they do not place many responsibilities on their children and avoid exercising any form of power or control. Instead, permissive parents often try to reason with their children when the children misbehave. Children of permissive parents are essentially allowed to roam free and do whatever they desire. For instance, children of permissive parents may be able to eat whatever food they want and stay up as late as they want at night. These parents place few, if any, demands on their children and tend to avoid confrontations.

### ***Uninvolved Parents***

Maccoby and Martin added uninvolved parenting as a fourth style to describe individuals who are not particularly warm or demanding. Specifically, these parents place few expectations on their children and often do not respond to their child's needs. In general, these parents do not put much energy into child care beyond the effort required to provide for the child's basic needs (i.e., food, shelter). These parents often show little interest in and commitment to parenting. Sometimes this lack of interest and commitment results from issues such as parental depression, stress, and substance abuse that prevent the parent from assuming a more active role in parenting. Uninvolved parents can be indifferent to their responsibilities as parents and even rejecting or neglectful in extreme cases.

## **Parenting Styles and Child Behavior**

Parenting styles are important, because studies demonstrate strong relationships between parenting styles and child outcomes. Specifically, Baumrind and other researchers have found that these different parenting styles can be used to predict both child and adolescent behavior and adjustment. Therefore, researchers have learned which styles are associated

with positive outcomes and have even developed interventions to change parenting styles.

### ***Children of Authoritative Parents***

Research demonstrates desirable outcomes in children and adolescents of authoritative parents. They seem to be assured by both their parents' love and their parents' discipline. Typically, these children are well adjusted socially. They often have high self-esteem and perform well academically. Additionally, as a whole, they tend to have well-developed morals and few disruptive behavior problems.

### ***Children of Authoritarian Parents***

Research shows that children and adolescents of authoritarian parents often exhibit many behavior problems. Additionally, children of authoritarian parents tend to have poorer social skills, lower self-esteem, and higher rates of depression than other children. However, these children tend to display satisfactory academic performance.

### ***Children of Permissive Parents***

Studies suggest that children and adolescents of permissive parents often have more behavior problems and lower academic achievement than other children. However, these children tend to have better social skills, a higher self-esteem, and fewer depressive symptoms than other children. Overall, these children tend to be immature, disobedient, rebellious, and overly dependent on adults.

### ***Children of Uninvolved Parents***

Research shows that children and adolescents of uninvolved parents are at an increased risk for many negative outcomes. For instance, these children often have psychological and behavioral problems such as delinquent behavior, a low frustration tolerance, and poor emotional regulation. Additionally, they tend to have problems functioning socially and academically.

## **Parent Training**

Given the importance of parenting for child behavior, many treatment programs have been developed with the goals of improving parenting and reducing child



behavior problems. In particular, parent training programs have been developed to address the two main components of parenting styles, parental responsiveness and parental demandingness. Specifically, parents learn how to enhance their relationship with their child while increasing their expectations and standards. There are many different approaches and formats used in parent training; therefore, this entry only includes a general overview of parent training as well as brief descriptions of several programs.

### **Definition**

Parent training, a behavioral intervention, teaches parents skills and techniques they can use to modify their child's behavior. Historically, parent training has been primarily used in the treatment of child externalizing disorders such as oppositional defiant disorder (ODD), conduct disorder (CD), and attention deficit/hyperactivity disorder (AD/HD). However, parent-training programs also have been modified to help treat other childhood disorders, including anxiety, depression, and autism.

### **History**

Parent-training programs have changed over time. Early programs emphasized specific behavioral skills such as how to positively reinforce their children and use time-out. Gerald Patterson was one of the first persons to develop a complete program for families of antisocial children. Patterson's program was based on his theory that child disruptive behavior relates to the child's interactions with other members of the family. Specifically, Patterson's coercion hypothesis suggests that children who use disruptive behavior to get their way with adults will continue to escalate their disruptive behavior as long as the parent gives in to the child. Patterson's hypothesis also states that parents who try unsuccessfully to manage their child's disruptive behavior will develop more coercive parenting techniques such as nagging and temper outbursts. Therefore, Patterson developed a program to teach parents to give commands, use positive reinforcement for compliance, and enforce consequences by using a time-out. Later Constance Hanf developed a two-stage model that placed a greater emphasis on enhancing the parent-child relationship. The first phase of Hanf's program focused on parental responsiveness by teaching parents to play with their children, provide positive

attention for desirable behaviors, and ignore negative behaviors. The second phase of Hanf's model focused on parental demandingness. In this phase, parents learned how to give effective instructions and use time-out for noncompliance. Hanf's two-stage model has been adapted by many researchers for use with different populations.

## **Applications of Parent Training**

There are many different applications of parent training. These applications use different formats (e.g., group or individual sessions) and approaches to parent training (e.g., videotape modeling, coaching). In addition, these applications vary in the childhood problems they target and the appropriate child age range for treatment. The following is a brief description of several well-known and research-supported parenting-training programs.

### ***Forehand and McMahon***

Rex Forehand and Robert McMahon developed one of the first applications of parent training, a program called *Helping the Noncompliant Child*, based on Hanf's two-stage model. This treatment targeted parents of children ages 3 to 7 with disruptive behavior problems. This treatment typically was implemented individually and could be completed in about 10 weekly sessions. In the first phase of this program, parents were coached to use skills to strengthen the parent-child relationship, including providing specific praise for behaviors that they wanted their child to exhibit and ignoring or using selective attention for behaviors that they wanted their child to stop exhibiting. In the second phase, parents learned how to give direct commands and use time-out for noncompliance.

### ***Parent-Child Interaction Therapy***

Parent-child interaction therapy (PCIT), a parent training program also based on the Hanf two-stage model, was developed by Sheila Eyberg. PCIT was used originally to treat children ages 2 to 7 with disruptive behavior problems, but it has now been extended to other populations, including parents who are physically abusive, children with separation anxiety, and children with developmental delays. PCIT contains two phases: child-directed interaction (CDI) and parent-directed interaction (PDI). In CDI, parents learn skills to



increase their warmth and responsiveness through playing with their child. In PDI, parents learn to manage defiant and disruptive behaviors through giving effective instructions and using time-out for noncompliance. Both phases are taught by a therapist who coaches the parents while they play with their child using a bug-in-the-ear microphone device. PCIT is assessment-driven in that parent progression from CDI to PDI as well as termination from the program are based on child and parent mastery of skills as determined by weekly coding of parent-child interactions.

### ***Incredible Years Parent Program***

The incredible years parent program, developed by Carolyn Webster-Stratton, is another program designed for parents of young children with disruptive behavior problems. This program, also based on Hanf's model, is appropriate for parents of children ages 2 to 8 with either ODD or CD. The program uses a group format to teach parents behavioral skills through observing and discussing videotapes that depict parent-child interactions.

### ***Barkley***

Russell Barkley developed another program, similar to others based on the Hanf model, specifically to address the needs of parents of children with AD/HD. Barkley's program, typically completed in 9 to 12 sessions, is flexible, because it can be used in a group or individual format. In addition to learning behavior management skills, parents in this program are educated about AD/HD. This program can be used in combination with other treatments such as medication and social skills training.

### ***Triple P Program***

The triple P or positive parenting program was developed by Matt Sanders for parents of newborns to children 12 years old. This program differs from the other programs described above, because it is a prevention program. Therefore, parents learn behavioral management skills designed to prevent the onset of childhood emotional, behavioral, and developmental problems. The triple P program has different levels based on the focus of treatment. For example, the program is different when it is used with parents of infants than when it is used with parents of

preadolescents. Also, the program varies depending on whether it targets parents in the general population or specific parents with children at risk for behavioral problems.

### ***Common Sense Parenting***

Common sense parenting is another parenting program used with a wide range of children, specifically ages 2 to 16. This program was developed to emphasize effective behavioral management techniques used by Girls and Boys Town, a nonprofit organization that specializes in treating children who have been abused or neglected. Components of a typical session of this program include review, instruction, modeling, practice and feedback, and summary.

### ***Functional Family Therapy***

Functional family therapy (FFT), a family-based prevention and intervention program developed by James Alexander and Bruce Parsons, was designed to target the needs of older children, specifically youth ages 10 through 18. FFT emphasizes parent and adolescent communication in parents of youth with a variety of problems, including substance abuse and CD. Also, this approach can be used to treat youth who are at risk for these and other behavioral problems.

### ***Systematic Training for Effective Parenting***

Systematic training for effective parenting (STEP), a nine-session skills-based parenting program developed by Don Dinkmeyer and Gary McKay, is based on the work of Alfred Adler and Rudolf Dreikurs. Some of the specific skills taught to parents in STEP include learning to understand the behavior and misbehavior of children, provide encouragement, improve parent-child communication, hold family meetings, apply natural and logical consequences to child misbehavior, and improve parental confidence.

*Stephanie M. Wagner, Kimberly P. Foley,  
and Cheryl B. McNeil*

*See also* Attachment Theory (v4); Externalizing Problems of Childhood (v1); Family Counseling (v1); Internalizing Problems of Childhood (v1); Legal Issues in Parenting (v1); Parent-Adolescent Relations (v1); Parenting Stress Index (v1); Teenage Parents (v1); Work-Family Balance (v4)



### Further Readings

- Baumrind, D. (1967). Child care practices anteceding three patterns of preschool behavior. *Genetic Psychology Monographs*, 75, 43–88.
- Briesmeister, J. M., & Schaefer, C. E. (Eds.). (1998). *Handbook of parent training: Parents as co-therapists for children's behavior problems* (2nd ed.). New York: Wiley.
- Maccoby, E. E., & Martin, J. A. (1983). Socialization in the context of the family: Parent-child interaction. In P. H. Mussen (Series Ed.) & E. M. Hetherington (Vol. Ed.), *Handbook of child psychology: Vol. 4. Socialization, personality, and social development* (pp. 1–101). New York: Wiley.
- Patterson, G. R. (1982). *Coercive family process*. Eugene, OR: Castalia.

---

## PARENTING STRESS INDEX

---

The Parenting Stress Index, 3rd Ed. (PSI) is a norm-referenced test developed by Richard R. Abidin. The PSI assesses for dysfunction in the parent–child relationship and is based on a theory that the level of stress in the parent–child dyad is the result of child, parent, and situational characteristics. The PSI attempts to identify parental levels of stress, dysfunctional parenting dynamics, and childhood behavior problems. The measure assumes a direct interaction between parental stress and behavior problems in children. The PSI can be a useful assessment for therapists working with parents and families, abusive or at-risk families, children with adjustment or behavior disorders, and clients in forensics settings.

### Description of the Instrument

The PSI is a 120-item self-report questionnaire that assesses child and parent behaviors on a number of domains. It typically takes a respondent 20 to 30 minutes to complete the questionnaire. The PSI is normed for parents of children between 1 month and 12 years of age. One unique feature of the PSI is that it starts out as a behavior checklist on which a caregiver rates a child, but in the middle of the questionnaire, it becomes a self-report checklist where the parent rates him- or herself. Consequently the PSI has subscales that compose a child domain and a parent domain.

### Child Domain

The child domain assesses for characteristics displayed by children that make them difficult to parent. Subscales that compose the child domain include the following:

*Distractibility/hyperactivity scale (DI)*—This scale assesses behaviors that are consistent with attention deficit/hyperactivity disorder (AD/HD). It is possible for a parent to rate a child highly on this scale but the child does not qualify for a diagnosis of AD/HD. In those cases, explanations for the parent's high ranking may include the parent lacking the necessary energy to deal with a normal child, the parent being older and having difficulty adjusting to life with a child, or the parent having unrealistic expectations for the child's behavior.

*Adaptability (AD)*—This scale assesses a child's ability to adapt to changes in his or her physical or social environment. High scores on this domain are associated with the need for routine and distress with change often seen in children with autistic spectrum disorders. Children with high scores also tend to overreact to changes in sensory stimulation, avoid interacting with others, have difficulty being calmed when upset, and have difficulty forming meaningful relationships.

*Reinforces parent (RE)*—This scale assesses how reinforcing it is for a parent to be with this child. High scores suggest that the parent–child interaction fails to produce positive feelings. Possible explanations for this situation include that a child is impaired in his or her response capacity, the child is depressed, the parent is depressed and projecting negative appraisals onto the child, or the parent is misinterpreting or unable to understand the child.

*Demandingness (DE)*—The demandingness scale assesses a parent's perception that the child is placing unrealistic demands upon him or her. High scores are associated with ratings that describe a child as being unreasonable, impatient, and needy. The stress associated with perceptions of demandingness can be magnified if the parent is overly committed to being a model parent. High scores on demandingness can also be associated with separation anxiety in young children and oppositional and defiant behaviors in older children.



*Mood (MO)*—The mood scale assesses symptoms associated with depression. High scores are associated with children who cry frequently, are unhappy, and appear depressed. Children who score high on demandingness tend to also score high on the mood scale. With extremely high scores, one also needs to consider lack of parental attachment, parents being psychologically unavailable, and parental substance abuse.

*Acceptability (AC)*—The acceptability scale assesses parental expectations for the child's physical, intellectual, or emotional adjustment. High scores basically suggest that this child is not the child that the parents had hoped for with regard to these dimensions.

### **Parent Domain**

The parent domain assesses sources of stress and potential dysfunction in the parent. High scores are usually associated with parents who feel overwhelmed and inadequate in the task of parenting their child. It is not uncommon for young parents or parents with limited experience working with children to have elevated scores, although they seldom score above the 90th percentile.

*Competence (CO)*—Competence is associated with a parent feeling lack of acceptance and criticism from others for the way he or she parents the child. Parents of children with severe physical or mental disabilities often score high on this scale, but so do parents with limited prior parenting experience, parents who lack knowledge of normal child development, and parents who have discovered that having children is not as reinforcing as they thought it would be.

*Isolation (IS)*—This scale is associated with parents who feel socially or emotionally isolated from their support systems. When this score is high, there are often relationship problems between the child's primary caregivers. In addition, high scores are also associated with increased risk for child abuse and neglect.

*Attachment (AT)*—This scale assesses the degree to which a parent feels a sense of emotional closeness with the child. High scores are usually associated with cold parent-child interactions. The parent may also be impaired in his or her ability to perceive and understand a child's feelings and needs accurately. Low

levels of parental monitoring and vigilance are also often associated with high scores.

*Health (HE)*—The health scale assesses a parent's perception that his or her physical health is deteriorating. Parents with chronic medical disorders often score higher on this scale.

*Role restriction (RO)*—This scale assesses the degree to which a parent feels his or her freedom has been restricted by the child. Parents who score high have frequently been frustrated in their attempts to maintain their own identity since the child entered their lives. These parents often report feeling overly controlled or dominated by their child's demands.

*Depression (DP)*—The depression scale assesses for symptoms of depression in the parent. Parents who score high on this scale often report finding it difficult to mobilize the energy necessary to fulfill their parenting roles.

*Spouse (SP)*—This scale assesses how much emotional and active support the parent feels that he or she receives from the child's other caregivers. Individuals with high scores report feeling unsupported in their parenting roles. While a high score may reflect stereotypical sex roles, it usually reflects dysfunction in the caregiver's relationships.

The PSI also provides a total stress score, which is essentially an average of the stress ratings on the child and parent domains. There is also a life stress scale that is composed of 18 true-false questions related to the presence of significant life stressors in the past year. Finally the PSI has a defensiveness scale to detect parents likely to be minimizing their concerns.

### **Standardization**

The PSI was standardized on over 2,600 mothers with children between the ages of 1 month and 12 years. Only 200 fathers with children between the ages of 6 months and 6 years were included in the standardization sample. For this reason, when interpreting PSI data obtained from fathers, particular caution is recommended. The normative sample was not random or stratified and represents primarily a sample of convenience; most participants came from central Virginia. The ethnic composition of the sample was



approximately 76% Caucasian, 11% African American, 10% Hispanic, and 2% Asian. Most participants were married (76%), and 60% had some education after graduating from high school.

### Psychometrics

The reported internal consistency reliabilities for the PSI appear to be adequate. The coefficient alpha for the child domain was .90, with subscales ranging from .70 to .83. The coefficient alpha for the parent domain was .93, with subscales ranging from .70 to .84. For the entire scale, the coefficient alpha was .95. The test-retest reliability for the entire scale is reported to range from .65 for a one year interval to .96 for a 1- to 3-month interval.

With regard to content-related validity, most of the stimulus items on the PSI were included because empirical research found the attribute to be related to parental stress. Items have also been modified based upon feedback from mental health professionals. Evidence for criterion-related validity suggests that the PSI correlates in the expected directions with various related measures. For example, the PSI child domain score correlated .56 with the Achenbach Child Behavior Checklist. The proposed factor structure of the PSI was not strongly supported by the factor analytic studies reported in the manual. Over half of the child domain items and almost half of the parent domain items had factor loadings below .30 for their respective subscales. For this reason, more emphasis should be placed on evaluating the total stress scores than the individual subscale scores.

### Additional Products

The PSI has a computer scoring and interpretation program that gives the examiner unlimited uses. The interpretation provides a variety of plausible treatment recommendations for a family based upon the ratings. An additional feature that the computer interpretation provides is a comparison of a particular profile to the average profiles of individuals in various clinical groups. For example, a clinician can compare a parent's ratings with the ratings of parents who have a child with autism, of parents who have physically abused their child, or of teenage parents living in the inner city. There are approximately 30 clinical groups to which a client's profile can be compared.

There is also available a 36-item PSI Short Form. This abbreviated PSI measure gives different

subscales but assesses both parent and child domains. Finally there is another measure that is an upward extension for older children and adolescents ages 11 to 19 called the Stress Index for Parents of Adolescents (SIPA). While the subscales are not identical to those found in the PSI, the SIPA also assesses child and parent domains.

*Brian D. Johnson and Yan Li*

*See also* Attachment Theory (v4); Child Maltreatment (v1); Conduct Disorder (v1); Ethics in Computer Aided Counseling (v1); Externalizing Problems of Childhood (v1); Family Counseling (v1); Internalizing Problems of Childhood (v1); Legal Issues in Parenting (v1); Parenting (v1); Stress (v2); Stress Management (v2)

### Further Readings

Abidin, R. R. (1995). *Parenting stress index, Third edition: Professional manual*. Odessa, FL: Psychological Assessment Resources.

---

## PHRENOLOGY

---

Phrenology, an outmoded scientific discipline, predicted individual traits and characteristics in humans by analyzing the shape of the skull. Franz Joseph Gall, a Viennese physician practicing in the late 18th century, held that the brain shaped the skull, and the resulting bumps and ridges could be used to predict human behaviors, aptitudes, and tendencies. Gall originally hypothesized 27 phrenological "organs." For example, the region above the right eye was used to predict perceptive intellect, and therefore someone with a large protuberance in this area was thought to demonstrate keener insight than those who either lacked a bump or possessed a lesser one.

If Gall was the father of phrenology, J. G. Spurzheim was its first son. Together, their research, publications, and lectures expanded phrenology in Europe. In Great Britain, George Combe became an important advocate and wrote prolifically on the topic. Phrenology left the relative obscurity of the medical literature, and mainstream phrenological societies were formed across Europe. The movement made its way to the United States upon the establishment of the Philadelphia Phrenological Society in 1822.



This success and growth was to be short lived, however. By the mid 1800s, phrenology was losing ground and being dismissed as mere divination.

However, phrenology made lasting contributions to science and set the stage for linking psychology and neurology to create a study of the different functions and utilities of the brain. Additionally, psychology and medicine were moved toward a monistic theory of mind and body. In other words, the mind and body came to be viewed as one entity in opposition to the prevailing dualistic theory that the mind and body were inherently separate.

To the modern student, the basis of phrenological theory might appear archaic. Although phrenology is now abandoned as a scientific method, some of its presuppositions remain paramount. For example, the idea that different parts of the brain account for varying functions of behavior and character remains routine in present neurology and psychology.

The localized psychological and cognitive processes of the brain are still only partially defined. The current neurological mechanisms used to understand this potential localization remain less than accurate. In its time, phrenology endured an upsurge of criticism primarily as a consequence of its theoretical exploration into brain functions. Phrenology postulated numerous ideas about the impact of these still-theoretical, exclusive areas of the brain and in many ways remains the theoretical mother to the scientific study of the mind.

*Michael J. Huxford*

*See also* Counseling, History of (v1); Counseling Psychology, History of (v1)

### Further Readings

- Kemp, M. (2001). Localized lumps. *Nature*, 410(6825), 148.
- Kragh, H. (2002). Problems and challenges in the historical study of the neurosciences. *Journal of the History of the Neurosciences*, 11(1), 55.
- Van Wyhe, J. (2002). The authority of human nature: The schadellehre of Franz Joseph Gall. *British Journal for the History of Science*, 35(124), 17.
- Van Wyhe, J. (2004). *Phrenology and the origins of Victorian scientific naturalism*. Burlington, VT: Ashgate.
- Van Wyhe, J. (2004). Was phrenology a reform science? Towards a new generalization for phrenology. *History of Science*, 42(3), 313.

## PLAY THERAPY

Play therapy can be defined as a cluster of theory-driven treatment modalities used to establish an interpersonal process wherein trained play therapists help clients prevent or resolve psychosocial difficulties, facilitate optimal development, and reestablish the ability to engage in adaptive play behavior. For more than half a century, it has been the most prevalent child mental health therapy in the United States. While play therapy is traditionally implemented with children ages 3 to 12, many play therapy techniques (e.g., tray construction with miniature objects) are also used as therapeutic interventions with teenagers and adults. There is no single play therapy approach; instead, there are several prominent theoretical schools of thought and numerous play therapy techniques. Though play therapy is most often used as an individual therapy, it is also implemented via group play therapy and family play therapy. Often, professional therapists conduct the play therapy, but parents and other care providers can also be taught to perform play therapy. The following play therapy overview includes discussion of the definition of play, the therapeutic use of play, play therapy history, play therapy outcomes, and play therapists' qualifications.

### Definition of Play

Although there are multiple definitions of play, it is generally considered to be an activity that is intrinsically motivated, freely chosen, nonliteral, actively engaged in, and pleasurable. In contrast, children with psychological disturbances often exhibit play that is compulsive, impulsive, irrational, and devoid of pleasure. Play has been called the singular central activity of childhood. It occurs in virtually all cultures and circumstances.

Given the prevalence of children's play, it is often seen as integral in human development. Jean Piaget described play as "a process that allows children to mentally digest experiences and situations." Play is fundamental in children's development of expressive language, communication skills, emotional development, social skills, decision-making skills, and cognitive development. The functions of play have been classified into four categories: biological (learn basic skills, relax and release excess energy, kinesthetic stimulation and exercise), intrapersonal (mastery of



situations, mastery of conflicts), interpersonal (develop social skills, separation-individuation), and sociocultural (imitate desired roles).

### Therapeutic Use of Play

Play has been described as a form of self-therapy for children. Through play, children have the opportunity to work through conflicts, relieve anxieties, and make sense of their worlds. Consequently, play functions well as a facilitative force in children's therapy. A goal of play therapy is to help disturbed children work through their issues, so they can experience pleasurable play again.

Researchers have identified specific qualities of play behavior that facilitate the therapeutic process (i.e., communication, relationship enhancement, creative thinking, overcoming resistance, catharsis, abreaction, role-play, fantasy/visualization, metaphoric teaching, attachment formation, positive emotion, mastering developmental fears, game play) and the accompanying beneficial outcomes (working alliance, understanding, self-esteem, innovative solutions to problems, emotional release, adjustment to trauma, practice/acquiring new behaviors, empathy, fantasy comprehension, insight, attachment, self-actualization, self-esteem, growth and development, socialization).

### Play Therapy History

Documentation of psychotherapy with children reaches to the early 1900s. Early records describe Sigmund Freud's work with Little Hans's father in the attempt to alleviate Hans's phobic reaction. Play was first directly applied to children's therapy in 1919 through Hermine Hug-Hellmuth's utilization of play for child assessment and treatment and analysis. Anna Freud began using play in 1928 as a way of building therapeutic alliances and enticing children into the process of analysis, and in 1932 Melanie Klein proposed using play as a substitute for children's verbalizations. These early forms of psychoanalytic play therapy were focused on the attainment of insight through interpretation of the child's play.

A variety of play therapy theories and techniques were developed and refined between the 1930s and 1950s, including psychoanalytic and goal-oriented *structured therapy* in the late 1930s; David Levy's 1938 *release therapy* for trauma treatment; Joseph

Solomon's 1938 *active play therapy* for impulsive acting-out children; Gove Hambridge's 1955 directed abreaction reenactment procedures; and the relationship therapies of Jessie Taft (1933), Frederick Allen (1942), and Clark Moustakas (1959). Carl Rogers's client-centered approach, developed in the 1940s, was modified into child-centered play therapy by Virginia Axline in 1947. This nondirective form of play therapy has come to be referred to as *traditional play therapy*.

In the late 1960s, Ann Jernberg developed an approach focused on recreating and fostering healthy parent-child attachments called *theraplay*. Bernard Guerney's 1964 *filial therapy* was designed to involve parents in the play therapy process. Constance Hanf developed a two-stage model in the early 1970s that became more well known in the 1990s as parent-child interaction therapy (PCIT). Viola Brody's 1978 *developmental play therapy* emphasizes the use of physical contact and semistructured sessions. Kevin O'Connor developed an approach that integrates a cognitive developmental framework and an ecosystemic perspective into *ecosystemic play therapy*.

The significant contributors throughout the history of play therapy have produced an abundance of approaches, including psychoanalytic, client-centered/humanistic/nondirective/traditional, behavioral, cognitive-behavioral, family, developmental, Adlerian, gestalt, reality, time-limited, theraplay, fair play, ecosystemic, and dynamic.

### Outcomes

It is important to demonstrate the effectiveness of play therapy to justify practice, provide court testimony, and receive third-party insurance payments. The widespread use of play therapy dictates that its effectiveness ought to be clearly established. However, there is ongoing controversy among researchers regarding how well play therapy works. Play therapy critics have asserted that there is not an adequate research base to demonstrate the efficacy of play therapy, largely due to small sample sizes, case studies, and anecdotal reports. In particular, critics cite too few well-defined and well-executed empirical studies evaluating the efficacy of play therapy.

Part of the efficacy controversy seems to stem from epistemological differences between positivist, empirical traditions and naturalistic, qualitative paradigms. Empirically based clinical studies have a well-established reputation in the field as hard research, but



qualitative traditions are still suspect by some researchers' values.

Others state that case studies can lend credibility to the effectiveness of play therapy. Sue Bratton and Dee Ray reviewed over 100 case studies that document effective results with play therapy treating children with a wide variety of therapeutic concerns. They also reviewed 82 experimental studies of play therapy and concluded that play therapy demonstrated effective results in treating self-concept, behavioral change, cognitive ability, social skills, and anxiety.

A meta-analysis of 94 play therapy efficacy studies by Ray and her colleagues found that play therapy is a helpful intervention in child psychotherapy. The authors summarized that play therapy worked in a variety of settings across modalities, age, and gender with clinical and nonclinical populations, and across various theoretical schools of thought. Not only did this research report the positive effect of play therapy, the overall effect size was in the large effect range.

This meta-analysis confirmed two findings previously reported by Michael LeBlanc and Martin Ritchie: Parental involvement significantly improves the effectiveness of play therapy, and the effectiveness of play therapy increases for up to 35 to 45 sessions. (At 45 sessions, effectiveness levels started to decline.) A 2005 meta-analysis of 93 controlled play therapy outcome studies also supported LeBlanc and Ritchie's research that maximum effect size was reached between 35 and 40 sessions and that involving the parents and using humanistic treatments resulted in more positive effects. Through a meta-analysis of 42 play therapy outcome studies, LeBlanc and Ritchie found maximum effect sizes between 30 and 35 sessions. While most research indicates greater gains from a larger number of sessions, significant positive results have been reported for as few as 12 to 15 child-centered play therapy sessions.

Finally, Ray and her colleagues concluded that through the use of further experimental studies with specific measures and clear definitions, play therapy research has adequately addressed the critics' concerns regarding the efficacy of play therapy, small sample sizes, case studies, and anecdotal reports. They recommended that play therapy researchers (a) produce more research on the immediate and long-term effects of play therapy, (b) compare play therapy to other child psychotherapies, (c) explore the optimal number of sessions, (d) examine the most appropriate issues

addressed by play therapy, (e) determine the most accurate outcome measures, and (f) utilize specific play therapy protocols so replication is more easily achieved.

## Training and Qualifications

Before providing play therapy, it is important to be qualified to do so. Ethical guidelines require that professional counselors provide competent services and not advertise or practice beyond their levels of training. Certainly there are qualified professionals who provide play therapy services who are not registered play therapists. At the same time, especially if play therapy is a major part of one's practice, it is wise to seek the highest level of training possible. The Association for Play Therapy (APT) is the primary organization that provides professional standards for play therapists. The APT is also referred to as the International Association for Play Therapy (IAPT) and is responsible for publishing the *International Journal of Play Therapy*. In 1982, Charles Schaefer and Kevin O'Connor cofounded APT to provide a forum for professionals interested in helping children through play therapy. Professionals interested in learning more about becoming registered play therapists (RPTs) or a registered play therapist supervisor (RPT-S) can find the necessary information at APT's Web site.

## Summary

The play therapy field includes a group of interventions with a rich history and a continually developing vision of how to best treat children's mental health needs. From the helping field's first pioneers to today's professionals, play has been employed as a natural tool to assist children in working through a wide range of issues. Because play is an activity with which most adults are familiar from their own childhood, some helping professionals without play therapy training erroneously assume that they can use play to effectively help children. Though playing with a child may be enjoyable, it may not be therapeutic. Thus, the more training and supervision play therapy professionals receive, the greater the likelihood of treatment success. As with all psychological interventions, play therapy can benefit from more rigorous research. This not withstanding, there are certainly a number of noteworthy studies that point to the helpfulness of play therapy.



With its long history and promising outcomes, play therapy will likely continue to evolve and be used as a primary intervention with children for decades to come.

*Susan C. M. Crane*

**See also** Adlerian Therapy (v2); Adventure Therapy (v1); Art Therapy (v1); Child Maltreatment (v1); Developmental Disorders (v1); Externalized Problems of Childhood (v1); Family Counseling (v1); Internalized Problems of Childhood (v1)

### Further Readings

- Axline, V. M. (1969). *Play therapy*. New York: Ballantine Books.
- Boik, B. L., & Goodwin, E. A. (2000). *Sandplay therapy: A step-by-step manual for psychotherapists of diverse orientations*. New York: Norton.
- Bratton, S., Ray, D., Rhine, T., & Jones, L. (2005). The efficacy of play therapy with children: A meta-analytic review of treatment outcomes. *Professional Psychology: Research and Practice*, 36, 376–390.
- Carmichael, K. D. (2006). *Play therapy: An introduction*. Glenview, IL: Prentice Hall.
- Hembree-Kigin, T. L., & McNeil, C. B. (1995). *Parent-child interaction therapy*. New York: Plenum Press.
- Hughes, F. P. (1999). *Children, play, and development* (3rd ed.). Boston: Allyn & Bacon.
- Landreth, G. L. (2002). *Play therapy: The art of the relationship*. New York: Brunner-Routledge.
- Leblanc, M., & Ritchie, M. (2001). A meta-analysis of play therapy outcomes. *Counseling Psychology Quarterly*, 14, 149–163.
- Muro, J., Ray, D., Schottelkorb, A., Smith, M. R., & Blanco, P. J. (2007). Quantitative analysis of long-term child-centered play therapy. *International Journal of Play Therapy*, 15, 35–58.
- Pedro-Carroll, J., & Reddy, L. (2005). A preventive play intervention to foster children's resilience in the aftermath of divorce. In L. Reddy, T. Files-Hall, & C. Schaefer (Eds.), *Empirically based play interventions for children* (pp. 51–75). Washington, DC: American Psychological Association.
- Ray, D., Bratton, S., Rhine, T., & Jones, L. (2001). The effectiveness of play therapy: Responding to the critics. *International Journal of Play Therapy*, 10, 85–108.
- Schaefer, C. E. (2003). *Play therapy with adults*. Hoboken, NJ: Wiley.

### Web Sites

Association for Play Therapy: <http://www.4apt.org>

## POSTDEGREE/PRELICENSURE SUPERVISION

Counselors have been eligible for licensing beginning in 1973 in Virginia. Currently, all states with the exception of Nevada and California have licensing, and there is considerable variability as to required credits, course titles and topics, and pre- and postgraduate hours of supervision. Credit requirements range from a master's degree (no credit hours specified) to 60 credits, with the majority being 45 to 48 credits. Supervision requirements vary from a low of 1,000 hours to a high of 4,500 hours, with the majority being 3,000 hours.

The purpose of this entry is to explore the purpose, definition, process, and ethics of the practice of prelicensure clinical supervision. While there are multiple definitions of supervision, the unifying theme is to assist the new counselors in applying their training with increasing effectiveness through careful observation, analysis, education, redirection, coaching, and mentoring by a seasoned, licensed professional. Some form of supervision occurs across all levels of applied social science and medicine.

### Supervision Defined

The Council on the Accreditation of Counseling and Related Educational Programs (CACREP) specifies the hours and functions of supervision in counselor preparation. However, in non-CACREP accredited programs, the approach to supervision may or may not be made explicit. Either way, a brief overview of the purpose and definitions of supervision is presented as a starting point.

Supervision is an intervention provided by a more senior member of a profession to a more junior member or members of that same profession. This relationship is evaluative, extends over time, and has the simultaneous purposes of enhancing the professional functioning of the more junior persons, monitoring the quality of the professional services offered to the clients they see, and serving as a gatekeeper for entry to the particular profession.

Supervision is a type of intervention that although distinct from the provision of counseling or psychotherapy, is a change agent in the development of a new professional. While supervision does include an educational component in the form of a predetermined curriculum for all students, supervision is tailored to



meet the unique developmental needs of the individual or group of supervisees. Although there may be points in the supervisory process where a supervisee's personal issues are addressed in relation to the clinical work, the supervisor does not engage in a therapeutic relationship with the supervisee to resolve these issues. Rather, the issues are addressed in a manner that heightens the supervisee's awareness of how these factors may affect his or her work with clients. It is the supervisor's responsibility to hold the supervisee accountable for effectively managing client issues and providing appropriate referrals. There is a distinction between consultation and supervision, where supervision is generally imposed by licensing requirements of the postgraduate/prelicensed counselor, while consultation is sought freely by the clinician, perhaps on a single occasion, and not necessarily from a member of his or her own discipline. Additionally, there is no evaluative component involved in a consultative relationship.

### **Postgraduate Supervision**

Supervision, required by counselor licensing and regulatory bodies, is provided by a senior member of a profession (who, at a minimum, is licensed) for a junior member of the same profession working toward licensing. Although various disciplines can aptly address theoretical orientations, skill set development, and case management skills, socialization into the profession and fostering a sense of professional identity come from within a discipline. Supervision involves assisting the new professional in attending to matters of professional importance, e.g., changes in licensing laws, third-party reimbursement, modification or issuance of practice guidelines. Moreover, it includes not only bringing such matters to the supervisee's attention but also developing the knowledge of how and what to attend to, finding sources of information pertinent to the profession, and participating in organizations relevant to the profession, i.e., the American Counseling Association and state branches.

Currently, supervision standards vary and may or may not require someone licensed from the same discipline, a licensee, or an approved supervisor credential such as the Approved Clinical Supervisor (ACS) credential from the Center for Credentialing Education (CCE) of the National Board for Certified Counselors (NBCC). Requirements about the length of time and hours of supervision required for licensing vary across states and territories. However, one

common practice is that the postgraduate counselor must be under supervision until licensed in order to practice independently. The supervisor is required to provide ongoing evaluation of the postgraduate counselor and to submit or withhold a recommendation to license the supervisee.

### **Models of Clinical Supervision**

Supervision is provided in various models and is often tied to a theoretical orientation, ranging across psychodynamic, developmental, narrative, cognitive-behavioral, person-centered, and eclectic/integrationist. Although supervisees often have little choice in the model of supervision they receive, new counselors should seek varying models and find supervision that best meets their theoretical orientation and needs and the needs of the clients with whom they work. Supervisors have an ethical obligation to encourage new counselors to explore several theoretical orientations rather than follow only the supervisor's model.

### **Ethics and Competency to Practice**

New counselors may have less day-to-day supervision during employment than in their internship and can benefit from the supervisor's knowledge in areas that provide a potential ethical slippery slope. Because of the varying levels of preparation and professional orientation, constant reference to a code of ethics in clinical supervision is essential. Addressing such issues as insurance payments, boundaries, and multiple relationships can start the new counselor off in a healthy ethical direction.

Supervisors also have a responsibility to insure that supervisees are employing the most current and effective practices and should be thoroughly familiar with the research on empirically supported treatments. Most licensing laws and regulations include a caveat that counselors provide services in areas in which they are trained. Therefore, clinical supervision should focus on the competency of supervisees in providing services or addressing client issues consistent with their training. When practicing outside the boundaries of their competency, additional supervision, training, reading, and regular consultation or referral can ensure ethical practice and prevent licensing violations. Licensure candidates must be knowledgeable of the scope of practice in their state, because states with the broadest language include "diagnose and treat," while other states have more restrictive language.



## Multicultural, Gender, and Sexual Orientation Sensitivity

Supervision, like counseling, requires an awareness of, and competency in, multicultural, gender, and sexual orientation issues present in the process. Most supervisors are White, middle class, and of European origin, and studies about the impact of multicultural supervision are limited. Multiculturally based supervision offers a conceptual framework, and supervisees benefit from a variety of supervisors who provide a diversity of cultural, racial, gender, and sexual orientation backgrounds. Counselors graduating from a CACREP accredited program are required to study multicultural counseling and have field experiences in a range of multicultural settings. Most licensing boards use the CACREP course distribution, requiring social and cultural competency. Thus, supervisees should be encouraged to continually assess their multicultural competencies relative to CACREP's multicultural counseling competencies and standards.

## Recommendations to Licensure Candidates

Because standards vary and the portability of licenses is not assured, new graduates should familiarize themselves with the supervision requirements of the state in which they intend to seek licensure. With regulations frequently changing, candidates are advised to continually check for modifications in requirements. Because the supervisor's role in licensing is critical, candidates should seek supervision from someone who is experienced and thoroughly versed in licensing requirements.

Finding a supervisor is often dependent on regulatory boards that provide a list of qualified supervisors. If there are no requirements, supervisees can find qualified counseling supervisors through their professional associations (ACA and state branches) or graduate programs. The American Association of State Counseling Boards (AASCB) is working to develop common standards among states by adopting a nationwide portability document and establishing the National Credentials Registry (NCR) to assist prelicense counselors with supervision documentation.

Interviewing potential supervisors can provide insight into their theoretical orientation, counseling identity, supervision model, and availability. New counselors should look for personal qualities in the

supervisor such as enthusiasm, a positive attitude, and openness to diversity as indicators of the potential for developing the working alliance between supervisor and supervisee. Ideally, seeking some, if not all, supervision from a licensed professional counselor will ensure a strong counseling identity and contribute toward future ethical practice.

*Laura Palmer, Jane Webber,  
and J. Barry Mascari*

---

*Authors' Note:* Comments in this article reflect the opinions of the authors and do not represent organizations or licensing boards.

**See also** Accreditation by the Council for Accreditation of Counseling and Related Educational Programs (v1); Code of Ethics and Standards of Practice (v2); Counseling, Definition of (v1); Counseling, History of (v1); Counseling Psychology, Definition of (v1); Counseling Psychology, History of (v1); Counseling Skills Training (v2); Credentialing Individuals (v1); Multicultural Counseling Competence (v3); Postdoctoral Training (v1); Predoctoral Internships (v1); Supervision (v1)

## Further Readings

- American Counseling Association. (2005). *Code of ethics*. Alexandria, VA: Author.
- American Association of State Counseling Boards. (2005). *AASCB national credentials registry: Portability policies and procedures*. Retrieved September 18, 2006, from <http://www.aascb.org>
- Bernard, J. M., & Goodyear, R. K. (2004). *Fundamentals of clinical supervision* (3rd ed.) Boston: Allyn & Bacon.
- Council for Accreditation for Counseling and Related Education Programs. (2001). *The 2001 standards*. Alexandria, VA: Author.
- D'Andrea, M., & Daniels, J. (1997). Multicultural counseling supervision: Central issues, theoretical considerations, and practical strategies. In D. B. Pope-Davis & H. L. K. Coleman (Eds.), *Multicultural counseling competencies: Assessment, education and training, and supervision* (pp. 290–309). Thousand Oaks, CA: Sage.
- Kurpius, D. M., Gibson, G., Lewis, J., & Corbett, M. (1991). Ethical issues in supervising counselor practitioners. *Counselor Education and Supervision*, 39, 66–75.
- Leong, F. T. L., & Wagner, N. S. (1994). Cross-cultural counseling supervision: What do we know? What do we need to know? *Counselor Education and Supervision*, 34, 117–131.
- Mascari, J. B., & Webber, J. (2006). Salting the slippery slope: What licensing violations tell us about preventing



dangerous ethical situations. In G. R. Walz, J. C. Bleuer, & R. K. Yep (Eds.), *Vistas: Compelling perspectives on counseling 2006* (pp. 165–168). Alexandria, VA: American Counseling Association.

Wing, D. S., Arrendondo, P., & McDavis, R. J. (1992). Multicultural counseling competencies and standards: A call to the profession. *Journal of Counseling and Development*, 70, 479–486.

---

## POSTDOCTORAL TRAINING

---

At present, postdoctoral supervised experience is required for licensure in most states, for some forms of institutional employment, and for board certification (e.g., American Board of Professional Psychology) in many specialty areas. However, there is ongoing debate regarding the requirement for postdoctoral hours for licensure as well as the definition of postdoctoral training itself. Recent years have witnessed a series of conferences related to postdoctoral education and training, the development and implementation of accreditation guidelines for postdoctoral training programs, and recommendations from the American Psychological Association (APA) to eliminate the postdoctoral requirement. There is variability in existing formalized programs in terms of accreditation status, funding, training focus, structure, and setting. The decision for students regarding seeking formalized postdoctoral training remains complicated, and individuals need to consider the most appropriate postdoctoral experience for themselves given their professional and personal goals.

### History

Postdoctoral training, or training that occurs following the receipt of the doctoral degree, has been the subject of long debate within psychology. The requirement for postdoctoral training dates back to the 1949 Boulder conference, during which conference participants asserted that to become proficient in psychotherapy, postdoctoral training would be needed. The value of postdoctoral training was further affirmed at the 1955 Stanford and 1958 Miami conferences; however, there was no consensus that it should be a required part of the education and training sequence. It was at the Chicago conference, held in 1965, that postdoctoral training was conceptualized as

a vehicle for securing advanced and specialized competence.

It was not until 1972, however, that the first conference devoted specifically to education and training at the postdoctoral level was held at the Menninger Clinic. However, no specific guidelines for postdoctoral training were devised. At the 1973 Vail conference, some attention was paid to postdoctoral training related to continuing professional development and to matters of access and flexibility. At the 1987 National Conference on Graduate Education in Psychology, conference participants concluded that narrow specialization most appropriately occurred postdoctorally. At the annual APA convention in 1990, there was a meeting to discuss a model for a national program of psychology postdoctoral training that would be offered through comprehensive psychology postdoctoral centers of excellence.

Some of the most ardent supporters for accreditation at the postdoctoral level were individuals in the specialties. Throughout the 1980s, guidelines were developed for postdoctoral training in various specialty areas, such as health, clinical child psychology, and clinical neuropsychology. In 1992, in response to concerns expressed at national conferences (e.g., the Gainesville conference) regarding the lack of consistency in internship training in the postdoctoral experience and to calls articulated by the Joint Council on Professional Education in Psychology (JCPEP) for general standards in postdoctoral training and formal specialty certification, the first National Conference on Postdoctoral Training in Professional Psychology, cosponsored by APA and the Association of Psychology Postdoctoral and Internship Centers (APPIC) was held in Ann Arbor, Michigan. Conference participants crafted a policy document that addressed the purposes of postdoctoral training; entrance requirements; program content, structure, and organization; faculty-staff; and evaluation mechanisms. They developed recommendations for initiatives to foster excellence and innovation in postdoctoral education and training and called for guidelines and principles for accrediting postdoctoral programs.

In 1994, the APA held a National Conference on Postdoctoral Education in Psychology in Norman, Oklahoma. Attendees provided models for postdoctoral and continuing education and training to develop and enhance the competence necessary for psychologists to contribute maximally to teaching, research, and practice; established a taxonomy and terminology



to describe postdoctoral and continuing professional education and training; proposed mechanisms for documenting program adequacy and trainee competence; identified and developed funding opportunities; and delineated the requisite steps to implement conference models for postdoctoral and continuing education and training.

### ***Development of National Standards***

APPIC first began accepting postdoctoral programs for membership in 1974–1975, and it established specific postdoctoral membership criteria in 1987. By the end of 2006, there were 103 APPIC-member postdoctoral programs. A subset of these programs receives APA accreditation. The current APPIC membership criteria for postdoctoral training programs include a planned and programmed sequence of training experiences, an appropriately qualified licensed psychologist as training director, two or more qualified and licensed psychologists on staff or faculty, 2 hours or more per week of individual supervision, additional hours of learning activities, and a requirement that candidates spend at least 25% of their postdoctoral fellowship time in professional psychological services. Programs must include a minimum of 1,500 hours of total time and can be completed on a full time or part time basis. Depending on the area of specialty, the program may be longer than 1 year in duration.

From the mid-1980s forward, there were calls for accreditation standards for postdoctoral training, and subsequently in the early 1990s, the Inter-Organizational Council for the Accreditation of Postdoctoral Training Programs (IOC) was formed. The IOC, in coordination with APA's Committee on Accreditation, developed generic guidelines and procedures for accrediting postdoctoral programs that were formally adopted in 1996 by the APA Council of Representatives. Postdoctoral programs were first accredited by APA in 1997. As of July 2006, there were 26 accredited postdoctoral residency training programs and 20 accredited specialty practice programs; some sites have more than one accredited program.

Typically, accredited postdoctoral programs are 1 year in length, except that certain specialty areas (e.g., clinical neuropsychology) require 2 years. Some specialties, notably neuropsychology, have a national organization representing their postdoctoral programs. For some specialty areas, APA's Council of

Specialties has augmented general accreditation guidelines with specialty-specific guidelines.

Despite efforts to develop national standards, most programs fall outside of the APPIC and APA system, and thus there is insufficient quality control for many programs. There also is a lack of consistent incentive for programs to seek APPIC membership or APA accreditation, because it is not an expectation of licensing boards nor is it the norm (except for Department of Veterans Affairs medical centers and in certain specialty areas). This state of affairs also makes it difficult to accurately depict the number and types of postdoctoral programs available in North America.

### ***Licensure***

The past 20 to 25 years have witnessed dramatic shifts with regard to licensure requirements. In 1985, 28 states required postdoctoral experience for licensure. In 2007, 48 states require postdoctoral experience. However, jurisdictions vary with regard to the clinical and supervisory requirements of the postdoctoral experience, number of hours that constitute a training year, and length of time required to, and allowed to, complete training. Information on postdoctoral requirements by jurisdiction can be found at the Association of State and Provincial Psychology Boards' Web site. The growth in the number of states requiring supervised work experience at the postdoctoral level for licensure was in response to the 1987 model act for state licensure of psychologists, in which APA recommended 2 years of supervised professional experience for licensure, 1 of which needed to be postdoctoral.

The requirement for the postdoctoral year for licensure was questioned by the Commission on Education and Training Leading to Licensure, established by the APA Council of Representatives, which met in 2000. The commission recommended retaining the 2-year experience requirement but argued for increased flexibility in the timing and sequencing of this experience. While the requirement for the internship was endorsed by commission members, they stated that the second year of experience could be obtained either through a preinternship practicum or postdoctoral experience. However, participants acknowledged that it was essential that the profession study the requisite competencies for licensure and determine when in the education and training sequence such competencies were obtained. There has been an active movement focusing on these competencies and their assessment in the past 5 years.



In an effort to implement the recommendations of the Commission on Education and Training Leading to Licensure, in February 2006, the APA Council of Representatives passed a statement recommending that for licensure, applicants must demonstrate that they have completed a sequential, organized, supervised professional experience, equivalent to 2 years of full-time training, that can be completed prior or subsequent to the granting of the doctoral degree. For applicants preparing for practice as health service providers, 1 of those 2 years must be a predoctoral internship. Although they recommended elimination of the postdoctoral requirement for licensure, the Council of Representatives did affirm that postdoctoral education and training remains an important aspect of continuing professional development and the credentialing process for professional psychologists, as it is a foundation for practice improvement, advanced competence, and interjurisdictional mobility. The council also supported the further development of competency goals and assessment methods in the professional education and training of psychologists. In anticipation of this new stand by APA, one jurisdiction (i.e., Washington) has eliminated the postdoctoral requirement, and several others are considering a similar change.

The elimination of the postdoctoral year was and remains quite controversial. Proponents of this decision cite difficulties faced by students trying to secure the required experience for licensure, problems finding suitable positions with appropriate supervision, the limited financial remuneration associated with the postdoctoral year, the heavy debt load that students have upon internship completion, the protracted duration of training, and the fact that the requirements for licensure in psychology are more stringent than those in most professions.

Opponents of the elimination of the requirement express concerns that many students who complete their doctoral degrees have not yet achieved certain competencies crucial for licensure, and that further training and supervision are imperative for students to obtain these competencies. They also believe that eliminating the requirement reduces the profession's efforts to protect the public and consumers of psychology. These concerns have arisen, in part, from the belief that many practicum experiences are not providing sufficient training or supervision necessary for the development of the competencies required for independent practice. Of note, in one survey, students

(graduate, interns, postdoctoral residents), trainers (graduate, internship, postdoctoral), and APA members endorsed the value of the postdoctoral requirement, although they did not believe that a formal program should be mandatory. Furthermore, a recent national survey revealed a discrepancy in training directors' views of trainees' readiness to practice independently. Academic training directors reported that trainees are readier for independent practice earlier in the training sequence than internship and postdoctoral training directors reported.

### ***Supply and Demand***

As noted above, it is difficult to be certain about the number of postdoctoral training programs. There was documented evidence of 22 sites in 1960–1962, 46 in 1967, 161 in 1986, 388 in 1993, and 480 sites that had paid positions in 1998. However, there is a relative shortfall in the number of sites and available slots given the number of individuals in predoctoral internship programs. This has resulted in an insufficient number of formalized positions. However, many students choose to complete their postdoctoral experience requirements through supervised work experience rather than via a formal postdoctoral training program.

## **Characteristics of Postdoctoral Training**

### ***Training Emphasis and Sites***

Postdoctoral training programs may emphasize clinical or research training. There are accredited programs that are broad and general in professional psychology as well as those in such specialty areas as clinical child, clinical health, clinical neuropsychology, and rehabilitation psychology. Most APPIC member programs are based in medical schools, university counseling centers, Veterans Affairs Medical Centers, and child settings. There also are positions in industry and government. The setting influences the experiences fellows will gain and the dominant populations with whom they work.

### ***Formal and Informal Postdoctoral Training***

Postdoctoral training may be informal or formal. Informal refers to on-the-job supervised experience, designed primarily to assist the individual in fulfilling



licensure requirements. These positions often entail high service demands and considerable levels of professional autonomy. Conversely, formal postdoctoral training occurs in the context of an organized and structured educational program designed to develop advanced competency and expertise for the professional practice of psychology. Stipends typically are set. These positions are advertised through the *APPIC Directory*, the *APA Monitor*, and the Association for Psychological Science's *APS Observer* as well as on various listservs.

A survey of interns revealed that, in general, they preferred an informal postdoctoral experience. This preference appeared to be based on personal and practical considerations, and such factors often outweigh professional considerations. Such considerations relate to finances, concerns about relocation, dual career demands, family goals, and relationship commitments.

Those who complete formal programs rate these experiences as more valuable than those who participate in informal programs, as these programs bolster their competence in professional practice, clinical research, supervision, and teaching; provide them experiences with particular populations; and enhance their job marketability. A study of individuals in formalized postdoctoral fellowships highlighted that a desire to secure focused training in specific areas and a need to obtain further experience that would increase their marketability were key in deciding to apply for formalized fellowships. Formalized postdoctoral training is essential for certain specialties and is highly desirable in certain geographic regions.

### **Specialty**

For many years, there has been a general consensus that postdoctoral education and training are valuable in terms of specialty practice. A position first evidenced at the Boulder conference, it was solidified at the Stanford, Miami, and Chicago conferences as well as at the National Conference on Implementing Public-Academic Linkages for Clinical Training in Psychology.

Many sites offer training at multiple levels (e.g., practicum, internship, postdoctoral) within a given specialty area, despite the fact that the only specialty programs that can be accredited are at the postdoctoral level. Within each specialty area, there is heterogeneity in the types of postdoctoral training offered, raising questions about core competencies to be achieved

in each specialty area at the postdoctoral level. Individuals who receive postdoctoral training in various specialty and proficiency areas reveal a high degree of satisfaction with their experience and an enhanced sense of competence. Specialty training at the postdoctoral level increases marketability and is mandatory for some specialties.

### **Developmental Perspective**

This phase of professional development is characterized by a focus on negotiating the tasks of individual and professional self-definition. Individuals begin to develop expertise in areas of personal interest; manifest a deepening commitment to the work; experience an enhanced sense of personal efficacy, confidence, and self-acceptance as psychologists; and are perceived by others as competent psychologists.

A postdoctoral training program offers a transition period between being a student and professional employment, and making this transition is a task with which individuals often struggle. Although supervision and training continues, there typically is greater professional autonomy during a postdoctoral training program than there was during the internship year, and thus the experience facilitates transition from dependence to independence. Many postdoctoral programs pay particular attention to assisting their trainees in securing their first professional employment in psychology.

### **Funding**

One major concern for students in making decisions regarding postdoctoral experience relates to funding. There are a broad range of financial arrangements for informal postdoctoral supervised work experience. However, formal postdoctoral positions are typically funded by the institutions in which they are embedded. As of the 2006–2007 training year, the mean salary for individuals in APPIC member postdoctoral training programs was \$35,000/year, with a range from \$15,000 to \$72,000/year. For APA accredited programs, the mean is \$42,800 and the range is \$29,000 to \$70,000/year. For the number of programs and slots to be increased, additional funding streams need to be secured. Limited graduate psychology education funds are available for accredited postdoctoral fellowship programs. APA has made efforts toward passing legislation that would allow graduate medical education



funding through Medicare to support psychology postdoctoral training programs. However, few institutions have been able to secure these funds for their programs.

### Future Directions

Individuals seeking postdoctoral training should define their training objectives, be cognizant of the relevant licensure requirements, and be mindful of the advantages of securing such training in terms of specialization and networking. Young professionals should examine their professional and personal goals to ascertain whether to seek formal or informal postdoctoral training and to determine the extent to which their training will be specialty specific. As jurisdictions become more variable with regard to the postdoctoral requirement, individuals need to determine if they will even need to secure such supervised experience.

It also may behoove the profession to better standardize the postdoctoral training requirements on a national basis. In addition, greater consideration could be given to implementing a matching process for formalized postdoctoral programs akin to that already in place for the neuropsychology postdoctoral programs and for internship programs. Finally, the profession could more effectively convey the value of postdoctoral education and training, particularly that which occurs in formalized programs.

*Nadine J. Kaslow and W. Gregory Keilin*

**See also** Conferences, Counseling Psychology (v1); Conferences in Counseling (v1); Continuing Education (v1); Counseling, Definition of (v1); Counseling, History of (v1); Counseling Psychology, Definition of (v1); Counseling Psychology, History of (v1); Counseling Skills Training (v2); Credentialing Individuals (v1); Multicultural Counseling Competence (v3); Postdegree/Prelicensure Supervision (v1); Predoctoral Internships (v1); Professional Degrees (v1); Supervision (v1)

### Further Readings

American Psychological Association. (1995). *Education and training beyond the doctoral degree: Proceedings of the American Psychological Association National Conference on Postdoctoral Education and Training in Psychology*. Washington, DC: Author.

American Psychological Association Committee on Legislation. (1987). Model act for state licensure of psychologists. *American Psychologist*, 42, 696–703.

- Belar, C. (1992). Conferences on internship and postdoctoral training. In A. E. Puente, J. Matthews, & C. Brewer (Eds.), *Teaching psychology in America: A history* (pp. 301–310). Washington, DC: American Psychological Association.
- Belar, C. D., Bieliauskas, L. A., Klepac, R. K., Larsen, K. G., Stigall, T. T., & Zimet, C. N. (1993). National Conference on Postdoctoral Training in Professional Psychology. *American Psychologist*, 48, 1284–1289.
- Belar, C. D., & Kaslow, N. J. (2003). The history of accreditation of internship programs and postdoctoral residencies. In E. M. Altmaier (Ed.), *Setting standards in graduate education: Psychology's commitment to excellence in accreditation* (pp. 61–89). Washington, DC: American Psychological Association.
- France, C. M., & Wolf, E. M. (2000). Issues related to postdoctoral education and training in professional psychology: Results of an opinion survey. *Professional Psychology: Research and Practice*, 31, 429–434.
- Kaslow, N. J. (2004). Competencies in professional psychology. *American Psychologist*, 59, 774–781.
- Kaslow, N. J., & Echols, M. M. (2006). Postdoctoral training and requirements for licensure and certification. In T. J. Vaughn (Ed.), *Psychology licensure and certification: What students need to know* (pp. 85–95). Washington, DC: American Psychological Association.
- Kaslow, N. J., Rubin, N. J., Bebeau, M., Leigh, I. W., Lichtenberg, J., Nelson, P. D., et al. (2007). Guiding principles and recommendations for the assessment of competence. *Professional Psychology: Research and Practice*, 38, 441–457.
- Reich, J. N., Sands, H., & Wiens, A. N. (Eds.). (1995). *Education and training beyond the doctoral degree: Proceedings of the American Psychological Association National Conference on Postdoctoral Education and Training in Psychology*. Washington, DC: American Psychological Association.
- Simon, V. A., & Spirito, A. (2003). Recommendations for a postdoctoral fellowship. In M. J. Prinstein & M. D. Patterson (Eds.), *The portable mentor: Expert guide to a successful career in psychology* (pp. 269–283). New York: Kluwer Academic/Plenum.
- Wiens, A. N. (1993). Postdoctoral education-training for specialty practice: Long anticipated, finally realized. *American Psychologist*, 48, 415–422.

### Web Sites

Association of State and Provincial Psychology Boards: <http://www.asppb.org>

Newpsychlist: <http://www.yahogroups.com>

Postdoc-network: <http://www.appic.org>



---

## PREDOCTORAL INTERNSHIPS

---

The predoctoral internship, a vital component of professional psychology education and training, is one of the formative experiences for individuals obtaining doctoral degrees and licenses in psychology. Generally considered the capstone year of doctoral training, it provides students the opportunity to expand upon and integrate their clinical experiences, to be exposed to diverse patient populations, and to experience a variety of perspectives both within and outside of psychology.

This entry begins by providing a historical backdrop of the predoctoral internship experience. The key issues and trends that dominate current thinking regarding internship training, with particular focus on supply and demand imbalance, financial considerations, areas of emphasis, the application process, and the APPIC Match are addressed. The student perspective on the internship experience also is offered.

### History

The American Psychological Association (APA) inaugurated internship training at the Boulder conference in 1949. Conference participants mandated that a 1-year, full-time internship experience would be required for the doctoral degree in applied psychology. Accreditation of predoctoral internship programs through the APA began in 1956, and by the end of 2006 there were 455 APA-accredited programs. The Canadian Psychological Association began accrediting programs in 1984. While the accreditation system has been modified over the years, it has been continuously supported by the profession. However, there have been and remain various perspectives regarding the value and structure of the accreditation process.

In 1968, the Association of Psychology Internship Centers (APIC) was formed as an informal cadre of psychologists invested in training predoctoral interns. In 1992, the organization expanded its mission to include postdoctoral training and was renamed the Association of Psychology Postdoctoral and Internship Centers (APPIC). APPIC, which is committed to enhancing internship and postdoctoral training in professional psychology, establishes minimal standards for quality training programs, develops selection policies and procedures for matching applicants to internship programs, publishes a directory of

programs, facilitates the placement of unmatched applicants, assists with the informal and formal resolution of problems related to internship and postdoctoral training, represents the views of internship and postdoctoral agencies at the North American level, and takes a leadership role in national and multinational psychology conferences. One such conference was the National Conference on Internship Training in Psychology held in Gainesville, Florida, in 1987, the only national meeting devoted exclusively to internship training. Delegates developed a policy statement on internship training and delineated core requirements for the internship experience.

From the 1972–1973 training year through the 1997–1998 year, APPIC coordinated a “uniform notification” system, a process by which internship offers were tendered and positions were accepted based on a specific set of rules. Given the multitude of problems associated with this system, APPIC in 1999 initiated a computer-based internship matching program (the APPIC Match) to facilitate the placement of applicants into available positions.

Psychology typically has emphasized 1-year, full-time internships, although many students with family, financial, or other obligations have great difficulty in completing a full-time training program. While the 2006–2007 *APPIC Directory* lists only 15 2-year, half-time funded internship positions (0.5%), 5% of applicants who responded to a 2005 APPIC survey reported that they would prefer a half-time internship experience. In 2005, a national conference identified the benefits of half-time internship training, obstacles to implementing such training, and potential solutions for overcoming these barriers. A compelling case is being built for developing and promulgating systematic and coherent half-time internship program designs and structures. There are a number of excellent examples of half-time internship models and efforts to ensure the quality of these programs.

### Supply and Demand

In the early to mid 1990s, concerns began to be raised about a potential imbalance between the number of applicants (supply) and the number of available internship positions (demand). This led to a 1997 APPIC-APA sponsored conference on “Supply and Demand: Training and Employment Opportunities in Professional Psychology.” This imbalance has become more pronounced over the last several years,



with a total of 3,210 applicants competing for 2,779 available positions in the 2006 APPIC Match. These figures do not consider those applicants who withdrew from the Match because they were rejected from all sites to which they applied or the fact that some students and programs crafted new funded or unfunded positions after the Match had been completed. Between 2001 and 2005, the number of registered applicants increased by 275 and the number of available positions increased by only 16, suggesting that the growing imbalance reflects an increase in the number of students rather than a reduction in the number of positions.

As the supply–demand imbalance continues to increase, applicants may feel growing pressure to focus more on obtaining a placement than on the quality of the placement itself. Similarly, doctoral faculty may experience pressure to lower their standards for internship to ensure their students' graduation. These phenomena can result in reduced incentives for new and existing internship programs to seek accreditation or APPIC membership, because those programs can easily fill their positions without meeting national standards. It also has increased pressure on students to complete more practicum hours to remain competitive, potentially interfering with their ability to complete other academic and research requirements. Further, students who accept nonaccredited or non-APPIC member internships run the risk of experiencing difficulties related to future licensure or employment.

### Financial Considerations

Financial issues related to internship training need to be considered for students and programs. First, given the supply and demand imbalance, students feel compelled to apply to and interview at an increasing number of sites, which is associated with significant costs in terms of time and money. For the 2006 APPIC Match, applicants reported spending an average of \$1,508 for the entire process. Second, intern applicants are underpaid; of the positions listed in the 2006–2007 *APPIC Directory*, the mean internship salary is \$21,600 for all APPIC-member programs and \$22,700 for all accredited programs. This is despite the fact that a growing number of programs have increased their stipends to \$23,660 consistent with the standard set by Fair Labor Standards Act. Third, there are limited federal funds to support internship training, as only recently have graduate psychology education funds

been accessible. Fourth, there are questions about the cost-effectiveness of programs given the time and resources required to train students and the fact that most agencies are not permitted to bill insurance companies for interns' services.

### Areas of Emphasis

Among the 621 member programs listed in the 2006–2007 *APPIC Directory*, internship training occurs in Veterans Affairs Medical Centers, medical schools, university counseling centers, state hospitals, community mental health centers, child and adolescent psychiatric or pediatric facilities, private general and psychiatric hospitals, military and correctional facilities, psychology departments, private outpatient clinics, and school districts. Some programs include the collaboration of multiple settings into a consortium model, and others involve affiliations between graduate programs and facilities at which internships are offered.

Sites vary in terms of populations served according to age, inpatient versus outpatient, individual and cultural diversity considerations, geographical location, and income of patients. They also differ in treatment modalities emphasized: therapy (individual, couples, family, group), community intervention, consultation and liaison, crisis intervention, brief and long-term therapy, and cognitive rehabilitation. Further, there is variability in the extent to which they provide training in supervision, although with the growing recognition in the field that supervision is a core competency, increasing numbers of sites offer extensive training in this domain. There is marked diversity with regard to specialty areas. Areas of special emphasis that have received considerable attention include those of children and older adults, health care in individuals across the life span, clinical neuropsychology, consultation, and working with individuals with severe and persistent mental illness. Internships also train psychologists for working in settings including managed care; market-driven practice; primary care; and public health, including prevention, public policy, and community action. Many programs highlight teaching in diversity, such as women's issues, religion and spirituality, and multiculturalism. A growing number of programs emphasize training in empirically supported treatments and research.

Recently, it has been argued that the structure of internship programs is not sufficiently responsive to



emerging trends and practice opportunities in the field but is rather overly focused on training individuals for the traditional clinical-provider role. This may contribute to an oversupply of clinical practitioners and a lack of adequate preparation for interns to compete for jobs in new areas of psychological practice.

Despite APA's efforts over the past decade in requiring internship programs to define and articulate their model of training, characteristics of a training program may be better described by the setting and areas of emphasis than by the articulated training model. Similarly, there appears to be a poor relationship between the model of students' doctoral programs and the model represented by students' choices of internship. Clearly, more work is required in this area. Because current training models do not capture differences in training sites, new paradigms are needed to better capture similarities and differences in approaches to training across programs.

### Application Process

There have been multiple changes to the internship application process in recent years. First, the *APPIC Directory* is now online, which allows students to more effectively search for sites that appear to be a good fit for their training interests. Second, instead of each internship site requiring its own unique application, most sites now accept a standardized application, the APPIC Application for Psychology Internships (AAPI). As of this writing, the AAPI includes background and educational information, documentation of supervised practicum experiences, test administration and report writing experience, professional conduct, and essay questions. Five essay questions require applicants to provide an autobiographical statement along with information about theoretical orientation, experience and training with diverse populations, research interests and experiences, and the fit between themselves and the specific site. Third, due to increasing concerns about the inflation of letters of recommendation and the lack of attention in such letters to applicants' limitations and areas of growth, suggestions for more balanced and useful letters have been provided. Programs in Canada have established guidelines for a uniform letter of recommendation that includes information about how the recommender knows the applicant, current professional and personal competencies of the student, areas for personal growth and development, and a summary recommendation.

While requirements vary across sites, a typical internship application packet consists of a cover letter, AAPI, verification of internship readiness from the graduate program, copies of graduate transcripts, and three letters of recommendation. Some sites require work samples (e.g., testing reports). Manuals and articles guide students in preparing strong applications, and research findings shed light on factors associated with positive and negative match outcomes. Applicants are most likely to be matched at a site when the site perceives a good fit between the applicant's goals and clinical experiences and the site's opportunities, when the student has impressive letters of recommendation, and when the person interviews well. Conversely, applicants are less likely to be successfully matched to a site when they have not completed their comprehensives and dissertation proposal defense, have incomplete course work, are not from accredited doctoral programs, and are not viewed as being a good fit.

### The APPIC Match

In 1999, APPIC made a dramatic change to the process in which students were placed into internship positions. Due to the myriad problems associated with the previous telephone-based system of making offers, APPIC implemented a computer-based matching program similar to the one used by medicine and other professions. The Match provides a number of benefits to participants: reduced stress, reduced violations of APPIC policies, better outcomes, elimination of gridlock, and improved experiences for couples. The APPIC Match is administered by National Matching Services, Incorporated (NMS), a Toronto-based company that specializes in the administration of matching programs. The matching process is governed by a set of rules called the "APPIC Match Policies" that are designed to ensure the smooth operation of the process and reduce stress and pressure on applicants.

Applicants typically begin the selection process in the summer or fall by identifying internship programs in which they are interested, usually with the assistance of the *APPIC Directory Online*. Application deadlines typically are between November 1 and December 1, with interviews occurring during December and January. Some programs offer telephone interviews, while others prefer applicants to interview on-site, usually at their own expense.

Upon completion of interviews, each applicant and program submits a "rank order list" (ROL) to NMS by



a predetermined deadline (currently in early February). An applicant's ROL consists of a list of programs in which he or she is interested in the order in which he or she prefers them. Similarly, a program's ROL consists of a ranked list of applicants. Both applicants and programs are encouraged strongly to rank according to their true preferences, without considering other factors (e.g., how others ranked them, competitiveness of a program), as this maximizes their chances of getting the best possible match. Special ranking procedures are available for couples so they can attempt to geographically coordinate their placements.

Results of the Match are provided in a two-step process currently held on a Friday and the following Monday in late February. Match results are considered binding on all parties. On Friday, applicants are told whether or not they matched, but they are not told the specific program to which they matched. Programs are not provided any results on that day. On the following Monday, applicants learn the site at which they matched. Programs receive a list of students to whom they matched. This three-day delay allows unmatched applicants the chance to regroup and prepare to participate in the "APPIC Clearinghouse," a process that facilitates placing unmatched applicants in positions left unfilled by the Match.

### Student Perspective

There has been some attention paid to factors that determine whether or not applicants apply to a particular site. Students appear to apply to sites based on a gut feeling of sense of fit with the program; perception of good fit between personal interests and program's strengths; program's prestige or reputation; amount, quality, and content of the education in terms of supervision and didactic activities; breadth of populations served; areas of special emphasis; and geographic location. They also are drawn to programs in which they perceive a sense of community, respectful treatment of clients and colleagues, and support for authentic interactions. Individuals interested in pursuing academic careers often consider research opportunities at the site. Applicants tend not to apply to sites if they perceive they have a limited fit with the program or location or if there are financial or partner concerns associated with the program. Thus, professional, personal, and practical considerations influence decision making.

During the internship year, interns solidify their professional identities, refine their competencies, and gain entry to the next phase of their careers. Interns experience their training year as a time of personal and professional transitions, "passages," and critical events, and they grapple in a condensed fashion with each of Erikson's psychosocial challenges. They encounter developmental stressors during the year, including adjusting to a new training and clinical environment, developing trusting relationships with supervisors and peers, questioning their competence as psychologists, taking risks to acquire new competencies with a broad array of populations, engaging in self-assessment, and career planning. They participate in myriad self-care activities to assist them in managing these stressors, including seeking support of family and friends, active problem solving, participating in pleasurable activities, and humor.

### Future Directions

Looking to the future, the profession may need to address a number of critical issues. First and foremost, the increasing supply-demand imbalance threatens professional psychologists' ability to effectively train students seeking their doctoral degrees and imposes severe delays and hardships on hundreds of students each year. Although myriad strategies have been proposed to redress the supply-demand imbalance, a systematic or concerted national effort may help ameliorate this growing crisis.

In addition, the profession may benefit from increasing the opportunities for 2-year, half-time internship experiences, enhancing advocacy efforts at the federal and state levels for increased financial support of psychology internship programs (such as the recently established graduate psychology education program), and ensuring that internship programs are appropriately preparing students for the new and emerging practice opportunities in professional psychology.

*W. Gregory Keilin and Nadine J. Kaslow*

*See also* Accreditation by the Council for Accreditation of Counseling and Related Educational Programs (v1); Counseling, Definition of (v1); Counseling, History of (v1); Counseling Psychology, Definition of (v1); Counseling Psychology, History of (v1); Counseling Skills Training (v2); Credentialing Individuals (v1); Multicultural Counseling Competence (v3); Postdegree/Prelicensure Supervision (v1); Professional Degrees (v1); Supervision (v1)



### Further Readings

- Belar, C. D., Bieliauskas, L. A., Larsen, K. G., Mensh, I. N., Poey, K., & Roehlke, H. J. (1989). The National Conference on Internship Training in Professional Psychology. *American Psychologist*, 44, 60–65.
- Belar, C. D., & Kaslow, N. J. (2003). The history of accreditation of internship programs and postdoctoral residencies. In E. M. Altmaier (Ed.), *Setting standards in graduate education: Psychology's commitment to excellence in accreditation* (pp. 61–89). Washington, DC: American Psychological Association.
- Boggs, K. R., & Douce, L. A. (2000). Current status and anticipated changes in psychology internships: Effects on counseling psychology training. *The Counseling Psychologist*, 28, 672–686.
- Constantine, M. G. (1997). Facilitating multicultural competency in counseling supervision: Operationalizing a practical framework. In D. Pope-Davis & H. L. K. Coleman (Eds.), *Multicultural counseling competencies: Assessment, education and training, and supervision* (pp. 310–324). Thousand Oaks, CA: Sage.
- Cornish, J. A. E., Smith-Acuna, S., & Nadkarni, L. (2005). Developing an exclusively affiliated psychology internship consortium: A novel approach to internship training. *Professional Psychology: Research and Practice*, 36, 9–15.
- Kaslow, N. J., & Keilin, W. G. (2006). Internship training in clinical psychology: Looking into our crystal ball. *Clinical Psychology: Science and Practice*, 13, 242–248.
- Keilin, W. G. (1998). Internship selection 30 years later: An overview of the APPIC matching program. *Professional Psychology: Research and Practice*, 29, 599–603.
- Lejuez, C. W., Read, J. P., Gollan, J. K., & Zvolensky, M. J. (2001). Identifying, obtaining, and completing a predoctoral psychology internship: Research considerations. *Professional Psychology: Research and Practice*, 32, 650–654.
- Megargee, E. I. (2002). *Megargee's guide to obtaining a psychology internship* (4th ed.). Washington, DC: Accelerated Development.
- Neimeyer, G. J., Saferstein, J., & Rice, K. G. (2005). Does the model matter? The relationship between science-practice emphasis and outcomes in academic training programs in counseling psychology. *The Counseling Psychologist*, 33, 635–654.
- Rodolfa, E. R., Kaslow, N. J., Stewart, A. E., Keilin, W. G., & Baker, J. (2005). Internship training: Do models really matter? *Professional Psychology: Research and Practice*, 36, 25–31.
- Stedman, J. M., Hatch, J. P., Schoenfeld, L. S., & Keilin, W. G. (2005). The structure of internship training: Current patterns and implications for the future of clinical and counseling psychologists. *Professional Psychology: Research and Practice*, 36, 3–8.
- Thorp, S. R., O'Donohue, W. T., & Gregg, J. (2005). The predoctoral internship: Is current training anachronistic? *Professional Psychology: Research and Practice*, 36, 16–24.

### Web Sites

- Association of Psychology Postdoctoral and Internship Centers: <http://www.appic.org>
- Canadian Council of Professional Psychology Programs: <http://www.ccppp.ca>

---

## PRESCRIPTION PRIVILEGES

---

Prescription privileges refers to the right to prescribe medication. The psychologist prescription privilege (PPP) debate refers to legal and ethical arguments for and against a psychologist prescribing medication. Presently, there are legal avenues by which a psychologist may earn the right to prescribe medication. A psychologist could elect to earn a supplemental degree in such fields as medicine or advanced practice nursing and gain legal authority to prescribe. Extending prescription privilege to psychologists would provide a different and, presumably, less onerous means for a psychologist to gain the right to prescribe. In the United States, granting prescription privileges to psychologists was attempted by various pilot programs in New Mexico, California and, most notably, in the military. Recently, two states, Louisiana and New Mexico, have passed laws to permit additional avenues whereby a psychologist may prescribe medications. As of April 2005, legislatures in 20 states either began studying the impacts of extending PPP or have proposed prescription privilege legislation.

In the United States, only physicians have full prescription privileges. Other professions such as optometry, dentistry, and podiatry are granted limited prescription privileges to prescribe medications that affect the body systems in their area. By the year 2002, approximately 75,000 nonphysicians, including nurse practitioners, midwives, and other clinical specialists had prescription privileges across the United



States. In 38 states, pharmacists had the power to prescribe medications.

Those psychologists in favor of granting prescription privileges to psychologists have been represented by the American Psychological Association (APA), an organization whose membership is largely composed of clinicians and independent practitioners. Those opposed to PPP represent two separate camps: those within the psychology profession and those outside of the psychology profession, many of whom are members of the medical establishment.

Psychologists standing in opposition to PPP have been represented by the American Association of Applied and Preventive Psychology (AAAPP), an organization created by psychologists opposing the proliferation of states authorizing PPP, and the Society for a Science of Clinical Psychology. Several physician groups, including the American Psychiatric Association and the American Medical Association (AMA), have also opposed allowing psychologists to have specific training permitting them to prescribe psychotropic medication.

### **The American Psychological Association's Proposal**

Currently, the APA proposes that psychologists earn the right to prescribe medication that directly affects individuals' mental health needs. Both Louisiana and New Mexico have passed legislation that has closely mirrored the APA's recommendations. The APA guidelines indicate that only those who hold a doctorate in psychology and have five years of experience in the health-care industry should earn prescription privileges. Once the doctoral degree has been earned, a psychologist should take 450 hours of training in five areas: neuroscience, clinical psychotherapeutics, physical and laboratory assessment, physiology and pathophysiology, and clinical and research pharmacology and psychopharmacology. Following the didactic portion of the training, psychologists complete a 400-hour practicum, including 2 hours of weekly supervision, and treat at least 100 patients with mental disorders. The practicum would be followed by a certification examination that would allow for a 2-year probationary period during which the psychologist would be supervised by a physician. Following these 2 years of supervised practice, the psychologist would become eligible to earn a license to prescribe medication.

## **History of Psychologist Prescription Privilege**

### ***The Military***

In 1989, the department of defense (DOD) launched a program to train psychologists in the military to prescribe medication. The program's base included 1 year of didactic training followed by 1 year of clinical training. Ten individuals went through the training. As of 2003, 7 of the psychologists who had initially been trained were continuing to actively prescribe medication, while the other 3 were working on advocacy or attending medical school. The DOD program, which cost over \$6 million, was stopped at the end of 1996. Proponents of the program claimed that psychologists had shown their ability to safely prescribe medications to patients and were able to provide both psychopharmacological and psychotherapeutic services together. Opponents felt that the program was expensive, that the psychologists were overly reliant on physicians, and that the psychologists were only able to prescribe to a restricted group of the active enlisted military.

### ***New Mexico***

In March of 2002, the state of New Mexico passed legislation allowing properly trained psychologists the right to prescribe medication on a limited basis. The regulations came into effect in January of 2005. The law closely followed the recommendations of the APA in terms of training and accreditation. The psychologists' training includes an 80-hour practicum in clinical assessment and pathophysiology. After a psychologist earns prescription privilege, and following a 2-year probationary period during which a psychologist works with a physician, a psychologist can apply to prescribe medication independently. However, when prescribing, a psychologist must maintain a close collaborative relationship with a patient's primary physician. This collaboration is designed to ensure that an individual is receiving regular medical physical exams, to ensure that there are no adverse reactions to the medication, and to provide a safeguard to prevent the prescription of medications that may have dangerous interactions with one another. To maintain a prescription license, a prescribing psychologist must receive 20 additional hours of training each year. A prescribing psychologist is allowed to prescribe medication and order requisite laboratory tests only for the treatment of mental



disorders. The licensing board charged with allowing psychologists the right to prescribe psychotropic medications is run by physicians. Many psychologists argue that the physicians are too conservative and may be predisposed against allowing PPP. The PPP proponents claim that this regulation limits many qualified psychologists from earning the prescription privilege.

### ***Louisiana's Medical Psychologists***

In May of 2004, Louisiana became the second state to allow psychologists to prescribe psychotropic medications. The Louisiana law stipulates that a psychologist must complete 2 years of postdoctoral training by earning a master's degree in clinical psychopharmacology from a regionally accredited institution. He or she must then pass a national examination. The psychologist is then allowed to prescribe medication provided he or she works in conjunction with the patient's primary physician. The law permits medical psychologists to prescribe medication only related to nervous and mental health disorders.

Louisiana's law is slightly different in that the board that oversees prescribing psychologists is the Louisiana state board of examiners of psychologists, a nonphysician board. Also, the Louisiana law does not require a 2-year probationary period during which a psychologist must work closely with a physician's oversight when prescribing medication.

## **The Psychologist Prescription Privilege Debate**

The issue of extending prescription privileges to psychologists (PPP) has become possibly the most contentious debated proposal advanced in the field's recent history. Few topics have a more polarizing effect. This rancor is likely a direct result of the debate's high stakes. The contest over prescription privileges has moved beyond the proposals and hypothetical ponderings first offered 18 years ago in the pages of professional and academic journals. In recent years, the issue has entered the realm of state legislative subcommittees, and in several states the issue has become a bill put up for a full state-level legislative vote.

### ***The Debate Among Psychologists***

The competing views of professional psychologists regarding the extension of prescription privileges to

psychologists were not adequately resolved before the question became a matter of public policy. The resulting high-stakes legislative debate has fueled a growing schism in the already fractionated field of professional psychology. Studies performed at the end of the 1990s found that nearly twice as many psychologists opposed PPP as favored it. However, as the movement has gained momentum, a greater percentage of psychologists have given at least tacit assent to the idea of advancing PPP. However, many argue that the interdisciplinary schisms within the field of psychology are sufficient to indicate that PPP should not be advanced. This public controversy has generated discussion rather than problem solving, and the opposing points of view have confused legislators and stalled or stopped several PPP bills from passage. Despite the confusion and controversy, the debate is more alive now than ever before. An increasing number of states are introducing bills that, if passed, would extend prescription privileges to psychologists. As these hotly contested bills are presented to states' legislative bodies for debate, psychologists and the professional organizations formed to advance their views and positions are submitting position statements, legal briefs, and sworn testimony to promote their respective positions for and against PPP.

## **The Pros and Cons of PPP**

A comprehensive review of the various positions articulated by psychologists for and against extending PPP reveals the following five central and recurrent themes around which the arguments are framed:

1. Would prescribing psychologists fill a real and pressing societal need?
2. Would prescribing psychologists provide a less expensive alternative to current prescribing health-care professionals?
3. Would the training of professional psychologists be adversely affected by additional course work necessary to develop the knowledge base and skills to competently prescribe?
4. Would prescribing psychologists provide greater continuity of care and a more comprehensive service than conventional collaborative models?
5. Does an ample precedent for successful PPP exist?



## ***Societal Need***

Regarding the issue of societal need for PPP, the position advanced by the APA claims that an insufficient number of psychiatrists are available to adequately offer a complete array of mental health services, including the prescription of psychoactive medications. As a result, traditionally underserved populations (e.g., women, children, the elderly, inner city residents, and members of rural communities) are being deprived of quality mental health assessment and intervention.

The APA offers statistics suggesting that the majority of visits to primary care physicians are made by persons for whom no diagnosis of physical illness can be made and whose complaints result from psychological issues. The argument follows that psychologists are more familiar with mental disorders than are nonpsychiatrist physicians (general practitioners) who are currently prescribing approximately two thirds of all psychotropic medications in the United States.

General practice medical doctors typically receive less than 2 months of training in mental health and psychiatry. The APA argues that, with the appropriate supplemental training in physiology, chemistry, biology, and psychopharmacology, psychologists would be adequately equipped to serve the psychopharmacologic needs of people suffering from mental disorders. Psychologists would be able to offer the unique blend of psychological and psychopharmacological interventions that have previously fallen only into the realm of psychiatry.

The AAAPP position simply holds that the need to prescribe is filled by a sufficient number of physicians, nurse practitioners, and other members of the medical community. In fact, they argue that there is a surplus of physicians. Issues of poor distribution of psychopharmacological health care to reach traditionally underserved populations would best be addressed through subsidies and incentive programs. Many of the nonpsychologists who oppose the extension of PPP claim that psychologists who have specific training in psychopharmacology may harm their patients due to their narrow training. They also claim that physicians would be required to provide intensive oversight to psychologists.

## ***Expense***

The APA believes that psychologists with prescriptive privilege can provide medical mental health care more cost effectively than can psychiatrists,

psychologists working in conjunction with physicians, or other combinations of mental health service provision. Frequently, a consumer of mental health care service will need to see a physician or psychiatrist for medication and a psychologist for psychotherapy and other behavioral health interventions, including case management and diagnosis. Psychologists with prescription privilege become valuable because they independently can serve the function of both general practice physicians and mental health treatment providers. These combined services result in fewer office visits for the consumer and, thus, less expense. Secondly, hourly rates for psychological services are typically significantly lower than costs for psychiatric or general practitioner services.

Proponents of PPP also dispute the claim that psychologists interested in prescription authority need only enter training programs for other professions who are able to prescribe, such as those for nurse practitioners or physician assistants. A training program that is focused only on psychotropic medication will provide only the necessary expertise for a psychologist who chooses to prescribe psychotropic medication. The time and expense involved in becoming a nurse practitioner, a physician assistant, a dentist, or a physician is prohibitive and results in an extraneous skill set for a psychologist. This savings in training would result in lower costs for both psychologists and for the general public.

The AAAPP argues that any cost savings a psychologist may have offered would be eliminated by the costs involved in training, regulating, and supervising psychologists with prescription privilege. For example, the military's attempt at training psychologists was exorbitantly expensive and cost prohibitive for civilian psychologists. These supplemental expenses would, as the AAAPP asserts, eventually be passed on to consumers.

## ***Training***

At the heart of the training debate is the question as to whether the APA's recommended education for psychologists interested in obtaining PPP will sufficiently prepare psychologists and safeguard the community from unqualified personnel. The current recommendations advanced by the APA include 2 years of postdoctoral training, a 400-hour supervised practicum specifically addressing psychoactive medication management, and 2 years of subsequent



clinical supervision by a physician. By contrast, nurse practitioners and physician assistants typically are required to complete 600 total hours of practicum experience, after which these professionals become license eligible. For physician assistants and nurse practitioners, these hours include nearly all training involved with patient care, not only medication management. Thus, the APA contends that the postdoctoral training of psychologists provides ample exposure to and practice with prescribing psychotropic medications. Moreover, because this training is postdoctoral and voluntary, it would not necessarily infringe upon the traditional training practices of professional psychology programs.

Many in the APA would argue that psychologists already represent the highest standard of nonmedical mental health care. These professionals offer expertise in the diagnosis and treatment of mental health disorders. This level of expertise far exceeds the experience of most general practice physicians and certainly that of physician assistants and nurse practitioners. A psychologist with supplemental training in prescribing psychoactive medication would offer a unique variety of interventions and a singularly proficient view of patient care.

Psychologist opponents to PPP articulate concerns that the fundamental focus of doctoral level psychological training programs would be altered substantially. These programs, as posited, would be required to focus much more intensely on the biological bases of behavior and on psychopharmacology. Additionally, undergraduate coursework in biology, chemistry, and other sciences may be additional requirements. If training programs focus more heavily on psychopharmacological interventions, nonmedical interventions and their subsequent benefits may be deemphasized in psychologists' practice. These concerns also extend to the entire enterprise of training psychologists. Professional psychology is currently a highly fractionated and diverse field. To properly train a highly qualified professional psychologist, a broad regimen must be undertaken. These training protocols require a psychologist to demonstrate competence across a broad array of theoretical orientations, clinical perspectives, and subdisciplines, including development, cognitive science, behavioral science, and counseling.

Those concerned by the introduction of PPP fear an overemphasis on psychopharmacological interventions, reliance on reductionistic solutions involving only medication, and a departure from the traditional province of

psychology, which may result in an underemphasis on areas where psychologists have traditionally excelled—in assessment, psychotherapy, and behavioral intervention. Further, PPP opponents are concerned that an increased emphasis on PPP would result in psychology following an increasingly medical model that is focused on extrinsic, individual pathology.

The American Medical Association (AMA) is also opposed to PPP on the basis of training. They assert that prescribing psychologists would require an unreasonably high level of ongoing supervision. This supervision would not only increase costs, but failure to provide this level of supervision would increase the risks to the general public. They argue that all medications affect the entire organism and that a training program focused only on psychotropic medications fails to appropriately address the complexity of the human system.

### ***Continuity of Care***

Those who support PPP argue that obligatory collaboration between various mental health care providers, by definition, interferes with continuity. When multiple care providers are involved in a patient's treatment, it fractionates care. A patient who elects to see a psychologist for psychotherapeutic and assessment services is required to see an entirely different individual for prescription and monitoring the effectiveness of medication. This is currently true under existing laws governing psychological practice in 48 of the 50 states. Additionally, in many cases, healthcare providers who are prescribing will conduct their own, independent assessment. Assessment techniques practiced by nonpsychologist practitioners often fail to meet the psychometric rigor and best practice standards of psychologists. In this way, multiple care providers are more likely to duplicate assessment services. This duplication not only generates unnecessary expense but also occasionally contributes to disagreements in diagnosis and treatment recommendations.

Disagreements in diagnosis and treatment recommendations stem not only from differences in philosophy, professional orientation, and training experiences but also from simple communication breakdowns. Discontinuity of care increases the likelihood of communication breakdowns. For example, an individual consumer of mental health care may become confused about which mental healthcare provider received



various pertinent details of case history. As a result, he or she may neglect to adequately supply a comprehensive account to one or both caregivers. This discontinuous approach often leads to incomplete assessment and treatment protocols, because necessary information is not fully gathered and not fully shared between care providers. Only in rare cases can caregivers sit down, compare notes, and discover omissions and inconsistencies. The risks involved in potential communication breakdowns between busy professionals put the client in danger of substandard care. These dangers may include conflicting diagnoses, incompatible treatment regimens, different methods of measuring outcomes, and divergent notions of treatment success.

Those opposed to PPP argue that collaboration is a standard aspect of both psychiatric and psychological practice. Representatives of these professions are accustomed to embracing other viewpoints and are trained in multidisciplinary treatment approaches. Patients benefit from the unique contribution supplied by practitioners versed in an array of specialties with varying areas of expertise. A multidisciplinary treatment approach is helpful, because specialists bring their own vantage to understanding psychopathology and subsequent treatment. Placing too many treatment options in one practitioner's arsenal may result in a narrowing of treatment protocols, thus failing to incorporate multiple viewpoints and possibly neglecting viable treatment options. In sum, the opponents of PPP suggest that the dangers articulated with the requirements of collaboration are overstated and overshadow the risks associated with nonphysicians prescribing medication.

### ***Precedent***

The APA position points to past and current instances of psychologists safely and effectively providing psychotropic medications to their patients. Such instances include the military's use of psychologists with prescribing authority and time-limited experimental programs executed in New Mexico and California. Further, the APA states that other nonphysician service providers have safely been extended prescription privilege.

During the mid-1970s, the state of California launched a program to extend prescription privileges to many nonphysician mental health providers. These individuals received extensive training in prescribing medications, but they were never legally extended the

privilege of prescribing medications. In the Indian Health Sciences Center in Santa Fe, New Mexico, a project that allowed one psychologist to prescribe a limited number of medications was also deemed to be effective during 1988–1989. There were further attempts to extend the prescription privileges to other nonpsychiatrist service providers that many argue were successful in both scope and safety. The APA also argues that reviews of the performance of psychologists in the DOD have indicated that psychologists have been able to prescribe psychopharmacological interventions safely. Through this program, called the Psychopharmacology Demonstration Project (PDP), 10 psychologists were trained to prescribe medications. Two independent reviews of the military's prescribing psychologists indicate that the psychologists demonstrated high levels of competence and offered excellent care when prescribing psychopharmacological medications. Further, proponents argue that these 10 psychologists have lessened the workload on physicians, have shortened wait times for mental health services and follow up, and have extended care to a broader constituency.

Those opposed to PPP state that previous pilot projects have been limited in scope and disproportionately expensive, and they have required psychologists to be closely monitored by physicians. For example, they state that the DOD project cost \$6 million dollar while training only 10 psychologists. Moreover, they argue that the psychologists needed to be so highly supervised by physicians that their independence was put into question. Finally, opponents argue that the military's psychologists were restricted to treating relatively uncomplicated cases. In the Santa Fe Indian Health Sciences Project, only one psychologist was extended prescription privilege, indicating a limited precedent. The AMA has argued that previous experiences with PPP have required physicians to undertake an undue financial and time burden in supervising relatively naïve psychologists. Thus, the opponents have stated that the expense and training obstacles have proved too onerous and have not resulted in sufficient benefit for the general public.

### **Future Directions**

The prescription privilege debate cuts across many intellectual and proprietary boundaries. Within the field of psychology, the debate focuses on the quality of service provided by psychologists and whether extending



PPP would improve or diminish psychologists' abilities to provide the highest quality mental health care. The discussion between members of the psychological community and those outside of the psychological community has focused on the effects of increasing the number of psychopharmacological prescribers and whether such expansion would provide better or worse service to the general public. As state psychological associations continue to propose legislation, and as physician and psychological groups oppose this legislation in various states, the debate will certainly continue for years to come.

*David M. Hulac and Joshua D. Bernstein*

**See also** Credentialing Individuals (v1); Empirically Based Professional Practice (v1); Ethical Decision Making (v1); Ethical Dilemmas (v1); Postdoctoral Training (v1); Psychopharmacology, Human Behavioral (v2); Supervision (v1)

### Further Readings

- American Psychological Association. (2002). *New Mexico governor signs landmark law on prescription privileges for psychologists*. Retrieved May 14, 2007, from [http://www.apa.org/practice/nm\\_rxp.html](http://www.apa.org/practice/nm_rxp.html)
- American Psychological Association, Division 40. (2002). *CAPP task force on prescription privileges: Sample provisions for prescription privilege legislation*. Retrieved May 14, 2007, from <http://www.lib.lsu.edu/special/apa/misc214.htm>
- Caccavale, J. (2002). Opposition to prescriptive authority: Is this a case of the tail wagging the dog? *Journal of Clinical Psychology*, 58(6), 623–633.
- Dittman, M. (2003). Psychology's first prescribers [Electronic version]. *Monitor on Psychology*, 34(2). Retrieved May 14, 2007, from <http://www.apa.org/monitor/feb03/prescribers.html>
- Heiby, E. M. (2002). Prescription privileges for psychologists: Can differing views be reconciled? *Journal of Clinical Psychology*, 58(6), 589–597.
- Lavoie, K. L., & Barone, S. (2006). Prescription privileges for psychologists: A comprehensive review and critical analysis of current issues and controversies. *CNS Drugs*, 20(1), 51–66.
- McFall, R. M. (2002). Training for prescriptions vs. prescriptions for training: Where are we now? Where should we be? How do we get there? *Journal of Clinical Psychology*, 58(6), 659–676.
- New Mexico Prescriptive Authority Law. 1967 Laws 23 §2 (2002). Retrieved May 14, 2007, from <http://www.nmpa.com/displaycommon.cfm?an=1&subarticlenbr=12>
- Norfleet, M. A. (2002). Responding to society's needs: Prescription privileges for psychologists. *Journal of Clinical Psychology* 58(6), 599–610.

---

## PROFESSIONAL ASSOCIATIONS, COUNSELING

---

The American Counseling Association (ACA) is the primary organization to which professional counselors belong. The association includes 19 divisions, 56 branches, and 5 professional partners (i.e., affiliated organizations). Approximately 45,000 counselors from the United States and 50 other countries belong to ACA. The headquarters are in Alexandria, Virginia. According to the association's bylaws, their mission is to "enhance quality of life in society by promoting the development of professional counselors, advancing the counseling profession, and using the profession and practice of counseling to promote respect for human dignity and diversity." Members of the association actively advocate for social justice as well as the promotion of the profession.

### History

Although the organization was incorporated in 1952, its history can be traced to the turn of the 20th century, when the association's first division, the National Vocational Guidance Association (NVGA), was established independently in 1913. Eleven years later, in 1924, the American College Personnel Association (ACPA) was founded. The Student Personnel Association for Teacher Education (SPATE) was formed in 1931. The National Association of Guidance and Counselor Trainers (NAGCT) originated in 1940.

Discussion of unifying these four groups was introduced in 1949 at a meeting of the Council of Guidance and Personnel Associations. Proponents supported the notion of "one national voice speaking for the guidance and personnel profession" (Simmons, 2002, p. 8). In response, the members of these four existing organizations established the American Personnel and Guidance Association (APGA) in 1952. The annual dues were \$6.00. The offices were leased from the American Psychological Association (APA), and many of the original members and leaders were psychologists. In fact, Donald Super, a psychologist who viewed the fledgling organization as an interest group, became the second president.



Despite Super's perception of APGA as an interest group, the association prevailed and flourished, and each of the original divisions contributed a cornerstone to its diverse areas of identity and philosophy. For example, facilitation of career development remains a hallmark of professional counseling (NVGA's influence). The notion of development extends across the life span, rather than remaining focused on childhood (ACPA's influence). Additionally, counselors have actively participated in various educational enterprises. Counselors have championed ethical practice, unconditional positive regard, equality, advocacy, and human rights (SPATE's influence). Founding members also recognized the importance of preparation for counselors, training standards, theory-based approaches to counseling, supervision, continuing education, and research (NAGCT's influence).

As the subgroups' identities evolved, their names were changed to the National Career Development Association (NCDA), the Counseling Association of Humanistic Education and Development (C-AHEAD), and the Association for Counselor Education and Supervision (ACES). ACPA disaffiliated in 1992. Other divisions were chartered as the organization grew and responded to the needs of its members and society.

By the 1970s, members of APGA recognized the importance of licensure, certification, and accreditation. With the development of these three areas of credentialing emerged standardization of training procedures, identification of minimum qualifications for practice of counseling, and a stronger professional identity. The first licensure law was enacted in 1976 in Virginia. The Council for the Accreditation of Counseling and Related Educational Programs (CACREP) was established in 1981, and the National Board for Certified Counselors (NBCC) was formed in 1982. These three separate but integrally related entities reflect consistency among standards for counselor education programs, licensure requirements, and certification criteria.

By 1987 APGA had grown to 57,000 members, and it became clear that the association had exceeded Super's notion of an interest group. Evolution of the umbrella organization and the addition of divisions during the first 30 years necessitated a change in the association's name. APGA reflected the emphases on students and guidance; it did not capture the essential philosophical underpinning of development or reflect the practice of counseling. Thus, in 1983, the members voted to change the name from APGA to the American Association for Counseling and Development

(AACD). Although this name reflected the philosophy and practice of the association's members, consumers did not easily understand it. Thus, in 1992, members selected the current name, American Counseling Association (ACA).

The early presence of three divisions reflected essential values and emphases among members of ACA. A forerunner of the Counseling Association of Humanistic Education and Development (C-AHEAD) was among the four founding divisions. The Association for Multicultural Counseling and Development (AMCD) was chartered in 1972. The Association for Spiritual, Ethical, and Religious Values in Counseling (ASERVIC) followed in 1974. In 1996 the Association for Gay, Lesbian, and Bisexual Issues in Counseling (AGLBIC) was founded. Counselors for Social Justice (CSJ) received its charter in 2004. The sustained presence of these divisions has demonstrated (a) a consistent commitment to all members and all clients, regardless of their culture; (b) a recognition of the importance of spirituality in counseling as well as development; and (c) a devotion to humanistic principles as applied to human development and potential.

## Partners

In addition to divisions and state branches, ACA has professional partnerships with five affiliates that operate with separate boards of directors.

### *ACA Insurance Trust*

Through the insurance trust, ACA members purchase a variety of insurance packages. The professional liability insurance provides a program in response to the unique needs of professional counselors and counselor supervisors, regardless of their work settings. Policyholders also have access to legal advice.

### *The American Counseling Association Foundation*

The foundation was formed to provide a mechanism for supporting counselors in training, recognizing excellence among ACA members, and publishing excellent materials. The foundation has responded to needs of children through the Growing Happy and Confident Kids program. Additionally, the foundation assists counselors adversely affected by natural disasters through the Counselors Care Fund.



### **The Council for Accreditation of Counseling and Related Educational Programs**

The Council for Accreditation of Counseling and Related Educational Programs (CACREP), mentioned previously, was created to provide standards and procedures for accrediting counselor education master's degree and doctoral programs. A separate board governs CACREP; however, there is a strong affiliation among ACA, CACREP, and NBCC in order to maintain consistent training and certification standards that meet appropriate levels of rigor.

### **National Board for Certified Counselors**

NBCC was formed in 1982 to provide a voluntary credential for professional counselors. Requirements for certification parallel those established by CACREP. Additionally, NBCC monitors specialization credentials such as national certified school counselor and certified clinical mental health counselor. NBCC has developed a variety of examinations that are used by counselor licensure boards (e.g., the National Counselor Examination for Licensure and Certification) and counselor education programs (e.g., the Counselor Preparation Comprehensive Examination). Its Web site contains an array of materials such as *What to Expect as a Client*.

### **Chi Sigma Iota**

Chi Sigma Iota (CSI), which was founded in 1985, is the official international honor society of the counseling profession. The society's mission is to promote scholarship, research, professionalism, leadership, and excellence in all aspects of counseling. Additionally, CSI leaders endorse the importance of CACREP accreditation. CSI includes at least 277 chapters and nearly 12,000 active members, which include counselors in training, professional counselors in a range of practices, and counselor educators. An essential requirement of membership is a clear identification with the profession of counseling, evidenced by counselor education as one's highest or terminal degree.

## **Publications**

The *Journal of Counseling and Development* (JCD) is the flagship journal; its history of title changes (six) reflects the development of the counseling profession.

For example, the original title was *The National Vocational Guidance Bulletin*, which was first published in 1921. The title was changed to *Personnel and Guidance Journal* in 1952 to parallel the formation of APGA. *Counseling Today* is the primary newsletter; it was originally called *Guidepost*. Divisions and branches also publish journals and newsletters.

Additionally a variety of books and other materials are published by ACA. Resources for counselors and counselors in training as well as clients are available on the association's Web site. One practical electronic document is the *Layperson's Guide to Counselor Ethics: What You Should Know About the Ethical Practice of Professional Counseling*.

ACA, several of its divisions, and NBCC have published codes of ethics and standards of practice. These documents are available for review on the various associations' Web sites.

## **Organizational Structure**

The organizational structure of ACA is not unlike that of many other professional groups. Subgroups of the association, known as divisions, are numerous and diverse. As special focus or interest groups, divisions vary in size and mission. State groups, known as branches, of ACA also have state divisions. Additionally, ACA has regional groupings of state branches and divisions as intermediate-level groupings. Representatives of the various divisions and regional groups, coupled with elected and appointed associational officers, compose the ACA Executive Council, the policy-making body of the ACA.

A significant revision in the ACA affiliation framework occurred in the 1990s. Prior to that time, one could be a member of an ACA division only if one were a member of the larger association. However, amid a variety of internal pressures and financial circumstances, the ACA Executive Council determined that a change was needed in the affiliation framework. Beginning in 1998, ACA divisions were allowed to determine whether one could participate in divisional membership without associational membership in the ACA. The previous model was sometimes described as a spoked wheel with strength stemming from the interrelationship between the hub and the various spokes of the wheel. The newer model emphasized the strength of the various spokes of the wheel. Some divisions retained the original affiliation framework, requiring associational membership for divisional



membership (e.g., Association for Counselor Education and Supervision), while others adopted the newer framework (e.g., American Mental Health Counselors Association).

Elements of fragmentation within ACA were obvious during the final decade of the 20th century. Thomas Sweeney noted a specific example in his Article "Accreditation, Credentialing, Professionalization: The Role of Specialties" (p. 123): An invited speaker addressing a group of ACA leaders queried, "Is this a group of groups or a group of the whole?" This statement was context for the speaker's next observation that "if the ACA is a group of groups, then the membership can expect to be ineffective in influencing external groups." However, he further noted that as a single discipline, "counseling could become a core healthcare provider through an amendment to the Public Health Services Act of 1973 similar to what social work, psychology, and marriage and family therapy had done." In this regard, the future of the ACA, while hopeful, remains precariously linked to whether it retains a centralized identity as a group of counselors or a fragmented identity as an amalgam of specialized practitioners and interest groups.

*Sandy Magnuson, S. Allen Wilcoxon,  
and Ken Norem*

**See also** Accreditation by the American Psychological Association (v1); Accreditation by the Council for Accreditation of Counseling and Related Educational Programs (v1); Conferences, Counseling Psychology (v1); Conferences in Counseling (v1); Counseling, History of (v1); Credentialing Individuals (v1); School Counseling (v1); Supervision (v1)

### Further Readings

- Gladding S. T. (2004). *Counseling: A comprehensive profession* (5th ed.). Upper Saddle River, NJ: Pearson Prentice Hall.
- Goodyear, R. K. (1984). On our journal's evolution: Historical developments, transitions, and future directions. *Journal of Counseling and Development*, 63, 3–9.
- Kaplan, D. M. (2002). Celebrating 50 years of excellence! *Journal of Counseling and Development*, 80, 261–263.
- Locke, D. C., Myers, J. E., & Herr, E. L. (2001). *The handbook of counseling*. Thousand Oaks, CA: Sage.
- Sheeley, V. L. (2002). American Counseling Association: The 50th year celebration of excellence. *Journal of Counseling and Development*, 80, 387–393.

- Simmons, J. (2002, January). A golden opportunity: ACA through the 1950s. *Counseling Today*, 44, 8–10.
- Sweeney, T. J. (1995). Accreditation, credentialing, professionalization: The role of specialties. *Journal of Counseling and Development*, 74, 117–125.
- West, J. D., Osborn, C. J., & Bubenzer, D. L. (2003). *Leaders and legacies: Contributions to the profession of counseling*. New York: Brunner-Routledge.

### Web Sites

- American Counseling Association: <http://www.counseling.org>
- Chi Sigma Iota: <http://www.sci-net.org>
- Council for Accreditation of Counseling and Related Educational Programs: <http://cacrep.org>
- National Board for Certified Counselors: <http://www.nbcc.org>

---

## PROFESSIONAL DEGREES

---

If individuals are interested in a career in counseling or psychology, there are various degrees they can pursue. These fields are very diverse and offer a number of opportunities for those who wish to obtain a master's or doctoral degree.

### Master's Degree

There are many different master's level programs that train students in basic counseling skills. These programs focus on areas such as community counseling, clinical counseling, couples and family therapy, addictions counseling, and vocational counseling. Programs will offer either a master of arts (M.A.) or master of science degree (M.S.). An individual may also obtain a master's degree in social work (M.S.W.). Generally, completion of a master's program in counseling, psychology, or social work requires 2 to 3 years of full-time coursework and a supervised internship.

Licensure varies from state to state for master's level clinicians, but, generally speaking, after completion of a master's program from an accredited university, a candidate may apply for licensure after 1 to 3 years of postgraduate experience supervised by a licensed clinician and after successful completion of the state licensure exam. With a master's degree in counseling or psychology, one can obtain one of two licenses in most states: licensed marriage and family



therapist (LMFT) or licensed professional counselor (LPC). If an individual possesses a master's degree in social work, he or she may obtain licensure as a licensed clinical social worker (LCSW).

Individuals who obtain a master's level degree in the discipline of social work or psychology work in a variety of settings, including community mental health agencies, guidance counseling centers, residential treatment facilities, and drug and alcohol treatment facilities and hospitals, to name a few.

### Doctoral Degree

There are also a variety of doctoral programs in counseling and psychology, some of which can be started after an individual receives a bachelor's degree and others that require that a master's degree be obtained first. Applied psychology doctoral programs include school psychology, counseling psychology, clinical psychology, and industrial-organizational psychology. In all 50 states, the doctorate is the entry level degree for licensed psychologists. Only individuals who have obtained a doctoral degree in professional psychology (clinical, counseling, school, or industrial-organizational) and met a variety of requirements for licensure may call themselves "psychologists." This title is protected and regulated by state licensing boards. The reasoning for such regulation is to protect the public from individuals who are not competently trained to treat individuals with psychological issues.

Most school psychology degrees are offered by an education department within a university, and candidates earn either a doctor of philosophy (Ph.D.) or doctor of education (Ed.D.) degree. School psychologists are specialists in the assessment and treatment of learning and behavior problems of children and young adults. While school psychologists are most commonly employed by school systems, they can also be found working in hospitals, universities, community mental health centers, and private practices. In some jurisdictions, it is possible for individuals to practice as a school psychologist without a doctoral degree. These individuals have earned an educational specialist degree (Ed.S.) and they can be called a school psychologist only while working in a school setting.

Programs in clinical and counseling psychology are offered through departments of education or psychology within a university. The most common degree for these programs is the Ph.D. However, the doctor of psychology degree (Psy.D.) is becoming more

common. Historically, the major distinction between Psy.D. and Ph.D. programs is that the Psy.D. programs focus more on the development of clinical skills than on research skills. Ph.D. programs focus on training clinicians, but they also have a much greater emphasis on the development of research skills as well. While these distinctions between Ph.D. and Psy.D. programs in clinical and counseling psychology generally remain, there is variability in the amount of emphasis a program places on the science and practice of psychology within each degree. There currently are Psy.D. programs that require their candidates to complete a research-based dissertation, and there are Ph.D. programs that permit their candidates to complete clinical case studies in lieu of a dissertation.

Clinical psychology programs educate students on mental health assessment and treatment. Historically, clinical psychologists emphasized the assessment and treatment of individuals with chronic psychiatric conditions. While some clinical psychologists still specialize in working with individuals who have severe psychopathology, others have specialized in helping less impaired individuals deal with life crises and stages. Clinical psychologists work in a variety of settings, including academia, private practice, mental health centers, and hospitals.

Counseling psychology programs tend to emphasize training in psychotherapy and research methods. Counseling psychologists generally work with persons suffering from adjustment issues rather than severe psychopathology. These psychologists are often employed in academia, college counseling centers, community mental health centers, hospitals, and private practice.

Individuals who get degrees in clinical, counseling, or school psychology may then enter a subspecialty in psychology. Some common subspecialties include forensic psychology, health psychology, and neuropsychology.

Forensic psychologists work in a variety of settings as well. These individuals function as clinicians in corrections facilities, work as consultants to trial lawyers, serve as expert witnesses in jury trials, and formulate public policy regarding psychology and the law. Some forensic psychologists have a juris doctor degree (J.D.) as well as a degree in clinical or counseling psychology. There are some programs in the United States that offer concurrent programs, so that the individual can earn both degrees at the same time.



Health psychologists have specialized training in how psychological variables impact health promotion and disease prevention. These individuals are interested in how psychology contributes to the promotion and maintenance of healthy living and to the prevention and treatment of illness. Health psychologists design programs for individuals who wish to stop smoking, lose weight, decrease stress, or maintain physical fitness. These persons are employed by rehabilitation centers, public health centers, academia, hospitals, and private practice. Individuals who function as health psychologists who focus on the treatment of children are called pediatric psychologists.

Neuropsychologists have specialized training in neurology and psychology. Their practice emphasizes how brain disorders and trauma may be manifested in a client's behavior, personality, and cognitive functioning. Neuropsychologists have developed various specialized assessment instruments that are intended to better isolate the likely region of brain dysfunction or differentiate between types of functional impairments that have resulted from brain impairments.

Finally, industrial-organizational psychologists, or I/O psychologists, are interested in the relationship between individuals and their work environments. These psychologists might work to increase workplace productivity while improving quality of life for the worker. Frequently, they play a role in personnel selection. I/O psychologists are employed by companies, businesses, government agencies, and academic settings.

Individuals can also obtain mental health doctoral degrees in fields that are outside of psychology. Two such fields are social work and counselor education. The Ph.D. is the most common degree for a doctorate in social work. Social work programs tend to take a

broader, systematic perspective in helping individuals deal with emotional, health, and adjustment issues. These individuals are trained to help clients identify and qualify for various types of assistance. The entry level degree for social work is the M.S.W., so most individuals seeking a Ph.D. in social work are doing so because they want to work in an academic environment.

The same is true for individuals who obtain a doctorate in counselor education. Counselor educators can become licensed as professional counselors and work in a variety of settings (hospitals, mental health clinics, private practice) with a variety of clients (children, adolescents, couples, and families). Counselor educators can become licensed as LPC. Since the entry level degree for the LPC license is the master's degree, most individuals seeking a Ph.D. in counselor education desire to work in an academic environment where they will specialize in training students seeking the MA degrees.

*Erica Hope*

*See also* Accreditation by the American Psychological Association (v1); Accreditation by the Council for Accreditation of Counseling and Related Educational Programs (v1); Continuing Education (v1); Credentialing Individuals (v1); Industrial/Organizational Psychology (v1); Postdegree/Prelicensure Supervision (v1); Predoctoral Internships (v1); Specialization Designation (v1)

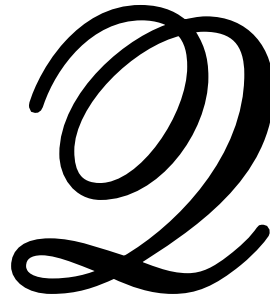
### Further Readings

- Lloyd, M. A. (2002). *Master's- and doctoral-level careers in psychology and related areas*. Available at <http://www.psychwww.com>
- Lloyd, R. R. (2006). *A guide to psychology and its practice*. Retrieved from <http://www.GuideToPsychology.com>









---

## QUALITATIVE METHODOLOGIES

---

Qualitative research may be broadly said to be research in which data in the form of words are collected and examined thematically. In other words, what is of interest to the researcher is an exploration, in a natural setting, of the meanings people bring to the qualities, nature, or essence of a phenomenon. The aim of qualitative research is to understand the meaning of human action and to explore and tell the human story. *Qualitative research* is a broad term that encompasses genres such as ethnography, case study, narrative inquiry, phenomenology, grounded theory, life history, oral history, biography, and auto-ethnography.

This entry briefly describes the background of qualitative research; five of the most prominent methodologies (grounded theory, phenomenology, ethnography, case study, narrative inquiry); how to collect data through the use of interviews, observations, and artifacts, data analysis; methods to enhance trustworthiness (a qualitative term for validity and reliability); and possible future directions of qualitative research.

### Background

While qualitative research has been around for some time (since the late 1800s in the United States; e.g. Chicago school sociology, 1892), it has been held in varying levels of respect and acceptance throughout the history of research. Over the last quarter of a century, qualitative research has seen a new level of acceptance in academia. At the same time, ironically, government funded research has touted the so-called

gold standard of experimental research, which has relegated government-funded qualitative research to mere window dressing for randomized experimental designs. The intersection of the tension between government research funding standards and current levels of interest in qualitative research as seen in the increase of qualitative journal articles, conferences, courses, textbooks, and dissertations is the point at which any qualitative researcher is situated today.

## Qualitative Methodologies

### *Grounded Theory*

Grounded theory (GT) is a type of qualitative research in which the primary purpose is to develop a theory based on data. GT is an approach that involves induction, deduction, and verification, although the primary focus is on induction. The term *grounded theory* refers to both the method of data investigation and the analysis as well as the final product of the research. Grounded theory consists of a set of analytic guidelines that allow researchers to inductively build theories. Data collection and analysis occur simultaneously. The process begins with initial data collection typically through unstructured interviews in the field. Data analysis begins by sorting the data into categories that can comprise events, instances, or happenings. The researcher then goes back into the field to collect more data in an attempt to verify or discredit emerging findings. Analysis continues as comparisons between the data are made and the emerging categories are tested and revised. This is referred to as the *constant comparative method*. Data collection and



analysis continue until saturation is reached. *Saturation* is the theoretical term for the moment when it seems no new data need to be collected due to repetition or redundancy in the data.

The data analysis portion of grounded theory consists of three types of coding: open, axial, and selective. When coding data, the researcher breaks field notes or interview transcripts into meaningful chunks or clusters. Each cluster is assigned a code, which is a word or phrase that encapsulates the meaning of the cluster. The clusters could be words, phrases, sentences, or paragraphs. This first phase of coding in a GT study is called *open coding*. It can be thought of as the first pass at creating categories. The researcher then identifies properties of the categories. Open coding is followed by a deeper level of coding called *axial coding*. When conducting axial coding, the researcher looks for new ways to categorize clusters of information. The researcher identifies a central phenomenon, explores occurrences, emotions, or beliefs that influence the phenomenon, and examines the results of the phenomenon. The final phase of coding in GT is *selective coding*. In selective coding, a “story line” is identified that integrates the codes found in axial coding. This story line becomes, in essence, the grounded theory.

While grounded theory refers to the iterative methods of data collection and analysis, it also describes the result, a social theory. The theory, or set of hypotheses, developed about the central phenomenon being studied is based completely in the data, in that all attempts are made to avoid using other theoretical ideas or notions to inform the analysis. The theory is “grounded” in the data, hence, grounded theory. Grounded theory is typically presented with five components: a central phenomenon, causal conditions, strategies, conditions and context, and consequences.

### Phenomenology

The focus of a phenomenological study is to explore the meaning of lived experiences. *Lived experiences* is a term that emphasizes the different and individual lives humans lead. The goal of a phenomenological study is to search for, understand, and explain the essential structure or essence of the phenomenon in question. The experiences are reduced to a description of what all the participants in the study experience.

Phenomenologists tend to use unstructured interviews as their main source of data. The first step in data analysis is to bracket, or set aside, their preconceived

experiences about the phenomenon of interest. Bracketing is also referred to as *epoche*. The phenomenological researcher wants to fully understand the phenomenon from each participant’s point of view. The second step in data analysis is *horizontalization*, in which all significant statements related to the topic are listed and given equal value. In the third step of analysis, the researcher clusters statements into themes and searches for meaning. Synthesis of themes results in a general description of the essence of the phenomenon.

### Ethnography

Ethnography has been said to be the gold standard or hallmark of qualitative research, and it is characterized by in-depth study of a culture’s naturally occurring behavior. While originally developed and employed by anthropologists to study human nature, the use of ethnography may increasingly be seen in the social sciences in general, with developed subfields such as educational ethnography and ethn nursing. Features of ethnography are that the researcher is in the field for long durations of time, uses participant observation to collect data, and examines culture. A long duration of time may be defined as at least one cycle of the phenomenon (e.g., one season, one semester, one treatment cycle). It is important to note that one may use ethnographic methods but may not be conducting a full ethnography. In these instances one may refer to one’s study as ethnographically informed or influenced.

### Case Study

While case study may be considered quantitative, mixed method, or qualitative research, this entry addresses holistic, qualitative case studies only. Case study often seems similar to other types of qualitative research such as in-depth interviews or ethnography. However, case study is distinguished from other research in that it is the intense description of one bounded unit (e.g., one client, therapy group, couple, clinic, organization). The holistic case is naturally occurring and bound to its context. The particular nature of the case is what is of interest to the researcher.

Case studies may be designed in multiple ways. The researcher might choose a case for what Robert Stake has called an *intrinsic* reason or an *instrumental* reason. Intrinsic means that something about the specific case is of interest. Instrumental cases, however,



are chosen to illustrate a general topic of interest. Additionally, multiple or *collective case* studies may be designed in which each case is similar, dissimilar, typical, or different. A *case within case* is a design in which a larger case is explored by examining smaller cases that occur within it. For example, a counseling clinic of interest may be explored by studying three of the counselors within the clinic in depth along with an overall study of all of the features of the clinic such as the caseload, funding, philosophy, and director.

Because it is a study of one bounded unit, generalizability of a case is an ongoing issue for case study research. A case study researcher typically believes, along with the field of qualitative researchers, that the detailed, holistic, rich, descriptive information of their research allows users of case studies to determine to what extent the case generalizes to their situations.

A case study researcher makes a case through the presentation of details that convince the reader and make clear the issues of the case. The small number of cases allows for significant depth of data collection. In holistic case study, data are gathered through observation, interviews, and artifact, whenever possible. Then, information is triangulated and presented in a rich, descriptive case report.

### **Narrative Inquiry**

Jean Clandinin and Michael Connelly have succinctly defined narrative inquiry as “stories lived and told.” Narrative inquiry may also be said to be a study of the generation of stories of life experiences, a discourse form of research in which a story is examined as it changes over time, and an exploration of experience through stories that people tell. Narratives are the unit of analysis. Most narrative researchers define *narrative* as text obtained from in-depth interviews or documents such as journals, diaries, letters, and memoirs. However, some narrative researchers have expanded this methodology to include observational research in which the researcher specifically looks for stories that occur contextually in the field.

Narrative analysis may include a variety of procedures for interpreting narrative data. The text tends to be analyzed using the perspective or techniques of a particular discipline. For example, a sociologist may be interested in the relationship of the narrative to meanings in society, while a counselor or psychologist may be more interested in memory, process of recall, and therapeutic understandings of story.

## **Data Collection**

In order to answer the question “what is going on here?” it is important for qualitative researchers to ask, observe, and even experience as much as possible in order to create rich descriptions of what is happening. In general, qualitative researchers first decide what they want to know about what is going on. If they wish to *discover something*, they may choose a grounded theory approach. If they are *seeking to understand*, they may choose ethnography. A case study would be used if they want to *explore a process*. *Describing the experience* would be accomplished with a phenomenology. If the researchers want to *report the stories*, then a narrative approach would be taken. In general, qualitative research questions begin with *what* or *how*. What is going on here? How does this person relate to the group? In seeking to answer these types of questions, the three common forms of collecting qualitative data are interviews, observations, and examining artifacts.

### **Interviews**

Interviews can be conducted with individuals or with groups that are referred to as group interviews or focus groups. Interviews can be structured, semistructured, or unstructured. Technology has also impacted interviews, so an interview may be face-to-face, over the phone, or through the Internet. Researchers conducting interviews begin with an interview *protocol*, which is a list of questions that will be asked of the participant. In structured individual interviews, the protocol lists each question along with a limited set of response categories. Responses to structured interviews are coded into pre-established categories. Unstructured interviews are in-depth and open-ended and are similar to a conversation with equal give-and-take between the researcher and participant. Unstructured interviews in counseling research are recommended for sensitive topics such as rape or incest and when interviewing young children. Semistructured interviews are a mixture of structured and unstructured questions and are the interview design most qualitative researchers employ.

### **Observations**

Observation is a key form of data collection. Observations range from being nonparticipatory in nature, in which the researcher tries to remain unnoticed, to participatory in nature, in which the researcher joins in on the activities being observed. In both



nonparticipatory and participatory observation, the researcher keeps field notes, or records of observations. Field notes may also be used to record feelings of the researcher. Field notes are considered data and can be synthesized with other types of data such as interviews to help create a complete understanding of the complexities of the cultural group being studied.

### Artifacts

In qualitative research, an artifact is anything made by humans that can be picked up and observed. A cultural artifact is something made by a person or a group of people that gives information about that group. Examining a clinic's physical layout or procedure manual are methods counseling qualitative researchers may use to explore a question. The idea of examining cultural artifacts to understand people emerged from anthropology. In counseling research, an artifact might be a counselor's case notes, videos of sessions, or a client's journal or artwork. When exploring the historical aspects of a participant, the artifact might be an historical document such as a legal document, letter, or diary.

### Analysis

It is important to note that from the first moment qualitative data are collected, analysis should be ongoing and recursive. If researchers wait to analyze the data until all the data are collected, they are missing a key opportunity to take advantage of the emergent, flexible, data-driven process of qualitative research. In other words, as each observation, interview, and artifact is examined, new questions emerge that may guide future data collection. With this in mind, data analysis has two major areas for discussion: data management or the organizing of data, and the process of breaking down, reassembling, and interpreting data through qualitative analysis.

When organizing data, it is vital to make copies of all-important papers and put them in at least two locations. Stories abound of lost data never to be generated again. Researchers are advised to allocate time daily to put field notes and interviews in order, catalogue all documents and artifacts, label and store all data, create a table of contents of stored data, check for missing data, and begin reading through and reviewing data, or what is commonly referred to as read, read, and rereading the data.

An organized set of data allows for analysis to begin in a meaningful fashion. Put simply, analysis

consists of looking for themes, patterns, or categories of similarities. It is important to note that outliers, notes of dissonance, and unique cases are highlighted and not discarded, because the uniqueness of humans is one of the areas of interest in qualitative research.

While there are a multitude of data analysis strategies, some of which were reviewed under the methodologies discussed previously, only one—an overview of Wolcott's analysis—will be presented here. The reader is advised to examine the literature for specific analysis strategies when conducting phenomenology and grounded theory. Wolcott has said that all analysis may be said to be a process of description, analysis, and interpretation. During *description*, the data speak for themselves, and long pieces of the final product are drawn directly from notes, journals, or interviews. The researcher essentially treats descriptive data as facts. While all researchers use description at some level, it is especially useful for concepts that have never been examined in a scholarly manner. *Analysis* then expands and builds on description using some detailed plan or approach to identifying key relationships in the data. Finally, data *interpretation* follows analysis or arises directly from description. During interpretation the researcher does not claim to be as scientific as during analysis and is not as restricted as during the description. Here the goal is to make sense of the data by making interpretations of, inferences from, and implications about the data for the field.

### Trustworthiness

*Trustworthiness* is an overarching term for validity and reliability. Other terms that are used may include *dependability*, *confirmability*, and *credibility*. Validity and reliability of research together compose one of the most hotly debated issues in qualitative inquiry, and they are at the root of many postpositivist researchers' lack of acceptance of qualitative research. Qualitative researchers are advised to have a full understanding of quantitative and qualitative notions of validity and reliability when defending their research. The most important idea to understand is that there are procedures common throughout the field of qualitative research that allow one to feel more confident that the research data presented show a fully fleshed out picture. However, this picture is not more "true" than the picture provided by quantitative data, just more fully explored. The use of most of these procedures depends on the type of research being conducted and the research question being examined. Some of the most



common procedures include member and peer checks, triangulation, audit trail, duration in the field, and reflexivity.

The use of reflexivity may be the most valuable yet least demonstrable way to enhance a study's trustworthiness. Reflexivity is a critical self-reflection on one's biases and predispositions. Researchers are encouraged to explore their bias in a researcher journal. Reflexivity may be a means for critically inspecting the entire research experience.

### Future Directions

In the first decade of the 21st century, there is a new emphasis among qualitative researchers on ethics, personal responsibility, and moral obligation. In general the field is taking on a new participatory, feminist, democratic, and reciprocal stance. Interviews are becoming more a negotiated accomplishment between the interviewer and the interviewee, and observations and artifacts are not seen as fact but as interpretable data.

Researchers are also increasingly blending qualitative and quantitative methodologies in mixed methods studies. While researchers such as evaluators find this a pragmatic design, others contest the blending of two such seemingly polarized paradigms, feeling either that the quantitative data are being used to "prove" the qualitative data or that the qualitative data are unnecessary in a rigorous quantitative design.

The tides are shifting in academia, as new faculty are less traditional than their predecessors in terms of their academic reporting of qualitative research. It is common to write research accounts of what went on behind the scenes in a study in an effort to make research practice transparent and informative to other researchers. This practice is a decided move away from an objective account that reports research results as though they are facts. Autoethnography, poems, performances, and photo methodologies are becoming acceptable forms of reporting qualitative research. Examples include ethnopoetics and photovoice, a method that uses photography to help give voice to those who otherwise would not have one (e.g., children, those with low language skills, non-English speakers).

*Maria K. E. Lahman and Monica R. Geist*

*See also* Ethics in Research (v1); Mixed Methodology Research (v1); Psychometric Properties (v2); Quantitative Methodologies (v1)

### Further Readings

- Charmaz, K. (2006). *Constructing grounded theory*. Thousand Oaks, CA: Sage.
- Clandinin, J., & Connelly, M. (2000). *Narrative inquiry: Experience and story in qualitative research*. San Francisco: Jossey-Bass.
- Coffey, A., & Atkinson, P. (1996). *Making sense of qualitative data: Complementary research strategies*. Thousand Oaks, CA: Sage.
- Creswell, J. W. (1998). *Qualitative inquiry and research design: Choosing among the five traditions*. Thousand Oaks, CA: Sage.
- Crotty, M. (1998). *The foundations of social research*. London: Sage.
- Denzin, N. K., & Lincoln, Y. S. (2005). *The SAGE handbook of qualitative research* (3rd ed.). Thousand Oaks, CA: Sage.
- Ellis, C., & Bochner, A. P. (1996). *Composing ethnography: Alternative forms of qualitative writing*. Walnut Creek, CA: AltaMira.
- Glaser, B., & Strauss, A. (1967). *The discovery of grounded theory*. Chicago: Aldine.
- Merriam, S. B. (1998). *Qualitative research and case study applications in education*. San Francisco: Jossey-Bass.
- Miles, M. B., & Huberman, A. M. (1994). *An expanded sourcebook: Qualitative data analysis* (2nd ed.). Thousand Oaks, CA: Sage.
- Morgan, D. L. (1997). *Focus groups as qualitative research* (2nd ed.). Thousand Oaks, CA: Sage.
- Moustakas, C. (1994). *Phenomenological research methods*. Thousand Oaks, CA: Sage.
- Patton, M. Q. (2002). *Qualitative research and evaluation methods* (3rd ed.). Thousand Oaks, CA: Sage.
- Richards, L. (2005). *Handling qualitative data: A practical guide*. London: Sage.
- Stake, R. E. (1995). *The art of case study research*. Thousand Oaks, CA: Sage.
- Stewart, D. W. (1990). *Focus groups: Theory and practice*. Newbury Park, CA: Sage.
- Strauss, A., & Corbin, J. (1998). *Basics of qualitative research: Techniques and procedures for developing grounded theory* (2nd ed.). Thousand Oaks, CA: Sage.

---

## QUANTITATIVE METHODOLOGIES

---

Quantitative methodologies can be generally defined as the various procedures used to examine differences between groups and relationships between variables with respect to quantifiable phenomena. The list of potentially quantifiable phenomena is immense and includes any type of behavior, attitude, perception,



knowledge domain, or other extant characteristic that can be measured numerically. Quantitative methodologies are applied across a variety of disciplines in the physical, biological, and social sciences and reflect contributions from the fields of statistics and measurement. Statistics include the procedures employed for summarizing numeric data and testing hypotheses, while measurement encompasses the processes used to assign meaningful numbers to the traits or variables of interest to a researcher.

The types of research designs in which quantitative methods are used include true experiments (also known as completely randomized designs), quasi-experiments, and nonexperimental designs (also termed passive observational or correlational). What differs among these designs is the extent to which the researcher exercises control over certain factors in the study and the extent to which randomization is present. Moreover, quantitative methods can be classified into those used solely for descriptive purposes (i.e., to characterize data in terms of distributional shape, central tendency, and variability) and those used for drawing inferences based on tests of hypotheses.

## Origins of Quantitative Methodology

### *Historical Background*

The quantitative methodologies in current use evolved from various disciplines including biology, mathematics, psychology, sociology, statistics, econometrics, and political science and can be classified broadly into the fields of statistics and measurement. Although the fields do share common roots, given the use of statistical methods in conducting measurement analyses and conversely, the reliance on valid and reliable measures to conduct meaningful statistical tests, the fields of statistics and measurement nevertheless have unique historical origins.

To those who have ever taken a course in statistics, the term *statistics* often conjures images of memorized formulas, lists of rules, and tedious calculations. However, the early history of modern statistics was far from dull, often characterized by volatile ideological and philosophical clashes, bitter rivalries, and in some cases, lifelong enmity among the key players in the development of the field. The first evidence of modern statistical reasoning appeared in the late 17th century, when statistical concepts that provide the foundation for modern statistical theory, such as probability, variability, and chance, were first proposed. Many would

argue that among the most profound developments in the history of statistics were Karl Pearson's mathematical formulation of the correlation coefficient in 1896 and Sir Ronald A. Fisher's first publication describing analysis of variance in 1921. Their work not only incited debate within the statistical community but also served as the impetus for subsequent advances in the field following both Pearson's nonexperimental design tradition and Fisher's randomized experimentation approach. During the past half century, new statistical procedures have extended our ability to study quantitative phenomena by accommodating simultaneous testing of multiple dependent variables (e.g., multivariate analysis of variance), modeling of more complex relationships among multiple variables (e.g., path analysis and structural equation modeling), and analysis of complex data structures (e.g., hierarchical linear modeling and multilevel modeling).

Somewhat parallel to the history of statistical methodology was the development of measurement methodology or psychometrics, which can trace its ancestry to early philosophers such as Plato and to scientists including Galileo who espoused the importance of quantifying physical phenomena. However, many modern measurement principles can be more directly attributed to advances in the field of psychology. For example, Gustav Fechner, founder of quantitative psychology, was among the first to propose methods for obtaining psychological measures under rigorously controlled conditions. Other early contributions to measurement from the field of psychology include Charles Spearman's development of factor analysis in 1904 as a means for understanding intelligence, L. L. Thurstone's scaling methods for measuring attitudes, and James M. Cattell's writings on the importance of large samples as the basis for group intelligence tests. Since the mid-1900s, among the most significant innovations in the field of measurement have been improvements in procedures for estimating reliability, such as the reliability coefficient presented by Lee J. Cronbach in 1951, as well as the realization of item response theory, which now dominates large-scale standardized testing and has made possible advances in the computer adaptive testing that is used with many assessments such as the Graduate Record Examination.

### *Philosophical Foundation*

While some would contend that quantitative methodology stems largely from logical positivism, in fact, quantitative methodology, particularly as applied



in the social sciences, derives primarily from postpositivism. Logical positivists espouse a deterministic view of reality, in which knowledge can be absolutely verified in a world of order and regularity. In contrast, postpositivists view reality as less certain and more probabilistic than deterministic. Researchers using methods of statistical inference likewise operate within a paradigm in which statements about knowledge must be couched in uncertainty and probability. Moreover, another fundamental tenet of postpositivism that underlies statistical practice is Popper's notion of falsification. As any student in a beginning statistics course knows, hypotheses are tested, not for the purpose of verification, but for the purpose of falsification, i.e., a hypothesis can never be proven true but can only be disproven. Thus, the statistical methods that exemplify much of quantitative methodology require a philosophical framework that is considerably less restrictive than logical positivism.

## Concepts and Underlying Principles

### *Probability and Chance*

A basic premise of inferential statistical analysis is the desire to use samples to infer characteristics about a larger population. Because any given sample represents only a subset of the larger population of interest, there is a possibility that the particular sample selected for a study does not adequately represent the population even if the sample is randomly selected. Consequently, there is always an element of chance or uncertainty when attempting to use sample data to estimate population characteristics or parameters. For the same reason, researchers using statistical procedures to conduct hypothesis testing can never be 100% certain that the results of their tests are correct or that the results actually reflect the idiosyncratic characteristics of the sample selected for their study.

This concept of uncertainty in quantitative analysis is the basis for significance testing in statistics and also embodies the risk of committing either a *type 1* or *type 2 error*. Type 1 error is analogous to a false positive and occurs when a researcher wrongly determines that a relationship or difference exists in the data when in fact such a relationship or difference does not exist. It should be noted that such an error does not represent an ethical breach but rather an incorrect finding based on any number of reasons, including features of the study's design, characteristics of the subjects in the study, or violation of one or more

statistical assumptions, where assumptions represent a prescribed set of conditions necessary for conducting any given statistical test. Furthermore, there is always some risk of committing a type 1 error when conducting statistical tests. When researchers set a particular *confidence level*, *level of significance*, or *alpha* prior to conducting their statistical analyses, they are in essence indicating the probability of type 1 error they are willing to risk.

The other type of decision error that is always possible is type 2 error, which is akin to a false negative. Researchers committing type 2 errors fail to detect significant differences or relationships that are actually present in the population. In such cases, their tests are said to lack *power*. Statistical tests may have insufficient power due to various factors, including small sample size, excessively stringent levels of significance, violation of statistical assumptions, the study's design, or unreliable measures of the variables.

Regarding the relative seriousness of the two types of errors, there is no absolute consensus; it clearly depends upon the nature of the study and the potential consequences of the error. For example, in some types of medical research, failure to correctly identify a drug as potentially effective in mitigating a life-threatening illness (type 2 error) arguably might present a more egregious mistake than incorrectly determining such a drug to be effective when it is not. However, by convention, most researchers tend to set their alpha (or risk of type 1 error) at .05 or .01 and type 2 error at .20, suggesting less tolerance for type 1 errors.

### *Variability*

Inherent in the use of quantitative methodology is an interest in understanding variability. In fact, it was curiosity about variation in such diverse phenomena as the size of sweet peas, the chest girths of Scottish soldiers, and the characteristics of hops used in brewing beer that drove development of early statistical theory. Through their observations, scientists noted both regularity and unpredictability in the variation associated with the events they observed. This fascination with variability provides the basis for the current inferential statistical analyses that researchers apply to understand, explain, or predict differences. Such differences might manifest themselves in disparities between groups, changes across time, or relationships between variables. Likewise, the field of measurement is founded on an interest in assessment and classification as a means for comprehending diversity. Consequently, the



presence of differences among the phenomena to be studied is assumed and is requisite to meaningful application of quantitative methodology.

Variability from the perspective of quantitative methodology is often classified into systematic versus random. This distinction in the nature of variability holds true in both statistics and measurement. In statistical analysis, tests of significance typically comprise two components: explained and unexplained variance. The explained component represents variability attributable to factors being examined in the study, such as a treatment effect, motivational influences, and so on, while the unexplained or random component reflects factors outside the control of the study, such as individual differences or environmental distractions. Accordingly, it should be evident that researchers engaging in statistical analyses seek to maximize systematic variance and to minimize random variance, which is often given the status of *noise* or *nuisance*. Likewise, in measurement, the variability in a set of scores, whether from psychological tests or physiological measures, is often partitioned into systematic variance associated with the trait of interest and random error variance due to faulty measurement.

### **Error**

Error is the presence of any type of random or systematic variance that adversely affects a study's outcome or the soundness of a measure. As noted above, there are two different types of decision errors critical to conducting statistical hypothesis testing. However, the concept of error in quantitative methodology comes in many guises. Sampling error, measurement error, and prediction error are among the sources of extraneous variance that compromise the utility of information obtained through statistical analysis and measurement. Concepts of measurement reliability and validity are related to the presence or absence of random and systematic error, respectively. Examples of random errors that could reduce reliability include examinees' mood states, guessing, memory lapses, and scoring errors. In contrast, potential systematic errors that could diminish validity include learning disabilities, reading comprehension, and personality attributes that consistently contribute to either inflated or underestimated scores on various types of measures. Errors in general are considered undesirable in applying quantitative methodology, whatever form they take. Much of the advice on designing sound research

focuses on attempts to minimize the various sources of potential error to the greatest degree possible.

### **Control**

Control in the context of quantitative methodology is essentially the ability to minimize or account for extraneous variability by ruling out plausible, alternative explanations for the findings of a study. Where sufficient control is absent, researchers are unable to unambiguously interpret the findings of their studies. Control can take many forms, including manipulation of conditions within a study, holding certain factors constant, randomization, and inclusion of potentially confounding variables in order to study their effects. Both manipulation and randomization are hallmarks of the experimental research designs pioneered by Fisher. Such designs, which form the basis for evidence-based research, are often dubbed the *gold standard* because of their ability to control for most extraneous variables. Both nonexperimental and quasi-experimental designs are sometimes considered less rigorous because of their inability to adequately control for extraneous factors. Nevertheless, many researchers use these types of designs when the topics for their research do not lend themselves either to manipulation of variables or to randomization.

## **Types of Quantitative Methods**

### **Statistical Procedures**

There is no single taxonomy for classifying the countless statistical procedures that have been or currently are in use, and compilation of a complete list would be daunting. However, several classification criteria can be used that illustrate features of different methods. For example, statistical procedures are often dichotomized into *descriptive* versus *inferential*. Within inferential statistics, procedures are often organized according to how variables are measured (e.g., whether they are categorical or continuous), whether analyses involve one or more than one independent and/or dependent variable, whether data are collected at one point in time or at two or more points in time, or to what extent assumptions are made about underlying characteristics of the data. Examples of commonly used statistical procedures include analysis of variance to examine mean differences among groups, chi-square test of independence to analyze associations



between categorical variables, and multiple regression to determine the extent to which a set of variables explain or predict some outcome. Newer, more complex multivariate procedures that have begun to see greater application in the past few decades include structural equation modeling, hierarchical linear modeling, and growth curve analysis.

### Measurement Procedures

Measurement procedures are quantitative tools used primarily to evaluate reliability and validity in order to determine the appropriateness of scores for a given purpose and population. Traditional approaches to assessing reliability include Cronbach's alpha and the test-retest method. In some settings, procedures based on item response theory (IRT), have replaced traditional methods. Although originally used almost exclusively with large-scale tests, IRT-based methods, particularly Rasch analysis, have become increasingly popular for analyzing scores from affective measures such as personality inventories and attitude scales. Validity-related procedures comprise a variety of techniques, including factor analysis, correlations, and other statistical methods to provide support for the meaning and appropriateness of scores from a particular measure.

### The Future of Quantitative Methodology

Given the emphasis on evidence-based research that is currently being mandated in a number of arenas, it is likely that quantitative research will continue to flourish. The No Child Left Behind legislation as well as other federal directives not only emphasize the application of randomized trials but also stipulate use of instruments producing valid and reliable scores,

implying a preference for quantitative outcome measures. In addition, with increasing computer capabilities, technology is allowing development of sophisticated statistical and psychometric methods that will enable quantitative researchers to analyze their data in ways researchers cannot currently envision. Twenty years ago, for example, hierarchical linear modeling was primarily a concept; now it is seen in an increasing number of applied studies to capture more accurately data that are clustered in some hierarchical fashion, such as occurs when students all experience the same classroom or clients share the same therapist. It is likely that future developments in quantitative methods will continue to expand our ability to understand the complexities of behaviors, events, and processes as well as their interrelationships to the extent that such phenomena can be quantified.

Susan R. Hutchinson

*See also* Behavioral Observation Methods, Assessment (v1); Empirically Based Professional Practice (v1); Ethics in Research (v1); Mixed Methodology Research (v1); Psychometric Properties (v2); Qualitative Methodologies (v1); Translation and Adaption of Psychological Tests (v1)

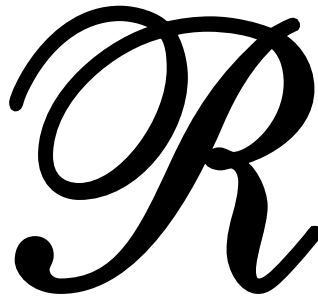
### Further Readings

- Cowles, M. (1989). *Statistics in psychology: An historical perspective*. Hillsdale, NJ: Lawrence Erlbaum.
- Crocker, L., & Algina, J. (1986). *Introduction to classical and modern test theory*. New York: Holt, Rinehart, and Winston.
- Michell, J. (2003). The quantitative imperative: Positivism, naïve realism and the place of qualitative methods in psychology. *Theory & Psychology, 13*, 5–31.
- Pedhazur, E. J., & Schmelkin, L. P. (1991). *Measurement, design, and analysis: An integrated approach*. Hillsdale, NJ: Lawrence Erlbaum.









---

## **RECRUITMENT: HISTORY AND RECENT TRENDS IN DIVERSITY**

---

Early in the history of the psychology/counseling profession, few efforts were made to “recruit” culturally diverse persons; rather, diverse persons, typically through grassroots and organizational efforts, sought entry into psychology despite major resistance. This was especially true during the late 19th and early 20th centuries. However, as time has passed, especially within the last 3 to 4 decades, more of a concerted effort to attract diverse persons has been made by professional mental health organizations.

The U.S. civil rights movement in the late 1960s was instrumental in raising awareness within psychology and counseling that the academic and professional ends of the fields might not be effectively meeting the needs of certain diverse groups, especially women and individuals from groups that differed racially or ethnically from the majority. This realization led to a focus on diversifying the personnel in the professions and the recruitment of persons from underrepresented groups.

However, this early recruitment effort did not immediately extend in equally forceful ways to all groups. For example, LGBT (lesbian, gay, bisexual, transsexual) individuals were not initially included. In addition, although women were initially an underrepresented group, the discipline of psychology is actually now more popular with women than with men at the undergraduate and graduate levels, especially within the applied branches. So, in the 21st century, the idea of who is underrepresented has changed, and

males are now considered underrepresented persons in psychology and counseling.

At the current time, there are many divisions of the American Psychological Association (APA) and special interest groups within the APA that focus on diverse groups, such as persons with physical disabilities (Division 22; Rehabilitation Psychology), persons from outside the United States (Division 52; International Psychology), persons with neurocognitive disorders (Division 33; Mental Rehabilitation and Developmental Disabilities and Division 40; Clinical Neuropsychology), men (Division 51; Psychology of Men and Masculinity) as well as more traditional demographic groups such as women (Division 35; Psychology of Women), LGBT persons (Division 44; Society for the Psychological Study of Lesbian, Gay, and Bisexual Issues), and people of color (Division 45; Society for the Psychological Study of Ethnic Minority Issues). In addition, the APA Public Interest Directorate also has committees focused on women (established in 1973), on LGBT persons (established in 1980), on persons with disabilities (established in 1985), and on socioeconomic status (established in 2006), among others.

The profession of counseling, represented by the American Counseling Association, also has specialty divisions focusing on diverse groups of people, such as the American Rehabilitation Counseling Association (established in 1958), the Association for Multicultural Counseling and Development (established in 1972), the Association for Adult Development and Aging (established in 1986), and the Association for Gay, Lesbian, and Bisexual Issues in Counseling (established in 1997).



## Recruitment of Women

Without question, the culturally diverse group with the most long-standing matriculation into psychology would be women, specifically European American women. The initially limited U.S. academic programs in psychology at the end of the 19th century (e.g., Johns Hopkins, Harvard, Columbia) were staffed solely with European American men, most frequently operating experimental labs focused on sensation and perception, physiological psychology, and learning and memory; these labs were patterned after those labs in which they trained in Europe. The entry of women into the ranks of psychology was a slow process, one pioneered by several outstanding female scholars such as Mary Caukins, Christine Ladd-Franklin, and Margret Floy Washburn. Even after these women proved to be psychological scientists par excellence, it still took several years before most academic training programs became truly coeducational. The application of psychology to everyday life and psychopathology, championed in the United States by Lightner Witmer and Hugo Munsterburg during the late 1800s, as well as Sigmund Freud's first and only visit to the United States to discuss his "talking cure" at Clark University in 1909, opened the doorway for the beginnings of clinical psychology and ultimately, from the 1960s on, the pathway for large numbers of women to matriculate into applied psychology training programs.

## Recruitment of Persons of Color

The recruitment of persons of color in psychology has largely highlighted the bringing of African Americans into the discipline; this parallels the focus of racial issues in the general U.S. society during the past 50 years as being predominantly about Black-White race relations. In 1963, an APA Ad Hoc Committee of Equality of Opportunity in Psychology was established to examine racial inequality in the discipline. Soon thereafter, in 1970, the Association of Black Psychologists (founded in 1968) developed a 10-point program for graduate departments of psychology as an effort to increase African American representation.

This initial recruitment effort by the APA aimed toward persons of color underwent a metamorphosis and expansion over the next few decades via the creation of the APA Ad Hoc Committee on Minority Affairs (1971), the APA Office of Ethnic Minority Affairs (OEMA, 1979), the APA Board of Ethnic

Minority Affairs (BEMA, 1980), and the APA Committee on Ethnic Minority Affairs (CEMA, 1990). The APA Public Interest Directorate also has a specific arm of the discipline focused on recruitment and retention of individuals from racially and ethnically diverse groups, the Committee on Ethnic Minority Recruitment, Retention, and Training in Psychology (CEMRRAT), established in 1994.

Changes in U.S. demographics over the past decades—specifically the sharp increase in numbers of Latino, Spanish-speaking persons, which has made this group bigger than that of African Americans—will likely bring more efforts to matriculate Latinos and Spanish speakers into the discipline. In addition, the increasing numbers and awareness of unique needs across all racial groups will likely bring more focus on Asian Americans and American Indians as well as on the many subgroups of the Latino group (e.g., Mexican, Puerto Rican, Cuban, Central and South American), Asian (e.g., Chinese, Japanese, Korean, Vietnamese, Thai) and American Indian (e.g., Cherokee, Choctaw, Chickasaw, Comanche) groups.

There are psychological organizations outside of APA for non-African American racial and ethnic groups, such as the National Latino/a Psychological Association, the Asian American Psychological Association (founded 1972), and the Society for Indian Psychologists, which parallel the mission of Association of Black Psychologists. Professional counselors may have state caucuses that focus on special interest groups (e.g., Black counselors)

## Recruitment of Lesbian, Gay, Bisexual, and Transgendered Persons

With respect to LGBT persons, this population was pathologized to a degree that outdistanced even the immense biases present in U.S. psychology (and society) against women and people of color. Homosexuality was defined as a mental illness until 1973 when the *Diagnostic and Statistical Manual of Mental Disorders* of the American Psychiatric Association formally removed the official disorder from its text (replacing it with the category of ego-dystonic homosexuality) and the American Psychological Association endorsed this new perspective for its own professional discipline in 1975. In the recent *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV)* and *Diagnostic and Statistical Manual of Mental Disorders,*



*Fourth Edition, Text Revision (DSM-IV-TR)*, homosexuality is no longer included specifically as a mental disorder, albeit the category of Sexual Disorder Not Otherwise Specified has “persistent and marked distress about sexual orientation” listed as an example of a situation warranting this diagnosis.

Although the awakening of psychology and counseling to its discriminatory position brought much needed attention and advocacy to LGBT persons and their psychological needs in the ensuing decades, the longstanding viewing of homosexuality as a mental disorder also suggests a lack of active recruitment of LGBT persons into the professions before the early 1970s.

Kimmel and Browning, in a historical review of APA Division 44, identified several initiatives put in place to support psychology students and professionals once they are in the pipeline; however, it is not as clear that specific efforts have been made by APA to actively recruit LGBT persons into the discipline and profession equivalent to those made to diversify the gender or racial balance of the discipline. Division 44 has historically provided a formal mentoring program, a divisional listserv, and informal programs at annual APA conventions as avenues to extend a warm and inclusive welcome to LGBT-affirming persons within psychology. Recent data from the APA Office of Research suggest that APA Division 44 enjoys a good number of student affiliates and members, indicating that many psychologists and psychology trainees are taking advantage of what this division has to offer.

### Future Directions

The field of psychology and counseling has made significant strides in diversifying its professional ranks as well as in eliminating oppression and discrimination against persons from culturally diverse groups. However, there is still a lack of parity within specific diverse group domains (e.g., race/ethnicity) and across diverse group domains (e.g., race/ethnicity, sexual orientation, sex) in terms of the extent to which professional organizations are expending resources to recruit diverse members into their ranks. The APA, for example, reports that the majority of students matriculating into psychology are women, but that people of color and LGBT students and trainees still are comparatively much less well represented. This lack of parity notwithstanding, the future looks hopeful in that there is increasing movement toward an approximation of

demographic variability within these mental health professions that more accurately reflects the demography and life experiences of the clientele they serve (and need to serve) in our society.

*Loreto R. Prieto*

**See also** Asian American Psychological Association (v3); Association of Black Psychologists (v3); Counseling Psychology, History of (v1); Diversity (v3); National Latina/o Psychological Association (v3); Professional Associations, Counseling (v1); Society for the Psychological Study of Ethnic Minority Issues (v3); Society of Indian Psychologists (v3)

### Further Readings

- American Psychological Association. (1997, January). *Visions and transformations: The final report of the Commission on Ethnic Minority Recruitment, Retention, and Training in psychology*. Washington, DC: Author.
- Scarborough, E., & Furumoto, L. (1987). *Untold lives: The first generation of American women in psychology*. New York: Columbia University Press.
- Vacc, N., & Loesch, L. (2000). *Professional orientation to counseling* (3rd ed.). Philadelphia: Brunner-Routledge.

---

## RETIREMENT, IMPLICATIONS OF

---

Retirement refers to an ongoing period in life that traditionally has been considered to begin at the point of withdrawal from work life. Retirement is a social concept implemented primarily during the past 100 years due to changes in life expectancies and population demographics. The increase in life expectancies over the past century has produced both challenges and opportunities during the retirement phase of life that continually require increased attention and resources. The arrival of the baby boom generation at retirement age has enormous implications for population demographics, the workforce, and a host of social and economic issues. A dramatic trend toward earlier retirement, coupled with increased life expectancy, ensures a growing focus on issues related to retirement. The fact that the average American can now expect to be in retirement for 15 to 20 years creates demands that no other generation has faced. Retirement has broad social and cultural implications.



For individual retirees, this period of life holds remarkable potential and risk as well.

The usual definitions of retirement address withdrawal from the workforce and the remaining years of life. Operationally, retirement has been conceptualized in a variety of ways: (a) a well-deserved rest as a reward for years of work, (b) a means of maintaining an effective work force, (c) a period of transition to old age, (d) a distinct period of human development, (e) a period for postretirement careers, and (f) a period of adjustment to loss of work identity. Perhaps all of these are applicable across or within particular cases. The development of a general theory or model for retirement has been difficult for several reasons. For example, the number of factors that influence the nature and quality of the retirement experience is substantial. Further, there is no real standard for the onset of retirement. Some workers choose to retire early; some choose not to retire at all; others are subject to forced retirement; some retire partially; and some return to work after retirement.

### Factors Influencing Retirement

Several specific factors interact to influence individuals' experience of retirement. These factors include finances, health and medical care, relationships, housing, existential issues, security, and satisfaction with career. Obviously, these factors are highly interrelated in regard to their impact, but they will be described individually.

#### *Finances*

The financial basis for retirement is probably near crisis levels for a large proportion of the population. Social Security was intended to be a supplemental source of income for retirees, but future recipients are likely to face reduced funding and delayed eligibility. Pensions have been another major source of retirement income, but now only about one fifth of working Americans will receive pension benefits. More recently, there has been a major shift toward personal savings to finance retirement, and this trend is being further encouraged by the federal government. Reverse mortgages have become a popular way to supplement Social Security and savings for many retirees. A reverse mortgage is a loan that enables senior homeowners to convert part of their home equity into tax-free income without having to sell

their home, forfeit title to it, or make monthly mortgage payments. Part-time employment for those who are able to work is becoming more common. Given the rapid shift toward personal mechanisms for funding retirement, an emphasis on early career planning is essential.

#### *Health and Medical Care*

The ongoing explosion of medical and pharmaceutical costs has a large, disproportional impact on retired persons due to their almost inevitable and disproportionate healthcare needs. Relatively few retirees have the personal savings required to cover a catastrophic illness without health insurance coverage, which can be very expensive to maintain. The Medicare program is a source of help to retirees over age 65, but satisfaction with the system tends to be low among recipients, and many healthcare providers have reservations about the system. It is clear that secure healthcare services are an essential component of the retirement experience.

#### *Relationships*

Aging itself is correlated with loss of important familial, professional, and personal relationships for a variety of reasons. Geographic mobility has greatly disrupted close, extended family relationships. Shifts away from inclusion of the elderly in their children's homes toward profit-based residential facilities often leads to reduced contact with children and grandchildren. Loss of a spouse to death can have an enormous emotional impact on retirees. Given that social withdrawal can precipitate or exacerbate depression, the maintenance of healthy, reciprocal relationships is essential.

#### *Housing*

A fundamental decision facing retirees is where they will live and in what form of housing. Many retirees choose to relocate geographically after completing careers. Relocation decisions may be driven by a desire to live in a more preferable climate, availability of recreational activities, proximity to family and friends, etc. Clearly, major relocations must be carefully considered and planned before being undertaken. One model is to vacation in selected locales on a trial basis prior to retirement.



Wherever retirees choose to live, there are many types of housing from which to choose. Maintaining a single family home is, of course, a possibility. As physical abilities decline, maintenance of homes and yards can become taxing. Condominium options, duplexes, and patio or garden homes where maintenance and lawn care are provided can be attractive and practical choices. More recently, communal arrangements are being piloted in which several retirees share a single housing unit. Such arrangements offer opportunities for sharing costs and providing for common needs. Retirement facilities now offer multiple forms of housing to accommodate residents in need of various levels of support and assistance. Generally, costs increase corresponding to needs. Clearly, financial planning for the duration of retirement needs to include contingency plans for increasing levels of care and support. Many preretirement options are being offered by insurance companies to provide for long-term care costs for the elderly.

### ***Existential Issues***

The struggle to find and maintain meaning in life continues to be central for many people throughout retirement. The prominence of these issues in adjustment to retirement across individuals will likely vary considerably. For example, individuals who derive meaning and personal identity heavily from their careers can expect some sense of loss after full retirement. Partial retirement is sometimes attractive to such people. For others who view work primarily as a means for achieving financial goals, retirement may represent a dramatic increase in freedom. In any case, engagement in satisfying and meaningful activities during retirement is essential to fostering a sense of well-being. Religious, volunteer, and family-based activities are all means by which individuals can pursue fulfillment. Inactivity and social withdrawal are typically self-destructive in this regard. Both mental and physical activity have profound effects on many dimensions of physical and psychological health, especially during the retirement period.

### ***Security***

Security needs are fundamental for most people. During the retirement phase, as health, relationships, and independence may decline, the need for psychological security may be expected to increase. Security

needs exist on several levels. Physical protection against abuse or exploitation is perhaps most basic. Many strategies exist in financial planning to protect assets. Housing choices have to include provisions for physical security. Particularly when financial resources are limited, security needs can be more challenging. Involving family, friends, and professionals in evaluating risks and ensuring freedom from exploitation and abuse may be advisable. Older retirees, in particular, may become the targets of predatory exploitive schemes. Unfortunately, family members themselves are often perpetrators of the exploitation of their parents and grandparents. The size of the problem is substantial, with approximately 70% of the nation's wealth controlled by people nearing, or already in, retirement. The use of professionals outside of the family, primarily certified public accountants (CPAs) and attorneys, can ensure effective protection of assets. The problem of exploitation of the elderly has become so concerning that Congress is currently considering legislation like the Elder Care Act to protect seniors from exploitation.

### ***Career Satisfaction***

Retirement, as a stage of life, is affected by the level of career satisfaction one has achieved. This aspect of retirement planning and preparation should be carefully considered. The kind of meaning one seeks in retirement is likely related to the level and kinds of fulfillment already experienced. One central aspect of retirement preparation is to reflect upon what has been satisfying or missing in one's career life. Retirement activities can build on accomplishments and provide for realizing unmet goals. Disappointments need not be ignored, and retirement can be designed to provide for personal fulfillment as the individual defines it. The career experience is typically a major influence upon this definition.

### ***Lifetime Perspectives***

There is a clear trend toward viewing retirement as an integrated developmental period of life. Increased life expectancies and improved health care have led to the extension of retirement for most people. This extension applies not only to years, but also to options and choices of lifestyle. As a continuing period of life, retirement is greatly affected by earlier periods and experiences. This may be most true in terms of the financial circumstances of retiring people.



There are literally thousands of Web sites devoted to planning for retirement, and a vast majority of these Web sites relate to financial planning. The evolution toward individual savings plans as a model for financing retirement is placing heavier responsibility on the individual for financial planning. The range of investment options with their associated risks and benefits makes the use of financial planning professionals a wise choice for most people. Many employers already provide retirement counseling services for employees for this purpose.

*Save early and save often* is a catchphrase that is often used for financial planning for retirement. Whether one is salaried or self-employed, there are major tax incentives for longer-term savings for retirement. The exponential growth of savings invested early in one's career adds further credibility to the catchphrase.

Financial conditions will have a major bearing on several dimensions of retirement. However, optimizing the retirement experience requires personal preparation and planning beyond the financial dimensions. One of the fundamental realities of retirement is that retirees will almost always have to assume more responsibility for structuring their time and activities after they leave the world of work, where such structure was largely provided for them. Leisure activities, for example, will typically increase in importance during retirement. Individuals are much more likely to have meaningful leisure activities in retirement when they have a well-established leisure history. Further, as individuals grow older, having several varied types of leisure activities can be useful. Given the profound and consistent relationship of physical activity to mental and physical health among the elderly, well-developed leisure patterns in midlife greatly contribute to quality of life in the retirement years.

Naturally, there are tremendous individual differences in personal needs, preferences, and motivations in retirement. *Lifestyle planning* is a broad term used to encapsulate the major dimensions of personal circumstances into the retirement years. Lifestyle planning encourages individuals to project a well-developed vision into retirement by answering a series of key questions:

1. What are the parameters of my financial resources?
2. What roles do important family and friends play in meeting my needs?
3. How might my retirement affect significant others, e.g., spouse, children?
4. What climate or locale best supports my envisioned retirement lifestyle?
5. Does part-time work fit into my lifestyle in meeting needs (e.g., productivity)?
6. How are my support needs likely to evolve over 5, 10, or 15 years of retirement?
7. What level of activity would I like to maintain across different areas?
8. Are there things I believe I have missed in life? How can retirement address these?
9. What are some concrete things I'd like to do? For example, would I like to travel, write, learn, or teach?
10. What am I grateful for in my life and how can I share that with others?

Retirement can lead to a sense of social isolation, especially when work relationships have been primary or retirement involves a geographical move. Social support systems are critical to most people. The need for social support also changes across the retirement years and requires some significant planning and adjustment. It is generally advisable to begin discussing retirement issues and plans with friends and family before the time to retire actually occurs. Access to family or others who will play a supportive role in retirement is a key dimension of satisfaction; consequently, everyone ought to be involved in the planning process. Certain support, with financial matters for example, may be best handled through professionals. From the perspective of generativity, retirees also need to make plans for contributing to the support of significant others (e.g., spouse, children, siblings). What needs might these individuals have for which the retiree would want to share responsibility?

The substantial increase in the numbers of retirees who return to work, at least part-time, reflects shifting financial demands. Others, though, choose to return to work for a variety of reasons. For example, they may see work as an opportunity to help others; to meet achievement/productivity needs; to stay engaged cognitively and socially; to share knowledge, skills, or experiences; or to gain the intrinsic rewards associated with engagement in work. Any of these objectives can also be met by doing volunteer work as well. The objective is for any work activities to be thoughtfully planned. Retirees returning to work ought to consider both the reason for assuming work responsibility and their specific expectations regarding the work.



It is very normal for retirees with a lifetime of experiences and increased free time to reflect on the meaning of life. The reality of mortality increases with age as well. Retirement can be a great opportunity, not only to reflect on purpose of life issues, accomplishments, and failures, but also to develop and project a vision of the future. Sharing the reflections of retirement with younger generations, staying engaged with social and religious institutions and activities, and engaging in service to others are all easily accessible ways of enhancing the meaningfulness of life in retirement. Of course, these skills, abilities, and motives are established and nurtured earlier in life.

*Dale R. Fuqua and Jody L. Newman*

*See also* Adult Development (v1); Adults in Transition (v4); Aging (v1); Career Planning (v4); Job Loss (v4); Leisure (v2); Life Transitions (v2); Life-Role Balance (v4); Retirement (v4); Theory of Work Adjustment (v4); Vocational Identity (v4)

### Further Readings

- Draayer, D. R. (2003). *Retirement straight talk: Stories and wisdom from educators*. Lanham, MD: Scarecrow Press.
- Ghilarducci, T. (2005). *In search of retirement security: The changing mix of social insurance, employee benefits, and individual responsibility*. New York: Century Foundation Press.
- Goodman, J. E. (2002). *Everyone's money book on retirement planning*. Chicago: Dearborn.
- Hebeler, H. K. (2001). *J. K. Lasser's your winning retirement plan*. New York: Wiley.
- Hirsch, D. (2003). *Crossroads after 50: Improving choices in work and retirement*. New York: Joseph Rowntree Foundation.
- Mitchell, O. S. (2002). *Innovation in retirement financing*. Philadelphia: University of Pennsylvania Press.
- Yolles, R. M., & Yolles, M. (2001). *Getting started in retirement planning*. New York: Wiley.
- Weiss, R. S. (2005). *The experience of retirement*. Ithaca, NY: Cornell University Press.

---

## ROEHLKE, HELEN J. (1931– )

---

Mentor, role model, supporter, founder, leader. Few people have the ability to touch the lives of others and to make positive changes in the world around them.

This will be Helen J. Roehlke's legacy to counseling psychology. Her gift to the field extends far beyond her scholarship and service through the impact she had on the lives of the graduate students and interns whom she trained and the professionals she mentored during their early career years. She was passionate about training the next generation of psychologists and dedicated a great deal of her professional time to mentoring and supporting students from underrepresented groups, particularly women; individuals of color; lesbian, gay and bisexual persons; and international students and young professionals. Throughout the span of her career as a counseling psychologist, Roehlke saw the field transform from a monocultural profession to one that promotes and encourages diverse perspectives and individuals from varied backgrounds. She inspired and touched students' lives and made a valuable contribution to the training of professionals in counseling psychology through her mentoring and guidance of generations of psychologists.

### Family Background

Roehlke was born in Chicago, Illinois, to Enriqueta and William Jackson. She was raised in a household with two working parents; her mother did office work and bookkeeping and her father was an accountant and tax consultant. She was the older of two children, but was raised as an only child due to the 15-year time span between her birth and that of her younger sister, Ginny.

Roehlke met her husband, Art, during her junior year at Carleton College, and they married in the summer of 1952 following their college graduation. They moved to Columbia, Missouri in 1955 and have lived in that area for over 50 years. They have three sons, Kurt, Kent, and Adam, and three grandchildren, Jake, Lauren, and Brennen.

### Educational Training Background

Throughout her elementary and secondary education, Roehlke was a good student and performed well academically. Her mother was an avid reader and always had books at home, so Roehlke learned to love reading at an early age. She received a great deal of encouragement and support for attending college from her parents and teachers as well as from a great aunt who was particularly influential in directing her toward higher education. This great aunt bought Roehlke books on literature and poetry when she was growing



up and discussed them with her, sparking Roehlke's early interests in this area. As a woman who was independent and who had traveled the world, her great aunt also helped to nurture Roehlke's career goals as a young woman.

At the suggestion of a young female physical education teacher in high school, Roehlke explored small liberal arts colleges in the Midwest for her college education. She received a number of scholarships from many of these schools and chose to attend Carleton College. As the first person in her family to attend college, Roehlke embarked on her postsecondary education at the young age of 16 and began as an art major. She received a bachelor's degree in 1952 with English literature as her major and psychology as her minor area of study.

Roehlke's venture into graduate study initially began because she wanted to avoid teaching English to high school students. While her husband was working on a master's degree in psychology at Drake University in Des Moines, Iowa, she worked as a psychometrist at the counseling center and enrolled in several master's level psychology courses. Upon completing his master's degree, Art applied and was accepted into the doctoral program in the psychology department at the University of Missouri, and the couple moved to Columbia. Roehlke received a stipend in the rehabilitation counseling program and completed a 60-hour master's degree in 1962. She entered Missouri's doctoral program in counseling psychology right after obtaining her master's. She was one of the few female graduate students working toward a doctoral degree at the time. In fact, only three women had received doctorates in counseling psychology prior to Roehlke. At this time, many faculty believed that doctoral level positions should not be made available to women, because they would just get married, have children, and leave the field. These attitudes made it particularly difficult for women in academia, and they received little encouragement from faculty for pursuing doctoral degrees and following their career dreams.

### Professional Accomplishments

Roehlke spent her entire professional career in Columbia, Missouri, and is widely recognized for her contributions to teaching, research, training, and service. She has numerous research publications and conference presentations focused primarily on clinical supervision, internship training and education, pre- and

postdoctoral accreditation, and counseling women; gay, lesbian and bisexual individuals; and international students. She also taught beginning and advanced practica and supervision courses for doctoral students in the program.

Roehlke coauthored, with Elizabeth Holloway, a seminal article regarding predoctoral internship training in psychology. Cutting-edge publications in supervision addressed effective supervisor behaviors, developmental approaches to teaching supervision, and intern level cross-racial supervisory relationships. Roehlke was one of the pioneering scholars in clinical supervision, and her conceptual and empirical work in this area was groundbreaking at the time. She also contributed to counseling psychology scholarship via her role as a reviewer. Roehlke was an editorial board member of the eminent journals in the counseling psychology field, *The Counseling Psychologist* and the *Journal of Counseling Psychology*, and she continues to serve as an ad hoc reviewer for both journals.

Selected examples of her service to the American Psychological Association's (APA) Division 17 (Society of Counseling Psychology) include Membership Committee chair, Fellows Committee member and chair, APA Awards Committee member and chair, and Division 17 delegate to the cross-specialties Inter-Organizational Committee (IOC). She was also a member of Division 17's Board of Directors while serving on APA's Council of Representatives, and she was on the Board during the planning and final restructuring of Division 17.

Some of Roehlke's founding activities in her early career included being one of the founders of the American Personnel and Guidance Association's Committee on Women and the American College Personnel Association's (ACPA's) Committee on Women; supporting the establishment of a Gay, Lesbian, Bisexual, Transgender (GLBT) Section in ACPA and being a member of this section; being one of first members of both Division 17's GLBT Special Interest Group (SIG) and its Section on Racial and Ethnic Diversity, and sponsoring the GLBT SIG to become a section while serving on ACPA's Board of Directors.

Roehlke was internship training director at the University of Missouri's counseling center for 25 years beginning in 1975. In her early years as training director, she recognized a need to organize other training directors, and she became one of the founding members of the Association of Counseling Center Training



Agencies (ACCTA). Known as the “mother of ACCTA,” Roehlke served as ACCTA’s second president for 7 years, from 1978 to 1985, and continued to serve this professional organization in various roles (i.e., as executive board member, liaison to APA’s divisions 17 and 44, trainer for accreditation site visits, and senior advisor) until she retired. In 1999, ACCTA established an annual award in her name (Helen J. Roehlke Lifetime Achievement Award) to honor a member who “exemplifies the spirit of ACCTA and through [whose] work [has] shown unwavering enthusiasm, commitment, support, and overall service to the organization and profession.”

During her years as training director, Roehlke was also involved with the Association of Pre- and Postdoctoral Internship Centers (APPIC). She was on the planning committee for the first national conference on intern training and was a delegate to that conference. She was also selected as a delegate to both the second and third national intern training conferences as well as to the first postdoctoral training national conference.

Due to her outstanding contributions to the field of psychology at the national level, Roehlke was recognized as a fellow of three divisions of APA: The Society of Counseling Psychology (Division 17) honored Roehlke in 1991, Psychotherapy (Division 29) honored her in 1994, and the Society for the Psychological Study of Lesbian, Gay, and Bisexual Issues (Division 44) honored her in 1999.

In Roehlke’s fellow’s address for Division 17, titled *The Counselor Is a Woman: From Analogy to Actuality*, she described her first-hand witnessing of the profession shift from a predominantly male-dominated field to a predominantly female-dominated field. In spite of the cosmetic changes apparent in the field, the needs of female students were still largely being ignored. Roehlke challenged the field to develop training and learning environments that were open and affirming to all students. The topic of her address reflected her advocacy efforts in allowing access into the profession to a wider circle of individuals than were admitted at the time when she entered the field. Following a format that a few women in the previous 2 years had used, her address also was noteworthy because of its personal nature; this was significant because it was uncharacteristic of previous fellows’ presentations. Today, fellows’ addresses have become a conference highlight largely because fellows are more likely to share aspects of their personal side.

Although she was widely recognized for a number of professional accomplishments and contributions, Roehlke had a profound impact on psychology training and practice as evidenced by her receiving in 1988 the distinguished John D. Black Award for Outstanding Contributions to Professional Practice, the highest practice award in APA’s Division 17. Roehlke represented a professional whose behaviors and practices were consistent with her values and beliefs. She expected the profession to embrace multiculturalism, and she demonstrated this by providing genuine support and encouragement to graduate students of color as well as to lesbian, bisexual, and gay students and to international students. Due in large part to her own experiences as a graduate student and the relative lack of support she felt as a woman in pursuit of her academic and career goals, Roehlke was keenly aware of and attuned to students’ needs and served as a valuable resource for scores of students. At her retirement party in the summer of 2000, many of these students acknowledged the importance of Roehlke’s presence and guidance during their graduate studies and early professional career development.

Lisa Y. Flores

*See also* Conferences in Counseling (v1); Counseling Skills Training (v2); Gay, Lesbian, and Bisexual Therapy (v2); Mentoring (v1); Postdegree/Prelicensure Supervision (v1); Postdoctoral Training (v1); Predoctoral Internships (v1); Recruitment: History and Recent Trends in Diversity (v1); Supervision (v1)

### Further Readings

- Duan, C., & Roehlke, H. J. (2001). A descriptive “snapshot” of cross-racial supervision in university counseling center internships. *Journal of Multicultural Counseling and Development, 29*, 131–146.
- Heppner, P. P., & Roehlke, H. J. (1984). Differences among supervisees at different levels of training: Implications for a developmental model of supervision. *Journal of Counseling Psychology, 31*, 76–90.
- Hollaway, E. L., & Roehlke, H. J. (1987). Internship: The applied training of a counseling psychologist. *The Counseling Psychologist, 15*, 205–260.
- Lamb, D. H., Roehlke, H. J., & Butler, A. C. (1986). Passages of psychologists: Career stages of internship directors. *Professional Psychology Research and Practice, 17*, 158–160.



- Roehlke, H. J. (1988). Critical incidents in counselor development: Examples of Jung's concept of synchronicity. *Journal of Counseling and Development*, 67, 133–134.
- Worthington, E. L., & Roehlke, H. J. (1979). Effective supervision as perceived by beginning counselors-in-training. *Journal of Counseling Psychology*, 26, 64–73.

---

## RURAL PRACTICE, CHALLENGES OF

---

The United States defines “rural” communities as those of 2,500 people or fewer. A more natural definition is tied to population density: People who live in geographically isolated, low-population areas where occupations are tied to natural resources have more in common with each other than they do with people in cities and towns of any size. The small size of their communities is key to understanding the vibrancy and tenacity of rural people as well as the peculiar dynamics of relationships and types of problems they experience.

Related to rural and farm life are unique pressures and stressors such as economic issues associated with the weather, lack of control over prices, cost of inputs, drought, disease, land costs and rentals, globalization, rural values, and social dynamics. The mental health community needs to be prepared to care for these people and help them with transitions and other stressors so that they can cope effectively.

### Rural Values

Values that undergird rural life tend to be social, based on the family and the community. The social and relational parts of rural life can be powerful in their psychological rewards. Rural people tend to understand what it means to belong to a close-knit community. They put stock in being a good neighbor. They have lifelong relationships with relatives close by and friends who seem like family.

Rural life tends to be characterized by rituals. Most often these rituals concern farming life: sowing and harvesting. They also concern social life: Young people becoming old people in the same place. Rural people accept the interplay between the good and the bad, accommodate themselves to the reality they see, and do what is necessary to be in harmony with their environment.

Rural people often participate in national affairs with great distinction. They offer wisdom in knowing how things fit together, a sense of continuity and history, a restraint against a rush toward change, and an awareness of how decisions will affect the lives of ordinary people.

In addition, rural people may be considered to be place-bound. To be removed from place can be a disorienting experience. One's importance may be diminished, and by being separated from place, one may lose the vital energy upon which one has come to depend for nourishment, strength, and even life. A high percentage of farm families who are forced out of farming stay in their local communities—possibly because of this characteristic. They may view moving to an unknown place, where they do not know the history and the people, as a drastic uprooting. They may fear not knowing how to act in a place where “place” may not be important.

### The Downside of Rural Life

In studying the social dynamics of a small community, psychologist Roger Barker found people take on many social roles to meet community needs. Functioning in multiple roles adds to stress. The same person may serve on different boards and community organizations and as a member of various groups. People may be recruited and pressured into community service.

At the same time, community members often see and meet each other at church, school functions, games, stores, dealerships, card parties, weddings, funerals, community fund-raisers, and local cafes and bars. They “change hats” frequently and make subtle shifts in relationships depending on the roles they are playing.

Rural people may cope with complicated social relationships when goals and ideas come into conflict by being “nice.” Being nice means not engaging in controversy and not giving strong opinions. It means ignoring conflict and living with the differences. In short, rural people often ignore their own feelings or underplay their emotional responses. Being nice is the socially correct way of living in a rural community; to be other than nice invites criticism.

A second concern is nonconformity. To feel out of step, judged, or excluded is painful. People in rural areas who have differences with their communities often live lives of pain, resentments, and anger, because they fear the pathway to reconciliation will



cause further and perhaps irreparable harm. They may live with private anger and opinions that they keep to themselves.

A third concern is avoiding personal risks. Those who have difficulty controlling their emotions or resolving conflict find it easier to keep the peace. Being nice means they don't have to think, take a stand, or risk rejection. If strong feelings and opinions are spontaneously expressed, a rural resident will likely encounter his or her antagonist later in various social settings. The tension between them may be awkward, as it may not be easy to keep roles and agendas separate.

Everyone has vested interests. If one opposes someone strongly in one setting, he or she may block one's goals in another. Strong political controversy can rip apart the social fabric of a rural community. People may not know how to act when lines of conflict divide the community. To be highly passionate on an issue may create tensions one lives with today, tomorrow, and possibly all throughout life. Harmony is the value that makes the rural community work. Even if power is concentrated and public interest isn't served, it still seems better to most people than raw, open controversy that upsets the social system.

A related concern is avoidance of conflict. When controversy spills over into the public arena, people may not know how to act. They may become polarized by the controversy. They may personalize the issue and take sides. They may not have enough experience with conflict to know how to negotiate or search for middle ground. Where does suppressed hostility and anger go? How does the community make important decisions and avoid community controversy? Unfortunately, gossip, social ostracism, and other indirect means of aggression may occur.

Some of the common dilemmas and problems facing people in rural communities are as follows:

- Dealing with powerful social expectations and pressures
- Finding it difficult to say no
- Not feeling reinforced for engaging in leisure or specialized interests unless community obligations are fulfilled
- Being expected to participate in time-consuming social and community events
- Being too successful in a community where others are easily threatened
- Being judged by social comparisons to peers in the local community
- Becoming easily upset or disturbed by adverse public opinion
- Maintaining appearances at a personal cost of being unauthentic; not feeling emotional safety in expressing feelings, problems, or divergent opinions—being criticized for being too open, spontaneous, and honest
- Getting behind a mask—social gain at the personal expense of stifling true opinions and feelings
- Not being able to solve problems because conflict itself is viewed as harmful—greater ease in covering up a problem than in getting people to try out poorly developed conflict-resolution skills
- Being too different or out-of-step with strict community standards

An urban person might say, “Who cares what other people think?” A rural person knows there is social accountability and obligation.

## Counseling in Rural Areas

Life in rural communities has its own value system with unique pressures and stressors. Social obligations, leadership, and volunteering associated with responsible community life lead to very busy, stressful lives. Another issue is the rural economy. The rural economy continues to suffer because of out-migration, declining population, and consolidating forces in the larger economy. Depression and anxiety are common problems when personal or business finances are precarious. Finally, complex technology, expensive inputs, seasonal pressures, the combination of the work and home environments, labor shortages, supervisory responsibilities, and other on-farm enterprises and off-farm employment all test the compatibility and coping skills of farm families.

Rural marriage problems also occur. The interplay between the demanding profession and being self-employed while working at the family residence can create marital conflict. Some male farmers are single-minded in their approach to farming and neglect the emotional needs of their spouse and children. Counselors have to give weight to the very real responsibilities and pressures farmers feel and to give voice to the spouse's need for a warm and nurturing relationship.

Another area of concern is helping farm families work effectively in intergenerational and multifamily farm and ranch operations. There are boundary issues as family members work out common goals and



share a common enterprise. Problems can build and create tensions and resentments while solutions may be stymied by poor communication and problem-solving skills.

The anonymity issue and accessibility of services are also counseling obstacles to overcome. There may be denial about depression, family problems, and alcoholism. There is a strong stigma about admitting a drinking problem rather than a mental health problem. Family doctors and mental health professionals become gatekeepers for the alcohol and substance abuse professionals. The social acceptability of alcohol use for adults and teens in many rural social situations can add to personal problems. While rural communities do not have a corner on alcohol problems, a lack of entertainment and recreation activities can lead to the use of alcohol to enliven social life. Some people are vulnerable to alcoholism or to the social pressures that go with regular drinking.

What are necessary skills for rural counselors? These counselors need to be approachable and down to earth. Effective counseling may be difficult if clients perceive counselors as being better than they are. Being respectful makes a huge difference. Counselors also have to be real and genuine. Additionally, being conversant and knowledgeable about rural dynamics and relationships can set clients at ease. Most clients do not want to feel as though they must educate their counselor about their problem. For most rural clients, travel is not an obstacle in seeking the right counselor.

Counselors also have to be trustworthy in terms of keeping confidences, because everybody knows everybody in rural communities. Dual relationships

interfere with good treatment and are ethically dangerous, though sometimes unavoidable, in rural communities. There may be a clinical half-life to a professional living in a small community.

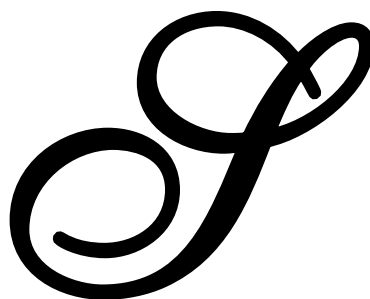
Val Farmer

**See also** Collectivism (v3); Community-Based Action Research (v1); Community-Based Health Promotion (v1); Mindfulness (v1); Relationships with Clients (v2); Social Class (v4)

### Further Readings

- Bray, J. H., Enright, M. F., & Easling, I. (2005). Psychological practice in rural primary care. In R. G. Frank, S. H. McDaniel, J. H. Bray, & M. Heldring (Eds.), *Primary care psychology* (pp. 243–257). Washington, DC: American Psychological Association.
- Finell, D. L., & Hovestadt, A. J. (2005). Rural mental health services. In R. G. Steele & M. C. Roberts (Eds.), *Handbook of mental health services for children, adolescents, and families* (pp. 245–258). New York: Kluwer Academic/Plenum.
- Jameson, J. P., & Blank, M. B. (2007). The role of clinical psychology in rural mental health services: Defining problems and developing solutions. *Clinical Psychology: Science and Practice*, 14(3), 283–298.
- Roberts, L. W., Warner, T. D., & Hammond, K. G. (2005). Ethical challenges of mental health clinicians in rural and frontier areas. *Psychiatric Services*, 56(3), 358–359.
- Sawyer, D., Gale, J., & Lambert, D. (2006). *Rural and frontier mental and behavioral health care: Barriers, effective policy strategies, best practices*. Waite Park, MN: National Association for Rural Mental Health.





---

## SCHOOL COUNSELING

---

In addition to their typical developmental issues, children and adolescents currently face many challenges to their healthy growth and development. According to the American School Counselor Association (ASCA), school counselors accept responsibility for helping all children and adolescents make age- or grade- appropriate progress in their personal, social, educational, and career development. School counselors also assist children and adolescents who present different degrees of need for special help in these areas—needing help with developmental issues *and* issues inherent in their own circumstances. These special issues may arise when children or adolescents are unable to accomplish developmental tasks or when circumstantial obstacles interfere with their progress. A familiar example of the former is the adolescent who prefers to spend time with friends rather than attend class. A familiar example of the latter is the child who cannot concentrate on schoolwork due to troubles at home. School counselors work with children and adolescents who are situated along the entire mental health–mental illness spectrum and from different cultures. School counselors also work with students’ parents, teachers, and administrators.

### **Comprehensive School Guidance and Counseling Programs**

In rising to the challenges of serving large caseloads of clients—the ASCA recommended ratio is 250:1; the current range across the states is 222:1 to 1301:1—with

developmental and circumstantial issues, school counseling professionals have reached consensus about the means for delivering school counseling to students. Initially conceptualized by Gysbers and Moore, the comprehensive school guidance and counseling program model is endorsed in the *ASCA National Model* and in the models of a majority of the states.

The four elements of a comprehensive school guidance and counseling program are those of content; organizational framework; resources; and development, management, and accountability. The content element describes standards for student competency development. To guide meaningful practice, competencies must be specified for each grade level or grade grouping. There are national content standards published by ASCA. Many state and local school district models include content competencies appropriate to their schools’ missions and communities.

The organizational framework element describes structure, activities, and time parameters that support program delivery. The structural components present the definition of, the assumptions behind, and the rationale for the program and its implementation design. The program activity components define activities as guidance curriculum, individual student planning, responsive services, or system support. The time portion of the element describes examples (as in the *National Model* and the text), or recommendations, guidelines, or rules (as in state models) for appropriations of school counselor time for each of the program activity components.

The resources element describes the personnel and financial and political resources needed to fully implement a program. The development, management, and



accountability element describes a systematic process for schools and school districts to use to tailor their programs to best assist their students' development that make wisest use of the allocated resources. The five phases of this process are planning, designing, implementing, evaluating, and enhancing.

### **Six Changes for the 21st Century**

Even in states and school districts with well-described programs, and even with research that documents the value added to students' development within fully implemented programs, program implementation is uneven at the present time. A legitimate goal on behalf of equitable services for all students is to have fully implemented programs in all schools. This entry identifies six goals for changes that may lead more schools to fuller implementation of their programs:

1. Clarity of school counselor professional identity
2. Meaningful school-based leadership for school counselors
3. Multicultural competence of school counselors
4. Relevant school counselor education and training
5. Use of technology for program and counselor accountability and evaluation
6. Fuller understanding and support for guidance and counseling by noncounselors

Each of these was the target of recent work, and the successes of these early efforts suggest that they are feasible improvements for all to consider.

#### ***School Counselor Professional Identity***

To fully implement comprehensive school guidance and counseling programs, school counselors need to be clear about their professional identity. The program establishes the framework for an appropriate job description for school counselors and the basis for school counselors' professional identity. Historically, there has been debate about whether school counselors are counselors *or* educators. School counselors are both. Their responsibilities include educator tasks, such as teaching (guidance curriculum) and guiding individual student planning, *and* counselor tasks, such as individual and small group counseling and

consulting (responsive services). Program development and management, collaborating with colleagues and administrators, and reaching out to the community (system support) are tasks done by both counselors and educators.

While the program model is helping change the situation, school counselors still spend a disproportionate amount of time doing nonguidance tasks (e.g., administrative, clerical, instructional, or student supervision duties). With clear standards for the program, for school counselor competence, and for ethical behaviors and values, counselors will continue to replace these tasks with those that apply their professional competence. Additionally, having one vision for the program and school counselors' jobs provides a common language for school counselors across the United States. Communication and affiliation among school counselors based on a shared identity strengthens that identity.

#### ***School-Based Leadership***

To fully implement comprehensive school guidance and counseling programs, school counselors need leadership. To maintain a meaningful program, leadership for its development and management is a continuous responsibility. To encourage their ongoing professional development, school counselors need administrative and clinical supervision by school counseling professionals.

At the school level, leadership of the majority of school counselors is provided by school principals. While they may be effective educational leaders, most school principals do not have expertise in school counseling. Some school counselors have leadership qualities, but they do not have training in leadership for program and staff development. At this time there is no identity for building-level or district-level school counselor leaders: There is no established job title and only a minimal amount of professional literature and research. Standards need to be established for their work. School counselor leaders need to be educated, trained, and certified to meet these standards.

#### ***Multicultural Competence***

To fully implement comprehensive school guidance and counseling programs, school counselors need to respond effectively to the diverse students,



parents, and educators whose cultural roots or backgrounds are different from theirs. They must be multiculturally competent. In 1998 Sue, Arredondo, and McDavis defined multicultural competence for professional counselors. The profession continues to produce much research-based information to inform counselors regarding most effective ways of assisting people in their own cultural context.

Multiculturally competent individuals are always works in progress. Education and training to become cross-culturally proficient begins in counselor preservice education and should continue in ongoing inservice training and other professional development activities for practicing school counselors. As with the counseling field as a whole, school counselors are predominantly from White, middle-class backgrounds. A counseling staff in a school should include representatives from the cultures of the communities the school serves.

Multicultural competence is also essential to enabling school counselors to provide equitable services to their students. School counselors must be competent at using culturally appropriate counseling interventions. When program priorities are established, different needs of different groups of students should be considered and responded to. Cultural differences should not be the basis of discrimination—either overt or covert. In addition, school counselors help students develop multicultural competence. Multiculturally competent school counselors must also advocate for culturally different students and collaborate with their educator colleagues to help schools be more responsive to their communities.

### ***School Counselor Education and Training***

To fully implement comprehensive school guidance and counseling programs, school counselors need education programs that provide them with the knowledge and skills they need to carry out the program. Currently, there is a shortage of counselor educators who have practiced as school counselors or who have worked in elementary or secondary schools. Doctoral programs in counselor education are not readily accessible to school counselors. Incentives are not typically offered by school districts to encourage doctoral level study, and school counselors must leave their jobs to attend a university full time.

In reality, education continues across the span of a school counselor's career. Counselor educators in

partnership with local schools and districts could assist in inducting new school counselors into actual school counseling practice and in providing ongoing professional development experiences for all school counselors. A majority of states have continuing education requirements for certificate renewal. Counselor educators may be the best resources for providing multicultural and technological competence development. They are also well positioned to develop and provide the leadership training needed by school counselor administrative and clinical supervisors.

### ***Use of Technology***

To fully implement comprehensive programs, school counselors need to use technology to meet expectations for accountability and evaluation. They need to be accountable for the efficient use of their resources (including their time) and to evaluate their effectiveness in program delivery (student results, program completeness). Technology facilitates data collection, management, interpretation, and reporting.

New counselors are more technologically literate than counselors trained several years ago. In-service training, consulting, and mentoring are required to help those who may be uncomfortable with using numbers, data, and technology. In most schools, there is access to the computer equipment and software programs needed (e.g., word processing, spreadsheets, presentation, databases, and the Internet). Many schools have technology specialists available to help counselors. Developers need to create accountability and evaluation models for school counselors that are practical and simple to use.

### ***Understanding and Support From Noncounselors***

To fully implement comprehensive school programs, school counselors need to continue to garner support for the program and the profession from principals, parents, and policymakers. Support is generated when noncounselors understand the value and purposes of the work. In tailoring the program model to their schools and districts, school counselors are urged, and mandated in some states, to collaborate with school staff, parents, and community representatives. When multidisciplinary groups are part of the design team, they are more apt to understand and believe in the program and its value. Counselors



themselves need to be open to receiving input as to desired program improvements. Accountability and evaluation data can be used to show the value to students of the program. When the program structure, the professionalism of school counselors, and the resultant benefits for students are clear, policymakers (e.g., school board members and legislators) are able to listen to, understand, and be supportive of school counselors' work.

*Patricia Henderson and Norman C. Gysbers*

*See also* Brief Therapy (v2); Career Counseling (v4); Career Counseling in Schools (v4); Developmental Counseling and Therapy (v2); Mental Health Issues in the Schools (v1); Multicultural Counseling Competence (v3); Psychological Well-Being, Dimensions of (v2); Racial Identity (v3); School Psychology (v1); School Refusal Behavior (v1); School-to-Work Transition (v4)

### Further Readings

- American School Counselor Association (ASCA). (2005). *The ASCA national model: A framework for school counseling programs* (2nd ed.). Alexandria, VA: Author.
- Gysbers, N. C., & Henderson, P. (2006). *Developing and managing your school guidance and counseling program*. Alexandria, VA: American Counseling Association.
- Gysbers, N. C., & Moore, E. J. (1981). *Improving guidance programs*. Englewood Cliffs, NJ: Prentice Hall.
- Henderson, P., & Gysbers, N. C. (1998). *Leading and managing your school guidance program staff*. Alexandria, VA: American Counseling Association.
- Sue, D. W., Arredondo, P., & McDavis, R. J. (1992). Multicultural counseling competencies and standards. *Journal of Counseling and Development*, 70, 477-486.

---

## SCHOOL PSYCHOLOGY

---

The profession of school psychology developed from the need of school personnel to classify and manage children with educational and behavioral problems. The purpose of this entry is to describe the growth of school psychology and to illustrate how school psychologists are uniquely trained to fulfill many roles, both within and outside of the school setting. School psychologists display skills and abilities that can be successfully applied toward meeting the future needs of a diverse society.

## History and Development

### *Lightner Witmer*

Lightner Witmer, considered the father of school and clinical psychology, was probably the earliest practitioner of school psychology. In 1888, Witmer started his career teaching English and history at a preparatory school, where he was intrigued by students who had difficulties learning despite being motivated and bright. This may have piqued his interest in the empirical study of learning, which characterized much of his future work. Witmer then pursued graduate study at the University of Pennsylvania, and later he led James Cattell's psychology laboratory, primarily to study children who had learning problems. Through his seminal work in the laboratory, Witmer provided the foundation for what has come to be known as the scientist-practitioner model.

### *The Scientist-Practitioner Model*

The scientist-practitioner model emphasizes both science and practice, so that one area informs the other, and the practice of professional psychologists represents an integration of science with professional skills. Using this approach, Witmer worked with children who displayed school-related difficulties. Specifically, one struggled with the English language, and one had been labeled a chronic bad speller. From these descriptions, these children would most probably be diagnosed today as having a learning disability. In a systematic manner, Witmer searched the literature and found that psychology had not investigated causes or treatments for these disorders. Witmer argued that there were no principles for him to follow, and thus, he had to scientifically study these children before developing appropriate interventions. In a paper presented at the Annual Meeting of the American Psychological Association (APA), Witmer proposed a plan involving the training of students for a new profession: psychological experts who would work with the schools and hospitals to help students who had difficulties.

### *Historical Conferences*

At the present time, the majority of school psychology training programs embrace the scientist-practitioner model of training articulated by Witmer. This model was recommended in 1949 at the Boulder



conference, which was held to examine the training of professional psychologists. The shortage of trained psychologists to serve school-age children after World War II led to the Thayer Conference in 1954. The purpose of the Thayer Conference was to address the roles, functions, and training specific to school psychologists. The Vail conference in 1973 led to advocacy of a professionally oriented model of training, emphasizing applied coursework and culminating in the awarding of the doctor of psychology degree (Psy.D.). This training model focused on the delivery of professional services, and although not many school psychology programs currently offer this degree, there has been growing interest in moving toward applied practice. The majority of school psychology programs offer degrees at the master's, educational specialist, or doctoral level.

### **Levels of Training**

Specialist and master's degree programs in school psychology typically include 3 years of full-time graduate study (including an internship). Most doctoral programs require 2 additional years of education. The specialist- and master's-level degrees appear to be the most cost-effective training option, because school psychologists can practice at the predoctoral level. Although specialist- or master's-level training seems to be sufficient for practice within the schools, additional competencies are provided by doctoral training and may be more important to successful practice in nonschool or clinical settings. School psychology programs of various levels may be accredited by the National Association of School Psychologists/National Council for Accreditation of Teacher Education or by the APA.

## **Training**

### **NASP/NCATE Accreditation and Standards**

The nationally recognized accrediting body for education specialties is the National Association of School Psychologists/National Council for Accreditation of Teacher Education (NASP/NCATE). These organizations accredit teacher education programs as well as educational training programs (e.g., school psychology). For member institutions of NASP/NCATE, the six training standards of NASP are enforced through the accreditation review process.

*Standard I, Values as a Program Foundation*, represents a commitment to understanding and responding to human diversity. *Standard II, Knowledge Base, Training Philosophy, Goals, and Objectives*, stresses the need for an integrated and sequential program of study and practice. *Standard III, Practica*, stresses the centrality of supervised practice and the nature of its training activities as preparatory to the internship. An internship of 1 academic year is specified in *Standard IV* along with specific features that should characterize this component of training. A systematic evaluation plan is encouraged in *Standard V, Performance-Based Program Accountability*, which emphasizes measures of program elements and student outcomes. *Standard VI, Program Level and Structural Requirements*, differentiates specialist-level programs from doctoral-level programs in total credit hours and includes evaluation of graduates and programs.

### **APA Doctoral Accreditation and Standards**

Recognized nationally as the accrediting body for doctoral psychology programs in professional psychology, the American Psychological Association (APA) accredits those programs that self-declare a specialization in primarily clinical, counseling, and school psychology. The APA accreditation model is based on three principles that rest at the core of the profession. First, doctoral education and training is conceptualized as being broad and professional in preparation for entry-level professional psychology practice. Second, the science and practice knowledge base should be relied on by the training programs in the preparation of professional psychologists. Third, considerable latitude is offered each program to define its own philosophy and model of training.

Although no APA school psychology training standards exist per se, APA has specified that APA-accredited school psychology programs must meet the definition of a school psychology program provided by APA Specialty Guidelines for the Delivery of Services by School Psychologists. In addition to being primarily psychological in nature and recognized by the institution as a school psychology program with an identifiable body of students, there must be an identifiable psychology faculty and a psychologist responsible for the program. As mentioned previously, doctoral-level school psychologists usually have expanded training that widens the scope of their skills and understanding, allowing them to serve more



diverse roles in society, including practice in schools and other clinical settings such as hospitals.

## Roles of School Psychologists

Although a wide variety of functions have been suggested as appropriate for the school psychologist, psychological and educational assessment of children for placement in special education programs has been school psychologists' most visible role. In earlier decades, this function was primarily psychometric, although the conceptualization and practice of assessment has broadened recently due to legislative initiatives and changing problem-solving strategies. Three conferences on the promise of school psychology (Spring Hill, Olympia, Futures) helped to broaden the role of psychologists in the schools, reducing a focus on assessment and establishing intervention (and sometimes prevention) as necessary activities for school psychologists.

Given this focus on intervention, new models have been developed such as the Response to Intervention (RTI) model that permits the delivery of services that are more closely related to the psychological and educational needs of children. Instead of focusing on psychometric testing to determine eligibility, RTI emphasizes evidence-based interventions guided by a functional analysis of behavior, which lead to the implementation of effective interventions in academic, social-behavioral, and psychological domains.

School psychologists currently work as members of teams in which a more comprehensive approach to service delivery is taken. School psychologists assist teachers by conducting individual and group interventions for students with academic, emotional, or behavioral problems. School psychologists work with teachers in more direct ways through individualized consultation. Consultation is one means by which school psychologists "give psychology away" to nonpsychologists. The goal of consultation is to help clients (usually students) indirectly through engaging in a problem-solving process with the consultee (usually teachers or parents).

By working directly with parents and community members, school psychologists act as change agents and accept leadership roles for enhancing positive relationships between schools, families, and the community. School psychologists are in an ideal position to facilitate initiatives surrounding planning, implementing, and evaluating strategies for building constructive relationships between the home, school, and

community. To help society, school psychologists may serve in medical settings, businesses, neurological settings, residential treatment facilities, and private practice. By involving students, families, and the community, school psychologists can lead initiatives to promote safe schools with positive climates free of drugs, violence, and fear.

## The Future of School Psychology

School psychologists are exceptionally well trained to apply skills and knowledge in various functions both in and out of the schools. Although school psychologists may earn an accredited degree at the master's, specialist, or doctoral level, the training afforded by doctoral programs enables school psychologists to perform a broader range of functions. With extensive training, school psychologists have the knowledge, skills, and dispositions needed to meet the changing needs of children, youth, teachers, and families in our problem-saturated society.

*Amanda H. Stoeckel and Rik Carl D'Amato*

**See also** Accreditation by the American Psychological Association (v1); Conduct Disorder (v1); Counseling Psychology, History of (v1); Developmental Disorders (v1); Functional Behavioral Assessment (v1); Language Difficulties, Clinical Assessment of (v2); Learning Disorders (v1); Mental Health Issues in the Schools (v1); Mental Retardation and Developmental Disabilities (v1); School Counseling (v1); School Refusal Behavior (v1); Scientist–Practitioner Model of Training (v1)

## Further Readings

- Conoley, J. C., & Gutkin, T. B. (1995). Why didn't—why doesn't—school psychology realize its promise? *Journal of School Psychology, 33*(3), 209–217.
- D'Amato, R. C. (2003). School psychology is not what it used to be: Thoughts from the new editor concerning our "Futures" and *School Psychology Quarterly*. *School Psychology Quarterly, 18*, 3–12.
- D'Amato, R. C., & Dean, R. S. (1989). The past, present, and future of nontraditional school psychology. In R. C. D'Amato & R. S. Dean (Eds.), *The school psychologist in nontraditional settings: Integrating clients, services, and settings* (pp. 185–209). Hillsdale, NJ: Lawrence Erlbaum.
- D'Amato, R. C., Fletcher-Janzen, E., & Reynolds, C. R. (Eds.). (2005). *Handbook of school neuropsychology*. New York: Wiley.



- Gutkin, T. B., & Sheridan, S. M. (2000). The ecology of school psychology: Examining and changing our paradigm for the 21st century. *School Psychology Review*, 29(4), 485–502.
- Sheridan, S. M., & D'Amato, R. C. (2003). Partnering to chart our futures: *School Psychology Review* and *School Psychology Quarterly* combined issue on the multisite conference on the Future of School Psychology. Article published jointly in *School Psychology Quarterly* and *School Psychology Review*. *School Psychology Quarterly*, 18(4), 352–357.

---

## SCHOOL REFUSAL BEHAVIOR

---

School refusal behavior refers to child-motivated refusal to attend school or difficulties remaining in classes for an entire day. The behavior applies to 5- to 17-year-old children who are completely absent from school, who skip classes or certain sections of a school day, who are chronically tardy to school, or who attend school under intense duress that precipitates pleas for future nonattendance. Many youths display a fluctuating course of school refusal behavior that may include full absence one day, partial absence another day, and tardiness or a skipped class still another day.

Acute school refusal behavior may be defined as absenteeism lasting less than 1 calendar year, whereas chronic school refusal behavior may be defined as absenteeism persisting for more than 1 calendar year. In general, school refusal behavior is considered problematic if it lasts at least 2 weeks or significantly interferes with daily functioning. School refusal behavior is distinguished from school withdrawal, which refers to a parent who deliberately keeps a child home from school. In addition, school refusal behavior is not meant to include youths who fail to attend school because of extenuating circumstances such as homelessness or maltreatment.

### Historical Overview

Many terms have been applied to school refusal behavior, including problematic absenteeism, truancy, psychoneurotic truancy, school phobia, and separation anxiety. Each term describes a subset of youths with school refusal behavior. For example, truancy refers to illegal absenteeism in which a child misses school without parental knowledge. Other terms describe

youths with anxiety-related conditions such as dread (psychoneurotic truancy), fear (school phobia), and worry about separation (separation anxiety). The term “school refusal” is often used to refer to anxiety-based absenteeism as well. Many of these terms have been poorly defined, however, and are used in various ways by educators, clinicians, and researchers. The umbrella term “school refusal behavior” has been proposed to cover all youths with problematic absenteeism, whether anxiety-related or not, and to provide consensus for educators, clinicians, and researchers.

### Characteristics of Youths With School Refusal Behavior

School refusal behavior affects an estimated 5% to 28% of school-age children. According to the National Center for Health Statistics, 0.9% of children did not attend school at all in 2003. Furthermore, 5.4% of youths missed 11 or more days of school, 11.3% missed 6 to 10 days of school, and 28.1% missed 3 to 5 days of school in 2003. The number of absences due specifically to school refusal behavior, however, is unclear.

Peak age of onset of school refusal behavior is 10 to 13 years, though many youths entering a school building for the first time appear especially vulnerable. School refusal behavior is equally common among boys and girls and across sociocultural groups, though school dropout rates tend to be higher among Hispanics than among the general population. School refusal behavior is generally associated with adequate academic achievement up to the onset of absenteeism.

A hallmark of youths with school refusal behavior is symptom heterogeneity. The clinical picture of youths who refuse school is quite varied and includes many internalizing (covert) and externalizing (overt) symptoms. Common internalizing symptoms include general and social anxiety, depression, fatigue, somatic complaints, fear, worry, and self-consciousness. More specifically, common somatic complaints include headaches, stomachaches, abdominal pain, nausea, vomiting, diarrhea, trembling, and heart palpitations. Common externalizing symptoms include noncompliance and defiance, refusal to move, running away from school or home, aggression, and acting-out behaviors in school in an attempt to be sent home.

Most children with school refusal behavior display a complicated diagnostic picture as well. The most common diagnoses associated with school refusal behavior are anxiety-related conditions, such as separation



anxiety disorder, generalized anxiety disorder, and social anxiety disorder, and depressive-related conditions such as major depression and dysthymia. However, about one third of this population meets criteria for no mental disorder.

In the short term, school absenteeism causes substantial stress for a child and family members and can lead to social alienation, declining grades, family conflict, and financial and legal troubles. In the long term, chronic absenteeism is a risk factor for juvenile delinquency and school dropout. Longitudinal studies of youths with chronic absenteeism also reveal increased risk for social, occupational, economic, marital, and psychiatric problems in adulthood.

### Functional Model

Many systems have been designed to classify youths with school refusal behavior with respect to various forms of internalizing and externalizing behavior. Examples include general clinical, diagnostic, and empirical/statistical methods of classification. These systems demonstrate only mixed success at categorizing large percentages of youths who refuse school because of the heterogeneity of symptoms for these children. An alternative functional model for classifying youths with school refusal behavior along the major reasons or reinforcers of absenteeism has gleaned substantial empirical support. These functions include avoidance of stimuli that provoke a general sense of negative affectivity (symptoms of anxiety and depression), escape from aversive social or evaluative situations, pursuit of attention from significant others, and pursuit of tangible rewards outside of school.

The first two functional conditions refer to youths who refuse school for negative reinforcement, or to avoid or escape something aversive at school. The latter two functional conditions refer to youths who refuse school for positive reinforcement, or to pursue rewards outside of school. Many youths refuse school as well for a combination of these functions. The functional model may serve as the basis for a comprehensive assessment and treatment process.

### Assessment

Assessing youths with school refusal behavior typically involves structured diagnostic interviews, child self-report measures of internalizing symptoms, parent- and

teacher-based measures of internalizing and externalizing behaviors, behavioral observation, and examination of medical, academic, and attendance records. In addition, the assessment process should focus on the function of a child's school refusal behavior. Medical assessment of somatic complaints and related physical conditions is common as well. Assessment is best conducted as a multidisciplinary process that involves parents, children, peers, school personnel, and health and mental health care professionals.

### Treatment

Treatment of youths with school refusal behavior often involves an emphasis on restoring full-time attendance and addressing anxiety and other mental conditions associated with the behavior. As such, treatment usually includes child-, parent-, and family-focused techniques. Child-based techniques include psychoeducation about the nature of anxiety, somatic control exercises to ease physical symptoms of anxiety (e.g., relaxation training, breathing retraining), cognitive restructuring to challenge and change irrational thoughts, and exposure-based practices to ease a child back into school. This last technique is often done by systematically adding hours, periods, or classes to a child's school day. The general goal of these child-based techniques is to reduce distress associated with school and increase school attendance on a gradual basis.

Parent-based techniques include restructuring parent commands toward brevity and clarity, ignoring a child's simple inappropriate behaviors (e.g., morning dawdling), establishing fixed routines in the morning and evening, establishing rewards and punishments for attendance and nonattendance, reducing excessive reassurance-seeking behavior, and engaging in forced school attendance under certain conditions. The general goal of these parent-based techniques is to reduce attention-seeking child behaviors and re-establish parental control via contingency management.

Family-based techniques for school refusal behavior include negotiating and designing written contracts, escorting youth to school and classes, communication skills training for family members, and peer refusal skills training to help youths decline peers' suggestions to miss school. The goal of these family techniques is to increase incentives for school attendance and decrease incentives for nonattendance while improving family problem-solving skills.



Treatment for school refusal behavior may also involve medication, monitoring of school attendance on a daily basis, increased parental and school supervision, resolution of peer- and teacher-related conflicts, social skills training, behavioral activation, and development and modification of 504 and individualized educational plans. Use of daily attendance journals and increased participation of the child in school-based extracurricular activities is recommended as well. In addition, ongoing consultation with a child's pediatrician, school guidance counselor, school psychologist, and teachers is often crucial to resolve a particular case of school refusal behavior. Relapse prevention following resumption of full-time attendance is also necessary in many cases.

*Christopher A. Kearney,  
Adrianna R. Wechsler, and Gillian Chapman*

**See also** Behavioral Observation Methods, Assessment (v1); Conduct Disorder (v1); Depression (v2); Externalizing Problems of Childhood (v1); Family Counseling (v1); Homeless Youth (v1); Internalizing Problems of Childhood (v1); Mental Health Issues in the Schools (v1); Panic Disorders (v2); Psychoeducation (v2); School Counseling (v1); School Psychology (v1)

### Further Readings

- Kearney, C. A. (2001). *School refusal behavior in youth: A functional approach to assessment and treatment*. Washington, DC: American Psychological Association.
- Kearney, C.A. (2003). Bridging the gap among professionals who address youth with school absenteeism: Overview and suggestions for consensus. *Professional Psychology: Research and Practice*, 34, 57–65.
- Kearney, C.A. (2006). Confirmatory factor analysis of the School Refusal Assessment Scale-Revised: Child and parent versions. *Journal of Psychopathology and Behavioral Assessment*, 28, 139–144.
- Kearney, C. A. (2007). Forms and functions of school refusal behavior in youth: An empirical analysis of absenteeism severity. *Journal of Child Psychology and Psychiatry*, 48, 53–61.
- Kearney, C. A., & Albano, A. M. (2000). *When children refuse school: A cognitive-behavioral therapy approach/Therapist's guide*. San Antonio, TX/New York: The Psychological Corporation/Oxford University Press.
- Kearney, C. A., & Silverman, W. K. (1999). Functionally-based prescriptive and nonprescriptive treatment for children and adolescents with school refusal behavior. *Behavior Therapy*, 30, 673–695.

## SCIENTIST–PRACTITIONER MODEL OF TRAINING

The integration of professional practice with scientific thinking and research has been a defining characteristic of professional psychology since its inception, although it was first formally articulated as part of the doctoral training model at the Boulder conference in 1949. The scientist–practitioner model has been central to counseling psychology identity and training since its endorsement at the Greyston conference in 1964 and reaffirmation at the Georgia conference in 1987. In 1990, The National Conference on Scientist–Practitioner Education and Training for the Professional Practice of Psychology reaffirmed the scientist–practitioner model as a true integration of science and practice in which each activity continually informs the other. In spite of the professional consensus that psychologists should approach their practice scientifically and base their practice activities on scientific evidence, there is an equally strong consensus that counseling psychology (and other areas of professional psychology) have fallen short of realizing the scientist–practitioner model.

Now, more than ever, a true integration of science and practice is needed. Changes in the healthcare system, increasingly demanding managed care entities, and competition with other mental health professions have created greater demand for proof that psychologists' activities and interventions are effective. Traditional fee-for-service psychological activities are being replaced by activities such as program development and administration, training and supervision of other mental health professionals, evaluating the effectiveness of behavioral healthcare and educational programs, and influencing public policy.

### History and Definitions

The scientist–practitioner model, also known as the Boulder model, was developed at the Conference on Graduate Education in Clinical Psychology held at the University of Colorado at Boulder in 1949. This 2-week-long conference was the first national meeting held to discuss standards for doctoral training in psychology in the United States. Conference attendees concluded that psychologists should provide both professional services and research contributions. Furthermore, the 1949 Boulder conference attendees



endorsed a wide range of psychological practice, including work with more normal clientele and traditional counseling psychology realms such as vocational counseling. In 1954, Pepinsky and Pepinsky further articulated the activities of the counselor-as-scientist. As early as 1961, however, psychologists began to recognize and be concerned about the scientist–practitioner split.

### Current Status

Hayes and colleagues, in perhaps the most comprehensive consideration to date of how psychologists enact the scientist–practitioner model, described an integrated model of science-based practice in managed behavioral health care, which includes psychologists' contributions to community-level prevention and health development services, practice guidelines and triage to services provided by different levels of practitioners, evaluation and outcome assessment, and the development of new treatments from innovation through program evaluation and efficacy testing to dissemination. Models such as this show how psychologists can integrate science and practice in a wide variety of ways in the full range of settings in which they work. However, there are still barriers to overcome as counseling psychology moves forward toward science–practice integration.

### Training Issues

Many members of the original Boulder delegation questioned whether all graduate students could be trained to do both science and practice. Not only has such integrated training in science and practice been impossible to date, but it has been shown to be unrealistic to expect all psychologists to be both skilled practitioners and productive researchers. The successful conduct of research and practice requires different styles and skills, and individuals seeking a career in professional psychology self-select into professional activities that reflect their unique personalities, aptitudes, and interests. Because of fundamental differences in the demands of science and practice, there are few truly integrated scientist–practitioners, in any setting, to serve as role models. The reality of graduate training in psychology is that science and practice activities are typically separated, with the majority of scientific training and mentoring occurring in classroom settings with faculty and the majority of practice training and mentoring occurring in external

practicum settings with psychologists who identify as practitioners.

A number of counseling psychologists have attempted to build more systematic scientist–practitioner attitudes and behaviors into counseling psychology training. Efforts have been made to develop models to incorporate scientific thinking and methods (e.g., hypothesis testing) into practice activities such as assessment. Changes have been suggested to the practicum training sequence to include systematic data collection using single-case or time series research methods and empirically based rationales for specific treatment interventions. Other suggested additions to a counseling psychology program curriculum to increase scientific activity include an ongoing research practicum, a qualitative methods course, and an advanced research design course specific to counseling psychology. To date, efforts to increase scientist–practitioner integration have been typically focused on increasing the scientific thinking and activity of practice-oriented students, and little attention has been given to increasing the practice orientation of researchers.

### Technological Issues

One of the greatest barriers to true integration of science and practice is the currently available research technology. Randomized clinical trials (RCTs), considered the gold standard in psychotherapy research, rarely yield information that practitioners can use. Current psychotherapy research methods, typically focused on treatment efficacy, have been used to identify treatments that work (i.e., yield outcomes better than no treatment). However, psychotherapy research methods have not consistently distinguished particular therapeutic approaches as more or less effective than others, making those methods of little utility to practitioners in terms of their professional decision making or accountability. Furthermore, RCT designs have relied upon strategies such as random assignment, uniform diagnostic groups, and treatment manualization, making them difficult to generalize to the real-world activities of practitioners who deal with complex cases and culturally diverse clients.

There have been recommendations for increased focus on effectiveness research, testing psychological treatments in real-world settings with real clients, but such effectiveness research initiatives are just beginning to yield methodological and outcome developments. Effectiveness research efforts are quite



promising, and effective interventions and therapists are being identified. However, conducting psychotherapy research in real-world practice settings poses a number of unique logistical, ethical, and methodological challenges.

One of the greatest challenges inherent in psychotherapy science and in the scientist–practitioner model is the need to develop methods that adequately tap into the scientific and therapeutic activities of practitioners. At this point, little is understood about the counselor-as-scientist (i.e., the processes that drive the moment-by-moment decisions of practitioners). The success of the scientist–practitioner model depends on counseling psychology’s ability not only to address questions derived from practice but also to learn from the scientific process of practitioners.

### Evidence-Based Practice

The newest development in science–practice integration is evidence-based practice. Evidence-based practice was originally defined as the systematic use of research evidence to make practice decisions. More recently, evidence-based practice has been more broadly conceptualized to include a general attitude toward gathering and using evidence, taking evidence from a variety of methods and sources, and using a wider range of information in making professional decisions. It has been argued that evidence-based practice can be a bridge over the scientist–practitioner split, as psychologists all begin to consider themselves to be evidence-based *practitioners*, rather than scientists *or* practitioners.

The American Psychological Association convened a panel of prominent practitioners and psychotherapy scientists to define evidence-based practice. The task force, in their 2005 policy statement, defined evidence-based practice in the most comprehensive manner to date—from any profession. Evidence-based practice demands that treatment decisions are based on the best available research evidence, on clinical expertise, and on client characteristics, culture, and preferences. Furthermore, the task force called for a broader conception of evidence (e.g., clinical observation, case studies, ethnographic research, process-outcome studies), for efforts to understand and facilitate the clinical expertise processes (e.g., studying clinician practices, developing measures clinicians can use, providing real-time client progress feedback), and for greater attention to the influence of client characteristics (e.g., testing tailored treatments,

applications to populations other than majority populations, improving psychologists’ competence with diverse clients, identifying models of client preference-based treatment decision making). Evidence-based practice, in this comprehensive formulation, may be the avenue by which psychologists come to embody the science–practice integration envisioned by the Boulder and Greyston delegates more than a half-century ago.

Kathleen Chwalisz

*See also* Conferences in Counseling (v1); Conferences, Counseling Psychology (v1); Counseling Psychology, Definition of (v1); Counseling Psychology, History of (v1); Counseling Skills Training (v2); Empirically Based Professional Practice (v1); Evidence-based Treatments (v2); Outcomes of Counseling and Psychotherapy (v2)

### Further Readings

- APA Presidential Task Force on Evidence-Based Practice. (2006). Evidence-based practice in psychology. *American Psychologist*, 61(4), 271–285.
- Belar, C. D., & Perry, N. W. (1992). National Conference on Scientist-Practitioner Education and Training for the Professional Practice of Psychology. *American Psychologist*, 47(1), 71–75.
- Heppner, P. P., Carter, J. A., Claiborn, C. D., Brooks, L., Gelso, C. J., Holloway, E. L., et al. (1992). A proposal to integrate science and practice in Counseling Psychology. *The Counseling Psychologist*, 20(1), 107–122.
- Meara, N. M., Schmidt, L. D., Carrington, C. H., Davis, K. L., Dixon, D. N., Fretz, B. R., et al. (1988). Training and accreditation in counseling psychology. *The Counseling Psychologist*, 16, 366–384.
- Stoltenberg, C. D., Pace, T. M., Kashubeck-West, S., Biever, J. L., Patterson, T., & Welch, I. D. (2000). Training models in counseling psychology: Scientist-practitioner versus practitioner-scholar. *The Counseling Psychologist*, 28(5), 622–640.
- Wampold, B. E. (2001). *The great psychotherapy debate: Models, methods, and findings*. Mahwah, NJ: Lawrence Erlbaum.

---

## SEXUAL VIOLENCE AND COERCION

---

The Centers for Disease Control and Prevention (CDC) have developed uniform, nonlegal definitions for sexual violence and related terms in an effort to



standardize the reporting and study of these crimes. Inclusionary criteria are broad and divide these crimes into five categories, which include (1) completed nonconsensual sex acts, including penetration, to any degree, of a genital opening or anus, and sodomy, (2) attempted nonconsensual sex acts, (3) abusive sexual contact, including any intentional touching that could be construed as sexual, (4) noncontact sexual abuse, including such acts as voyeurism, harassment, and pornography, and (5) sexual violence, unspecified type. Contact is considered nonconsensual if the victim says no at any time; participates because of pressure, coercion, or intimidation; or is unable to consent because of age, intoxication, illness, being asleep, or any other disabling condition.

Under a grant funded through the CDC and the National Institute of Justice, the National Violence Against Women Survey (NVAWS) found that 1 in 6 women and 1 in 33 men reported being victims of attempted or completed rape in their lifetimes. Alarming, 54% of female victims reported being raped before age 18. Rape is often accompanied by other forms of physical assault, including beating, choking, kicking, and use of a weapon, to name a few. In contradiction to the stereotypical portrayal of the rapist as a stranger, in most cases the perpetrator is a current or former intimate partner, an acquaintance, or a relative. A majority of children who experience sexual violence or coercion without penetration or sodomy also know and trust their perpetrators. Estimates of childhood sexual abuse vary, but range from a low of 6% for females and 3% for males to a high of 62% for females and 31% for males.

While the majority of victims of sexual assault are female, the majority of perpetrators are male, regardless of the sex of the victim. Sexual assault and coercion are crimes of violence and abuse of power, not of sexual desire. The intention of the perpetrator is to humiliate and to control the victim, not to obtain sexual gratification from or intimacy with another person.

Survivors of sexual violence are likely to face a number of psychological challenges in their attempts to cope with and adapt to their victimization and their lack of real or perceived safety. Feelings of shame, doubt, helplessness, hopelessness, unreality, fear, and anger, to name a few, are common, and while reactions vary in relation to age and psychological resources, the experience of sexual assault has strong negative consequences for most victims. Unfortunately, it appears that few victims of sexual violence, including those who sustain physical injury, seek treatment for their difficulties.

Without treatment, individuals who have been traumatized tend to live traumatizing lives, and sexual violence tends to recur in the lives of individuals who have previously been victims, serving to confirm their lack of safety and leading to more psychological distress.

Initial concerns in the treatment of survivors of sexual violence include provision of emotional and physical safety, both in and out of therapy, monitoring for suicidal ideation, and developing a strong, trusting therapeutic relationship. Victims of rape have high rates of attempted suicide, and often experience questionable support. Unfortunately, rape and sexual abuse appear to be among the few violent crimes for which the victim is perceived as, and often feels, partially responsible. It is important to address the issues of shame surrounding experiences of sexual violence and to help victims understand that they were not at fault. Personal safety issues should be addressed in the context of what can be done to help keep the individual safe now and in the future, with careful assessment of the survivor's reaction to these offerings. It is essential to balance fostering a sense of control with engaging in strategies that help survivors move from an intellectual understanding of the perpetrator's responsibility for the crime to an emotional sense of their own innocence. It can be dangerous to cultivate an attitude that "if only I had done something different, this would not have happened to me," as it tends to feed the victim's sense of personal responsibility for a violent act that was perpetrated against him or her. Because treatment of difficulties related to sexual violence and coercion is a specialized area, it is important that therapists choosing to treat survivors gain the required competencies.

Given the nature of our society's attitude toward sexual violence, seeking closure through legal channels can be a disappointing and degrading process, as it is estimated that a very small percentage of rapists are incarcerated due to prosecution. It is important that therapists who treat victims of these crimes have a broad understanding of the statistics and literature related to the legal issues involved. Survivors of sexual violence should be given as much control over their decisions as possible while taking into consideration all relevant information.

*Libbe A. Gray*

*See also* Abuse (v2); Child Maltreatment (v1); Disasters, Impact on Children (v1); Externalizing Problems of Childhood (v1); Help-Seeking Behavior (v3); Internalizing Problems of Childhood (v1); Power and Powerlessness (v3); Sexual Harassment (v4)



## Further Readings

- Panel on Research on Child Abuse and Neglect, National Research Council. (1993). *Understanding child abuse and neglect*. Washington, DC: National Academies Press.
- Tjaden, P., & Thoennes, N. (2000). *Full report of the prevalence, incidence, and consequences of violence against women*. Retrieved April 15, 2006, from <http://www.ncjrs.gov/txtfiles/nij/183;781.txt>
- U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics. (2002). *Selected findings, rape and sexual assault: Reporting to police and medical attention, 1992–2000*. NCJ 194530. Washington, DC: Author.

## Web Sites

- The Academy of Experts on Traumatic Stress:  
<http://www.aaets.org/index.html>

---

## SLEEP DISORDERS

---

“Sleep tight and sweet dreams” used to be the phrase used when bidding a family member good night. Unfortunately, a significant number of individuals have difficulty either falling asleep or staying asleep for the 7 to 8 hours recommended by the National Institutes of Health. (However, this is a general recommendation and varies by both age and the individual. For example, infants need on average about 16 hours of sleep per day, teenagers approximately 9 hours, adults the 7 to 8 recommended hours, with older adults requiring about the same as younger adults or up to 9 hours sleep.) Between 50 million and 70 million individuals are impacted by sleep-related problems. This is a serious issue, as sleep is a neurobiological need. The ultimate result of sustained sleep loss can be death. Not only is a significant percentage of the U.S. population impacted by sleep disorders, sleep has also become a big business; there are over 2,800 U.S.-based sleep centers. Sleep center revenue is expected to climb to \$4.4 billion by the year 2011, and this does not account for the estimated \$3 billion in revenue to pharmaceutical companies from the 43 million prescriptions written annually for sleep disorders.

The National Institutes of Health has classified over 80 types of sleep disorders. The *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR)* organizes sleep disorders into four major categories: primary sleep

disorders, sleep disorder related to another mental disorder, sleep disorder due to a general medical condition, and substance-induced sleep disorder. Included within these categories causing sleep disturbance are psychiatric illnesses like depression and posttraumatic stress disorder (PTSD); medical or biological contributors like hypertension and coronary artery disease; situational contributors of shift work, poor environment, and jet lag; medicine or drugs, which includes alcohol, stimulants, and narcotics; and numerous others like sleep apnea, genetics, ethnicity, and the aging process. It appears from all the data that the United States is becoming a sleep-deprived nation. The good news is that there is rapidly growing attention to this problem, as more than \$110 million has been invested in sleep related research since 1996.

## Definition of Sleep Disorder

An all-encompassing definition of a sleep disorder is difficult due to the broad categories and significant number of sleep disorders within each category. However, to establish some frame of reference, following are examples of major sleep disorders as defined by *DSM-IV-TR*:

*Primary insomnia*: “Difficulty initiating or maintaining sleep or of a nonrestorative sleep that lasts for at least 1 month (Criterion A) and caused clinically significant distress or impairment in social, occupational, or other important areas of functioning (Criterion B).” This is the most common of the sleep disorders.

*Breathing-related sleep disorder*: “Sleep disruption, leading to excessive sleepiness or, less commonly, to insomnia, that is judged to be due to abnormalities of ventilation during sleep (e.g., sleep apnea or central alveolar hypoventilation).”

*Circadian rhythm sleep disorder*: “Persistent or recurrent pattern of sleep disruption that results from altered function of the circadian timing system or from a mismatch between the individual’s endogenous circadian sleep-wake system and exogenous demands regarding the timing and duration of sleep.”

*Dyssomnia not otherwise specified* includes “complaints of clinically significant insomnia or hypersomnia that are attributable to environmental factors (e.g., noise, light, frequent interruptions); excessive sleepiness that is attributable to ongoing sleep deprivation;



‘Restless legs syndrome’ characterized by a desire to move the legs or arms, associated with uncomfortable sensations typically described as creeping, crawling, tingling, burning, or itching.”

The definitions continue for additional sleep disorders, including nightmare disorder, sleep terror disorder, sleepwalking disorder, sleep disorders related to another mental disorder, sleep disorder due to a general medical condition, and substance-induced sleep disorder.

### **The Impact of Sleep Disorder**

The list of negative impacts from sleep deprivation and disorders is lengthy. The impact can depend upon many factors, including gender; age differences; and situational factors like stress, loss of a loved one, or jet lag. There are the physical consequences like lowered attention and executive functions resulting in loss of productivity at work, and impaired learning and memory. An estimated 56,000 automobile crashes annually are related to driver drowsiness and fatigue. Other impacts are a weakened immune system, a link between brain damage and sleep apnea, the inhibition of aggression and negative consequences to overall mood, emotional impacts such as the correlation between depressive symptoms and prominent fatigue, and an overall impaired quality of life.

### **Treatment: Psychology Versus Pharmacology**

Focusing on insomnia as the most prevalent of sleep disorders, several treatments are effective, including pharmacology, cognitive-behavioral therapy, stimulus control therapy, biofeedback, and relaxation training. Cognitive-behavioral therapy (CBT) has been shown to be an effective treatment for insomnia. Comparisons between CBT, pharmacological therapy, and the combination of the two on treatment for insomnia suggests that medications and the combination of medication and CBT produced greater short-term effects, but CBT alone appears to have the greatest long-term effect on improving sleep disturbances.

### **Advancements and Research Results**

There is still much to investigate regarding sleep disorders, but much progress has been made. Several clock genes have been discovered that have a significant role

in mammalian circadian timing, and newly discovered neurotransmitter systems influence regulation of rapid eye movement (REM). Regarding molecular biological approaches, the hypocretin system has been found to have a role in narcolepsy and behavior control, and cell groups in the hypothalamus and neurochemical phenotypes of neurons are important to REM. Research is also exploring the genetic basis of sleep. Treatment of neurological disorders can cause sleep disorders. Epileptic seizures can place individuals at further risk for sleep disorders. An interesting observation relating to age and gender is that approximately 90% of the individuals impacted by REM behavior disorder (RBD) are male, and most are over 50 years old. Disruption of sleep has also been found with most psychiatric disorders. The same is true for substance abuse.

Conversely, chronic insomnia can put an individual at risk for development of psychiatric disorders. The expression of some genes for synaptic plasticity in children can be impacted by sleep loss. Researchers now better understand sleep and the environment, including the impact of light, temperature, noise, motion (bed partners), location, position, and sleeping surface. Researchers also understand that chronic sleep deprivation can lead to cognitive deficits, weakening of the immune system, weight gain, heart disease, diabetes, and if severe enough even death. From a gender perspective, changes in a woman’s biochemistry, like those associated with pregnancy or menopause, can cause sleep deprivation. Ethnicity is also a factor in sleep disorders. The risk of sleep-disordered breathing (SDB) is approximately twice as great in young African Americans as in Caucasians. Adults that are non-Caucasian are at almost twice the risk of insomnia, which also affects approximately one third of older adults.

Technology has brought new and fresh perspectives to researching sleep disorders over the last 5 years. These include functional neuroimaging technologies like positron emission tomography (PET), functional magnetic resonance imaging (fMRI), single photon emission computed tomography (SPECT), near-infrared optical imaging (NIR), and others that allow researchers to see the brain in new ways. Additionally, electroencephalographic (EEG) brain-mapping studies, combined with electrooculographic (EOG) and submental electromyographic signals (EMG), allow researchers to view the patterns of connectivity between brain regions and how the brain responds while performing specific tasks. They can



demonstrate how functionality and cognitive capacity are altered by sleep loss. The combination of pharmacology, technology, and ongoing research into biology, genetics, psychology, and biochemical makeup holds great promise for successful treatment of many of the categorized sleep disorders.

*Michael H. LeBlond*

*See also* Aging (v1); Cognitive-Behavioral Therapy and Techniques (v2); Neuropsychological Functioning (v2); Physical Health (v2); Psychopharmacology, Human Behavioral (v2); Quality of Life (v2)

### Further Readings

- American Psychiatric Association. (2005). *Diagnostic and Statistical Manual of Mental Disorders* (4th ed., Text rev.). Washington, DC: Author.
- U.S. Department of Health and Human Services, National Center on Sleep Disorders Research. (2003). *2003 national sleep disorders research plan*. NIH publication no. 03-5209. Washington, DC: Author.
- Verbeek, I. H., Konings, G. M., Aldenkamp, A. P., Declerck, A. C., & Klip, E. C. (2006). Cognitive behavioral treatment in clinically referred chronic insomniacs: Group versus individual treatment. *Behavioral Sleep Medicine*, 4(3), 135–151.
- Wu, R., Bao, J., Zhang, C., Deng, J., & Long, C. (2006). Comparison of sleep condition and sleep-related psychological activity after cognitive-behavior and pharmacological therapy for chronic insomnia. *Psychotherapy & Psychosomatics* 75, 220–228.

---

## SMOKING

---

*See* CIGARETTE SMOKING

---

## SPECIALIZATION DESIGNATION

---

Professional psychology as a field includes rigorous training covering a broad range of competencies, often within the domain of a specified course of study such as clinical psychology, counseling psychology, school psychology, or another area. Due to a variety of factors, an increasing focus on competency-based training and recognition of specialty training, with accompanying

board certification in that specialty, has evolved within the field. As a result, more psychologists seek board certification as a means of demonstrating competency in a specific area of specialization.

Within professional psychology, specialty areas are defined areas of practice or service addressing specific problems and populations. Specialty practice requires advanced knowledge, skills, and attitudes that have been acquired in addition to the more broad, general knowledge and training that serves as a foundation for professional psychology.

Specialization may begin during graduate training, yet it continues well beyond completion of the doctoral degree program. It is following several years of graduate study, completion of internship, and postdoctoral training that one becomes eligible to sit for the Examination for the Professional Practice of Psychology (EPPP) leading to licensure for practice within the profession. In most jurisdictions, that licensure is granted as a generic license to practice within the scope of one's training. Thus, licensure as a psychologist, in and of itself, is not considered recognition of specialization. Recognition of specialty in a specific area of psychology is generally made through a board certification process, most often under the processes established and conducted by the American Board of Professional Psychology (ABPP).

### Entities Involved in the Evolution of Specialization and Specialty Designation

Several organizations, most related directly or indirectly in some fashion to the American Psychological Association (APA), have played some role in the genesis and evolution of specialization and specialty designation in professional psychology. Among these are APA entities such as the Committee on Accreditation (COA), the Council for the Recognition of Specialties and Proficiencies in Professional Psychology (CRSPPP), the Association of Predoctoral, Postdoctoral, and Internship Centers (APPIC), the Association of State and Provincial Psychology Boards (ASPPB), the National Register (NR), the Canadian National Register (CNR), the Canadian Psychological Association (CPA), and the Council of Credentialing Organizations in Professional Psychology (CCOPP). A focus on postdoctoral training within the APA and COA and the establishment of the CRSPPP significantly advanced progress in recognition of psychological



specialties during more recent years. The Interorganizational Council for Accreditation of Postdoctoral Programs in Psychology (IOC), composed of several of these bodies, existed from 1992 through 1997 and led to the establishment of the Council of Specialties (CoS) in professional psychology.

The CoS was initially established jointly by the APA and the American Board of Professional Psychology (ABPP) and has provided a working definition of specialty in professional psychology similar to that provided above. Historically, ABPP has generally been recognized as the primary organization that examines, credentials, and certifies professional psychologists; the CoS indicates recognition of ABPP as the *only* such organization.

### Graduate Education

In 1977, the National Conference on Education and Credentialing in Psychology established guidelines for defining a doctoral degree program in psychology. This conference served as the basis for eventual establishment of programs that became accredited by the APA. The joint efforts of the ASPPB and the NR have resulted in recognition of many programs that, although not APA-accredited, are deemed to meet sufficiently similar standards for the purposes of licensing and credentialing. Recognized as ASPPB/NR Designated Doctoral Programs, these programs can be found listed on the Web sites of the ASPPB and the NR. The course of study is for all practical purposes the same as that of an APA-accredited program, and these are often referred to as APA-equivalent programs.

To be so recognized, a graduate program must be clearly identified as a psychology program, be offered through a regionally accredited institution of higher education, be an integrated and organized sequence of study, have an identifiable and sufficient faculty to function adequately, include supervised practicum and internship training, and require a minimum of 3 academic years of full-time graduate study, among other items. The program must also require that students demonstrate competency in the areas of (1) scientific and professional ethics and standards; (2) research design and methodology; (3) statistics and psychometric theory; (4) biological bases of behavior, including physiological psychology and comparative psychology; (5) neuropsychology, sensation and perception, and psychopharmacology; (6) cognitive-affective bases of behavior, including learning, thinking, motivation,

and emotion; (7) social bases of behavior, including social psychology, group processes, organizational theory, and systems theory; and (8) individual differences, including personality theory, human development, and abnormal psychology. As well, the programs must include course requirements in specialty areas. This graduate academic training establishes what have become recognized as the foundational competencies within professional psychology, while further postdoctoral training and experience lead to establishment of the functional competencies.

### Specialty Recognition and Credentialing

#### *The American Board of Professional Psychology*

In the 1940s, the APA formed a committee to study credentialing psychologists. That committee led to the establishment of the American Board of Examiners in Professional Psychology (ABEPP) in 1947. It was recognized that although members of APA might belong to divisions of that organization that are more or less specialized, those divisions are interest groups and could not reasonably be presumed to represent their members as necessarily being specialists in the area. An inherent potential conflict of interest between protection of the public and advancing the interest of division members existed; thus, with support from the APA, the development and establishment of ABEPP as a separate entity proceeded.

Initially, ABEPP certified practitioners in areas it labeled clinical, personnel-industrial, and personnel-educational psychology. The latter two areas evolved into industrial/organization psychology (later becoming organizational and business consulting psychology) and counseling and guidance (later becoming counseling psychology).

The organization changed its name to the American Board of Professional Psychology (ABPP) in 1968. Additional specialty areas were added, until eventually it grew to include 13 specialty boards as of this writing. These are the following: child and adolescent psychology, clinical psychology, clinical health psychology, clinical neuropsychology, cognitive and behavioral psychology, counseling psychology, family psychology, forensic psychology, group psychology, organizational and business consulting psychology, psychoanalysis, rehabilitation psychology, and school psychology.



The original ABEPP organized with the express intention of certifying only the most advanced practitioners in a given area of specialization, believing that state psychological associations should be responsible for those less advanced. Over time, this focus led to concern among some that the organization was elitist and not representing the mainstream of psychological specialists. As well, the question of whether board certification is necessary continues, often with responses suggesting that although it may not be *necessary* to an *individual* now, it is *essential* to the growth of professional psychology in the long run.

Concomitant with a national pursuit of competency-based training throughout the educational and training years in psychology, the organization has evolved into the current ABPP, recognizing the need to examine and certify psychologists at a level of competency that is beyond that of generic licensure yet not limited to only the most elite. It is expected that, akin to individuals in medical specialty areas, most adequately trained psychologists would meet the criteria and be able to pass the ABPP examination in their area of specialty following the completion of appropriate residency training experience ranging from 2 to 5 years of postdoctoral training and experience.

### ***Becoming Credentialed In Counseling Psychology***

Recognition of competency in a specific psychological specialty entails multiple steps. All ABPP specialty boards have similar basic, or generic, requirements, with each specialty board having additional, specialty-specific criteria. A psychologist must undergo credentials review and licensure verification, submit practice samples for review, and pass an oral examination in the specialty area. Some ABPP specialty boards also include a written examination.

Specialty credentialing in counseling psychology is conducted by the American Board of Counseling Psychology (ABCP), a specialty board of the ABPP. Summary information about specialty credentialing through the ABCP is found below, while more details may be found at the board's Web site (<http://www.abpp.org>). The ABCP indicates that counseling psychologists engage in helping people with personal and interpersonal functioning by way of individual, group, and community interventions that deal with emotional, behavioral, vocational, and mental health issues. They may use preventive, developmental, and

remedial approaches in assessment, diagnosis, and treatment of psychopathology. They may engage in psychotherapy, assessment, teaching, research, supervision, and career counseling.

### **Credential Review and Licensure Verification**

ABPP conducts a review of the education and training experience(s) of a candidate. This is conducted at a *generic* level for all candidates, and it consists of verification of training in an APA-accredited or ASPPB/NR-designated doctoral program, verification of internship and postdoctoral experience, and verification of licensure. When these criteria are established as having been met, credentials are reviewed by the ABCP at a *specialty* level to determine that requirements for appropriate training and experience in the specialty area have also been satisfied. In counseling psychology, the specialty criteria that must be met are (1) completion of an acceptable internship program, (2) 1 year of postdoctoral supervision, and (3) 2 years of postlicense experience. Acceptable supervision is one-on-one, face-to-face weekly supervision. All applicants must submit a copy of their curriculum vitae or resume. Graduates of a counseling psychology program accredited by APA must provide endorsement from two psychologists, and graduates of any program other than an APA-accredited counseling psychology program must provide attestations of their functioning as a counseling psychologist from two psychologists.

### **Practice Sample Submission**

The ABCP requires that counseling psychologists submit a professional self-study (PSS) as well as a case study (CS). The PSS is a document that describes training and experiences that have led the psychologist to the specialization in counseling psychology, including a description of theoretical bases for practice and a description of the approach(es) the psychologist makes use of in assessment and intervention. The CS is intended to demonstrate the psychologist's competency in counseling psychology. It may be an individual case, group work, or another demonstration of competency and may be submitted in written form. (The use of a video of the psychologist's work may also be acceptable in some cases.) The PSS and CS are reviewed by board certified peers for evidence of adequate competency in the areas of assessment,



intervention, consultation, and other areas appropriate to the practice of counseling psychology. Once this submission is approved, the candidate is invited to participate in the oral examination phase of the board certification process.

### Oral Examination

The board uses an assessment center model to conduct oral examinations, wherein a candidate moves through several separate examination areas, each with a focus on a particular competency area. The oral examination is conducted over a morning and an afternoon and consists of five competency domains: (1) assessment, (2) intervention, (3) alternative interventions, (4) ethics, and (5) professional issues. The candidate interacts with different examiners during different phases of the examination.

The oral examination includes discussion of the PSS as well as the CS that were previously submitted during the practice sample phase of the process. Additionally, the candidate provides a videotape of an individual client session to the oral examination committee chair 30 days prior to the date of the candidate's oral examination. The criteria used to evaluate oral examination performance are the same for all candidates without regard to their years of postdoctoral experience. On successful completion of the oral examination phase, the counseling psychologist is awarded the ABPP diploma in counseling psychology.

### Future Importance

The importance of specialization within the field of professional psychology is growing. Becoming board certified through an organization such as ABPP can facilitate mobility, or a psychologist's ability to practice in different states. Many states recognize a psychologist who has attained the ABPP board certification as having met the criteria necessary for licensure in the state and require only that (for example) an examination on state-specific regulations be passed prior to granting a license for the practice of psychology in that state. Board certification also represents increased responsiveness to protection of the consumer public. Recent developments have included states working to restrict the use of the term *board certified* or *specialist* to those psychologists who have attained board certification through an organization recognized by the state licensing

body. It is anticipated that specialization and appropriate credentialing of specialists will continue to become more of the norm and expectation within the field of psychology.

David R. Cox

*See also* Counseling Psychology, Definition of (v1); Credentialing Individuals (v1); Cross-Cultural Psychology (v3); Multicultural Psychology (v3); Postdegree/Prelicensure Supervision (v1); Postdoctoral Training (v1); Predoctoral Internships (v1); Professional Degrees (v1); School Psychology (v1); Society for Vocational Psychology (v4); Supervision (v1)

### Further Readings

- American Psychological Association. (1981). Specialty guidelines for the delivery of services by counseling psychologists. *American Psychologist*, 36, 652–663.
- APA Task Force on the Assessment of Competence in Professional Psychology. (2006). *Final report*. Washington, DC: Author.
- Benjamin, L. T., Jr. (2001). American psychology's struggles with its curriculum: Should a thousand flowers bloom? *American Psychologist*, 56, 735–742.
- Bent, R. J., Packard, R. E., & Goldberg, R. W. (1999). The American Board of Professional Psychology, 1947 to 1997: A historical perspective. *Professional Psychology: Research and Practice*, 30, 65–73.
- Dattilio, F. M. (2002). Board certification in psychology: Is it really necessary? *Professional Psychology: Research and Practice*, 33, 54–57.
- Drum, D. J., & Blom, B. E. (2001). The dynamics of specialization in professional psychology. *Professional Psychology: Research and Practice*, 32, 513–521.
- Elman, N. S., Ilfelder-Kaye, J., & Robiner, W. N. (2005). Professional development: Training for professionalism as a foundation for competent practice in psychology. *Professional Psychology: Research and Practice*, 36, 367–375.
- Peterson, R. L., Peterson, D. R., Abrams, J. C., & Stricker, G. (2006). The National Council of Schools and Programs of Professional Psychology educational model. *Training and Education in Professional Psychology*, 5(1), 17–36.
- Roberts, M. C. (2006). Essential tension: Specialization with broad and general training in psychology. *American Psychologist*, 61, 862–870.
- Robinson, J. D., & Habben, C. J. (2003). The role of the American Board of Professional Psychology in professional mobility. *Professional Psychology: Research and Practice*, 34, 474–475.



---

## STRESS-RELATED DISORDERS

---

There is a lack of consensus on how to best define the concept of stress. Concerns related to the scientific status of the construct have led some authors to suggest that it be abandoned altogether or restricted to nontechnical usage. Even at the level of physiology, the mechanisms involved in a stress response cannot be adequately differentiated from anxiety or depression. Likewise, responses to stress are broad and can include anger and hostility, emotional suppression or repression, and disengagement, all of which are similarly confounded with other constructs. Further, the nature of stressors can be confounded with traumatic events depending on how the individual experiences the event.

There is compelling, albeit limited, research that has demonstrated a relationship between the experience of negative life events, especially those that are objectively measured and chronic in nature, and functional changes in the immune system. The possible association between stress and the development and progression of serious illnesses such as coronary heart disease and cancer will need to be studied more extensively before researchers have a better understanding of the potential interplay between them. Some effective interventions for stress have been developed, including stress management techniques, but these are closely related to relaxation treatment approaches designed to treat anxiety. It does appear that the treatment literature emphasizes a cognitive behavioral perspective that, given the role of appraisals and coping mechanisms, holds considerable promise.

### The Concept of Stress

The term *stress* is typically meant to describe an individual's response to negative life events and involves cognitive, behavioral, emotional, and physiological components. Due to its multifaceted nature, the concept of stress has proved to be an imprecise term for the purpose of scientific investigations. Stress has been operationalized in many ways, and as such, it is often confounded with depression, anxiety, lack of social support, Type A behavior, hostility, and anger. Although no consensus has been achieved regarding the definition of stress, one generally accepted conceptualization of stress is that it is a response to a threat or environmental challenge that exists on a continuum between excitement and anxiety and is normally experienced as

tension or negative affect. The severity of the individual's response depends on the degree to which he or she feels a sense of control over the challenge and the level of belief he or she has about the ability to cope effectively with the challenge. Stress has various dimensions, including its duration (acute vs. chronic), quantity (discrete events vs. cumulative events), and quality (interpersonal vs. noninterpersonal events).

Several factors contribute to a stress response. In order for a stress response to occur, there must be the presence of a stressor. Stressors are events or conditions that present a demand or challenge or in some way constrain the individual and may involve catastrophic events (e.g., a natural disaster or being the victim of violence or war), major life changes, minor events, or chronic conditions (e.g., occupational stress). Lazarus and Folkman also noted the importance of cognitive appraisal in the stress process. An event needs to be judged in two ways: One is its relevance to one's physical and psychological well-being, and the other is whether one has the resources available to cope with the problem. This appraisal process influences the quality and intensity of one's emotional response as well as guides the selection of either emotion-regulation or problem-solution strategies for coping.

### Physiology of Stress

There also appears to be consensus that stress involves a physiological response. While Selye initially popularized the concept of stress, the first researcher to describe the phenomenon was Cannon, who described the "fight or flight" response. Selye later observed a set of generalized physical processes that he termed the general adaptation syndrome (GAS), which is the body's response to the awareness of a harmful stimulus and the interpretation of that stimulus as threatening. Current conceptualizations underscore how stress is mediated through the nervous, endocrine, and immune systems. The autonomic nervous system, with its sympathetic and parasympathetic branches, serves a particularly important role in the fight or flight response. The interplay of these systems has implications for the effects of stress on health and illness. For example, the role of one of the cranial nerves, the vagus, is involved with sympathetic activity with regard to heart rate and heart rate variability (HRV). Reduced HRV has been implicated in cardiac disease as well as in both anxiety and depression. Similarly, a real or perceived threat involves the hypothalamic pituitary axis, which



activates a number of hormonal responses that have long-term implications for physical functioning.

### The Assessment of Stress

Due to its multifaceted nature, stress has been assessed in a variety of ways. Given that life change is commonly implicated in the onset of the stress response, it is not surprising that this has been one focus of stress assessment. Holmes and Rahe developed a scale that incorporates both positive and negative life events that are weighted based on the degree of stress involved. There are also measures that assess the impact of traumatic events as well as daily hassles. In addition to self-report measures, there are interview and observational measures, such as those developed to assess Type A personality. There is also a substantial body of research examining how personality may be a risk factor for illness, with emphases on constructs as broad as neuroticism, and including anger, attachment style, emotional suppression, resiliency, helplessness, shyness, and so on. Given the emphasis on biological systems, stress has also been assessed in the laboratory measuring such diverse characteristics as the heart rate and HRV, skin conductance, muscle tension, and catecholamine and neurohormone levels, among others.

### The Relationship Between Psychological Stress and Physical Illness

There is compelling empirical evidence supporting the connection between stressful life events and changes in the immune system. In a meta-analytic review of studies examining the influence of stress on immunity changes, researchers found a significant relationship between stress and both functional and enumerative immune measures. The results indicated that objective reports of stress were related to greater immune changes than subjective self-reports of stress were, interpersonal life events were related to greater changes in some immune outcomes compared to nonsocial life events, and long-term naturalistic stressors were associated with immunological changes. A second meta-analysis of over 300 investigations of the relationship between stress and changes in the immune system found that acute, time-limited stressors brought about adaptive immunological changes consistent with fight-or-flight responses, while chronic stressors were correlated with the suppression of cellular and humoral indices. Similar to the former

meta-analysis, this review indicated that subjective reports of stress were not significantly related to immunological changes.

Conflicting evidence exists regarding the impact of stress on the onset or progression of coronary heart disease and cancer. There appears to be some evidence that acute and chronic stress may have important effects on coronary heart disease. However, this relationship has been viewed with some skepticism given the lack of consensus about how stress should be defined and measured as well as the complex nature of coronary disease. Stress may contribute to the development of cancer through its effects on primary cellular function, such as DNA repair, and it also appears that an individual's level of adjustment to having cancer may affect the progression of the cancer. The mechanisms involved in the relationship between stress and specific diseases are highly complex and therefore require additional prospective community-based studies to define this relationship.

### Treating Stress

Despite 2 decades of research in the area of stress and coping, no gold standard interventions have been developed for managing stress. Research on coping behaviors indicates that the manner in which a person responds to stress is greatly influenced by longstanding characterological traits and therefore may be only somewhat amenable to psychological interventions. However, researchers have demonstrated that stress management interventions can bolster the immune system during treatment for HIV-positive patients and that stress management, coping skills training, and social support have been shown to affect progression of cancer. An emerging area of research is that of *positive psychology*, which focuses on catalyzing positive change in the face of overwhelming stress. There are a growing number of research studies that demonstrate that interventions consistent with positive psychology are able to promote positive mood in individuals suffering from chronic stress. For example, researchers were able to increase positive affect in AIDS caregivers with the use of problem-focused coping, positive reappraisal, and the reframing of ordinary life events with positive meaning.

*Cheryl N. Carmin and Elise D. Massie*

**See also** Affect (Mood States), Assessment of (v2);  
Cognitive-Behavioral Therapy and Techniques (v2);  
Coping (v2); Depression (v2); Occupational Stress (v1);



Panic Disorders (v2); Physical Health (v2); Positive Psychology (v2); Quality of Life (v2); Stress (v2); Stress Management (v2); Work Stress (v4)

### Further Readings

- Barlow, D. H. (2002). *Anxiety and its disorders: The nature and treatment of anxiety and panic* (2nd ed.). New York: Guilford Press.
- Baum, A., & Posluszny, D. M. (1999). Health psychology: Mapping biobehavioral contributions to health and illness. *Annual Review of Psychology*, 50, 137–163.
- Contrada, R. J., & Guyll, M. (2001). On who gets sick and why: The role of personality and stress. In A. Baum, T. A. Revenson, & J. E. Singer (Eds.), *Handbook of health psychology* (pp 50–84). Mahwah, NJ: Lawrence Erlbaum.
- Folkman, S., & Moskowitz, J. T. (2004). Coping: Pitfalls and promise. *Annual Review of Psychology*, 55, 745–774.
- Herbert, T. B., & Cohen, S. (1993). Stress and immunity in humans: A meta-analytical review. *Psychosomatic Medicine*, 55, 364–379.
- Krantz, D. S., & McCeney, M. K. (2002). Effects of psychological and social factors on organic disease: A critical assessment of research on coronary heart disease. *Annual Review of Psychology*, 53, 341–369.
- Lazarus, R. S., & Folkman, S. (1984). *Stress, appraisal, and coping*. NY: Springer.
- Moskowitz, J. T., Folkman, S., Collette, L., & Vittinghoff, E. (1996). Coping and mood during AIDS-related caregiving and bereavement. *Annals of Behavioral Medicine*, 18, 49–57.
- Segerstrom, S. C., & Miller, G. E. (2004). Psychological stress and the human immune system: A meta-analytic study of 30 years of inquiry. *Psychological Bulletin*, 130, 601–630.
- Selye, H. (1956). *The stress of life*. New York: McGraw-Hill.
- Snyder, J. J. (1989). *Health psychology and behavioral medicine*. Englewood Cliffs, NJ: Prentice Hall.
- Somerfield, M. R., & McCrae, R. R. (2000). Stress and coping research: Methodological challenges, theoretical advances, and clinical applications. *American Psychologist*, 55, 620–625.

---

## SUE, DERALD WING (1942– )

---

Derald Wing Sue is undoubtedly one of the most prominent figures in the area of multicultural counseling and research. Throughout his career he has challenged the ethnocentric monoculturalism of Western psychology. He pioneered the field of multicultural

counseling through his vision, courage, and tireless efforts. Among his contributions are conducting research on Asian Americans' mental health, creating courses on multicultural counseling, addressing President Clinton's Race Advisory Board, forming the Asian American Psychological Association, serving as the president of several professional organizations, organizing a national multicultural conference and summit, authoring seminal books, editing several journals, and developing the criteria for multicultural competencies. He has authored or coauthored over 80 journal articles and book chapters, 12 books, and 15 media productions. Sue is currently a professor at Teachers College of Columbia University, professor emeritus at California State University, and the president of A Psychological Corporation, a consultation firm. He continues to conduct research and write in the area of racism and racial microaggression.

### Early Years

Sue was born in Portland, Oregon, the second oldest of five brothers and one sister. His father, who emigrated from China around the age of 13, and his Chinese American mother never received formal education beyond third grade. His father's pride in his cultural heritage and his mother's hard work in raising six children and working at various jobs shaped Sue's early years. Society's prejudice, discrimination, and racism toward him and his racial, ethnic identity also left their imprint on his early years. His family experienced financial hardships, and all the family members worked to contribute to the family budget. His parents emphasized the importance of a strong work ethic and the power of education, and all Sue children eventually received degrees from institutions of higher education. Sue's initial experiences with racism and discrimination came through institutions of formal education and the attitudes of childhood peers. His grade school teacher scolded him for speaking Chinese with his brother, the high school guidance counselor discouraged him from pursuing a career in social science because Asian Americans lacked social skills, and his peers teased him about the way he looked. These experiences eventually fueled his passion to understand the effects of racism and seek system-level change. Sue was also able to challenge his own attitude regarding his ethnic and racial identity, free himself from the limitations set by the society, and pursue a challenging yet successful career in psychology.



## Early Career Years

At a time when multicultural issues and racial equality were rarely, if at all, discussed, Sue was a true pioneer in bringing such issues to the attention of counseling psychologists. After obtaining his bachelor's degree from Oregon State University, and his master's and Ph.D. degrees from the University of Oregon, Sue worked as a counselor at the University of California at Berkeley's counseling center. He became known as the counselor who supported and helped Asian American students. During his years at Berkeley, he conducted studies on the mental health of Asian Americans. Inspired by his early work and research with Asian Americans, he coauthored the books *A Theory of Multicultural Counseling and Therapy* and *Understanding Abnormal Behavior*. Realizing his skill and joy in teaching, writing, and research, Sue transitioned into a tenure-track academic position at California State University at Hayward. He developed and taught the first multicultural counseling course and received the Outstanding Professor award in 1973.

## Major Contributions to the Field

During his undergraduate and graduate training, Sue was influenced by the teachings of the Black leaders of the civil rights movement, such as Martin Luther King and Malcolm X. During the years following his graduation, he witnessed the formation of Black, Latino, and Native American professional organizations. He was inspired to form the Asian American Psychological Association in collaboration with his brother Stanley Sue in 1972, and he served as the first president of the association. The following year, he was asked to serve as the guest editor for a special issue of the *Personnel and Guidance Journal*, and 3 years later he was appointed as the editor for this journal. During his editorship, he introduced changes to the format and content of the journal and emphasized cultural issues as well as prevention issues. He broadened the existing Black-White focus to encompass a more inclusive multiculturalism, addressing other ethnic groups. Although his vision for the journal was revolutionary in doing so, it met with considerable resistance from more senior members of the profession. He was reminded how difficult it can be to go against the status quo and bring about much needed change.

Despite the struggle of bringing changes to the field of counseling psychology, Sue continued to

make major contributions to the field. In 1997 he was invited to address President Clinton's Race Advisory Board. He discussed issues regarding racial equality and invited his countrymen and women to look at personal and institutional sources of racism. The same year he was also elected president of Division 45 (Society for the Psychological Study of Ethnic Minority Issues) of the American Psychological Association (APA). During his presidency he collaborated with other presidents to organize a national multicultural conference and summit in 1999. This conference and summit, now held every other year, facilitates a dialogue on issues of race, privilege, culture, and diversity among diverse groups of people and is now sponsored by professional organizations due to Sue's efforts to secure external funding.

Sue's book *Counseling the Culturally Diverse: Theory and Practice* was another major contribution to the field of counseling psychology. His book was one of the first textbooks that organized and integrated information on cross-cultural counseling and is considered a seminal book in graduate counseling training. In fact, it is used in approximately 50% of all counseling psychology training programs. His more recent publication, *Overcoming Our Racism: The Journey to Liberation*, was geared toward the general public in order to challenge individuals to acknowledge their racism and consider ways of moving toward societal equality.

Sue also theorized and defined multicultural competencies for more than 20 years. He chaired the committee instrumental in developing a list of multicultural competencies for counseling psychologists in 1980. Despite his continued efforts in this area for years, the criteria for multicultural competencies were not put in practice until 22 years later. In 2002 the APA adopted policies regarding guidelines on multicultural education, training, research, and practice.

## Recent Work

In 2007 Sue's recent work has focused on racial microaggressions and the Asian American experience. He believes that overt expression of racism has evolved into more subtle, ambiguous, and unintentional manifestations toward Asian Americans in American social, political, and economic life. Racial microaggression describes racism that occurs daily in the lives of individuals who are ethnically different from the mainstream. People of color experience



subtle insults, comments, or put-downs that happen automatically and unconsciously.

Asian Americans are often perceived as the “model minority” and as successful and exempt from racism. This stereotype has often pitted Asian Americans against other people of color. Using qualitative methods, Sue gleaned various themes and created a taxonomy of microaggression. These themes provided support for the notion that microaggressions continue to affect the lives of Asian Americans. Once again, Sue continues to push multicultural research forward by delving deeper into the various aspects of subtle and implicit racism and the impact it has on people of color.

Sue has held various roles as an educator, researcher, scientist, and social justice advocate. These roles have been fostered by his other roles as son, brother, husband, and father. Sue’s work has continually challenged the current social status and incorporated other worldviews. Personal reflections on Sue by his colleagues and students often emphasize the effect that his science and his search for justice have had on the field of psychology. Sue continues to promote the goal of social justice, which incorporates full and equal participation of all groups in a society that is mutually shaped to meet the needs of all groups. The commitment to social justice includes a vision in which the distribution of resources is equitable and all members of society are physically and psychologically safe and secure. It is evident that Sue’s lifelong work has focused on this goal by informing and educating academicians, practitioners, and business about the importance of rights and privileges for all groups.

*Deniz Canel Çınarbaş  
and Patricia L. Mestas Vigil*

**See also** Asian American Psychological Association (v3); Asian Americans (v3); Cross-Cultural Psychology (v3); Cross-Cultural Training (v3); Culture (v3); Discrimination (v3); Multicultural Counseling Competence (v3); Multiculturalism (v3); Racial Microaggressions (v3); Racism (v3); Social Justice (v3); Society for the Psychological Study of Ethnic Minority Issues (v3); Sue, Derald Wing: Contributions to Multicultural Psychology and Counseling (v3); Sue, Stanley (v3)

### Further Readings

Romero, D., & Chan, A. (2005). Profiling Derald Wing Sue: Blazing the trail for the multicultural journey and social justice in counseling. *Journal of Counseling and Development*, 83, 202–213.

Sue, D. W. (1998). A personal look at psychology in my life. In L. T. Hoshmand (Ed.), *Creativity and moral vision in psychology* (pp. 106–125). Thousand Oaks, CA: Sage.

Sue, D. W. (2001). Surviving monoculturalism and racism: A personal and professional journey. In J. G. Ponterotto, J. M. Casas, L. A. Suzuki, & C. M. Alexander (Eds.), *Handbook of multicultural counseling* (pp. 45–54). Thousand Oaks, CA: Sage.

Sue, D. W., & Sue, D. (2003). *Counseling the culturally diverse: Theory and practice*. New York: Wiley.

---

## SUICIDE POSTVENTION

---

Suicide postvention is a response or reaction to a community or individual following a suicide attempt or completion by someone known to that community in order to facilitate healthy psychological adjustment. Suicide postvention typically involves counselors or others in paraprofessional roles providing factual information about the attempt or completion, educating those affected by the suicide about the expected range of emotional and psychological responses, offering referrals for further psychological services, and providing opportunities for follow-up consultations.

Counselors participating in suicide postvention strive to ensure that those affected by the suicide are coping in a healthy manner that will lead to resuming normal functioning rather than developing chronic, severe psychological symptoms. For example, postvention programs educate survivors on how to distinguish between expected bereavement symptoms and prolonged, more severe symptoms of depression that are cause for concern. One indicator of healthy adjustment to a suicide comes when survivors are able to talk about both positive and negative attributes of the deceased. With suicide, in particular, it is also important for postvention to help survivors move on from the question of why an individual committed suicide, because fixating on this difficult question can keep survivors from progressing through the bereavement process.

Postvention programs also prepare communities to expect a wide range of emotional or cognitive reactions to a suicide, depending on the survivors’ proximity to the victim. For example, some survivors might feel anger toward the victim, while others who have experienced the long-term depression of or threat of



suicide from the victim might feel a sense of relief when finality is reached. Both of these reactions can be normalized during postvention.

Postvention programs also strive to ensure that others do not attempt or complete suicide in response to the original event. Well-meaning communities may highly publicize a suicide in a way that gives significant attention to the victim or portrays the individual in a heroic light. However, suicide postvention programs are focused on acknowledging the individual's or community's loss without glorifying suicide in a way that could entice others to attempt it in order to receive similar attention. As part of a postvention response, counselors may facilitate community discussions about how to best commemorate or honor the victim's life without glorifying the death.

Communities, such as schools, churches, or other organizations, are best served by comprehensive suicide postvention plans that are circulated among all potential responders before a suicide occurs. Such plans include information about what local psychological services are available to those affected by a suicide and identify who will serve as the overall postvention coordinator, media liaison, and community relations liaison.

Comprehensive suicide postvention programs also can include what some researchers have termed a "psychological autopsy." The psychological autopsy involves learning about the events leading up to the victim's suicidal behavior, possibly by reviewing medical records or interviewing friends or family who might have known about the victim's thoughts, feelings, problems, or behaviors.

Overall, postvention programs are valuable to communities because they can help return affected individuals and groups to presuicide levels of functioning relatively quickly while simultaneously preventing copycat suicides.

*Julie Jenks Kettmann*

**See also** Bereavement (v1); Community-Based Health Promotion (v1); Consultation (v2); Crisis Counseling (v2); Death and Dying (v1); Family Counseling (v1); Psychoeducation (v2); Suicide Potential (v2)

### Further Readings

Campbell, F. R., Cataldie, L., McIntosh, J., & Millet, K. (2004). An active postvention program. *Crisis*, 25, 30–32.

Celotta, B. (1995). The aftermath of suicide: Postvention in a school setting. *Journal of Mental Health Counseling*, 17, 397–413.

Clark, S. (2001). Bereavement after suicide: How far have we come and where do we go from here? *Crisis*, 22, 102–108.

Grieger, I., & Greene, P. (1998). The psychological autopsy as a tool in student affairs. *Journal of College Student Development*, 39, 388–389.

Petretic-Jackson, P., Pitman, L., & Jackson, T. (1996). Suicide postvention programs for university athletic departments. *Crisis Intervention*, 3, 25–41.

Stone, G. L. (1993). Psychological challenges and responses to a campus tragedy: The Iowa experience. *Journal of College Student Psychotherapy*, 8, 259–271.

---

## SUPERVISION

---

The supervision of counselor and psychotherapist supervisees is one of the most important processes in training individuals to become practicing counseling psychologists. Supervision is the process by which a more experienced professional provides oversight, guidance, and consultation to one or more less experienced professionals (junior colleagues) or to one or more trainees aspiring to enter the profession (students). The primary function of this relationship, which extends over time (usually months, sometimes years), is to ensure that quality services are provided by the supervisee. A secondary, but very important, function is to enhance the professional development of the trainee. These goals are accomplished through the development of a facilitative relationship between the supervisor and supervisee that includes components of evaluation, teaching and learning, counseling and support, and consultation.

### The Supervision Process

#### **Supervisor Role**

Supervisors are typically associated with the same agency or training program as their supervisees. They are responsible for ensuring that quality services are provided by the supervisees to their clients and that these services are delivered in a manner consistent with ethical guidelines of the profession (e.g., those of the American Psychological Association or the American Counseling Association) and relevant law. In addition, supervisors are also typically responsible for providing



administrative oversight for the supervisee, making sure that procedures, paperwork, and so on required by the agency are followed. To accomplish this, supervisors must have ongoing access to all relevant information concerning the supervisee's work with clients, including client files, case notes, and assessment information as well as the ability to monitor the supervisee's interactions with clients through direct observation, video, or (minimally) audio recording mechanisms.

Supervisors typically meet weekly for at least an hour with each of their supervisees and may have additional meetings with groups of supervisees that allow trainees to learn from and give input to colleagues. It is also often necessary, depending upon the level of experience of the supervisee and the presence or absence of other qualified personnel at the agency, for the supervisor to be available at times when the supervisee is working with clients for immediate consultation or crisis intervention. Early on in the supervisory relationship, the availability of the supervisor and regular supervision sessions need to be arranged. In addition, mechanisms should be arranged for feedback to the supervisee from the supervisor and to the supervisor from the supervisee. The specific domains of professional practice that the supervisee will engage in and the method for evaluating the effectiveness of service delivery by the supervisee should be clarified and agreed upon. It is important that the supervisor is competent in the domains of professional practice that will be supervised in addition to having competence in the supervisory process itself.

Supervisors are also responsible for encouraging the professional development of their supervisees. Thus, supervisors need to be aware of the level of competence of their supervisees for the various professional activities they will engage in under supervision. Generally speaking, the less experience and competence the trainee has in particular activities, the more structure, specific direction, and information are provided by the supervisor. Supervisors should also be familiar with various modes of supervision (e.g., individual, group, direct observation, case conferences) as well as different classes of supervisory interventions (e.g., support, positive reinforcement, prescriptive directives, problem solving, process comments).

### **Supervisee Role**

Supervisees may engage in a breadth of professional activities depending upon the training setting.

They may do individual, marital and family, or group counseling or psychotherapy as well as assessments, consultation, supervision of others, psychoeducational programs, and so on. Supervisees typically have had some prior instruction regarding the particular domains of activity they will engage in while being supervised, so that they have a foundation of knowledge from which to develop intervention skills. Additional information and perspectives as well as skills in case conceptualization and implementing interventions are acquired by the supervisee through the supervisory process.

For supervisees to experience optimal development through supervision, as well as to ensure client welfare, they must approach the supervision process with an openness and willingness to learn. To receive the most useful input from their supervisors, supervisees must be willing to share all relevant aspects of their interactions with clients as well as their reactions to them. They must be willing to be observed and be open to feedback and direction from their supervisors. It is also crucially important for supervisees to familiarize themselves with ethical guidelines that guide professional practice and to commit themselves to adherence to these guidelines. Finally, client welfare and the intent to provide effective services must be viewed as paramount by supervisees.

### **Growth of the Field**

Some form of supervision and training has probably occurred since early practitioners began engaging in counseling and psychotherapy. Unfortunately, it took considerable time for the process to be subjected to empirical scrutiny and for specific models to be developed to explain and guide the practice. For example, Carl Rogers, the pioneer of client-centered therapy, noted in 1957 that research in supervision was rare but that platitudes were plentiful. A fairly common assumption at the time was that if one could do counseling and psychotherapy, then one could supervise others doing counseling and psychotherapy. This perspective continues today, although it has been challenged by the emergence of specific models of supervision training and development.

An early and continuing perspective on supervision has viewed the process as an extension of theories of counseling and psychotherapy. For example, in 1972, R. Eckstein and R. Wallerstein published a volume on supervision and described the process as



going through stages in which early assessments of strengths and weaknesses of both supervisor and supervisee lead to attributions of authority as well as influence. Confrontations and conflicts that surfaced along with defenses and avoidance were worked through, which eventually led to more independence of the supervisee.

The 1960s and 1970s saw a dramatic growth of the influence of client-centered therapy, which translated into facilitative approaches to supervision. Although modeling served as an important component of training, R. Carkhuff and B. Berenson found that aspects of client-centered therapy such as support, empathy, warmth, and genuineness by the supervisor were characteristic of effective supervision. Similarly, behavioral therapists (and, later, cognitive-behaviorists) viewed supervision as assisting the supervisee in directing the behavior of his or her clients toward specified goals. Learning how to use aversive conditioning, goal setting, counter conditioning, systematic desensitization, and later, cognitive restructuring and other treatments is the primary focus of supervision. Proficiency is developed through an apprenticeship with an experienced therapist in which the supervisee becomes more knowledgeable about learning theory. Similarly, practitioners who use systemic and family systems theories have devised approaches to supervision using interventions that are consistent with those used by systemic therapists with their clients (e.g., strategic or paradoxical interventions).

Another important category of supervision models includes those that rely less on adherence to a particular theory and more on the process and the specific tasks of supervision. An example of this approach is the skills training model, which is widely used in early methods and techniques of counseling courses. A. Ivey has been influential in proposing that a communication skills laboratory approach is an effective method of training. In this approach, specific skills are learned in limited and focused training segments. These skills are assumed to be fundamental across most, if not all, approaches to counseling and psychotherapy. A variation of this approach by N. Kagan includes the client in a process review of what occurred during a counseling session and the client's reactions to the process. An important contribution of the skills training approach, in addition to delineating "core" counseling skills, is the amount of research stimulated by the models. Although some studies indicated that the approach was superior to the facilitative model of supervision, others suggested that the skills

learned through this approach didn't transfer well to other situations and would decay over time. However, the skills training model remains a broadly used approach for training beginning counselors and psychotherapists.

Another example of an atheoretical approach to supervision is J. Bernard's discrimination model. This approach limits its focus to process skills (interventions), conceptualization skills, and personalization skills. Consistent with earlier models, the supervisor is viewed as assuming certain roles in assisting supervisees; these include the teacher role, the counselor role, and the consultant role. Other atheoretical models examine the context of supervision as it occurs within multiple interacting systems, including those represented by the client, supervisee, supervisor, and the agencies in which they function. Additional models have conceptualized supervision from an eclectic or integrative approach, relying on various theories of psychotherapy to generate interventions and approaches to the supervision process.

Most models of supervision have little direct empirical support to argue for their efficacy. Although these models and their descendents remain influential in the practice of supervision, the field has moved toward models that conceptualize the supervision process as different from counseling and therapy and largely independent of the type of therapy that is being supervised. For example, B. Kell and J. Burrow offered a blended model of supervision that relied on psychodynamic theory, a facilitative style of therapy, and used behavioral terminology. The supervisor engaged in the role of therapist when helping the supervisee deal with anxiety and conflict, in the role of teacher in tracing the sources of conflict, and as a consultant to advanced trainees who set their own goals for supervision. Additional work by J. Fleming in 1953 and R. Hogan in 1964 formed the basis for conceptualizing the supervision process from a developmental perspective, which remains an important influence in models of training and supervision research today.

As a prelude to the growth of developmental models of supervision that occurred in the 1980s and 1990s, J. Littrell, N. Lee-Borden, and J. Lorenz examined common roles of supervisors at the time and integrated them into a single model. The supervisor roles of teacher, counselor, consultant, and self-supervisor were combined into a sequence that suggested a developmental influence. Two later models were instrumental in integrating developmental theory into an approach to supervision. The first supervision model



that attempted to integrate developmental theory into the supervision process was proposed in 1981 by C. Stoltenberg, who built upon Hogan's early ideas and introduced concepts from theories of cognitive development. This model viewed trainees as moving through four stages: (1) anxious and dependent, (2) less anxious with a dependency-autonomy conflict, (3) conditional dependency, and (4) culmination, in which the trainee had become a fully functioning autonomous professional. Specific supervision environments were proposed that started with high levels of structure provided by the supervisor and moved toward more supervisee structured and collegial supervision as the supervisee gained experience.

The next year, C. Loganbill, E. Hardy, and U. Delworth published a supervision model that also relied heavily on developmental theory. This approach also conceptualized the supervision process as a stage model that describes trainee growth over time through three stages while eight content issues (e.g., competence, emotional awareness) provide the basis for examining and assessing this growth. This model views trainees as recycling through this developmental process to ever deepening levels.

In the late 1980s, Stoltenberg and Delworth collaborated in publishing the integrated developmental model of supervision (IDM), which built upon two earlier models and more fully integrated developmental issues with the growing body of research on supervision. Among other issues, the revised model attends more directly to domains of professional activity and posits that trainees develop in similar ways but often at different rates across these domains. Thus, supervisors must be cognizant of the differing developmental levels of their supervisees for various domains (e.g., intervention skills competence, psychological assessment, consultation). Development is monitored (and encouraged) across these levels and domains by attending to a progression of change in supervisees for the structures of awareness, motivation, and autonomy. As supervisee professional development occurs within these domains, the supervisor also attends to integrating this growth across domains. The model was expanded and updated again in the late 1990s (with B. McNeill) and remains influential today.

Research addressing developmental models of supervision has been extensive and has been viewed as largely supportive of the important constructs of the models, although problems with the quality of the studies have been raised. In addition, developmental models have been faulted for being too complex as

well as too simplistic to fully explain the supervision process.

Constructs from developmental theories have also been applied to supervisors, positing similar processes in the growth of competence in conducting supervision as is seen in counselor and psychotherapist development. More specifically, the development of internship directors, interns, and postdoctoral fellows has also been examined.

## Current Status

In general, supervision appears to be an effective mechanism for training professional psychologists. As the number of scholarly articles and research studies examining the supervision process has grown from a few studies prior to 1980 to an impressive body of work, supporting evidence has accumulated. Based on a range of studies, although some of them provide only indirect support, it appears that supervision and training enhances outcomes for the clients of the supervisees. It is also apparent that supervision increases proficiencies in supervisees. Research on psychotherapy has indicated that the therapist–client working alliance is important for success in therapy, and research in supervision suggests that the supervision process enhances the supervisory working alliance, which in turn has a positive impact on the therapist–client working alliance. In addition, evidence suggests that mere experience in conducting counseling and psychotherapy doesn't enhance therapist development as much as when these experiences are supervised. Thus, it appears that having the opportunity to process what occurs in therapy sessions with a more experienced supervisor enhances the professional development of the supervisee.

Although supervision has been assumed to be an important process in the education and training of counselors and psychotherapists for decades, it has achieved the status of a professional competency only over the last 10 or so years. Important guidelines by professional associations (e.g., the Association of Counselor Education and Supervision, the American Psychological Association Committee on Accreditation) have increased the attention paid to the competency and training of supervisors. However, recent surveys still find that many professional psychologists across settings provide supervision with little formal training in how to do it or exposure to models of supervision. Consequently, they have limited or no familiarity with the empirical research literature that examines the utility and limitations of the supervision process. Thus,



many supervisors still largely rely on their own personal experiences in supervision and their understanding of the practice of counseling and psychotherapy to guide their work with their supervisees.

This contrast between the professed importance of supervision to the training of counselors and psychotherapists and the lack of training in this area for most supervisors has prompted increased attention to indices of competence in the practice of supervision. For example, the Association of Psychology Postdoctoral and Internship Centers organized a conference in 2002 that was cosponsored by 34 professional associations and was attended by 127 delegates (mostly psychologists). The charge of the conference was to explore and articulate the competencies psychologists should acquire across a breadth of professional domains, including supervision. A working assumption of the work group examining supervision competence was that the process is developmental in nature. One of the products of this event was the delineation of a number of aspects of competencies for supervisors. Information, attitudes, skills, and values necessary for one to perform as an effective supervisor were addressed. Specifically, these included knowledge bases such as the area being supervised (clinical domain), models and modalities of supervision, and relevant research, ethics and legal issues, evaluation, and diversity.

Similarly, a set of skill areas for supervisors were offered as important for effective supervision, including building a working alliance in supervision, promoting trainee growth, assessment of self and trainee skill levels, teaching, using and delivering formative and summative feedback, setting boundaries, and scientific thinking. Values were also seen as important areas of competence, including assuming responsibility for supervisee training, reaching a balance between clinical and training needs, sensitivity to diversity, using scientific research, and knowing one's own limitations. It was also concluded that supervisors should receive formal training, including courses in supervision addressing the knowledge and skill areas of the field. Also, applied training was viewed as critically important, including receiving direct supervision by an experienced supervisor of the supervision provided to trainees. This supervision of supervision should include direct observation (live, video, or audio) of the supervision process by a competent supervisor. Suggestions were also made regarding how these competencies could be assessed.

In order for a supervisor to encourage the growth of supervisees, it is helpful to have articulated competencies for effective counselors and psychotherapists. To be most useful, these competencies should be organized into expectations for various levels of training of supervisees. R. Hatcher and K. Lassiter, in a report written for the Association of Directors of Psychology Training Clinics, conceptualize supervisees as changing in their response to training in counseling and psychotherapy in a progression from novice to intermediate, advanced, proficient, and expert levels. They delineated competencies as including personality characteristics, intellectual and personal skills, knowledge from classroom experience, relationship and interpersonal skills, and competencies in working with colleagues and supervisors, among others. The intent of the report was to describe core competencies for professional psychologists and characterize the level of competency to be expected at the end of the practicum experience prior to internship training.

Taking this report and other studies together, it is evident that the field of supervision has made considerable progress in articulating competencies required for professional psychologists and trainees. Reaching these competency goals is enabled by conducting effective supervision informed by knowledge of models of the supervision process, particularly those that articulate a developmental sequence to guide training for various levels of trainees. Finally, competencies that lead to augmenting the influence of the skilled supervisor and forming baseline expectations for the practice of supervision are becoming more clearly defined. A better, more complete picture is emerging of the characteristics of trainees at different points in the training process and of how to encourage their development through levels of professional competency. In addition, the competencies associated with effectively guiding the supervision process and evaluating this progress are becoming clearer. However, a great deal of work is needed to more adequately delineate and expand upon our understanding of the process of supervision as well as evaluate the effectiveness of the training process.

## Future Directions

It appears likely that the growth in attention to issues related to supervision will continue into the foreseeable future. The next 5 to 10 years are likely to bring about more specific guidelines for the practice of supervision



and the credentialing of psychologists who engage in it. Professional ethical guidelines call for psychologists to practice within their areas of competence. As supervision competencies become more clearly articulated, providing evidence for these skills, attitudes, and values will become more important. The American Counseling Association has supported the establishment of training standards for supervisors, and organizations within the field of psychology have shown similar interest in examining this possibility for the training of professional psychologists.

Although the growth of scholarship and research in supervision has been impressive over the past couple of decades, much work remains in investigating the supervision process. For example, it is not clear why at a given point in time for a particular trainee a specific supervisory intervention is effective, when at other times or when used with other trainees it may be ineffective. Attention to issues related to trainee characteristics and needs at different levels of development may shed much needed light on this issue, but specific evidence is lacking. Similarly, why certain interventions that appear to work for some trainees frustrate and inhibit the growth of others needs further clarification. Again, perhaps timing is an important consideration, as the structure and prescriptive interventions that a supervisor might use effectively with a trainee of limited experience may produce resistance and lack of progress with a more experienced supervisee. On the other hand, providing the limited structure and guidance favored by more experienced supervisees may elicit distracting anxiety and confusion in inexperienced supervisees. More specifically, for the same trainee, will these different approaches prove more or less effective depending upon the particular domain of practice that is the focus of supervision at any given point in time? Indeed, do supervisees develop at different rates across domains of practice as a function of experience and training? How do personal characteristics of the supervisee and supervisor (including racial/ethnic/cultural identity) affect the supervision process and, subsequently, the outcomes with clients?

The scientist-practitioner training model that is characteristic of the field of counseling psychology holds much promise for advances in our knowledge and practice of supervision. Through extensive research on supervision informed by practice, and through the practice of supervision informed by research, competence as a field in this important

training process should continue to be enhanced. Ultimately, this should have a positive impact on service delivery to clients.

*Cal D. Stoltenberg*

**See also** Accreditation by the American Psychological Association (v1); Counseling, Definition of (v1); Counseling Skills Training (v2); Ethical Codes (v1); Mentoring (v1); Postdegree/Prelicensure Supervision (v1); Postdoctoral Training (v1); Predoctoral Internships (v1); Professional Associations, Counseling (v1); Professional Degrees (v1); Scientist-Practitioner Model of Training (v1)

### Further Readings

- Bernard, J. M. (1997). The discrimination model. In C. E. Watkins (Ed.), *Handbook of psychotherapy supervision* (pp. 310–327). New York: Wiley.
- Bernard, J. M., & Goodyear, R. K. (2004). *Fundamentals of clinical supervision* (3rd ed.). Boston: Allyn & Bacon.
- Bradley, L. J., Kottler, J. A., & Lehrman-Waterman, D. (2001). Ethical issues in supervision. In L. J. Bradley & N. Ladany (Eds.), *Counselor supervision* (3rd ed., pp. 342–360). Philadelphia: Brunner-Routledge.
- Ellis, M. V., & Ladany, N. (1997). Inferences concerning supervisees and clients in clinical supervision: An integrative review. In C. E. Watkins, Jr. (Ed.), *Handbook of psychotherapy supervision* (pp. 447–507). New York: Wiley.
- Falender, C. A., Cornish, J. A. E., Goodyear, R., Hatcher, R., Kaslow, N. J., Leventhal, G., et al. (2004). Defining competencies in psychology supervision: A consensus statement. *Journal of Clinical Psychology*, 60, 771–785.
- Goodyear, R. K., & Guzzardo, C. R. (2000). Psychotherapy supervision and training. In S. D. Brown & R. W. Lent (Eds.), *Handbook of counseling psychology* (3rd ed.). New York: Wiley.
- Hatcher, R. L., & Lassiter, K. D. (2005). *Report on practicum competencies*. Retrieved from [http://www/adptc.org/public\\_files/CCTCPracticumCompetenciesChartRevFeb2005.doc](http://www/adptc.org/public_files/CCTCPracticumCompetenciesChartRevFeb2005.doc)
- Saccuzzo, D. P. (2002). Liability for failure to supervise adequately: Let the master beware. *The National Register of Health Services Providers in Psychology: The psychologist's legal update*, 13, 1–14.
- Scott, K. J., Ingram, K. M., Vitanza, S. A., & Smith, N. G. (2000). Training in supervision: A survey of current practices. *The Counseling Psychologist*, 28, 403–422.
- Stoltenberg, C. D. (2005). Enhancing professional competence through developmental approaches to supervision. *American Psychologist*, 60, 857–864.



Stoltenberg, C. D., McNeill, B. W., & Delworth, U. (1998). *IDM supervision: An integrated developmental model for supervising counselors and therapists*. San Francisco: Jossey-Bass.

Watkins, C. E., Jr. (Ed.). (1997). *Handbook of psychotherapy supervision*. New York: Wiley.





---

## TECHNOLOGY AND TREATMENT

---

Technology provides tools to help counselors accomplish their work more effectively and efficiently beyond what they can do without it. Counselors now have high-tech methods for better managing, supporting, conducting, delivering, and describing their work as before never imagined. Such power, however, comes with great responsibility. Counselors must work diligently to make certain that technological literacy and implementation is an important part of their ongoing professional development. They must identify and plan for overcoming barriers that technology can pose, such as intrusions into personal lives. Finally, counselors must recognize how the very same technology that helps them can hurt themselves and their clients. Thus, important parts of counselors' technological literacy and implementation are understanding potentials and opportunities that technology affords counselors, evaluating how technology is used, and considering the impact that technology has on their lives.

Technology is having a profound impact on every aspect of life, including how people work, how they play, and even how they view the world. The introduction of technology into counseling is an evolutionary process that is happening quickly, if not always easily. Those who grew up at a time when there were no computers have struggled to gain the skills necessary to function in a rapidly changing, technologically literate society, while those of younger generations use technology almost effortlessly, because they were introduced to it at a very early age. The most recent advances in assessment and diagnosis, counseling

techniques, and career development utilize technology in one fashion or another. From Internet-based counseling to telecounseling, the range of human services provided in schools, agencies, and private practice is changing and advancing.

### **The Nature of Counselor Technological Literacy**

So what is technological literacy as it pertains to counselors? Many people have written on the subject of technological literacy. Technological literacy may be seen as having knowledge and abilities to select and apply appropriate technologies in a given context. There are three components to technological literacy: the technology of making things, the technology of organization, and, the technology of using information. Applying a Delphi technique to opinions expressed by experts, Croft evolved a panel of characteristics of a technologically literate student. Those are abilities to make decisions about technology; possession of basic literacy skills required to solve technology problems; ability to make wise decisions about uses of technology; ability to apply knowledge, tools, and skills for the benefit of society; and ability to describe the basic technology systems of society.

A theme among various attempts to define technological literacy is that technology has evolved to become a powerful medium—not only a set of high-tech tools. If technology functioned merely as a set of tools, the problem of advancing technological literacy would not be so challenging. But technology has become more than a set of devices to be picked up and used when a person decides he or she needs them.



It has become a required medium that mediates experience in most aspects of peoples' lives. Broadly speaking, technological literacy, then, can be described as the intellectual processes, abilities, and dispositions needed for individuals to understand the link between technology, themselves, and society in general. Technological literacy is concerned with developing one's awareness of how technology is related to the broader social system and how technological systems cannot be fully separated from the political, cultural, and economic frameworks that shape them.

This means that counselors who have adequate levels of technological literacy are able to understand the nature and role of technology in both their personal and professional lives; understand how technological systems are designed, used, and controlled; value the benefits and assess the risks associated with technology; respond rationally to ethical dilemmas caused by technology; assess the effectiveness of technological solutions; feel comfortable learning about and using systems and tools of technology in the home, in leisure activities, and in the workplace; and critically examine and question technological progress and innovation.

### How Counselors Use Technology in Their Work

Counselors use technology to help them be more effective and efficient in their work, ultimately maximizing positive counseling outcomes, in one or more of the following four areas:

1. *Information/Resource.* In the form of words, graphics, video, and even three-dimensional virtual environments, technology affords counselors a dynamic and rapidly growing library of information and knowledge.
2. *Communication/Collaboration.* Chat rooms, bulletin boards, virtual shared environments, video conferencing, online conferences, electronic meeting services, e-mail—technology now enables people to connect, exchange information, collaborate, and make shared decisions.
3. *Interaction/Productivity.* The maturing of software and Web-based programming has launched a new level of available tools, both off the shelf and customized for the counseling professional. These high-tech tools can help counselors build and create anything ranging from a personalized business card to a set of personalized Web site links. For

example, interactive tools help counselors to process data and manipulate information, convert text to speech, create a graph, or even determine the interactive effects of popular prescription drugs.

4. *Delivery of Services.* Most controversial, yet growing in popularity, is counselors' use of technology to meet with clients and deliver counseling services in an online or virtual environment (i.e., at a distance).

Across these four areas, counselors are incorporating technology in their work in many different ways. Following is a cross-section of examples:

A therapist recorded an in-session relaxation session as well as specific exchanges between the clinician and client focusing on specific client difficulties such as mastering a breathing technique. This custom-made tape then becomes a review for the client in the following days as he or she works on relaxation at home. The same therapist used recording technology with another client whom he instructed to tape "conversations with yourself" to better identify irrational, unrealistic, or illogical thinking patterns.

Susan, a community counselor, needed to provide periodic reports to a funding agency regarding the nature of clients served by her counseling group over several months as part of a grant. Counselors where she worked used a software program shared over a network for record keeping, so that demographic data, diagnostic information, treatment plans, and insurance information—among other types of information—were uniformly stored for each client. The system allowed Susan to choose data of interest and then add several basic formulas to aggregate the data to display descriptive statistics (e.g., average client age, percentages of clients with certain diagnoses, changes in GAF scores over time). Finally, she merged relevant information into a report template provided by the funding agency. After she generated the first report, subsequent reports required only that she repeat the procedure for exporting the data from the system and then copy and paste the existing formulas instead of recreating them.

One school counselor conducted a psychoeducation group for all students at the same time by creating a multimedia presentation, transferring it to video, and then broadcasting it on the school's television network. For classes that had computers, the counselor



used the Internet to conduct a live chat about the topic. For classes that did not have computers, the counselor followed up that day and conducted live discussions.

### **Online Counseling**

One area of technology that seems to be receiving the greatest amount of attention is online counseling. This type of counseling goes by names such as e-therapy, e-counseling, cybertherapy, and telecounseling. Specifically, online counseling refers to counseling that occurs across some distance instead of in an office setting with both counselor and client in the same room or office. According to Sabella, the continued evolution of the Internet offers many future possibilities and much potential for this type of counseling.

### **Delivery of Services**

Counseling over the Internet may be a useful medium for those with physical disabilities who find traveling even a short distance to be a significant obstacle. For others who are reticent to meet with a counselor or who have difficulty with self-disclosing, the Internet may foster the counseling process. Similarly, the Net is a convenient and quick way to deliver important information. In cybercounseling, information might be in the form of a homework assignment between sessions or bibliocounseling. Also, electronic file transfer of client records, including intake data, case notes, assessment reports, and selected key audio and video recordings of client sessions, could be used as preparation for individual supervision, group supervision, case conferences, and research.

### **Assessment and Evaluation**

Access to a wide variety of assessment, instructional, and information resources in formats appropriate in a wide variety of ethnic, gender, and age contexts could be accomplished via the World Wide Web.

### **Communications**

Especially via e-mail, counselors and clients can exchange messages throughout the counseling process. Messages may inform both counselor and client of pertinent changes or progress. E-mail can provide an excellent forum for answering simple questions, providing social support, or scheduling actual or virtual meeting times.

### **Marriage and Family Counseling**

If face-to-face interaction is not possible on a regular basis, marriage counseling might be delivered via video conferencing, in which each couple and the counselor (or counselors) are in different geographic locations. After independent use of multimedia-based computer-assisted instruction on communication skills, spouses could use video conferencing to complete assigned homework (e.g., communication exercises).

### **Supervision**

Anecdotal evidence has shown that e-mail is an enhancing tool in the process of counselor supervision and consultation. It provides an immediate and ongoing channel of communication between and among as many people as the counselor or supervisor chooses.

### **Credentials**

Because cybercounseling can occur anytime and anywhere, it may pressure the profession and governance to formulate a national, or perhaps international, counseling licensure or certification. Definitely an enormous undertaking, this measure would facilitate uniform standards of training and practice while expediting reciprocity among states and countries. Cybercounseling may very well become the impetus for the ultimate in counselor credential portability.

### **Potential Pitfalls**

#### **Confidentiality**

Although encryption and security methods have become highly sophisticated, unauthorized access to online communications remains a possibility without special attention to security measures. Counselors who practice online must ethically and legally protect their clients, their profession, and themselves by using all known and reasonable security measures.

#### **Computer Competency**

Both the counselor and client must be adequately computer literate for the computer/network environment to be a viable interactive medium. From typing skills to electronic data transfer, both the counselor and client must effectively harness the power and function of both hardware and software. As in face-to-face counseling, cybercounselors must not attempt to



perform services outside the limitations of their technological competence.

### ***Location-Specific Factors***

A lack of appreciation on the part of geographically remote counselors of location-specific conditions, events, and cultural issues that affect clients may limit counselor credibility or lead to inappropriate counseling interventions. For example, a geographically remote counselor may be unaware of recent traumatic events at the local level exacerbating a client's reaction to work and family stressors. It may also be possible that differences in local or regional cultural norms between the client's community and the counselor's could lead a counselor to misinterpret the thoughts, feelings, or behavior of the client. Counselors need to prepare for counseling a client in a remote location by becoming familiar with the client's recent local events and local cultural norms. If a counselor encounters an unanticipated reaction on the part of the client, the counselor needs to proceed slowly, clarifying clients' perceptions of their own thoughts, feelings, and behavior.

### ***Equity***

Web counseling has the potential to exacerbate equity issues already confronting live counseling. If counseling online is a viable alternative, steps need to be taken to ensure that costs do not create another obstacle for some clients. As well, if some service providers view cybercounseling as an inexpensive alternative, then it may inappropriately become the tool for those who cannot afford more traditional approaches. Alternatively, if cost issues are addressed and access is available equally for everyone, cybercounseling may further alienate potential clients who have less technological expertise, creating a different type of equity gap.

### ***High Tech Versus High Touch***

How can counselors foster the development of trusting, caring, and genuine working relationships in cyberspace? Until virtual reality is realized for individuals and small institutions, cybercounseling relies on a process limited in nonverbal or extraverbal behavior. Questions remain about whether counseling can be effectively conducted without an actual human

presence—a presence that includes a holistic experience greater than the sum of its parts.

### ***Impersonation***

Many people hide behind the Net's veil of anonymity to communicate messages they ordinarily would not communicate in real life. The reality is that it is almost impossible to know who a cyberclient really is. A client who is a minor may depict himself or herself as an adult. Other clients may disguise their gender, race, or other personal distinctions in a manner that threatens the validity or integrity of the counselor's efforts.

### ***Credentials***

One of the counseling profession's main concerns will be those who are unlicensed persons promoting themselves as competent Internet counselors. When a counselor is unlicensed, a state has no regulatory authority, unless there is a law in that state that will allow prosecution for practicing counseling without a license as a criminal act or that gives the state's licensing board regulatory authority. According to Hughes, unlicensed cybercounselors are legally almost untouchable, especially when they display a disclaimer stating that what they are doing is not therapy.

More than ever before, cybercounseling may have created a need for the profession to educate consumers about choosing an appropriately trained and credential counselor. Many questions regarding cybercounseling and credentials need to be answered: How will insurance companies handle requests from cybercounselors interested in purchasing professional liability insurance specifically to conduct cybercounseling? How will certification and licensure laws apply to the Internet as state and national borders are crossed electronically? Will cybercounselors be forced to maintain licensure or certification in the states in which their clients reside, or must counselors only obtain licensure or certification in the state from which they practice? Similarly, who will monitor service complaints out-of-state or internationally?

### ***Ethics***

How do current ethical statements for counselors apply or adapt to situations encountered online? For



the most part, counselors can make the leap into cyberspace and use current ethical guidelines to conduct themselves in an ethical fashion. However, problems exist. The future will inevitably see a change in what it means to be ethical as we learn the exact nature of counseling online.

*Russell A. Sabella*

*See also* Assessment (v4); Computer-Assisted Career Counseling (v4); Credentialing Individuals (v1); E-Counseling (v1); Ethics in Computer-Aided Counseling (v1); Human Subjects Review in an Online World (v1); Occupational Information Network (v4); Relationships With Clients (v2)

### Further Readings

Sabella, R. A., & Booker, B. (2003). Using technology to promote your guidance and counseling program among stake holders. *Professional School Counseling*, 6, 206–213.

Shaw, H. E., & Shaw, S. F. (2006). Critical ethical issues in online counseling: Assessing current practices with an ethical intent checklist. *Journal of Counseling & Development*, 84, 41–53.

Sussman, R. J. (2002). *Counseling over the Internet: Benefits and challenges in the use of new technologies*. Retrieved June 21, 2002, from [http://www.aworc.org/went2001/projects/amazon/project\\_site/pages/counseling.htm](http://www.aworc.org/went2001/projects/amazon/project_site/pages/counseling.htm)

Tyler, J. M., & Sabella, R. A. (2004). *Using technology to improve counseling practice: A primer for the 21st century*. Alexandria, VA: American Counseling Association.

---

## TEENAGE PARENTS

---

Teenage parenthood is a social problem in Western culture. This is due, in part, to concerns about the ability of adolescents to meet their own needs for identity exploration and development while also meeting the developmental needs of an infant for stability and commitment. Further, teenage parenthood presents a long-term economic stress to society, as teenage mothers are often unmarried, rarely able to support themselves, and at risk for dropping out of high school, thereby reducing future employment options. The inability of teenage parents to financially support themselves results in a significant burden to the

welfare system. Yet, despite numerous programs designed to prevent teenage pregnancy, the United States remains the industrial nation with the highest rate of teenage births.

The availability of birth control, legal abortion, and adoption suggests that adolescent parenting is not wholly due to ignorance or accident. Although teenagers may not fully comprehend the implications and expectations of parenthood, there are, at least for some, positive aspects of becoming a parent within their social context. In order to understand the reasons that teenagers become parents and their special needs as parents, this entry addresses the psychosocial factors that influence teenage pregnancy and parenthood and the risk and protective factors associated with their outcomes.

### Becoming a Teenage Parent

Historically, teenage pregnancies have been viewed as accidental, a function of limited resources, early sexual activity, and poor access to family planning. However, the number of young women and men who continue to become teenage parents, including those who have multiple children within a period of a few years, suggests that other factors contribute to this phenomenon.

Many studies have identified risk factors for becoming a teenage parent with the goal of using this information to prevent teenage pregnancy and parenting. Relative to older first-time parents, adolescent parents are more likely to live in poverty and have unsuccessful educational experiences, while a disproportionate number evidence psychiatric concerns or a history of abuse. They are also more likely to have had teenage parents, and to become sexually active at a younger age, than are older first time parents. Many of these factors are interrelated. For example, adolescents who experience early abuse are more likely to experience psychiatric disorders, while youth who have experienced abuse or psychiatric problems are more likely to engage in early sexual behavior.

While the risk factors for adolescent pregnancy are clear, there is less understanding of why adolescents, after becoming pregnant, decide to parent their children. In some instances, adolescent women may have limited knowledge of their alternatives. Other explanations also help account for the continued expansion of this group, however. Some teenage women who become parents perceive themselves as



having limited options in the workforce as a function of having unsatisfying educational experiences and as a result of living in communities with high rates of unemployment and poor job satisfaction. Motherhood provides a role definition for these teens. In instances where teenage parents had teenage parents, they may be modeling their parents' early sexual activity and lifestyle. Studies in which teenage mothers have been interviewed find them identifying positive aspects to early parenting, including strong feelings of connection to their families and the fathers of the children and positive attention from others. Even when support from the family of origin and the father of the baby are not forthcoming, adolescent girls may embrace motherhood because of feelings of connection toward their children. From a societal viewpoint, this accelerated role transition to parenthood is problematic because of concerns about the mother's ability to adequately parent her child, and the need for external resources to sustain the mother and child. However, these young mothers already experience high levels of stress and may find additional fulfillment in their role as parents.

There are significant racial differences in the prevalence of teenage parenting. Both African Americans and Latino ethnic groups have a higher proportion of teenage mothers than do Caucasians. This is largely accounted for by the disproportionate number of African Americans and Latinos with risk factors for teenage pregnancy, including low income and limited educational success. There are a disproportionate number of multigenerational, ethnic minority families with teenage parents, making early sexual activity and parenting the norm for some communities, which contributes to the perpetuation of this cycle.

### **Outcomes for Teenage Parents**

One of the major issues addressed in the literature is the extent to which teenage parents experience greater stress and have more long-term, psychosocial problems than do others. These findings depend on who the "others" are to whom teen parents are compared. In comparison to older first-time mothers, adolescent mothers report more psychological distress, including higher levels of depression, substance abuse, and domestic violence as well as more problems in parenting. However, teenagers who become parents differ from older first-time parents on a number of psychosocial dimensions prior to becoming parents.

Teenage parents are more likely to be poor, be less educated, come from less stable homes, and themselves have younger parents than do those who first parent as adults. Thus, differences in the distress exhibited by teenage parents and older parents in part reflect socioeconomic and demographic differences that existed prior to parenthood.

Because youth who become pregnant tend to come from poor socioeconomic environments, having a child may only minimally increase their already high level of stress while also providing them with an adult purpose in a social context in which they see limited options for themselves. Studies that compare adolescent parents to adolescents who are not parents but who come from similar socioeconomic backgrounds find fewer differences between these groups in terms of overall stress, although both groups tend to have high stress levels and a disproportionate percentage experience stress-related psychopathology. This suggests that the emotional distress found among teenage parents is largely, but not fully, due to the socioeconomic circumstances under which they live rather than their parenting responsibilities alone.

The demands of parenthood may interfere with normative adolescent development, including the development of a strong sense of self and an understanding of one's needs regarding a partner, schooling, and employment. Studies on the later psychosocial functioning of adolescent parents as well as the development of their children have yielded mixed results. Studies on small numbers of adolescents report positive or negative outcomes depending on the sample chosen. Larger studies tend to find a mix of outcomes, with some youthful parents successfully transitioning into adulthood and others continuing to have problems over a period of years.

One of the older longitudinal studies that included teen parents was conducted by Emmy Warner and Ruth Smith. They followed the entire birth cohort in Kauai in 1955, including 28 infants born to teenage mothers, for the next 30 years. While differing in ethnicity from adolescents in studies on the mainland, these teenage mothers shared many characteristics with those of other studies; most were from single parent homes, one third had been born to adolescent mothers, and a majority had problems in school as well as parents who also had limited education. However, over the course of time these young women became more self-sufficient. They obtained additional education when schooling was available at accessible



times, and they gained employment as their children entered school.

Given the heterogeneity in outcomes, understanding the risk and protective factors for teenage parent outcomes is critical for effectively serving this population. Key among these factors is support from one's family of origin and the mother's relationship with the father of the child.

### ***Family of Origin Support***

A key protective factor for teenage mothers is the presence of social support. Family support is particularly important for teenage mothers who are unmarried and may not have stable relationships with the fathers of their children. Teenage parents need continued support from their families to develop self-confidence and self-sufficiency as adults. They also need immediate instrumental support, including housing, financial assistance, child care, instruction on parenting, and help in completing their education and obtaining employment.

Support from extended family can be a strong protective factor for both the adolescent parent and the child. In many instances, both maternal and paternal grandparents play significant caretaking roles in the lives of their grandchildren. In some instances they provide the primary parenting to their grandchildren while continuing also to parent their adolescents. Support from extended family can provide respite for adolescent parents, allowing them to complete school and meet other developmental needs, while also modeling parenting behavior, teaching the adolescent to become more self-sufficient. Extended family members can influence child development directly and indirectly through their impact on the teenage mother and father.

However, the complex nature of new family relationships can also create stress. Criticism of the adolescent parent can interfere with his or her ability to learn to take responsibility for the child. Further, grandparents may experience stress in caring for an infant while also helping their adolescent gain necessary parenting skills. There are many instances in which this transition does not occur, and the grandparent remains the infant's primary caregiver. This pattern has been associated with increased rates of subsequent pregnancies for mothers in their teens. It is necessary to understand the family system of the adolescent in order to help the adolescent develop a plan that works for all.

### ***Teenage Fathers***

Research on adolescent parents has focused primarily on adolescent mothers. Thus, research on partner support focuses on adolescent fathers. Most adolescent mothers report an unmarried relationship with the father of the child before they became pregnant. The fathers of children born to adolescent mothers tend to be 2 to 4 years older than the mothers. Although there is a similar pattern of age difference between adult parents, some consider this age difference among adolescents as suggestive of an exploitative sexual relationship between older adult males and younger adolescent females.

Paternal involvement is often reported as a positive factor associated with lower maternal stress and better child outcomes. However, some fathers are abusive and increase the family stress rather than reduce it. The quality of the teenagers' relationship prior to parenthood predicts the likelihood that adolescent parents will remain together. If the father plays a role in the prebirth decision to raise the child, he is likely to have a higher level of involvement in the child's life. While fathers often report the intention to remain involved in their children's lives, consistent contact tends to decrease as the children become older. There are many factors that affect continued involvement, including lack of employment and financial stress. Continued paternal involvement may also be complicated by disapproval from the adolescent mother's family of origin, particularly if the teens are relying on them for housing and other financial support.

Although partner support is associated with positive psychosocial outcomes for the mother and child, teens who cite pregnancy as a primary reason for marriage evidence higher rates of divorce. Further, when there are different fathers for the adolescent mother's subsequent children, there is greater complexity of paternal involvement with each child.

### **Development of Children of Teenage Parents**

Children born to adolescent mothers are at risk for lower academic achievement, higher rates of emotional and behavioral problems, and poorer social adaptation than are children born to older mothers. However, most of these differences can be accounted for by the social and economic risk factors associated with teenage parenting; once poor socioeconomic



status, low maternal educational achievement, and single marital status are taken into account, the relationship between maternal age and adverse child outcomes is not significant. Maternal education is one of the stronger predictors of adverse outcomes for children; this is encouraging for those engaged in prevention and intervention efforts, in that education is a variable that can be targeted and changed.

While children born to adolescent parents are at greater risk than children born to older parents, many function within normal limits. Positive child outcomes are associated with the absence of multiple risk factors, such as maternal stress and abuse, and the presence of protective factors. Protective factors include characteristics of the child, such as intellectual ability and self-esteem; characteristics of the mother, such as low levels of depression; and parenting behavior, such as consistent and nonpunitive disciplinary practices. The presence of the father is a protective factor when he provides support to the teenage mother, thereby reducing her stress, but can also be a risk factor if he is abusive and increases the level of family stress.

### Interventions to Help Teenage Parents

Public interventions for teenage parents typically target those on public assistance, with the goal of making these parents more self-sufficient and less dependent on welfare. Typically, these programs provide case managers to help the adolescents obtain needed schooling, work training, and child care. Many of these programs have been successful in helping some teen parents remain in school, obtain a GED or high school diploma, and obtain employment. However, outcomes are often limited by the low educational achievement of some of the participants and by the other stressors that affect their performance.

Interventions have also been developed to encourage teenage parents to delay subsequent pregnancies. Studies find that a majority of teenage parents have a second child within 2 years of having their first child and that larger families create additional risks for child outcomes. These programs have had, at best, small impact on adolescent parents' family planning.

Finally, welfare policies frequently change with the intent of creating greater self-sufficiency among those on welfare by providing assistance to obtain schooling and employment. The impact of programs designed to

decrease reliance of teenage parents on welfare is unclear, and it warrants continued evaluation.

Although interventions designed to assist adolescent mothers with their education and employment have met with some success, interventions designed to reduce teenage pregnancy and parenting have not. Interventions to reduce teenage parenting may be more effective if they focus, instead, on changing the broader context in which teenage parenting occurs by creating educational and community environments that foster access to a wider range of options during these adolescents' formative years.

*Merith Cosden and Sara Walker*

*See also* Adult Development (v1); Community-Based Health Promotion (v1); Externalizing Problems of Childhood (v1); Family Counseling (v1); Internalizing Problems of Childhood (v1); Parent-Adolescent Relations (v1); Parenting (v1); Parenting Stress Index (v1)

### Further Readings

- Barber, J. S. (2001). The intergenerational transmission of age at first birth among married and unmarried men and women. *Social Science Research*, 30, 219–247.
- Coley, R. L., & Chase-Lansdale, P. L. (1998). Adolescent pregnancy and parenthood: Recent evidence and future directions. *American Psychologist*, 53, 152–166.
- Milan, S., Ickovics, J. R., Kershaw, T., Lewis, J., & Meade, C. (2004). Prevalence, course and predictors of emotional distress in pregnant and parenting adolescents. *Journal of Consulting and Clinical Psychology*, 72, 328–340.
- Moore, K. A., Miller, B., Gleib, D., & Morrison, D. R. (1995). *Adolescent sex, contraception and childbearing: A review of recent research*. Washington, DC: Child Trends.
- Werner, E. E., & Smith, R. S. (2001). Teenage mothers: From high risk pregnancy to successful midlife adaptation. In E. E. Werner & R. S. Smith, *Journeys from childhood to midlife: Risk resilience and recovery* (pp. 80–102). Ithaca, NY: Cornell University Press.

---

## TRANSLATION AND ADAPTATION OF PSYCHOLOGICAL TESTS

---

The translation and adaptation of psychological tests used for practice and research requires careful attention to issues of bias and equivalence. Thorough translation methods help reduce bias and enhance



equivalence of multilingual versions of a test. Of equal importance is statistical verification of equivalence.

*Equivalence* addresses the question of comparability of observations and test scores across cultures. Lonner described four types: functional, conceptual, metric, and linguistic equivalence. These refer to issues of comparability of behavior and concepts across cultures to issues of test item characteristics (form, meaning structure). Van de Vijver also discussed four types of equivalence. Construct *nonequivalence* refers to constructs being so dissimilar across cultures they cannot be compared. Construct equivalence occurs when a scale measures the same underlying construct and nomological network across cultural groups, but may not be defined the same way. With measurement unit equivalence, the measurement scales for the instruments are equivalent (e.g., interval level), but their origins are different across groups. Equivalence at this level may limit comparability of two language versions of an instrument. The origins of the two versions may *appear* the same (both include interval scales), but because of differential familiarity with the response format used (e.g., Likert scale), the two versions are not identical. The same holds if the two cultural groups vary in response style (e.g., acquiescence). At the highest level of equivalence is scalar equivalence or full score comparability. Equivalent instruments at this level measure a concept with the same interval/ratio scale across cultures and the origins of the scales are similar. At this level, bias has been ruled out and direct cross-cultural comparisons of scores on an instrument can be made.

*Bias* negatively influences equivalence and refers to factors limiting comparability of test scores across cultural groups. Construct bias occurs when a construct is not identical across cultural groups (e.g., incomplete construct coverage). Method bias may limit scalar equivalence and can stem from specific characteristics of the instrument (e.g., differential response styles) or from its administration. Item bias can result from poor translation and item formulation and because item content may not be equally relevant across cultural groups.

Use of proper translation procedures can minimize bias and help establish equivalence. The International Test Commission (ITC) published translation guidelines to encourage attention to the cross-cultural validity of translated or adapted instruments. The context guidelines emphasize minimizing construct, method, and item bias, and assessing construct similarity or

equivalence across cultural groups before embarking on instrument translation. The development guidelines refer to the translation process itself, while the administration guidelines suggest ways to minimize method bias. The interpretation guidelines recommend verification of equivalence between language versions of an instrument.

Two general approaches have been identified when translating or adapting tests. In the applied approach, items are literally translated. Item content is not changed to a new cultural context, and the linguistic and psychological appropriateness of the items are assumed. With the adaptation approach, some items may be literally translated while others require modification of wording and content to enhance their appropriateness to a new culture. This approach is chosen if there is concern with construct bias. For both approaches, attention to equivalence and absence of bias is important. Building on the ITC guidelines and the work of others, the following should be considered when translating or adapting tests.

Bilingual persons fluent in the original and target languages should perform the translation. A single person or committee can be used. Employing test translators who are familiar with the target culture, the construct being assessed, and principles of assessment minimizes item biases that may result from literal translations.

After the translation team has agreed on the best translation, the measure should be independently back-translated by additional person(s) into the original language. The back-translated version is then compared to the original for linguistic equivalence. If the two versions are not identical, the researcher works with the team to revise problematic items through a translation/back-translation process until agreement is reached about equivalence. This process, however, does not guarantee a good scale translation, as it often leads to literal translation at the cost of readability and naturalness of the translated version. To minimize this problem, an expert in linguistics should be consulted. Test instructions also need to go through the translation/back-translation process.

Once there is judgmental evidence of the equivalence of the two language versions, the translated scale needs to be pretested. One approach is administering both versions to bilingual persons. Item responses can then be compared using statistical methods. If item differences are discovered between versions, the translations are reviewed and changed



accordingly. Additionally, a small group of bilingual individuals can be employed to rate each item from both versions on a predetermined scale in regard to the similarity of meaning conveyed. Problematic items are then refined until satisfactory.

A small sample of participants speaking the target language can also provide verbal or written feedback about each item. The researcher may, for instance, randomly select scale items and ask probing questions (e.g., what do you mean by your response?). Responses considered unfitting an item are scrutinized and the translation changed. This method provides insight into how well the meaning of the original items has fared in the translation. Another method may involve respondents rating their perceptions about item clarity and appropriateness on a predetermined scale. Unclear items or items not fitting are changed. Finally a focus group approach can be used in which participants respond to the translated version and discuss with the researcher(s) the meaning they associated with the items and their perception about the clarity and cultural appropriateness of the items. Item wording can be changed based on participants' responses.

Along with the judgmental evidence just mentioned, statistical methods must be performed to verify equivalence and lack of bias. Cronbach's alpha, item-total scale correlations, and item means and variations provide information about instruments' psychometric properties. Significantly different reliability coefficients, for example, may indicate item or construct bias. Comparing these statistics across different language versions of an instrument offers preliminary data about equivalence.

Construct, conceptual, and measurement equivalence can also be measured at the scale level using factor analyses, multidimensional scaling, and cluster analysis. Scalar or full score equivalence is more difficult to establish than construct and measurement unit equivalence, and various biases (e.g., item and method bias) may threaten this level of equivalence. Item bias can be found by studying the distribution of item scores for all cultural groups. Item response theory, in which differential item functioning is examined, may be used for this purpose, as can analysis of variance (ANOVA), logistic regression, multiple-group standard error of the mean (SEM) invariance analyses, and multiple-group mean and covariance structures analysis. Last, factors contributing to method bias can be assessed and

statistically held constant when measuring constructs across cultures.

There are many examples of psychological measures translated from English to other languages. For instance, the Minnesota Multiphasic Personality Inventory-2 (MMPI-2), including the adolescent form (MMPI-A), is available in nearly 20 languages. Multilingual versions of the Myers-Briggs Type Indicator, Strong Interest Inventory, California Psychological Inventory Sixteen Personality Factor Questionnaire (16 PF), Self-Directed Search, Millon Clinical Multiaxial Inventory-III, Revised NEO Personality Inventory (NEO PI-R), Hare Psychopathy Checklist-Revised, Beck Depression Inventory, State-Trait Anxiety Inventory, and Wechsler Intelligence tests are also available.

Often, information about availability and psychometric properties of translations and adaptations of tests can be accessed from the tests' developers or distributors. It is unclear, however, how translations of the measures mentioned above were performed and whether the tests were adapted for different cultural and linguistic contexts.

If one uses a test that has been translated into the language of a specific target population, but that has not been specifically developed and normed for that population, there is little to guarantee equivalence across such factors as item difficulty and relevance, cultural bias, comprehension/decoding, and validity within a differing cultural context. Beyond language, culture, and relevance, even the factor structure of a specific test cannot be assumed to exist in an adapted translation. This has, for instance, been observed in discussions regarding a 5- or 6-factor solution for the NEO PI-R in some specific cultural/linguistic adaptations. Psychologists worldwide, however, are striving to develop culturally sensitive and linguistically accurate translations of existing English version instruments. They are also developing measures for particular national and ethnic populations.

*Stefania Ægisdóttir, Lawrence H. Gerstein,  
and James W. Bartee*

*See also* Achievement, Aptitude, and Ability Tests (v4); Cross-Cultural Psychology (v3); Cultural Equivalence (v3); Culture-Free Testing (v3); Intelligence Tests (v3); International Test Commission (v1); Psychometric Properties (v2); Translation Methods (v3)



### Further Readings

- Ægisdóttir, S., Gerstein, L. H., & Çinarbaş, D. C. (2007, October 9). Methodological issues in cross-cultural counseling research: Equivalence, bias and translations. *The Counseling Psychologist*. Retrieved from <http://tcp.sagepub.com/cgi/content/abstract/0011000007305384v1>
- Brislin, R. W. (1986). The wording and translation of research instruments. In W. J. Lonner & J. W. Berry (Eds.), *Field methods in cross-cultural research* (pp. 137–164). Beverly Hills, CA: Sage.
- Byrne, B. M. (2004). Testing for multigroup invariance using AMOS graphics: A road less traveled. *Structural Equation Modeling: A Multidisciplinary Journal*, 11, 272–300.
- Cleary, T. A., & Hilton, T. L. (1968). An investigation of item bias. *Educational and Psychological Measurement*, 28, 61–75.
- Hambleton, R. K. (2001). The next generation of the ITC test translation and adaptation guidelines. *European Journal of Psychological Assessment*, 17, 164–172.
- Hambleton, R. K., & de Jong, J. H. A. L. (2003). Advances in translating and adapting educational and psychological tests. *Language Testing*, 20, 127–134.
- Little, T. D. (2000). On the comparability of constructs in cross-cultural research: A critique of Cheung and Rensvold. *Journal of Cross-Cultural Psychology*, 31, 213–219.
- Lonner, W. J. (1985). Issues in testing and assessment in cross-cultural counseling. *The Counseling Psychologist*, 13, 599–614.
- van de Vijver, F. J. R., & Hambleton, R. K. (1996). Translating tests: Some practical guidelines. *European Psychologist*, 1, 89–99.
- van de Vijver, F. J. R., & Leung, K. (1997). *Methods and data analysis for cross-cultural research*. Thousand Oaks, CA: Sage.

---

## TRAUMATIC BRAIN INJURY AND REHABILITATION

---

Traumatic brain injury (TBI) refers to damage to the brain caused by external physical force. It is the leading cause of long-term disability in young adults. Approximately 1.5 million Americans survive brain injuries each year, and an estimated 70,000 to 90,000 of these survivors are left with long-term impairments that interfere with their psychosocial adjustment and reintegration into the community. In the United States, an estimated five million individuals live with residual symptoms of TBI severe enough to interfere with

basic activities of daily living. TBI is most prevalent under age 24 and more than twice as common among men as among women.

### Causes and Mechanisms of Injury

TBI differs from other types of brain damage in its noncongenital and nondegenerative etiology and sudden occurrence during the course of normal health and development. Nearly half of all TBI occurs as a result of motor vehicle accidents; other common causes include falls, assault, and sporting accidents.

In open head injuries, damage to brain tissue tends to be localized at the site of injury. In contrast, closed head injuries tend to produce damage that is more diffuse. In incidents involving a blow to the head, the injury typically involves abrasions, lacerations, and contusions to the brain caused by impact with bony protrusions and rough membranes within the skull. A *coup-contrecoup injury* occurs when bruising occurs both at the site of impact and on the opposite side, as the brain bounces backwards in the skull.

In vehicular accidents, strong inertial forces can cause rotation of the brain within the skull. This twisting motion can strain fragile nerve fibers and blood vessels, and diffuse axonal shearing may result from the stretching and tearing of these microscopic structures. On the cellular level, disruptions in chemical connections between neurons and changes in basic metabolic processes may occur. The accumulation of molecules related to the cellular response to injury can create a toxic environment for surrounding neurons, leading to degeneration of these cells.

### Sequelae of Traumatic Brain Injury

Advances in emergency medicine and neurosurgery have led to increases in the TBI survival rate and a corresponding increase in the number of TBI survivors living with long-term adjustment problems. Typical problems include motor, perceptual, communication, and cognitive deficits.

Even with full physical and medical recovery, TBI survivors may experience persistent cognitive deficits in attention, concentration, memory, and higher-level executive functions involved in reasoning, planning, problem solving, emotional self-regulation, and judgment. In general, it is such cognitive and emotional changes, rather than any physical impairment per se, that contribute most to the disruption of life activities



for people with TBI. These impairments can compromise the individual's capacity to resume preinjury work and social roles, and the impact on quality of life can be profound. Long-term adjustment issues following TBI include unemployment, criminal behavior, loneliness, substance abuse, and loss of important social and family roles. Because the typical TBI survivor is a young adult with a normal life expectancy, cognitive deficits may lead to many years of social, vocational, and familial dysfunction, in which a person who may well be physically able is nonetheless dependent on others.

### Rehabilitation Methods

The Consensus Development Panel on Rehabilitation of Persons with Traumatic Brain Injury, convened in 1998 by the National Institutes of Health, recommended that rehabilitation be individualized, based on the person's residual strengths and limitations. Depending on severity of injury and the individual's needs, the rehabilitation team may include physiatrists, psychologists, speech and language pathologists, physical and occupational therapists, social workers, and vocational counselors. Rehabilitation may be provided on an inpatient, outpatient, or home-based basis or as part of a comprehensive day treatment program. Whatever the setting, counselors and psychologists face unique challenges in addressing the varied rehabilitation needs of people with TBI.

### Cognitive Rehabilitation

Cognitive rehabilitation is a systematic intervention designed to improve functional abilities and increase levels of independence following TBI. Prior to beginning cognitive rehabilitation, the individual typically completes a comprehensive neuropsychological evaluation to identify specific cognitive deficits, develop measurable goals, and guide treatment planning.

There are two general approaches to cognitive rehabilitation: restoration and compensation. The restoration approach is based on the premise that repetitive exercise can restore compromised cognitive abilities. Techniques include visual and auditory exercises, numerical tasks, computer-assisted exercises, feedback on performance, practice, and reinforcement. The compensation approach reinforces the individual's residual cognitive strengths while teaching strategies to circumvent (or compensate for) impaired cognitive abilities, with the goal of increasing independent

functioning. Compensatory strategies include the use of cues, written instructions, notes, calendars, date books, and electronic devices such as beepers and pagers. The individual is taught to minimize distractions, break complex tasks down into steps, and to self-monitor and self-regulate behavior. The two approaches are not mutually exclusive; both techniques are usually employed as necessary, depending upon the individual's needs.

### Psychological Issues and Interventions

Although there has been general support for the overall effectiveness of cognitive rehabilitation, evidence-based reviews have cited the need for more systematic study of treatment outcomes to determine practice guidelines. Despite obvious issues in impaired brain-behavior functions following TBI, accumulating data indicate that long-term adjustment is influenced by individual differences and by behavioral and social mechanisms to the extent that these factors account for more variance in any given outcome variable than diagnostic indicators of severity (particularly among persons with mild to moderate TBI). For example, persons with preinjury substance abuse histories are more likely to experience an array of personal and social problems after TBI. In general, individuals with a preinjury history of optimal personal, vocational, and social adjustment fare better than persons who do not. Current research indicates that persons who report more effective social problem-solving abilities following TBI are less distressed and less impaired than persons who report ineffective problem-solving styles, consistent with the extant literature concerning social problem-solving abilities among people in general.

Families are affected by TBI. Qualitative research has found that husbands of women with TBI report specific problems with their wives' loss of autonomy, mood swings, insecurities, overprotectiveness, reluctance to leave home, and change in lifestyle as particularly stressful. Wives of men with TBI report specific problems with husbands' personality changes, memory loss, lack of insight, lack of acceptance, reduction in financial resources, loss of emotional support, and feeling unable to meet children's needs. Family members who assume caregiver duties for a loved one with TBI have many concerns about interpersonal relationships, quality of life, and emotional commitments. Community-residing individuals with TBI report ongoing needs with improving memory, solving problems,



managing stress and emotional upsets, and in managing money and paying bills; these needs are particularly complicated by cognitive abilities, unemployment, and substance abuse.

Structured employment strategies appear to have the most promise in helping individuals with TBI return to work. Although other strategies exist, vocational rehabilitation efforts are hampered by decreasing financial support and the amount of time often required for successful training, placement, and work adjustment.

Cognitive-behavioral interventions have demonstrated some effectiveness for persons living with TBI. Problem-solving training has been associated with decreases in distress in psychoeducational group sessions with persons with TBI and in web-based programs for families living with TBI. It should be noted, however, there has been a long-standing interest in interpersonal group formats that could promote personal awareness and insight in a social context and could improve self-concept. Motivational interviewing has been espoused as an efficient and strategic method for addressing substance abuse issues among persons with TBI.

### Future Directions

The steady rate of growth in TBI in modern society constitutes a major healthcare and socioeconomic concern. Experts recently have witnessed an increase in TBI sustained by soldiers fighting in Afghanistan and Iraq, prompting Veterans Affairs hospitals to set up special TBI treatment and rehabilitation centers. As the number of TBI survivors continues to grow, millions, in the United States alone, now live with residual symptoms and long-term adjustment problems.

Researchers are optimistic that ongoing studies will lead to further advances in treatment and rehabilitation for people with TBI. Early research has indicated that cholinesterase inhibitors (currently used to treat early symptoms of Alzheimer's disease), may prove to be an effective treatment for TBI-related deficits in attention, concentration, and memory. Recent advances in genetics are also promising. For example, the apolipoprotein E4 (apoE-e4) genotype appears to increase the risk of poor outcome following TBI. Discoveries such as this may lead to the development of targeted medications or gene therapy for TBI treatment and rehabilitation.

Functional magnetic resonance imaging (fMRI) appears to be an important tool for understanding the neurobiological changes that occur in the brain during

cognitive rehabilitation. Preliminary research suggests that fMRI has the potential to identify changes that occur in functional neural networks during cognitive rehabilitation, thereby allowing for more targeted rehabilitative interventions. Finally, developments in stem cell research indicate potential benefits for people with TBI. Researchers have used adult human stem cells to grow functioning brain cells. Although this research is still in its infancy, stem cells from a patient's own bone marrow one day may be used to regrow and replace brain cells that have been damaged by TBI.

*Joseph F. Rath and Timothy R. Elliott*

**See also** Americans with Disabilities Act (v1); Caregiver Burden (v1); Low-Incidence Disabilities (v1); Neuropsychological Functioning (v2); Physical Health (v2); Rehabilitation Counseling (v2)

### Further Readings

- Cicerone, K. D., Dahlberg, C., Malec, J. F., Langenbahn, D. M., Felicetti, T., Kneipp, S., et al. (2005). Evidence-based cognitive rehabilitation: Updated review of the literature from 1998 through 2002. *Archives of Physical Medicine and Rehabilitation*, 86, 1681–1692.
- National Institute of Neurological Disorders and Stroke. (2002). *Traumatic brain injury: Hope through research* (NIH Publication No. 02–158). Bethesda, MD: Author.
- NIH Consensus Development Panel on Rehabilitation of Persons With Traumatic Brain Injury. (1999). Rehabilitation of persons with traumatic brain injury. *Journal of the American Medical Association*, 282, 974–983.
- Rath, J. F., Simon, D., Langenbahn, D. M., Sherr, R. L., & Diller, L. (2003). Group treatment of problem-solving deficits in outpatients with traumatic brain injury: A randomized outcome study. *Neuropsychological Rehabilitation*, 13, 461–488.
- Willer, B. S., Allen, K., Liss, M., & Zicht, M. (1991). Problems and coping strategies of individuals with traumatic brain injury and their spouses. *Archives of Physical Medicine and Rehabilitation*, 72, 460–464.

---

## TREATMENT COMPLIANCE

---

*Compliance* is defined as the degree to which patients' behaviors (e.g., attending follow-up appointments, engaging in preventive care, following recommended medical regimens) correspond with the professional medical advice prescribed. The terms *compliance* and



*adherence* are often used interchangeably; however, because compliance may carry a negative connotation, some prefer to use *adherence* to emphasize patients' active roles in healthcare management as opposed to the submissiveness suggested in the definition of *compliance*. This distinction in definition acknowledges that patients and providers can move away from the patriarchal model of health care, promotes patient autonomy, and takes into account evidence suggesting that those who adhere steadfastly to providers' instructions may not be the healthiest psychologically or physically. While the patient's active role is considered vital in committing to a treatment regimen, for the purposes of this overview, the term *compliance* is utilized to maintain consistency.

### Compliance Rates and Consequences of Noncompliance

When adults are diagnosed with chronic illnesses, they are often inundated with treatment options. Outright refusal to accept treatment is rare. Many who initially refuse later comply. As M. Robin DiMatteo found, on average, 75.2% of adults with chronic illnesses comply with prescribed treatments. While compliance rates for behavioral interventions (e.g., exercise regimens, smoking cessation) are consistently lower than this average (ranging from 40% to 75%), patients attend scheduled appointments at higher rates (up to 90%). Interestingly, despite the shift toward greater patient decision-making autonomy, across treatment regimens compliance rates have increased from 62.6% prior to 1980 to 76.3% thereafter. Among adults, highest compliance rates are documented for human immunodeficiency virus (HIV), arthritis, and gastrointestinal disorders. While an estimated 50% of children and adolescents with chronic illnesses fully comply with medical recommendations, rates fluctuate depending on the illness. Among children and adolescents with cancer, compliance ranges from 40% to 66%. Compliance for sickle cell disease ranges from 49% to 79%; approximately 66% of patients with cystic fibrosis and diabetes fully comply.

The consequences of noncompliance lie on a continuum ranging from relatively no direct patient risk to severely increased morbidity and mortality and an increased global threat of treatment-resistant diseases. Additionally, noncompliance results in medical resource waste and large-scale medical industry monetary losses exceeding \$100 billion per year.

## Assessing Compliance

### Self-Reports

Self-reports are commonly used to assess compliance. Examples include Likert scale questionnaires, handheld computers, and phone diaries. Although self-report measures are the simplest measures to use, report bias and recall precision issues often make results inaccurate. These inaccuracies can result in over-reporting, because patients may answer questionnaires consistently with what they believe promotes support and approval from providers. Underreporting is also concerning, with some research suggesting higher compliance when using objective measures as compared to self-reports. Despite challenges involved and acknowledgment that self-reports should be interpreted cautiously, because of their practicality, research supports using self-reports in clinical settings.

### Objective Measures

Pill counts, electronic bottles, and urine or blood serum levels are examples of objective measures of compliance. Although these measures can be expensive, many lessen opportunities for recall bias and human error via electronic tracking (e.g., counting number of puffs pressed on an inhaler). While they cannot guarantee that the patient completed the treatment, increased accuracy has been reported when using objective measures of compliance. Parents also report feeling more comfortable allowing their children to take control of treatment protocols when such devices are utilized.

### Collateral Reports

A third method of measuring compliance is through reports by family and healthcare providers. Although this method is rarely used, except with young children, it can be valuable to compare self-reports to reports from third parties.

## Correlates and Predictors of Compliance

### Adults

Compliance increases when patients believe treatments are necessary and important. Healthcare providers play a critical role in this process by helping patients weigh the risks and benefits while taking into



consideration social contexts and perceived barriers. Successful compliance also requires that an individual develops the motivation and self-efficacy required to confront a long-term stressor.

Decision-making autonomy enables the patient to feel more control and self-responsibility, perceive treatments as valuable, and achieve increased quality of life (QOL). Noncompliance risk factors include distress, perceived vulnerability, patient characteristics (e.g., demographics, social support), disease and treatment variables (e.g., complexity, side effects), contextual factors (e.g., provider-patient relationship, media exposure), and cognitive functioning (e.g., memory).

Examples of predictors of compliance are readily available. Online surveys find that most cancer patients and providers believe good communication promotes compliance; unfortunately, relatively few providers are comfortable discussing alternative or complementary therapies. Additionally, research among HIV/AIDS (acquired immune deficiency syndrome) patients suggests that poor social support, underestimation of illness severity, lack of factual information (e.g., not knowing the difference between HIV and AIDS), healthcare system distrust, side effects, and beliefs that medications are ineffective all decrease compliance.

Most research shows no major differences in compliance based on gender, marital status, country of birth, or primary language. Although conflicting findings exist with respect to the relationship between ethnicity and compliance across chronic illnesses, as compared to European Americans, fewer minority HIV-positive patients comply with treatment. Income-specific factors combined with high treatment costs also play a role in lower compliance rates, and many patients state that they must cut back on necessities like food or heat to pay for medications.

### **Children and Adolescents**

For children and adolescents, treatment compliance is influenced by numerous factors. In general, females are more compliant than males, and adolescents are less compliant than younger children. Among adolescents, researchers report that compliance may be related to adolescents' needs for independence combined with their willingness (or lack thereof) to accept the authority of healthcare providers. For example, research suggests that a cancer diagnosis coupled with cognitive impairments resulting from aggressive treatments

predicts poorer decision-making abilities, including higher incidences of high-risk behaviors (e.g., smoking, drug use). Self-esteem, cognitive and social functioning, lower socioeconomic status, lower parent education, feelings of invincibility, illness knowledge, perceived vulnerability, treatment complexity, emotional problems, and prevailing psychiatric illness also relate to compliance.

The overall strength of the parent-child relationship, including communication and familial organization, is crucial in successfully treating chronic illnesses. Parents must be prepared to complete a variety of tasks ranging from administering medications to assisting medical staff with invasive procedures. A lack of cooperation between parents and children and parenting inconsistency can result in added emotional distress, exacerbation of behavioral problems, and lowered compliance with medical protocols and other daily tasks. When anxious parents are overly restrictive, adolescents are less likely to follow prescribed treatments.

Predictors and correlates of compliance also vary by specific illness. For asthma patients, inadequate healthcare access, limited disease knowledge, inability to seek emergency care, conflicts with healthcare providers, family dysfunction, and poverty are all barriers. Among childhood cancer patients, noncompliance is more likely once maintenance therapy is introduced, because the most acute phase of treatment is administered by professionals, making noncompliance less probable. Children with sickle cell disease or juvenile rheumatoid arthritis are usually compliant with pain management interventions but may not comply with behavioral exercises and other treatments due to side effects and the amount of time required. In addition to time constraints, cystic fibrosis treatment can promote family conflict. Regardless of the specific illness, children and adolescents with chronic illness often report fears that compliance will interrupt typical life activities and change how they are perceived by peers.

## **Theory and Interventions Promoting Compliance**

### **Adults**

Several extant theories suggest factors fostering treatment compliance. Often these theories serve as foundations for interventions designed to increase behavioral compliance. Examples include the health



belief model by Marshall Becker and colleagues, which states that compliance is related to beliefs about illness severity and treatment regimen benefits as well as vulnerability perceptions. Irwin Rosenstock and colleagues' health benefits model add that patients will weigh the treatment costs and benefits before deciding whether to perform the recommended behaviors. Individuals who view themselves as more vulnerable or who view their illness as very serious are likely to exhibit greater compliance with health behaviors, thereby promoting positive outcomes. The role of self-efficacy, included in models such as Howard Leventhal's self-regulatory model of illness and Ronald Roger's protection motivation theory, is also salient in that patients displaying higher levels of confidence in their ability to complete treatment are more likely to succeed.

The way in which treatment is offered to patients can help promote compliance. Home health care increases compliance by increasing satisfaction with staff and decreasing treatment administration wait times. As compared to home health care, similar improvements in compliance are identified through educational interventions aimed at enhancing disease and treatment knowledge and through behavioral interventions, which assist with pain management and pill-taking procedures. Healthcare providers often also emphasize relaxation therapy and systematic desensitization to control side effects and promote compliance, although these approaches are less empirically supported.

A recent review of interventions targeting hypertension, schizophrenia and psychosis, asthma, depression, HIV, diabetes, rheumatoid arthritis, and epilepsy found that certain interventions work better for specific illnesses. Complex interventions involving care at the worksite, special pill containers, counseling sessions, phone calls, information pamphlets, workbooks, and support groups successfully increase compliance for hypertension and asthma. For patients with diabetes, self-care educational calls with a nurse work well, whereas individual counseling promotes compliance among HIV and epilepsy patients. Disease and drug informational pamphlets and teaching self-monitoring techniques also enhance compliance among those with epilepsy. Family therapy and individual educational sessions work best for individuals with schizophrenia and psychosis. Among patients with depression, informational pamphlets and drug counseling decrease depressive symptoms, decrease relapses, and increase compliance. When patients are depressed and have a

chronic illness, behavioral therapies have successfully extinguished depressive symptomology and increased reinforcement of healthy behaviors, including treatment compliance.

### Children and Adolescents

As Dennis Drotar argued, when developing interventions promoting compliance among children and adolescents, special considerations are required. Specifically, it is necessary to include the entire family in facilitating change. A well-developed intervention sets its own unique objectives, identifies risk factors, and works to enhance resilience factors and competencies. The underlying theory must be identifiable. If an intervention is successful but the theory cannot be identified, it will be nearly impossible to identify the mechanism of change. Many competing theories involving the entire family have been utilized to explain barriers to compliance. Examples include models that aim to separate risk factors, such as psychological stressors and functional independence, from resilience factors, such as dispositional traits and coping ability (James Varni and Jan Wallander's disability, stress, and coping model) and models focusing on the family's level of stress and burden as predictors of aversive outcomes (Reuben Hill's ABCX family crisis model).

Three primary strategies exist in intervening to encourage compliance. Educational interventions focus on teaching families about the child's disease, treatment requirements, and self-management proficiencies. Organizational interventions work to modify the physical healthcare setting to make it more welcoming and accommodating. This may include decreasing wait times and increasing the frequency of follow-up care. Behavioral interventions include stimulus control techniques that utilize visual cues and written reminders, self-control techniques (i.e., self-monitoring medication use), and reinforcement control techniques (i.e., token economies).

Treatment plans and interventions must be determined with a great deal of individualization based on the needs of each child. For example, among children with asthma, compliance is often problematic, because the disease can be unpredictable with long symptom-free periods. Plans for preventive care, avoidance of triggers, and promotion of medication compliance are all necessary and are enhanced through simple behavioral interventions such as teaching how and when to use medications, goal-setting techniques, and



self-management skill development. Healthcare providers must also be taught to provide developmentally appropriate written or pictorial explanations of their recommendations. Across varying types of chronic illnesses, healthcare providers who are willing to spend extra time communicating, supporting, and supervising care are more likely to achieve better compliance.

### Future Research Considerations

For interventions to be effective, researchers and healthcare providers must first understand the predictors of successful compliance and factors encouraging noncompliance, including the patient's emotional status, culture, and belief system. Healthcare providers often play a primary role in influencing a patient's belief systems. It is commonly understood that patients must trust healthcare providers before complying with treatment; however, research must work to specify precisely how variables such as rapport, mutual respect, empathy, and humanism impact compliance. The examination of what types of information patients can absorb at certain stages of their diagnoses and treatments and how practitioners engage patients in the decision-making process are also pertinent. There are many other questions that remain unanswered as well. Several of these questions center on patient beliefs such as determining the role of prognosis, illness severity, denial, guilt, and alternative or homeopathic therapies on compliance. Practical matters like daily chronic stressors, motivation, peer influences, emotional distress, family dysfunction, and family cohesiveness also require further investigation.

*Rebecca H. Foster and Marilyn Stern*

**See also** Cancer Management (v1); Children with Chronic Illness (v1); Chronic Illness (v1); Client Attitudes and Behaviors (v2); Health Belief Model (v1); Medication Adherence (v1); Relationships with Clients (v2)

### Further Readings

- DiMatteo, M. R. (2004). Variations in patients' adherence to medical recommendations: A quantitative review of 50 years of research. *Medical Care*, 42, 200–209.
- Drotar, D. (Ed.). (2006). *Psychological interventions in childhood chronic illness*. Washington, DC: American Psychological Association.
- Horne, R., & Weinman, J. (1998). Predicting treatment adherence: An overview of theoretical models. In L. B. Myers & K. Midence (Eds.), *Adherence to treatment in medical conditions* (pp. 25–50). Amsterdam: Harwood Academic.
- Ievers-Landis, C. E., & Drotar, D. (2000). Parental and child knowledge of the treatment regimen for childhood chronic illnesses: Related factors and adherence to treatment. In D. Drotar (Ed.), *Promoting adherence to medical treatment in chronic childhood illness: Concepts, methods, and interventions* (pp. 259–285). Mahwah, NJ: Lawrence Erlbaum.
- Kennard, B. D., Stewart, S. M., Olvera, R., Bawdon, R. E., hAilin, A. O., Lewis, C. P., et al. (2004). Nonadherence in adolescent oncology patients: Preliminary data on psychological risk factors and relationships to outcome. *Journal of Clinical Psychology in Medical Settings*, 11, 30–39.
- Lemanek, K. L. (2004). Adherence. In R. T. Brown (Ed.), *Handbook of pediatric psychology in school settings* (pp. 129–148). Mahwah, NJ: Lawrence Erlbaum.
- Manne, S. L., Miller, D. L., & Meyers, P. (1999). Difficulties completing treatment tasks among newly diagnosed children with cancer. *Children's Health Care*, 28, 255–276.
- McDonald, H. P., Garg, A. X., & Haynes, R. B. (2002). Interventions to enhance patient adherence to medication prescriptions: Scientific review. *Journal of the American Medical Association*, 288, 2868–2879.
- Oggins, J. (2003). Notions of HIV and medication among multiethnic people living with HIV. *Health & Social Work*, 28, 53–62.
- Peterman, A. H., & Cella, D. F. (1998). Adherence issues among cancer patients. In S. A. Shumaker, E. B. Schron, J. K. Ockene, & W. L. McBee (Eds.), *The handbook of health behavior change* (2nd ed., pp. 462–482). New York: Springer.
- Quittner, A. L., & Espelage, D. L. (2000). Measuring adherence to medical treatments in childhood chronic illness: Considering multiple methods and sources of information. *Journal of Clinical Psychology in Medical Settings*, 7, 41–54.
- Roberts, C., Benjamin, H., & Chen, L. (2005). Assessing communication between oncology professionals and their patients. *Journal of Cancer Education*, 20, 113–118.
- Simoni, J. M., Frick, P. A., & Huang, B. (2006). A longitudinal evaluation of a social support model of medication adherence among HIV-positive men and women on antiretroviral therapy. *Health Psychology*, 25, 74–81.
- Taylor, S. E., Kemeny, M. E., Reed, G. M., Bower, J. E., & Gruenewald, T. L. (2000). Psychological resources, positive illusions, and health. *American Psychologist*, 55, 99–109.



---

## TYLER, LEONA E. (1906–1993)

---

Leona Elizabeth Tyler was born in Chetek, Wisconsin, on May 10, 1906; she died at the age of 86 in Eugene, Oregon, on April 23, 1993. By her own admission, an established field of counseling psychology did not exist when she began her full-time graduate training at the University of Minnesota in 1938, but Tyler made a significant contribution to the definition and evolution of the discipline throughout her career. She founded a university counseling service; wrote an authoritative counseling text, *The Work of the Counselor*; served as president of the American Psychological Association's (APA's) Division of Counseling Psychology (1959–1960); and was ultimately elected president of the APA (1972–1973). In fact, Tyler's contributions to the counseling field were so significant that counseling psychology's most prestigious award is named in her honor. Her professional and scholarly work was not confined, however, to counseling. Her career at the University of Oregon spanned more than three decades and included appointments as a professor in the psychology department and dean of the graduate college. A prolific author, she published more than 50 journal articles and penned books on diverse topics, including individual differences, developmental psychology, clinical psychology, psychological testing, intelligence, and creative thinking.

### Education and Training

Although born in Wisconsin, Tyler lived most of her early years in Minnesota in the area of the Mesabi Iron Range. Her parents had not earned college degrees, but she spent 2 years at Virginia Junior College and ultimately graduated from the University of Minnesota at age 19 with a degree in English. She then began a career as a junior high school teacher. In her own writings, Tyler noted that she enjoyed teaching but found maintaining classroom discipline stressful. After more than a decade, she considered making a career change and becoming a counselor, which led her to enroll in a summer class at the University of Minnesota in 1937. Her professor for that class, Donald G. Paterson, recognized her talent, convinced her to pursue full-time graduate studies in psychology, and helped her to obtain a graduate assistantship.

The psychology department in Minnesota did not provide specialty training at that time, but Tyler noted

it did present significant opportunities for training in counseling. She completed a practicum at the University Testing Center and learned about assessment techniques, particularly interest assessment, and practiced educational and career guidance. In addition to her counseling experiences, Tyler's comprehensive graduate training included a minor in statistics and interactions with noted professionals, such as developmental psychologist Florence Goodenough. Tyler became well versed in general psychology as well as specialized topics, which prepared her to teach courses from counseling and guidance to social psychology and research methods. She ultimately taught in all of these domains during her academic career at the University of Oregon, which began with her appointment as an instructor in the psychology department in 1940.

### Early Years at the University of Oregon

When Tyler took the position in Oregon, she became the only woman in its small psychology department. These early years were both professionally productive and personally satisfying to Tyler, who would later describe them as some of her happiest. She enjoyed the intellectual stimulation that came from working with other faculty members and graduate students, and she considered herself quite successful at this career stage.

Always one to bridge the gap between science and practice, Tyler stayed active as a counselor while maintaining her scholarly and teaching activities. Although there were no counseling facilities at the University of Oregon, Tyler quickly started a counseling service to provide occupational assessment and guidance to students. However, as World War II came to an end, her focus shifted to providing counseling to veterans as they returned home from the war. Through the years, this counseling service developed into the official University Counseling Center, and she continued to work there part-time until 1965.

In addition to her success as a counselor and teacher, Tyler also published her first book, *The Psychology of Human Differences*, in 1947. The text, which would appear in three editions, addressed issues related to measuring and understanding individual differences in a wide range of constructs, including intelligence, personality, and perception. Tyler also discussed group differences in various domains based on sex, race or ethnicity, and social class.



## Establishment as a Scholar and Professional

Although satisfied with her career progress at the time, Tyler acknowledged later that her advancement was most likely slowed by sexist attitudes held by many in the field. Her scholarly productivity continued, however, and she received recognition for her work during the 1950s. She identified her 1951 sabbatical in London as a pivotal time in her career for several reasons. First, she enjoyed scholarly success and had the opportunity to focus on data analysis and writing. Her time in London also brought her into contact with noted personality theorist Hans Eysenck. As important as her professional endeavors, her personal experiences in London broadened her cultural horizons and exerted a key influence. In fact, it was there that she first encountered existentialism, which she credited for impacting much of her later work.

Tyler also started her second book, *The Work of the Counselor*, during her sabbatical year. Published in 1953, this textbook for counselors in training became profoundly influential. It was used in training programs across the globe, spawned two subsequent editions, and established her as an expert in the field. These texts integrated research and practice and covered everything from conducting the first interview to evaluating the effects of counseling.

Following the success of her second book, Tyler assumed a number of professional leadership roles. She became the president of the Oregon Psychological Association in 1956, the Western Psychological Association in 1957, and the APA's Division of Counseling Psychology in 1959. Her allegiance to counseling did not keep her from branching into other disciplines. She collaborated on a developmental psychology text with Florence Goodenough, a graduate school mentor, and wrote a clinical psychology textbook with colleague Norman Sundberg.

Tyler is best known for her books and her work in professional leadership roles, but she also enjoyed success during this time publishing original research. Her work often involved interest measurement in children and adolescents. She also developed a new theoretical framework for individuality. She used her 1958 Western Psychological Association presidential address to present her perspective that a person's uniqueness results from making choices among available possibilities and providing a mental organization

to those choices. She viewed these ideas as an important complement to existing approaches to trait measurement, and they influenced her development of the choice pattern technique as a career counseling assessment tool.

## Late Career and Professional Legacy

Already a textbook author and authority in counseling, clinical, and developmental psychology, Tyler added psychological testing to that list with the publication of *Tests and Measurements* in 1963. Her scholarly work during the 1960s and 1970s also included several collaborative cross-cultural studies, including an examination of choice patterns in teens from India, the Netherlands, and the United States.

Tyler's final appointment at the University of Oregon was as the first female dean of the graduate college, a position she held from 1965 until she reached mandatory retirement age in 1971. Even after official retirement, she continued with an active professional life. She served as president of the American Psychological Association from 1972 to 1973, and she worked on various boards for the organization into the 1980s. She also wrote with consistency and frequency, authoring books on individuality and creative thinking.

Tyler's legacy is significant. She influenced the field of psychology as a whole through substantial empirical research, important books in several fields, a record of mentoring significant numbers of graduate students, and work within APA governance at its highest levels. Her mark on the counseling profession was profound. In fact, she helped to define the counseling field and its professional training with her text, research, counseling center work, and service to the Division of Counseling Psychology. Beginning with *The Work of the Counselor* in the 1950s and continuing into the 1990s, Tyler advocated for counseling as an activity and profession that could be helpful to any person by facilitating self-understanding, development, and making the choices she saw as so central to individuality.

*Kristin M. Vespia and Ryan C. Martin*

**See also** Counseling, Definition of (v1); Counseling, History of (v1); Counseling Psychology, Definition of (v1); Counseling Psychology, History of (v1); Tyler, Leona E.: Human Multipotentiality (v2)



**Further Readings**

- Delworth, U. (2000). Leona Tyler: Explorer and map maker. *The Counseling Psychologist*, 28, 425–433.
- Fassinger, R. E. (2003). Leona Tyler: Pioneer of possibilities. In G. A. Kimble & M. Wertheimer (Eds.), *Portraits of pioneers in psychology* (Vol. V, pp. 231–247). Washington, DC: American Psychological Association.
- Sundberg, N. D. (1991) Award citation. *American Psychologist*, 46, 330–332.
- Sundberg, N. D., & Littman, R. A. (1993). Leona Elizabeth Tyler (1906–1993). *American Psychologist*, 49, 211–212.
- Tyler, L. E. (1956). *The psychology of human differences* (2nd ed.). New York: Appleton-Century-Crofts.
- Tyler, L. E. (1959). Toward a workable psychology of individuality. *American Psychologist*, 14, 75–81.
- Tyler, L. E. (1961). *The work of the counselor* (2nd ed.). New York: Appleton-Century-Crofts.
- Tyler, L. E. (1972). Reflections on counseling psychology. *The Counseling Psychologist*, 3, 6–11.
- Tyler, L. E. (1973). Design for a hopeful psychology. *American Psychologist*, 28, 1021–1029.
- Tyler, L. E. (1988). Leona E. Tyler. In A. N. O’Connell & N. F. Russo (Eds.), *Models of achievement: Reflections on eminent women in psychology* (Vol. 2, pp. 44–55). Hillsdale, NJ: Lawrence Erlbaum.
- Tyler, L. E. (1992). Counseling psychology—Why? *Professional Psychology: Research and Practice*, 23, 342–344.





---

## UNIVERSITY COUNSELING CENTERS

---

Universities and colleges have provided counseling services to students for over 80 years. Early on, counseling was often conducted by psychiatrists who worked in student health services. In the 1930s, there was movement for counseling to be conducted by counselors and psychologists who viewed students' problems from a normative developmental model and were trained in student personnel programs or psychology departments. Since then, university counseling centers have emerged as a specialty area within counseling psychology that calls for psychologists to provide counseling for students with both developmental and adjustment-related concerns as well as more serious pathology. In addition to clinical services, university counseling center psychologists provide outreach and consultation to the larger university campus communities, provide training for graduate practicum counselors and predoctoral interns in counseling and clinical psychology and social work programs, attend to staff development within their agencies, conduct research applicable to college student populations and therapeutic practices, and develop administrative policies and programs that help to inform and guide the counseling psychology field. This entry begins with a brief historical overview of university counseling centers and then describes the current six counseling center functions as originally outlined by Stone and Archer, as well as multicultural and diversity factors that are involved throughout these functions.

### Historical Overview

University counseling centers (UCCs) have transformed greatly since their formative years, and these transformations have often mirrored emerging mental health needs and personal growth concerns of the larger culture. During the 1940s, the role of clinical counselor was developed as an individual who could work with the specialized needs of college students. Following World War II, counselors were called on to provide vocational guidance services for returning veterans. During the 1950s through 1970s, outreach and consultation services were added to the work of university counseling centers, causing counselors to view the entire university as their "client" rather than just individual college students. In the 1980s, UCCs were faced with increasing numbers of students with serious mental health concerns (e.g., sexual violence, eating disorders, suicide) and with the need for campus education and consultation to address these issues.

From the 1990s through the beginning of the 21st century, university counseling centers have continued to work with students with serious mental health concerns, but during this time financial constraints have necessitated decreases in service provision, such as limiting counseling sessions. This limitation of counseling sessions is similar to the current therapeutic practice allowances of many third party payment plans, which has contributed to an increase in a medical model approach. This includes a reliance on diagnosis (e.g., the use of the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition: DSM-IV*), psychotropic medications, and standard of



care approaches that involve the professional practice of reasonable and prudent mental health professionals who have specialized training in the diagnosis and treatment of clinical issues.

In many ways, the field has seen a full circle that also embraces many of the emerging perspectives of the last 80 years, from counseling provided by psychiatrists from a medical model during the 1920s to counselors providing mental health treatment from a developmental and adjustment-oriented perspective and back to current practices of considering both developmental and medical models when working a college student population.

### University Counseling Center Functions

University counseling centers have moved away from their early, primary function of only providing mental health care for students to one that now also provides educational programming to and consultation with the larger campus community, conducts preventive and remedial interventions, and does so in ways that adhere to innovative counseling, consultation, and educative practices. Over thirty years ago, Morrill, Oetting, and Hurst developed the cube model to describe the varying dimensions of counselor functioning within the UCC setting. This cube included the *targets* of interventions (individual, primary group, associational group, and institution or community), the *purpose* of interventions (remediation, prevention, or development), and the *method* of intervention (direct services, consultation and training, and media).

More than 20 years later, Pace, Stamler, Yarris, and June further developed the cube model to one that was “rounded out” to describe the evolution of UCC functioning that better addressed the interdependent university community. This newer model addressed the demands on UCCs to interact with various university and community agencies in more complex ways managing student development and counseling needs. Rather than viewing UCCs as an independent entity within the university and one that considered the targets, purpose, and methods of intervention as independent from one another, the rounded out model embraces the interdependence, collaboration, and flexibility necessary to improve the developmental and clinical needs of the student population.

University counseling centers today have evolved into multifaceted agencies that are well integrated into

the larger university system and provide a variety of functions. Stone and Archer randomly surveyed UCC directors and training directors and, from their findings, developed six different counseling center functions: clinical services, outreach and consultation services, training, staff development, research, and administration. While not all UCCs address these functions (e.g., not all UCCs offer training to graduate students in counseling and clinical psychology and social work), most UCCs’ functioning includes many of these areas. As a follow-up to these findings, Guinness and Ness surveyed UCC directors to assess whether there had been, in recent years, significant changes in these areas that were central to UCC functioning. They determined that more than half of the directors surveyed indicated positive changes in all six areas, suggesting that these functions remain essential to UCCs and that ongoing assessment can help identify areas of improvement.

### Clinical Services

Research suggests that UCC psychologists believe that students’ presenting problems in counseling are more severe than in previous years, leading one author to suggest that UCCs are looking more like community clinics. These problems include drug and alcohol abuse, eating disorders, sexual violence and other trauma-related concerns, self-mutilation, severe mood disorders, and suicide. There are varying reasons as to why students may be presenting with more pathology than in past years.

Levine and Cureton suggest that in today’s college culture, students are less prepared academically, and they seek ways to escape from their overwhelming distress about their current concerns and uncertain future. Avoiding distress may contribute to depressive and anxiety disorders, and some escape activities (e.g., alcohol abuse) are detrimental to positive mental health. Kadison and DiGeronimo, in addressing this idea of students’ increasingly experiencing feeling overwhelmed by life, also note that some psychological concerns are likely to first manifest during young adulthood (such as bipolar disorders and eating disorders). Third, new and available psychotropic medications enable students who might not have previously been able to attend college to do so today. Fourth, college students today report valuing counseling and agree that they would seek counseling if the need were to arise. They also expect that counseling should be available at universities. Finally, the popular media



have noted the rise of “helicopter parents,” or parents that pay extremely close attention to their child attending college. Such parents may be more able than parents in the past to pick up on emotional difficulties of their college student children and are likely to refer them to counseling.

At the same time that UCCs are asked to address the increased severity of students’ mental health concerns, because of financial limitations, UCCs are not increasing the number of staff to provide counseling for students. Additionally, due to dwindling resources, UCCs have increasingly instituted session limits on counseling. The challenge becomes how to address college students’ clinical severity within a brief psychotherapy model and with fewer staff than in the past. One suggestion is that UCC psychologists use empirical research and standard of care treatment options to inform them on how to best provide counseling to students with various, complex presenting difficulties in a session-limited counseling model. Another suggestion is to use outreach and consultation efforts as a primary prevention targeted to all students and asking those in close contact with students (e.g., residence hall personnel) to help identify those who are in distress. Doing so may lead these students to start counseling before they are in crisis, thus decreasing the need for numbers of counseling sessions that may be greater than overall session limits. An additional option is to employ more testing and assessments with complex cases to better diagnose and provide treatment recommendations in a timely manner. A final suggestion is for UCCs to annually assess the chronicity and severity of students’ presenting difficulties to alert university and college administration about the need for additional resources.

### ***Outreach and Consultation***

Outreach, consultation, and other related services have become an increasingly important component of university counseling centers. Stone and Archer defined *outreach* as an “organized program, workshop, media effort, class, or systemic attempt to provide psychological education” and *consultation* as an “activity where a staff member provides advice and assistance based on psychological principles to a clearly understood client (group, office, department, club, and others)” (p. 557).

Providing outreach and consultation allows UCCs to diversify their methods of service delivery, meet the

needs of the ever-changing college student population, and provide educative and supportive efforts to students and university personnel outside of the counseling office.

### **Outreach**

Organized programming and workshops can serve the needs of students who traditionally do not access counseling services, such as men and students of color. Such programming may demystify and destigmatize counseling, educate university personnel or friends of students about how to encourage those in need to seek counseling services, and inform students about ways to prevent problems during particularly stressful times (e.g., avoiding alcohol abuse during the first week living in the residence halls). Outreach efforts may also encourage students to seek counseling when they struggle with a concern but, because of varying stages of readiness to change, may not otherwise do so.

Outreach programming may include addressing less serious concerns, such as decreasing test anxiety, reducing general stress, improving time management, and dealing with long-distance relationships as well as addressing more serious concerns such as sexual assault prevention, drug and alcohol abuse prevention, body image concerns, identifying the warning signs of depression and suicide, and dealing with hate crimes on campus. Innovative methods might include using peer presenters when appropriate, online workshops, and focus groups and post presentation surveys to help improve future attendance and delivery methods.

One particularly useful way to identify the outreach presentations often used at UCCs as well as assistance in developing new programs is to visit Workshop Central at the online Counseling Center Village at the University of Buffalo. Outreach outlines and handouts, workshop design strategies, and program evaluation paperwork that have been used successfully at other universities and colleges are readily available on this site.

### **Consultation**

The most effective consultation methods involve multifaceted services that focus on student advocacy and support as well as faculty and staff training. Quite often, distressed students come initially to the attention of faculty members, other university personnel, friends, or parents who do not know how to approach students



about their concerns or where to refer them for help. Additionally, issues may arise with students that are not necessarily directly counseling related but may be distressful within a campus community. As examples, this may include how to deal with offensive student remarks directed at international students in a classroom or how to address a Greek residence when a fraternity member has been called to military service and whose fraternity brothers have differing views on war.

A variety of consultation models exist to help UCC psychologists provide advice and assistance to a client, whether the client is a faculty member in a classroom or a Greek advisor living in a fraternity house. As an example, in process consultation, a UCC psychologist acts as a facilitator who targets the interactions of group members, helps develop goals, helps the group come up with viable solutions to reach these goals, and assists the group in making the changes necessary to reach their goals. Process consultation has been further developed to address the unique needs within the university setting and help UCC psychologists more effectively provide assistance to campus departments, agencies, and groups.

### ***Graduate Training***

Training models for graduate counseling psychology programs started in the late 1940s, and, in 1979, the American Psychological Association (APA) developed accreditation standards that required a predoctoral internship to obtain a doctoral degree in psychology. The Association of Counseling Center Training Agencies (ACCTA) was founded in 1978 to represent the interests of UCC training sites at national and state levels, provide liaisons with other groups involved in the training and credentialing of counseling psychologists, and serve as a forum for issues related to training predoctoral interns and practicum counselors. Currently, 150 UCC training directors are members of ACCTA.

In 2007, 3,430 doctoral students sought predoctoral internships at 640 sites and competed for 2,884 positions accredited by the Association of Psychology Postdoctoral and Internship Centers. Many of those who obtained an internship will be doing so at a UCC. University counseling centers provide more counseling and clinical predoctoral internship positions than other training sites. In addition to providing predoctoral internship training, UCCs also provide practicum training for doctoral students. Given the

increased competitiveness of internship applicants (in 2007, 842 doctoral students were not matched at internship sites) and to strengthen their chances of obtaining an internship, students are completing more practicum hours than in past years. Unfortunately, despite the amount of predoctoral interns and practicum counselors who receive their training at UCCs, there are some concerns that academic training programs may not adequately prepare students to provide a wide range of services necessary to work in a university setting.

University counseling center psychologists need to be trained to work with developmental issues unique to college students as well to diagnose and treat more serious concerns. Ethical standards within counseling and clinical psychology are moving toward the adoption of uniform standards of care within the field, and UCC psychologists are increasingly expected to use the standards competently. Counseling session limits are commonplace in UCCs, and graduate programs need to train students to work within briefer therapy models. Additionally, UCC psychologists need to be well versed in assessing risk management, providing crisis intervention and group work, and addressing public health issues relevant to a college population. Training should also include competence in clinical and learning disability testing as well as drug and alcohol abuse assessment and treatment. Finally, additional competencies necessary for training include program development, outreach programming, consultation, career development, and clinical supervision and training.

All of these specialized clinical and other mental health services need to be conducted in a multiculturally competent manner. Graduate programs must provide training for future psychologists to work with multicultural and diverse communities. As the United States is becoming an increasingly diverse and multicultural society, so are student populations. As a result, multiculturally attuned UCCs are imperative in order to work effectively with the ever-changing university community. Necessary multicultural competencies for a graduate student to work in UCCs include a counselor's awareness of her or his own assumptions, values, and biases; understanding of the worldview of culturally different clients; and the development of appropriate intervention strategies and techniques that take into account the clients' beliefs, attitudes, knowledge, and skills.

In response to the call for graduate training in diversity and multiculturalism, in 2000, the APA adopted



the *Guidelines for Psychotherapy With Lesbian, Gay, and Bisexual Clients*; in 2002, the APA adopted the *Guidelines on Multicultural Education, Training, Research, Practice, and Organizational Change for Psychologists*; and in 2007, the APA council approved the *Guidelines for Psychological Practice With Women and Girls*. These policies serve as aspirational documents for psychologists to integrate and infuse multicultural and sexual diversity issues and issues pertinent to the treatment of women and girls in all aspects of the practice of psychology. The adaptation of these policies in the UCC setting is a step in addressing the specific needs of increasingly multicultural and diverse student populations.

### **Staff Development**

In order to address changes in student populations and presenting difficulties of students who seek counseling, it is important for UCC psychologists to keep up with changes in the field of professional psychology. University counseling centers must assess the demands unique to their student populations as well as changes in the broader field and modify their practices to meet these new demands. UCCs need to actively pursue well-planned programs for staff development. This may include continual improvement in clinical assessment skills, risk management and crisis interventions, and brief and solution-focused psychotherapies. In the past, UCCs have often hired psychologists who are generalists and can work with a variety of client difficulties. In response to the increased chronicity and severity of student presenting concerns and the need to respond more effectively to populations that may be underrepresented (e.g., students of color), UCCs may want to encourage staff members to seek specialization in certain clinical areas or with particular populations. Finally, it is critical that all UCC psychologists continually develop their diversity and multicultural competencies.

Additional to addressing the need for ongoing staff development to improve clinical services, UCC psychologists also need to attend to their own career satisfaction. University counseling centers are a popular career choice for new doctorates in professional psychology, and most new psychologists are satisfied with most aspects of their first professional positions. Despite this overall initial satisfaction, Parham noted three central career issues for UCC psychologists 7 to 10 years into their careers, which may provide reasons for

psychologists to search elsewhere for professional positions. These include professional burnout, difficulty with finding time for personal and other professional activities, and a shift in age relative to the student population. There are a number of ways UCC administrations can address these career concerns. Developing and maintaining a supportive and positive UCC culture that provides ongoing encouragement for staff career and professional development and opportunities for leadership and administrative skill development, encouraging staff to develop programs in their areas of interest and to participate in professional organizations and research, and keeping staff involved in the planning and operation of the UCC and to confront job satisfaction issues (such as burnout) from a developmental perspective are ways to help staff improve career fulfillment.

### **Research**

The International Association of Counseling Services (IACS) identified conducting research as a core role and function of UCCs. According to the IACS standards, research efforts include the evaluation of clinical services, program assessment, and scholarly study. Even though IACS notes the importance of conducting ongoing research, especially to determine the effectiveness and improve the quality of services, most UCCs do not do so in any systemic manner. One reason for the lack of research activity includes a lack of time and resources. UCCs' missions are likely to focus more on clinical and ancillary service delivery than on conducting research. With dwindling resources to hire more psychologists to address increasing clinical need, research often falls as a distant priority to providing counseling and outreach services.

Another reason may be a move from some psychologists viewing themselves as scientist-practitioners to identifying as practitioner-scholars. That is, with more programs increasingly emphasizing the practice of counseling over developing research skills, psychologists who choose to work at UCCs may be less likely to value conducting research.

A final reason for the lack of research involvement is that UCC psychologists may believe that research only entails conducting carefully controlled experimental studies that are published in scholarly, peer-reviewed journals. To counter this belief, Boyd, Roberts, and Cook proposed a UCC research program: conducting research to identify demands for services, understand and assess changes in student



characteristics, recognize counseling effective outcomes, and provide a data resource for the campus housed within the UCC.

### Administration

UCCs may be organized in one of six ways: as a center that provides educational services; a counseling center for students and employees; a health-services counseling center; a privately contracted counseling service; a center that provides consultation for organizational and community development; and a center that provides comprehensive counseling services and community development. The way in which a UCC is organized is usually based upon the size, location, funding pattern, or philosophy of the university or college. While one organizational model is not inherently better than another, some have suggested that for the survival of UCCs, it is imperative to align UCC goals with those of the larger institution.

To this end, it may be that the preferred UCC model is one that provides multiculturally sensitive, comprehensive counseling services and community development. This type of UCC is one that offers the following: comprehensive counseling services (individual, couples, career, and group counseling); specialized counseling for more serious problems (e.g., eating disorders, alcohol and drug abuse, sexual violence); crisis services (including after-hours care); outreach and consultation services for student groups, staff, and faculty; training and supervision of graduate practicum counselors and predoctoral interns; research that involves service accountability; psychiatric care; and community development work that involves and includes many different university departments and services and local community agencies.

### Future Directions

Counseling for university and college students has changed and evolved over the course of 80 years. The current mission of university counseling centers is to be full-service agencies that provide counseling for individuals, couples, and groups with developmentally related concerns as well as more complex and serious problems. Additionally, they provide outreach and consultation services, provide graduate training and supervision for counseling and clinical doctoral students and interns, attend to staff development within their agencies, conduct research and program evaluation,

and help to develop administrative models and policies relevant to the field of counseling psychology. Future efforts will continue to focus on ways to provide exceptional counseling services to students in the face of dwindling resources and ways that university counseling center psychologists can conduct research to improve their efficiency while also attending to the demands of counseling and ancillary services.

Cassandra N. Nichols

**See also** Career Counseling in Colleges and Universities (v4); Consultation (v2); Counseling, Definition of (v1); Counseling, History of (v1); Multicultural Counseling Competence (v3); School Counseling (v1); School Psychology (v1); Sexual Violence and Coercion (v1); Substance Abuse and Dependence (v2); Suicide Potential (v2)

### Further Readings

- Erdur-Baker, O., Aberson, C. L., Barrow, J. C., & Draper, M. R. (2006). Nature and severity of college students' psychological concerns: A comparison of clinical and nonclinical national samples. *Professional Psychology: Research and Practice, 37*, 317–323.
- Guiness, J. P., & Ness, M. E. (2000). Counseling centers of the 1990s: Challenges and changes. *The Counseling Psychologist, 28*, 267–280.
- Hodges, S. (2001). University counseling centers at the twenty-first century: Looking forward, looking back. *Journal of College Counseling, 4*, 161–174.
- Kadison, R., & DiGeronimo, T. F. (2004). *College of the overwhelmed: The campus mental health crisis and what to do about it*. San Francisco: Jossey-Bass.
- Morrill, W. H., Oetting, E. R., & Hurst, J. C. (1974). Dimensions of counseling functioning. *Personnel and Guidance Journal, 52*, 354–359.
- Pace, D., Stamler, V. L., Yarris, E., & June, L. (1996). Rounding out the cube: Evolution to a global model for counseling centers. *Journal of Counseling and Development, 74*, 321–325.
- Parham, W. D. (1994). Personal and professional issues for counseling center psychologists: 7–10 years postdoctorate. *Counseling Psychologist, 20*, 32–38.
- Stone, G. L., & Archer, J., Jr. (1990). College and university counseling centers of the 1990s: Challenges and limits. *The Counseling Psychologist, 18*, 539–607.
- Sue, D. W., Arredondo, P., & McDavis, R. (1992). Multicultural counseling competencies and standards: A call to the profession. *Journal of Counseling & Development, 70*, 477–486.



- Uffelman, R. A., & Hardin, S. I. (2002). Session limits at university counseling centers: Effects on help-seeking attitudes. *Journal of Counseling Psychology, 49*, 127–132.
- Wolgast, B. M., Rader, J., Roche, D., Thompson, C. P., von Zuben, F. C., & Golberg, A. (2005). Investigation of clinically significant change by severity level in college counseling center clients. *Journal of College Counseling, 8*, 140–152.

### Web Sites

Workshop Central, Counseling Center Village:  
<http://ccvillage.buffalo.edu>









---

## VASQUEZ, MELBA J. T. (1951– )

---

The professional accomplishments of Melba J. T. Vasquez are innumerable. Clinical practice, leadership, advocacy, education, and research are among the areas in which she has excelled. Vasquez's work has positioned her not only as a pioneer within the field of psychology but also as a true example of determination and perseverance. Having grown up and later come of age around a climate of intense racial and political unrest, Vasquez encountered challenges that later became empowering experiences that influenced and continue to influence her work in many ways.

Vasquez is the first of seven children born to her parents and grew up in San Marcos, a small town in central Texas. In her writings, she has described enjoying considerable attention from her parents and extended family members, feeling safe in her community even though it was socially segregated, and not realizing her family was poor until she reached the age of 6. As she was growing up, Vasquez's parents were very active in their community, participating in political rallies, voter registration projects, and fundraisers for Latina/o students. She noted her mother emphasized the significance of education, justice, and behaving as if they were deserving even if others did not seem to agree with such message.

Vasquez recalls feeling unsafe for the first time when she began elementary school and realized there was not a single teacher or administrator of color. Though she was very young and unable to put words to her experience, Vasquez notes she felt sadness and the loss of positive regard at a personal and group

level due to seeing that children of a similar background were treated negatively. She soon learned that being a good student was the best way to get positive regard and a feeling of safety back.

Throughout her school years, Vasquez encountered difficult experiences such as hearing from her second-grade boyfriend that she could not be his girlfriend due to her ethnicity, finding out that the boys in the homecoming court were not willing to escort her for the same reason, and discovering that fellow high school cheerleaders excluded her from social gatherings.

The meaning of sisterhood began to emerge during Vasquez's elementary school years. The importance of allies became easier to elucidate after an African American young girl defiantly interceded for Vasquez and her sister when they were being bullied by a White boy. In high school, Vasquez was elected to leadership positions by students of various ethnic backgrounds who had formed networks to gain representation. She excelled despite the painful challenges she encountered.

Vasquez received a bachelor's degree in English and political science with a teaching certification from Southwest Texas State University. While in college, she encountered other salient life experiences. For example, she realized that individuals of White ethnic background can also be allies and found a mentor in Colleen Conoley, a woman who encouraged her to pursue a doctorate in counseling psychology.

In college, Vasquez represented one of her student organizations in a beauty pageant. She was chosen as a semifinalist and later evoked the astonishment of friends and advisors when she declined to participate in another beauty contest. She could not yet articulate her



disapproval of patriarchy's objectification of women, but this experience awakened the feminist in her.

Vasquez notes that Conoley suggested a doctoral degree in counseling psychology would provide more extensive options for her. At that point in time, Vasquez had been teaching for about a year and was engaged in part-time graduate work toward a master's degree in school counseling. Though not fully grasping what those options would entail, Vasquez was intrigued by the study of human behavior and was interested in achievement, as she suspected racism, sexism, and lack of opportunity were intricately related. Motivated by the desire to dissipate some of her confusion via the acquisition and later the creation of knowledge, Vasquez embarked on a path toward doctoral education at the University of Texas (UT) at Austin. She completed her doctoral degree in counseling psychology in 1978. She encountered discouraging situations with some professors, and at times questioned whether she belonged but was determined to prove that she did, in fact, belong. Vasquez received great support and mentorship from other professors, especially those who were part of her committee. In addition, being one of the first recipients of the American Psychological Association's (APA) minority fellowship became an additional incentive to continue her studies.

Vasquez recognizes that affirmative action made it possible for her to be a psychologist and views this initiative as a central strategy to promote social justice. She also poses that affirmative action may have been a contributing factor to her subsequent job attainments at Colorado State University's and UT at Austin's counseling centers, where she served as director of training. Vasquez has been successfully dedicated to full-time independent practice for over 15 years and provides consultation and training for organizations as well as forensic consultation in addition to individual and group therapy. She has published extensively on a wide variety of topics, including psychology of women, feminism, professional ethics, ethnic minority psychology, training and supervision, and multicultural competence.

Vasquez's dynamism and leadership are present across various divisions of the APA. She is a fellow of divisions 1, 17, 35, 42, 45, and 49 and is a member of divisions 9, 31, 44, and 56. She has presided over APA's divisions 17 and 35 and the Texas Psychological Association, she is the treasurer of division 56, and she is the first Latina/o to be a member of APA's Board of Directors in the 117-year history of APA. She has

chaired APA's Board of Professional Affairs, the Board for Professional Advancement, the Ad Hoc Council Committee on the Revision of Standards for Educational and Psychological Testing, the Ad Hoc Committee on Legal and Ethical Issues in the Treatment of Interpersonal Violence, the Task Force on Communication with Minority Constituents, and the Board of Ethnic Minority Affairs. More recently she has been part of APA's Council of Representatives Task Force on the World Conference Against Racism's Report and of APA President Ron Levant's Task Force on Enhancing Diversity.

Vasquez's influence has also been present in conference planning endeavors. She was part of the steering committee for the Competencies Conference 2002: Future Directions in Education and Credentialing in Professional Psychology, which was hosted by the Association of Psychology Postdoctoral and Internship Centers. In 1999, she joined forces with other influential and visionary psychologists to establish and organize the annual National Multicultural Conference and Summit, which highlights research and practice that centers on multicultural psychology.

Additional affiliations include Vasquez's involvement in the foundation of the National Latina/o Psychological Association and in the Texas Psychological Association, an organization which was recently under her direction. She was recently associated with the Southwest Texas Foundation Development Board and with the Austin Women's Psychotherapy Project, of which she is a cofounder.

Through her parents' activism, Vasquez learned that the pain and anger resulting from disenfranchisement were to be directed by way of proactive involvement. This lesson seems to be palpable in her endeavors and her commitment to the advancement of psychology. Her efforts have been celebrated by multiple awards, recently including receiving APA's Award for Distinguished Professional Contributions to Independent or Institutional Practice in the Private Sector, being named Woman of the Year by Division 17's Section for the Advancement of Women, being awarded an honorary doctorate degree by Phillips Graduate Institute, and receiving APA's James M. Jones Lifetime Achievement Award.

Vasquez is a pioneer, an excellent role model who, regardless of her current status as a prominent psychologist, continues to be loyal to her principles and vision of what psychology as a profession should provide for Latinos/as, women, and other marginalized



groups in society. Vasquez also leads by example as she promotes the importance of coalition building and the necessity to build bridges and resolve conflict between communities. Vasquez's indefatigable labor continues via multifarious venues. She is a *mujer* of character and her work as a therapist, researcher, lecturer, advocate, and leader is *sui generis*.

Patricia Celaya

**See also** Counseling Psychology, History of (v1); Community-Based Action Research (v1); Cross-Cultural Training (v3); Feminization of Psychology (v1); Latinos (v3); Multicultural Counseling Competence (v3); Professional Associations, Counseling (v1); Racism (v3); Sexism (v3); Social Justice (v3)

### Further Readings

- Pope, K., & Vasquez, M. J. T. (2007) *Ethics in psychotherapy & counseling: A practical guide* (3rd ed.). San Francisco: Jossey-Bass.
- Vasquez, M. J. T. (2001). Leveling the playing field: Toward the emancipation of women. *Psychology of Women Quarterly*, 25, 89–97.
- Vasquez, M. J. T. (2001). Reflections on unearned advantages, unearned disadvantages, and empowering experiences. In J. G. Ponterotto, J. M. Casas, L. A. Suzuki, & C. M. Alexander (Eds.), *Handbook of multicultural counseling* (2nd ed., pp. 64–77). Thousand Oaks, CA: Sage.
- Vasquez, M. J. T. (2005). Independent practice settings and the multicultural guidelines. In M. G. Constantine & D. W. Sue (Eds.), *Strategies for building multicultural competence in mental health and educational settings* (pp. 91–108). Washington, DC: American Psychological Association.
- Vasquez, M. J. T., & Jones, J. M. (2006). Increasing the number of psychologists of color: Public policy issues for affirmative diversity. *American Psychologist*, 61, 132–143.

perspectives, and these are the moral principles that are commonly accepted. So, for example, many ethical codes rest on the following principles: respect for autonomy (agreeing that another person has the right to think and choose as he or she wishes), nonmaleficence (not harming another person), beneficence (taking positive actions toward another person), justice (equality in the distribution of benefits and tasks), fidelity (meeting one's responsibilities in a relationship based on trust and commitment), and veracity (truthfulness and integrity). The difficulty with any set of ethics based on principles is that principles can "collide" in an ethical dilemma. So, for example, in informing another person that one's client wishes to do harm to that person, a therapist is elevating the principle of nonmaleficence over that of autonomy.

Virtue ethics is a contrasting perspective on ethics. Virtue ethics, expanded in large part by Naomi Meara, is the belief that a person's motivation, character, morality, and ideals are more likely to lead to ethical actions, or the lack thereof, than principles or regulations. Virtue ethics calls individuals to aspire to personal standards of ethics and morality that rise above those of *de minimis* actions and represent aspirations or ideals that are striven for. People who are "virtuous" in this sense of the word share common characteristics, according to Meara, Lyle Schmidt, and Jeanne Day. They are "motivated to do what is good, possess vision and discernment, realize the role of affect or emotion in assessing or judging proper conduct, have a high degree of self-understanding, and are connected with and understand the importance of community in moral development and decision making" (pp. 28–29).

One difficulty with this approach is that there is a range of virtues, just as there is a range of principles and of ethical standards. How is a psychologist or counselor to choose from among them? Virtues have differed dramatically over the course of history and from culture to culture. Are there virtues that can be considered as common among humans, let alone psychologists? While there is room for discussion, Meara, Schmidt, and Day selected four virtues as possible common virtues, two of which have to do with how people conduct themselves and two of which pertain to how people interact with others.

The first self-pertaining virtue is *prudence*. Prudence is defined as the combination of abilities that allows one to make plans, to exercise good judgment, to work hard and with foresight, and to prioritize

---

## VIRTUE ETHICS

---

Ethics can be considered in a variety of ways: as a set of ethical codes, as a decision-making model, or as a set of principles. For example, other entries in this volume discuss ethics from all of these perspectives. There is typically a set of common principles that underlie these



long-term outcomes over short-term gains. For a counselor or psychologist to behave in an ethical manner, even within codes, standards, or principles, actually requires the virtue of prudence, because ethical dilemmas require prudence for their resolution.

The second virtue regarding the self is *integrity*. The value of integrity is contained in the ethical codes and standards of any profession, as the value means to perform actions for the right reasons and to avoid actions that are wrong or are performed for wrong reasons. People who have integrity make decisions over a period of time that reflect an integration of a coherent set of moral values and actions.

*Respect* is the third virtue and the first of two that focus on others. When a person respects another person, the first person gives the second person regard, attention, consideration, and worth. Respect denotes an appreciation for the intrinsic value of the other person regardless of his or her outward signs of value.

The last virtue is *benevolence*. Benevolence is defined as wanting to do good, to contribute to the well-being of persons and communities, to enhance the welfare of others, and to have social responsibility. Benevolence exists in most ethical codes and principles as well as decision-making models as a prime requirement. For a counselor or psychologist to be oriented toward the client requires benevolence.

Virtue ethics is a significant contribution to discussions on ethics, because it allows a consideration of the role of culture in defining ethical virtues, and it creates a climate in which the interaction of the individual within the community is considered in resolving ethical dilemmas.

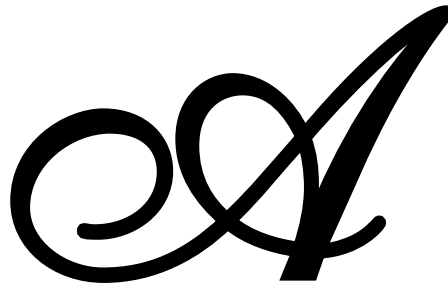
*Elizabeth M. Altmaier*

*See also* Ethical Codes (v1); Ethical Decision Making (v1); Ethical Dilemmas (v1); Ethics in Research (v1)

### Further Readings

- Jordan, A. E., & Meara, N. M. (1990). Ethics and the professional practice of psychologists: The role of virtues and principles. *Professional Psychology: Research and Practice, 21*, 107–114.
- Meara, N. M., Schmidt, L. D., & Day, J. D. (1996). Principles and virtues: A foundation for ethical decisions, policies, and character. *The Counseling Psychologist, 24*, 4–77.
- Punzo, V. A., & Meara, N. M. (1993). The virtues of a psychology of personal morality. *Journal of Theoretical and Philosophical Psychology, 13*, 25–39.
- Vasquez, M. J. T. (1996). Will virtue ethics improve ethical conduct in multicultural settings and interactions? *The Counseling Psychologist, 24*, 98–104.





---

## ABUSE

---

Abuse refers to physical, sexual, or emotional harm to a person perpetrated by a relative, caregiver, or spouse, or others in a social relationship with the abused person. Common forms of abuse include intimate partner abuse, partner or marital rape, and elder abuse. All of these forms of abuse are typically contained within the broad term *domestic violence*.

In many cases, survivors of sexual abuse, physical abuse, intimate partner violence (IPV), or elder abuse may be referred to counseling and therapy by law enforcement or other professionals, such as medical doctors and nurses, social workers, police officers, and the court. Counselors should be aware that a client may live in the same household with the abuser at the time of referral; therefore, the client may be afraid or ashamed to disclose the abuse because of economic dependency or fear of further physical or psychological harm from the abuser. It is important for therapists working with abused clients to first ensure their physical safety. It is critical to acknowledge that the cause of the abuse resides in the person who abuses rather than in the survivor. Therapists may effectively use techniques from many therapeutic orientations when working with abused clients, as long as they possess sufficient knowledge of the nature of the abuse, consequences of abuse, available services and resources for treatment, and legal issues.

### Intimate Partner Abuse

Intimate partner abuse is interpersonal violence that occurs between current and former marital partners,

cohabiting partners, separated marital partners, or same-sex partners. Several terms are used to describe violence or abuse between intimate partners. These include *marital abuse*, *spouse abuse*, and *domestic violence*. However, the terms *intimate partner abuse* and *intimate partner violence* are more commonly used today. Intimate partner violence occurs among heterosexual and same-sex partners as well as across different racial and ethnic groups. It is estimated that IPV occurs in 10% to 20% of intimate couples in the United States. Some research suggests that the prevalence rate may be higher among some marginalized groups, including couples that cohabit without marriage, rural populations, disabled individuals, and recent immigrants.

Violence against intimate partners includes physical violence, sexual violence, threats of violence, stalking, and psychological abuse. Each act can be placed on a continuum ranging from mild verbal abuse to severe physical violence and even partner homicide. Men and women are equally likely to be initiators of IPV; however, women are more often survivors of severe violence resulting in injury and death.

In addition to physical injury, negative consequences of IPV include psychological stress and financial costs in lost wages and medical fees for treatment. Survivors of IPV often experience strong psychological stress such as helplessness, fear, anger, and anxiety. Some survivors may develop nightmares, intrusive thoughts, intense anxiety, and fears associated with violence. These are common symptoms of posttraumatic stress disorder. Survivors of repeated violence may develop learned helplessness, a psychological condition in which survivors no longer attempt to escape from a painful situation because of previous failed



attempts. These strong emotional stressors may further impair survivors' cognitive and coping skills and even diminish survivors' abilities to leave abusers.

IPV increases the cost of mental and medical health care and shelter services. Violence occurring between intimate partners is the number one cause of injury for women in the United States. Those injured in severe physical or sexual violence often need immediate medical attention. Multiple medical care visits may occur as a result of each violent incidence. Furthermore, female survivors of intimate partner violence suffer more reproductive health problems, sexually transmitted diseases, and unwanted pregnancies than other females. For some survivors, psychological stress due to living in a violent home environment can develop into physical illnesses such as headaches and back pain. In addition to medical costs, intimate partner violence also increases the need for mental health services. Nearly one third of female intimate partner survivors report using mental health counseling, often with multiple visits. For physically injured survivors, violence may mean a loss of productivity from both paid work and household chores. In some cases, survivors may lose their employment or become homeless due to the victimization or attempts of escape from abusers. In fact, family violence is one of the major causes of female homelessness in the United States, and shelter services are required as a result.

### ***Explanations for Intimate Partner Violence***

Risk factors are factors that have been shown to increase the likelihood of involvement in IPV victimization or perpetration. A combination of individual, relational, cultural, and social factors contribute to the risk of involvement in IPV. Identifying risk factors can be useful in prevention and intervention. However, it is important to remember that risk factors are not causes of violence and they do not predict who will become involved in IPV.

IPV occurs in every racial and socioeconomic group, although it is more prevalent among families with low socioeconomic status. In addition, younger partners (age 16 to 24) appear to be the most violent. Exposure to parental violence and childhood abuse increases the likelihood of becoming a perpetrator and a survivor of intimate partner violence. Children who are exposed to parental violence may learn to use violent acts as a means of conflict resolution with intimate partners.

Drug and alcohol abuse are frequently associated with IPV. Men with alcohol problems are more likely to perpetrate intimate partner abuse than those who do not abuse alcohol or other substances. However, not all perpetrators have histories of alcohol or drug problems. Therefore, some research suggests that the relationship between alcohol consumption and partner abuse may be accounted for by antisocial personality traits rather than drinking behavior alone. In fact, a significant proportion of IPV perpetrators report more depression, lower self-esteem, and more aggression than do nonviolent intimate partners. Evidence indicates that violent intimate partners may be more likely than others to have personality disorders or attachment problems.

Cultural acceptance of violence has been associated with IPV, especially patriarchal attitudes that assume men's power over women and their right to control their female partners. Higher IPV rates occur among women who have little work experience and are dependent on their male partners for financial resources. However, the cultural value of patriarchy is not the sole cause of IPV.

### ***Reasons for Leaving or Remaining in an Abusive Relationship***

Even though "just leaving" seems a simple solution for terminating an abusive relationship, the decision survivors make to leave or remain in an abusive relationship is complex. Some internal barriers and external considerations may slow the process. In fact, it often takes several attempts before survivors permanently terminate their abusive relationships. Even though most women eventually terminate abusive relationships, research has found it is a difficult, stressful, and often dangerous process. In addition, counselors should not assume that leaving is the preferred intervention; for many survivors, this is not a desirable option, and their therapists should work from a harm reduction model.

Internal factors, such as low self-esteem and self-blame, denial of the abusive nature of the relationship, and emotional dependence may play a significant role in abused partners remaining in an abusive relationship. Many IPV survivors want to remain in the relationship, but have the battering stop. Research suggests that changes in beliefs regarding the likelihood of this wish are needed in order for IPV survivors to leave an abusive relationship. Survivors may experience events that act as a catalyst, leading them



to the realization that the relationship will not improve. Following this realization, survivors may give up the dream of an idealized committed relationship and search for ways to safely leave the abuser.

In many cases, violent relationships are maintained through power and control. The abused partner may depend on the abuser for basic economic needs. Some IPV survivors remain in the abusive relationship simply because they have nowhere to go. They may not have economic resources, social support, or shelter information. Furthermore, leaving an abusive partner can be a dangerous process. When survivors try to leave their violent partners, perpetrators frequently threaten to harm the survivor or survivor's children and family. Since laws often fail to protect survivors attempting to leave an abusive relationship, many survivors experience an increase in victimization when they attempt to leave. Therefore, it is important for counselors not to guarantee the safety of a client who is leaving a relationship; rather, they should assist in helping the client establish as many safeguards as possible during the transition.

Male IPV survivors may have additional barriers because traditional male gender roles emphasizing strength and independence may hinder them from reporting violent acts and seeking help. In addition, there are indeed fewer shelter resources and treatment groups available for male survivors of interpersonal violence. Similarly, sexual minorities may find a lack of services for treatment, given that many interventions and shelters were created from a male heterosexual perpetrator model.

### ***Counseling Concerns***

The primary counseling concern for survivors of IPV is their physical safety. Safety plans are strategies counselors can use to help survivors develop means of protecting themselves and their children during an abusive incident or when preparing to leave an abusive relationship.

A safety plan for survivors to use during an abusive incident includes staying out of rooms with no exit and staying away from rooms in which potential weapons may be accessible, such as the kitchen. Survivors can invent code words that alert friends, children, neighbors, or family to call the police. A safety plan for survivors preparing to leave an abusive relationship involves such strategies as the client's opening a checking account in her or his own name and involving

people or agencies that may be helpful. Survivors should prepare an extra set of keys and a bag packed with necessities, and should have important documents stored in an undisclosed location such as a friend's home. Because many IPV survivors have limited financial resources, it is important to help them achieve economic independence by means such as obtaining temporary welfare benefits and improving their job-finding skills. Shelter treatments provide survivors with a temporary separation from abusers and assist them in developing safe leaving plans. Survivors may receive help from domestic violence programs or shelter workers to obtain restraining orders or other legal procedures and counseling and educational services. It is important to help clients establish a record of physical abuse by their partners, such as filing restraining orders, phoning 911 when incidents occur, and keeping photographs and other evidence (e.g., threatening or controlling letters).

If the abuser has left the shared residence, safety plans include changing locks on doors and windows, changing telephone numbers, screening calls and blocking caller ID, obtaining an order of protection, and inserting a peephole in the door. In addition, it is important to make sure that schools and day care centers know who is allowed to pick up the children. In terms of safety on the job and in public, survivors should be advised to keep orders of protection with them at all times. They should call police immediately if the abuser violates the order of protection. It is desirable to change regular travel routes and try to get rides with different people. Clients should let supervisors, human resource personnel, and/or security guards know about the situation and how to respond should the abuser show up at the workplace.

IPV survivors may recover from victimization through empowerment. Some IPV survivors may not be able to distinguish the differences between normal and abusive relationships; they may perceive their abusive situations as normative. Counselors help survivors realize that they are not the cause of the violence or the ones responsible for stopping the abuse. It is also essential for counselors to help survivors identify their strengths and help them develop coping skills so that survivors become more assertive and make self-directed decisions. In addition to individual therapy, survivors can be empowered by learning and supporting one another in a group setting. Group members may gain the awareness that their situation is not unique and they are not alone; they may be



inspired by senior members who have made substantial progress; they may benefit by the chance to help and support other group members; and they may learn interpersonal and social skills during the course of therapy. Another important counseling concern is to help IPV survivors establish support systems. Social support networks are one of the most essential elements in helping survivors leave their abusive relationships. Survivors with diminished or nonexistent support networks are more likely to return to their abusers. Counseling should help survivors establish support systems from family members, friends, and religious groups.

Counselors need to possess knowledge about community resources, including social, psychological, healthcare, legal, and political services. The healthcare community should regularly screen clients for IPV. Once IPV survivors have been identified, they should be provided information and referred to appropriate agencies. If IPV survivors have drug or alcohol abuse problems, therapy addressing substance abuse should be considered. If survivors have prior victimizations, such as childhood sexual or physical abuse, therapists may help survivors process their early abuse experiences in relationship to their current abusive relationship.

Counselors need to possess additional knowledge when working with survivors with diverse backgrounds. For example, physically disabled survivors may need transportation assistance in order to access community services or go to court buildings. Lesbian IPV survivors may have limited support from family and peers who may not want to shed negative light on the lesbian community. Immigrant women may have difficulty understanding English and need interpreters.

### **Sexual Assault and Intimate Partner Rape**

Sexual assault is any type of sexual act that is not consensual. These acts can be physical, verbal, or psychological and include inappropriate touching, attempted rape, and rape (e.g., vaginal, anal, or oral penetration). Often, sexual assaults are perpetrated by someone the survivor knows, such as a spouse, family member, date, coworker, friend, or acquaintance. If sexual violence occurs between intimate partners, it is often referred to as a form of intimate partner violence. Individuals may be forced into unwanted sexual activities because of threats or intimidation from the perpetrator, or they may be under the influence of

drugs or alcohol and unable to give consent. Some individuals are unable to give consent because of age, physical disability, or mental illness. Although anyone can be a potential victim of sexual assault, females are the most common victims of sexual violence. Young women, women with physical and mental disabilities, and women living with limited economic resources are at higher risk.

Sexual assaults by intimate partners are often more violent, cause more injuries, and have a longer-lasting negative impact on survivors than sexual assaults by acquaintances. Aftermath effects may include emotional shock, panic, guilt, anger, denial, and/or feelings of powerlessness. Some survivors of sexual assault experience intense fear and nightmares associated with their victimization. Other short-term and long-term effects of sexual violence include gynecological problems, gastrointestinal disorders, substance abuse, somatic conditions, depression, eating disorders, high-risk behaviors, and suicidal thoughts and attempts.

### **Counseling Concerns**

Psychological first aid immediately after a sexual assault is essential to help survivors recover from the victimization. Counselors need to be sensitive and provide support to survivors. Survivors of sexual assault should be advised to receive medical attention and report the assault. Preventive treatment for sexually transmitted diseases and administration of emergency contraception may be considered. Hospital emergency rooms have standard procedures for assisting survivors of sexual assault, such as collecting medical evidence or DNA samples for criminal prosecution. Additional information about legal services should be offered.

Counselors should make clear to sexual assault survivors that they are not to blame for the incident, even if they were attacked by an acquaintance, date, friend, or spouse; had sexual relations with the person before; were under the influence of alcohol or drugs; or were wearing clothes that society may consider seductive. No matter what the previous situations or circumstances were, they were assaulted if they were unable to say “no” or to physically fight back.

Counseling can help survivors understand the course of recovery from sexual assault, help them process and express their feelings, and encourage them to seek support from friends and family who can validate their feelings and affirm their strengths. Survivors can benefit from techniques that help them



reduce anxiety, such as relaxation exercises, walking, yoga, music, reading, and hot baths. Journaling may also be a means for survivors to release feelings. Group therapy may provide an opportunity for survivors of sexual assault to normalize their feelings of guilt and shame and support one another.

Male survivors of sexual assault may experience additional emotional stress, as there are myths that only women are sexually assaulted, only gay men are assaulted, and men cannot be assaulted by women. These myths can further increase the emotional pain and shame that male sexual assault survivors may experience and increase their feelings of isolation. For these reasons, male survivors are less likely to seek help and report their crimes. Heterosexual, gay, and bisexual men are all potential victims of sexual assault. Being a victim is a difficult concept for most men to accept. Therefore, male survivors may define their assault as a loss of masculinity and blame themselves. In response to feelings of guilt, shame, and anger, some male survivors may engage in self-destructive behavior such as exhibiting more aggression, increasing drug and alcohol use, or withdrawing from social relationships. Some male survivors experience sexual difficulties after being assaulted, because negative feelings associated with sexual assault may be triggered by intimate sexual contact. They may have difficulty resuming sexual relationships or starting new ones after the assault.

For both heterosexual and gay men, sexual assault can lead to questions about their sexuality. Heterosexual men may feel confused about their sexual orientation after a male-perpetrated assault if they believe that only gay men will be sexually assaulted. Therefore, clients should be made aware that sexual orientation is unrelated to the experience of being sexually assaulted. For gay men, sexual assault may lead to feelings of self-blame attached to their sexuality. Some gay men with internalized homophobia may believe that somehow they deserved the assault. It is important to reassure survivors that sexual assault is an act of violence, power, and control and that no one engages in any behavior to provoke it. Gay men may also be less likely to report the assault due to fears of blame by police or medical personnel, resulting in insufficient treatment for the incident.

## Elder Abuse

Elder abuse refers to intentional or unintentional acts by caregivers or other persons that cause harm or a

serious risk of harm to a vulnerable adult. This abuse can happen to men and women, people of all ethnic backgrounds and social status, and gay, lesbian, bisexual, and transgender elders. The 1987 Amendments to the Older Americans Act was the first time the federal government defined elder abuse, neglect, and exploitation. These definitions, however, served only as guidelines for identifying elder abuse. Currently, elder abuse is defined by state laws, and these definitions vary by state in terms of what constitutes elder abuse. The broad definition of elder abuse includes physical abuse, emotional or psychological abuse, sexual abuse, financial or material exploitation, neglect, self-neglect, and abandonment.

*Physical abuse* consists of using enough force to cause unnecessary pain or injury to an elderly person. Physical abuse can range from slapping, shoving, and restraining to severe beatings. *Emotional* or *psychological abuse* occurs when a family member or a caregiver acts in a way that causes an elder person emotional distress or fear. The abuse can range from verbal assaults and threats of physical harm to isolating elders from other family members or regular social activities. *Material* or *financial exploitation* includes the misuse or exploitation of older adults' material or monetary assets. *Sexual abuse* consists of any sexual activity for which an elder does not consent or is incapable of giving consent. The sexual activity can range from exhibitionism to fondling to oral, anal, or vaginal intercourse. *Self-neglect* is when elder persons fail to meet their own physical, psychological, and social needs due to illness, dementia, substance abuse, depression, and/or poverty.

Elder abuse falls into three basic categories: domestic, institutional, and self-neglect or self-abuse. *Domestic abuse* constitutes maltreatment by caregivers in the elder's or caregiver's home. *Institutional abuse* occurs in elderly care facilities, such as nursing homes, group homes, and board and care facilities. Sometimes elders neglect their own care, which can lead to illness or injury. *Self-neglect* can include behaviors such as not eating or drinking, leading to dehydration; poor hygiene; and failure to take medications. For some elders, the problem is coupled with Alzheimer's disease or dementia, isolation, depression, and declining health. It is debated whether self-neglect is abuse, because the elder person chooses to neglect his or her own needs. Therefore, there is controversy over whether involuntary intervention should be implemented for elder people who engage in self-neglect.



Elder abuse is a complex issue. There is no single explanation for elder abuse, and many factors may contribute to its occurrence. The unique ways in which these factors interact with each other depends on the home environment of the perpetrator and victim of elder abuse. These factors may include family characteristics, caregiver issues, and the levels of dependency and impairment of the elderly people involved.

Elder abuse may be an extension of the family's violent interaction behavior. Intergenerational violence may perpetuate elder abuse. Family stress and caregiver stress are often associated with elder abuse. Caring for a mentally-impaired or physically-ailing older adult is highly stressful. Caregivers who do not have sufficient information, skills, or financial and psychological resources may find caring extremely challenging and stressful, which may lead to abusive acts.

Some caregivers who are at risk for abusing elders have their own psychological maladjustment or difficulties. Caring for an elderly person demands psychological and physical energy, and caregivers who have emotional or substance abuse problems may have limited ability to cope with stressful life situations. Caring for an elderly person may exacerbate their psychological vulnerability and lead to abuse. Caring for an elderly person also requires financial resources. When a family is financially struggling, the family may fail to provide adequate care for an elderly family member. For some families, financial exploitation may occur when the family is financially in need or economically dependent on the elderly person. Social isolation is another risk factor for elder abuse because without social support and outside help, the care of an elderly person can increase the stress level of caregivers. If abuse does occur, social isolation may prolong the occurrence of the abuse since no one outside the family is aware of the abuse.

Certain societal attitudes toward elders may hinder the prevention and termination of elder abuse. Some members of society may devalue or lack respect for elderly people. The problem of elder abuse is not widely publicized or understood. In addition, given the strong emphasis on personal and familial privacy, elder abuse is often hidden within the family. Furthermore, abused elders commonly feel too humiliated or fearful to talk about the abuse; this lessens the possibility of intervention to stop the abuse.

The most important step in elder abuse prevention is acknowledging human dignity, which exists

regardless of a person's age and level of physical and psychological functioning. The media should offer positive images of elder lives and increase public awareness of elder abuse. Social resources and support groups need to be available to elderly individuals and their family members. Counseling and treatment resources should be available for families caring for elderly people. Mental and medical healthcare workers play a vital role in assisting elder abuse survivors, and regular medical screening of possible elder abuse is vital for detecting potential abuse. If suspicion of abuse arises, a call to local or state agencies may help stop future abuse.

*Mei-Chuan Wang and Sharon G. Horne*

*See also* Child Maltreatment (v1); Crisis Counseling (v2); Counseling the Elderly (v1); Duty to Warn and Protect (v2); Physical Health (v1); Self-Disclosure (v2); Sexual Violence and Coercion (v1)

### Further Readings

American Psychological Association. (2006). *Elder abuse and neglect: In search of solutions*. Retrieved July 31, 2006, from <http://www.apa.org/pi/aging/eldabuse.html>

Barnett, O., Miller-Perrin, C., & Perrin, P. (2005). *Family violence across the lifespan* (2nd ed.). Thousand Oaks, CA: Sage.

### Web Sites

Eldercare Locator: <http://www.eldercare.gov>

National Center on Elder Abuse: <http://www.elderabusecenter.org>

---

## ACADEMIC ACHIEVEMENT

---

An achievement test is any test designed to assess an individual's attainment of a specific knowledge or skill in a specified content area within which the individual has received some level of instruction or training. However, achievement tests are often confused with aptitude tests. Aptitude tests may not differ in form from achievement tests, but they typically differ in both use and interpretation. Aptitude tests are typically designed to estimate an individual's future



performance on a task and/or his or her aptitude to develop new skills or knowledge if provided instruction or training. Essentially, achievement tests assess current performance after specific training; aptitude tests assess the potential for future performance.

For more than 100 years, achievement and aptitude testing have steadily gained momentum and support from psychologists, educators, policymakers, and the general public. Recent laws at both federal and state levels clearly demonstrate the emerging importance of achievement and aptitude testing in a data-driven political system. However, regardless of such apparent support, considerable confusion remains about the nature, use, and appropriate interpretation of achievement tests.

### Aptitude Testing

Because achievement and aptitude tests are frequently used in combination with one another, a brief discussion of aptitude tests is warranted. The Sixteenth Mental Measurements Yearbook (MMY) groups aptitude and ability tests into a single classification (i.e., Intelligence and Scholastic Aptitude) that includes measures of general or specific knowledge and aptitudes or cognitive abilities. As mentioned, aptitude tests are essentially measurements of an individual's performance on a selected task or tasks, which are then used to predict that same individual's future performance. They can assist external parties in predicting performance in selection processes, and help individuals gain a better understanding of their abilities in making life decisions (e.g., career or educational choices). The MMY includes a plethora of assessments under this category, including those of verbal and nonverbal reasoning; critical, abstract, and creative thinking; cognitive and mental abilities (including traditional intelligence tests); memory aptitudes; and learning aptitude, potential, and efficiency.

The predictions made from aptitude test results are not always limited to tasks or situations that are similar to those initially measured. In fact, some aptitude tests focus on predicting seemingly unconnected tasks and skills, while others are used to predict future performance in entirely different situations. For instance, high school students interested in particular careers might be given aptitude tests to measure their aptitudes for those careers. The students' test results can then be used to help advise them about available academic or training programs beyond high school

(rather than simply whether they should actually pursue the specified careers).

Aptitude tests can also vary in the number of aptitudes measured by a single instrument. *Multiaptitude batteries* are aptitude tests that measure a broad array of ability areas (e.g., verbal reasoning, numerical reasoning, and mechanical reasoning) during a single administration. These batteries are used primarily for intellectual, educational, and vocational assessment, and they are well suited to show individuals' relative strengths and weaknesses. For that reason, multiaptitude batteries are generally more useful in career and academic counseling than are single-aptitude assessments.

One of the more common multiaptitude batteries is the Armed Services Vocational Aptitude Battery (ASVAB), which was first developed in 1966 and is now on forms 23 and 24. Most, if not all, new recruits to the U.S. Armed Forces take the ASVAB. It measures aptitudes for general academic areas and career areas that are involved in most civilian and military careers. Scores from the eight subtests can be used to locate possible career options in OCCU-FIND—a manual listing more than 400 occupations, including about 150 military careers.

Although multiaptitude batteries are more useful than single-aptitude tests in certain circumstances, there are also instances in which more specialized aptitude tests are preferable. For instance, broad-based multiaptitude tests such as the Wechsler Adult Intelligence Scale (WAIS) can predict a variety of cognitive and mental aptitudes. However, they do not measure all possible cognitive abilities, and they do not necessarily provide the most accurate predictions of future performance in specialized tasks, such as mechanics, art, and music. In fact, the MMY provides a classification of specialized assessment instruments (e.g., fine arts, mathematics, reading, science, and social studies) and lists both aptitude and ability tests within each group. The following examples provide some indication of the broad array of specialized aptitude tests available to psychologists:

- The Mechanical Aptitude Test is a 45-minute test that measures high school students' and adults' mechanical abilities, such as comprehension of mechanical tasks, use of tools and materials, and matching tools with operations.
- The O'Connor Finger Dexterity Test assesses psychomotor aptitudes (i.e., ability to perform bodily



movements), and it is used to predict how well a person would be able to perform certain motor tasks in various situations (e.g., working on a rapid assembly, performing watch repair).

- The Meier Art Tests are examples of specialized assessments for artistic aptitude. Among these tests is one for Aesthetic Perception. This test presents an examinee with four versions of the same artistic work that differ along an important aesthetic dimension (e.g., proportion or form). The individual ranks the works in order of merit, and the results can be used to predict the individual's future success in tasks involving these aesthetic concepts.
- The Seashore Measures of Musical Talents is a 60-minute assessment of musical aptitude. The assessment battery includes a listening test with six subtests measuring dimensions of auditory discrimination (e.g., pitch, loudness, rhythm, and tonal memory).

### Hybrid Testing

Admissions tests are some of the most commonly used assessments within the realm of aptitude and achievement tests, yet they are also the most difficult to define according to traditional definitions. Confusion can arise when applying the standard definition of either achievement or aptitude tests to scholastic assessments, because scholastic ability/aptitude tests combine the predictive goals of aptitude tests with the performance assessment goals of achievement tests. As such, it is not uncommon for classification systems to place admissions tests into a hybrid category.

The SAT is one of the three most common admissions tests, and a prime example of such confusion about whether admission tests are achievement or aptitude tests. Originally introduced in 1901, the SAT is now taken by over 2 million students annually and is accepted by nearly every American college and university as the entrance examination component of the admissions process. The debate about the purpose and usefulness of the SAT led to several changes in its name throughout the 20th century. The SAT was first introduced as the "Scholastic Achievement Test," renamed the "Scholastic Aptitude Test" in 1941, and became the "Scholastic Assessment Test" in 1990. Following the 1994 revision, and continuing with the most recent 2005 revision, "SAT" is no longer an acronym. The test is presently known as the "SAT Reasoning Test."

The other widely used hybrid tests are the ACT and Graduate Records Examination (GRE). Similar to the SAT, the "American College Test" was renamed "ACT" in 1996. Most American colleges and universities use the ACT and GRE, respectively, to make decisions about the admission of applicants to undergraduate and graduate programs of study.

### Achievement Testing

Although hybrid tests incorporate elements of achievement tests, more traditionally defined achievements tests are clearly differentiated from aptitude and ability tests. The focus of achievement tests on measuring acquired knowledge makes them the primary type of instrument used in educational programs at all levels. Although this essential element is consistent across achievement tests, these tests can be further categorized using several nonexclusive characteristics.

#### ***Standardized Versus Nonstandardized Achievement Tests***

One characteristic that can be used to distinguish among achievement tests is whether the test has been standardized. *Standardized achievement tests* are those that have been administered, revised, and tested to establish an average level of performance. Standardization allows an individual's test results to be compared to those of other test takers. Because the individual's achievement is compared to that of a reference group, scores on standardized achievements tests are generally indicated by a percentile rank. Scores may also be indicated using grade-level equivalency (e.g., an eighth-grade student scores a 10 on a standardized achievement test, indicating that she scored as well as the average tenth-grade student).

Although standardized tests are generally considered more robust and valid measures of achievement, the majority of achievement tests used in educational settings are nonstandardized. Such *nonstandardized tests* include exams, tests, and other instances where the intent is to simply indicate how much an individual learned, without referencing a specific performance standard established by a reference group. Toward this end, nonstandardized tests essentially assess individual achievement as a proportion of the maximum potential level of achievement, as defined by the trainer, educator, or external test developer. Nonstandardized tests can be scored more subjectively (e.g., essay tests and



short answer tests) or more objectively (e.g., multiple choice and matching tests), but the ultimate score will always be a proportion of the total potential achievement. Typically, scores are reported as pass or fail, a percentage of the total possible score (e.g., 93% out of possible 100%), a letter grade (e.g., A, A-, B), or a number grade (e.g., 17 out of 32).

### ***Norm-Referenced Versus Criterion-Referenced Achievement Tests***

As mentioned above, standardized achievement tests require referencing an individual's performance to an established standard level of performance. There are two methods for establishing these standardized performance levels: norm referencing (also known as *nomathetic* and *standards* referencing) and criterion referencing (also known as *idiographic* and *domain* referencing). *Norm-referenced* achievement tests compare each individual's achievement to the achievement of others taking the same measure. As such, achievement level is based on the average performance of the norm group, rather than on the actual percentage of correct answers. In order to enhance such comparison of individual scores to the norm group, norm-referenced tests are typically created to mimic the normal curve. Individuals are then provided a scaled score or percentile rank according to the normal curve. Some of the most common norm-referenced tests are the California Achievement Test (CAT), Comprehensive Test of Basic Skills (CTBS), and Tests of Academic Proficiency (TAP).

There are several criticisms of norm-referenced achievement tests. For instance, because norm-referenced achievement tests are designed for national or international use, there is a possibility that the content being tested is not covered by the education or training actually provided to the individual. When this difficulty becomes salient, instructors sometimes change the material they teach, which leads to the criticism that some instructors are "teaching to the test." In addition to content, critics note that the norms of many achievement tests are too old to measure achievement according to current standards and/or teaching methods. Furthermore, the norms may be too limited to provide meaningful normative comparisons for all demographic groups, specifically those of culture or ethnicity. There are also arguments that such assessments may sacrifice accuracy or breadth in order to ensure that examinees' scores conform to a

normal distribution. In addition, a mathematical property of the normal curve is that changes in the number of correct answers do not lead to the same change in the percentile rank for all individuals. These arguments have led major test makers to address criticisms through redesign and/or renorming of their achievement tests, and to emphasize that norm-referenced achievement tests should not be the sole basis for making critical decisions about students' retention or graduation.

Although most achievement tests are norm referenced, their limitations have led to the continued use of criterion-referenced tests in certain situations. *Criterion-referenced* tests compare each individual's performance to a predetermined standard or criterion level, rather than a norm group. They focus on mastery of a given objective or skill, and typically include many items measuring a single objective. Because criterion-referenced tests are scored against an absolute standard, usually the percentage of correct answers, criterion-referenced tests are more common in the daily assessment of individuals in educational settings. Unlike norm-referenced achievement tests that force individuals into a normal curve, criterion-referenced tests do not limit the number of examinees that can demonstrate outstanding performance and mastery.

In an effort to draw upon the strengths of both norm-referenced and criterion-referenced tests, some achievement tests incorporate both standardization procedures. Scores on such tests are reported in terms of both how the examinees compare to others and how well they mastered the assessed content. For instance, the TerraNova (also known as the California Achievement Test, Sixth Edition or CAT/6) indicates both a student's grade equivalency and that student's level of mastery.

### ***Individually Versus Group-Administered Tests***

The majority of achievement tests can be administered to a group of individuals. This is particularly useful in educational settings where thousands of students might take the same instrument within a similar time frame. However, information such as behavioral observations can be obtained only during an individual test administration. Individualized achievement assessment is particularly useful for assessing the vocational rehabilitation of adults and learning disabilities of children and adolescents. There are



several individually-administered achievement tests, as well as many that can be administered either to individuals or to groups.

### ***Survey Achievement Batteries***

Achievement tests also vary in terms of the number of achievement domains being assessed. Survey achievement batteries, which assess a broad array of areas, are the most widely used format. The survey achievement battery typically has a number of subject-based subtests. They are most commonly used to assess achievement in the areas emphasized in K–12 education, thereby providing educators with information about student achievement across the educational curriculum with a single administration. One of the most popular of the survey achievement batteries is the Iowa Test of Basic Skills, designed for students in kindergarten through Grade 8. This battery assesses achievement in areas such as vocabulary, reading comprehension, language, mathematics, spelling, science, maps and diagrams, and reference materials.

### ***Examples of Achievement Tests***

While there are hundreds of achievement tests, the following provide examples of the more frequently administered instruments:

- The Woodcock-Johnson® III (WJ III) is a widely used comprehensive system (i.e., hybrid battery) for measuring general intellectual ability (or *g*), specific cognitive abilities, scholastic aptitude, oral language, and academic achievement. These variables are measured through two distinct batteries: The WJ III Tests of Cognitive Abilities and the WJ III Tests of Achievement. The WJ III can be administered to any individual over the age of 2. Because of its breadth and its assessment of achievement, the WJ III is often used to diagnose learning disabilities, guide educational programs, assess growth, and identify discrepancies between an individual's levels of aptitude and achievement.

- The Wechsler Individual Achievement Test—Second Edition (WIAT–II), is a test of reading and mathematics achievement that is suitable for individuals age 4 and older. The WIAT–II evaluates both the correctness of the response and the process by which the examinee arrived at the response, thus allowing for a more accurate assessment of problem-solving skills than other achievement measures. The WIAT–II

is also conformed with the Wechsler Intelligence Scale for Children—Fourth Edition (WISC–IV), which is the most commonly used test of intellectual and cognitive functioning for children.

- The Wide Range Achievement Test 4 (WRAT4) is designed to assess individuals between the ages of 5 and 75. The WRAT4 assesses the achievement of reading, spelling, and arithmetic skills.

- The Kaufman Test of Educational Achievement, Second Edition (K-TEA II) provides a broad assessment of academic achievement. It can be administered in a longer (five-subtest) comprehensive form or a brief (three-subtest) screening form to students in first through twelfth grade. Both the comprehensive and brief versions provide an assessment of key academic skills in reading, mathematics, written language, and oral language.

### ***Federally Mandated Statewide Achievement Tests***

On January 8, 2002, the No Child Left Behind Act of 2001 (NCLB) was enacted, which emphasized standards and accountability with educational systems. The NCLB was intended to hold states, school districts, and schools accountable for the adequate education of American youth. Specific initiatives within NCLB were designed to assess and reduce the achievement gaps that existed between ethnic/racial minority students and majority group students, and among students from differing socioeconomic statuses. The NCLB act created the necessity for an ongoing assessment of achievement on a national scale.

Since 1969, the National Assessment of Educational Progress (NAEP) has provided the only national assessment of students' achievement in major academic areas. However, the NAEP originally assessed only a national sample of fourth-grade students every 2 to 4 years. Currently, under the NCLB, the NAEP assesses a national sample of fourth- and eighth-grade students every 2 years. However, there are clear limitations of such a national norm-based test. In particular, it is impossible for a single measure to accurately test all individual academic standards as defined by each state's education department. As such, the NCLB requires all states and territories receiving federal funding to develop and implement a procedure to independently obtain achievement data on all public school students.



The purpose of the state assessment requirement is to provide an independent, objective measure of the educational progress of each student, school, school district, and state/territory. These assessments are expected to measure how well each student achieves the individual state's academic standards in reading, mathematics, and science. Academic standards have been developed by every state to indicate what students at particular grade levels should learn in specific subject areas. The underlying assumption is that students will perform well on the state achievement tests if teachers are competent and cover the material required by the standards. Hence, education departments argue that there should be no need to "teach to the test" and/or engage in specific test preparation or coaching.

The NCLB mandates that the state assessment procedure must include at least one criterion-referenced or norm-referenced assessment, may include multiple assessments, must address the depth and breadth of the state academic standards, and must be reliable and valid. Because all students are expected to achieve the same high levels of learning, the NCLB requires states to hold all public elementary and secondary school students to the same academic content and achievement standards. Thus, the same rigorous test must be used throughout the entire state. Beginning with the 2007–2008 academic year, all states must administer annual achievement tests for reading/language arts and mathematics in each of Grades 3 through 8, and at least once in Grades 10 through 12. In addition, annual achievement tests for science must be given at least once in each of the following: Grades 3 through 5, Grades 6 through 9, and Grades 10 through 12.

As with other high-stakes tests, data obtained from state achievement tests can have a significant effect on the future of the test takers. Aggregated results can have subsequent effects on schools, school districts, and even states. The most basic use of statewide achievement tests is to provide teachers and administrators with information about individuals, and tailor services to address a student's demonstrated difficulties. The "high stakes" designation of such achievement tests comes from the fact that many states use a student's performance to determine whether students have gained enough knowledge to progress to the next grade level. Although the *Standards for Educational and Psychological Testing* stress the importance of taking into consideration several points of data when making such decisions, many states consider achievement test results to overrule all other measures.

Statewide achievement data can also provide information on the curriculum being used and the quality of instruction being provided. In this way, the statewide assessment also becomes "high stakes" for teachers and their curriculum. Poor results could indicate a need to revise the curriculum to better achieve the desired academic standards, or a need to provide the teacher with additional training to improve the quality of instruction. In some states, teachers who have a large percentage of low-achieving students may be removed from their positions, as may principals and superintendents. Conversely, teachers who have a large percentage of high-achieving students sometimes receive additional monetary compensation as a reward for their success.

Statewide assessments also become "high stakes" for the schools and school districts themselves, as the NCLB requires that the scores of all eligible students be aggregated to determine whether the school or school district made "adequate yearly progress" during the course of a specified period of time, generally 2 years. In so doing, the state specifies a minimum level of improvement in student performance that schools must achieve. This minimum is based on the performance of the lowest-achieving demographic group or lowest-achieving schools in the state. The state then sets a threshold for adequate progress, and this threshold is raised at least once every 3 years. The goal is that, at the end of 12 years, all students in every state will demonstrate adequate levels of achievement on the respective state assessments. Schools that do not make adequate yearly progress can be required to develop a corrective action plan or to fund options for students to attend another school or to receive additional tutoring. In addition, the school district could initiate a restructuring that results in the replacement of all or most of the staff, or in the assumption of school operations by the state or a private company.

### ***Pitfalls in Statewide Achievement Testing***

Although achievement tests have demonstrated usefulness in a variety of situations, controversy and criticisms still exist about how these tests are developed, standardized, and utilized. One such criticism is that improvements in the reliability, accuracy, and validity of many achievement tests have narrowed their range of application. For instance, some test developers have improved norm referencing by standardizing their tests on multiple norm groups based on



age, ethnicity/race, and seasonal norms. As a consequence, each form of the test is applicable to a more narrowly defined group. Therefore, it is important to select achievement tests that reliably and validly measure the intended subject and that yield results that are generalizable to the population being tested.

Although achievement tests are useful tools to help guide decisions, one of the strongest criticisms of achievement testing surfaces when educational decisions are made solely upon the basis of achievement test results. Such criticism becomes particularly salient when critics focus upon differential treatment of cultural groups (e.g., ethnicity, income level, special needs). For instance, the American Civil Liberties Unions (ACLU) has expressed concern about the federal requirement that the same test be given to those with special needs and/or limited English proficiency. Other critics argue that achievement tests do not uniformly indicate achievement across other cultural groups, such as ethnicity and gender. Although well intended, such criticisms are generally antiquated, as development or revisions of the most widely used achievement tests have addressed many previous criticisms about the differential applicability to various populations. Indeed, meta-analyses on hundreds of thousands of examinees indicate that the most widely used achievement tests do not differ in their predictive accuracy as a function of ethnicity or gender.

More specific to statewide achievement testing, critics have argued that such assessments evaluate the curriculum and instructional method used by teachers, rather than students' abilities to learn the information provided. Such critics argue that negative consequences of achievement test results (e.g., holding a student back a grade) could punish the student for the failure of the school or teacher. Critics further argue that this becomes particularly problematic in the nation's poorest schools, where the quality of education is substantially lower than in more affluent schools. Although there is little research to refute the claim that curricula and teacher quality are positively correlated to student achievement, counterarguments to such criticism often reference research studies and meta-analyses that reveal a plethora of other variables affecting student achievement. Such variables include per-pupil expenditures, larger class sizes, parent involvement, student motivation, school attendance rate, and student satisfaction with school. Furthermore, it is important to note that the intent of statewide achievement testing is not to make educational

decisions for individual students, but to identify schools and school districts that require additional assistance and/or resources to ensure students make gains in academic achievement.

Because achievement tests can only measure a limited amount of information, they are unable to assess the full range of information learned by the student or the ability of the student to apply information they have learned in real-world situations. Related to this, critics argue that achievement tests lead teachers to overemphasize memorization and de-emphasize thinking and the application of knowledge. Because of the limited nature of achievement tests, "teaching to the test" can be effective in increasing achievement scores, but it also narrows and weakens academic curricula. Critics argue that this can lead schools to remove courses that do not clearly promote the rote memorization necessary to score high on achievement tests (e.g., physical education, art, and music). Indeed, as the federal government has defined "improvement" in terms of achievement test results and has tied funding to this definition, critics argue that schools are shifting from education to test coaching. That being said, proponents of statewide achievement testing note a distinct difference between "teaching *to* the test" and "teaching *the* test," the former being when teachers align their curriculum to proven indicators of student success and the latter being when teachers provide only the exact information on the test. Indeed, proponents argue that teaching knowledge and skills based on a standard curriculum with specific indicators, which are then assessed by the achievement test, is considered "curriculum alignment" and is believed to lead to higher quality schools and curriculum.

## Conclusion

For more than 10 decades, achievement and aptitude tests have gained popularity and drawn considerable attention from psychologists, researchers, educators, and the general public. Although initially achievement tests were heavily criticized and limited in their applicability, the past four decades have seen dramatic improvements in their quality, reliability, validity, and generalizability. Such improvements have been further enhanced and expedited by state and federal funding in the wake of federal law requiring the statewide achievement testing of all public school children. Psychologists and educators can now choose from hundreds of research-based achievement tests with



demonstrated reliability and validity. It is not surprising that the growing popularity and the high-stakes nature of achievement testing in many settings (e.g., educational, forensic, diagnostic) has led to new criticisms and a rehashing of older criticisms. However, nearly every criticism of achievement testing has been largely refuted by psychological and educational research. Ultimately, when selected, applied, and interpreted appropriately and professionally, achievement tests provide the best means for the assessment of acquired knowledge and skills of all individuals in a wide variety of settings.

*Charles E. Byrd and Teraesa S. Vinson*

**See also** Academic Achievement, Nature and Use of (v4); Achievement, Aptitude, and Ability Tests (v4); Achievement Gap (v3); Assessment (v4); Cognition/Intelligence, Assessment of (v2); Distance Education/Dispersed Learning (v1); Individuals with Disabilities Education Act (v1); Intelligence (v2); Intelligence Tests (v3); Learning Disorders (v1); School Counseling (v1); Test Interpretation (v2)

### Further Readings

- Aiken, L. R., & Groth-Marnat, G. (2006). *Psychological testing and assessment* (12th ed.). Boston: Pearson Education.
- American Educational Research Association, American Psychological Association, and National Council on Measurement in Education. (1999). *The Standards for Educational and Psychological Testing*. Washington, DC: American Educational Research Association.
- American Psychological Association, Joint Committee on Testing Practices. (2005). *Code of Fair Testing Practices in Education*. Washington, DC: Author.
- Carpenter, S. (2001). The high stakes of educational testing. *Monitor on Psychology*, 32(4).
- Darling-Hammond, L. (1999). *Teacher quality and student achievement: A review of state policy evidence*. Seattle, WA: Center for the Study of Teaching and Policy.
- Gronlund, N. E. (1998). *Assessment of student achievement* (6th ed.). Needham Heights, MA: Allyn & Bacon.
- Kane, T. J., & Staiger, D. O. (2002). The promise and pitfalls of using imprecise school accountability measures. *The Journal of Economic Perspectives*, 16(4), 91–114.
- Linn, R. L. (2003). Accountability: Responsibility and reasonable expectations. *Educational Researcher*, 32(7), 3–13.
- National Council on Measurement in Education. (1995). *Code of Professional Responsibilities in Educational Measurement*. Madison, WI: Author.

Resnick, M. (2003). *NCLB Action alert: Tools & tactics for making the law work*. Alexandria, VA: National School Boards Association.

Spies, R. A., & Plake, B. S. (Eds.). (2005). *The Sixteenth Mental Measurements Yearbook*. Lincoln, NE: Buros Institute of Mental Measurements.

---

## ADAPTIVE BEHAVIOR TESTING

---

Adaptive behavior is the extent to which an individual demonstrates the culturally established standards for effective personal independence and social responsibility needed for daily living. This includes how well an individual manages the demands of day-to-day functioning (e.g., hygiene, domestic chores), motor functioning (e.g., ambulation), and communication (e.g., receptive and expressive language). It also includes cognition (e.g., problem solving, managing finances) and social functioning (e.g., use of leisure time, maintaining friendships). The American Association on Mental Retardation explains that adaptive behavior involves three broad areas: Conceptual (e.g., language and academic skills); Social (e.g., interpersonal skills, obeying laws); and Practical (e.g., self-help skills and occupational skills). Adaptive behavior can be contrasted with intellectual functioning, which involves problem solving, reasoning, conceptual thinking, and learning efficiency. Although they represent different constructs, intelligence and adaptive functioning are moderately correlated (around .3 to .4), and the correlation between these constructs increases with the severity of intellectual and adaptive impairment. This suggests that intelligence and adaptive functioning are not totally independent constructs.

### Assessment

Formal adaptive behavior assessment typically involves using a norm-referenced instrument to obtain information about how well the individual functions independently at home, school, and in the community. Typically this information is obtained from an informant (e.g., parent, teacher, or guardian) using an interview format. The instrument is normally administered, scored, and interpreted by a school psychologist, school counselor, or special education teacher if the individual is in school or by a clinical psychologist or social worker if the individual is out of school or is an



adult. In all cases the examiner must have specialized training to interpret the data.

There are six or eight adaptive behavior scales, and most take approximately 1 hour to administer and score. Unfortunately, different adaptive tests and different informants can yield different scores. Therefore, the first goal of any examiner is to select a psychometrically sound instrument and interview an informant who is very familiar with the individual being evaluated. Regional differences regarding which adaptive scale to use are common and are often due to personal preferences, the influence of training programs, and access to updated norms (i.e., revised editions). Frequently used adaptive scales include the Scales of Independent Behavior-Revised (SIB-R), the Vineland Adaptive Behavior Scales, Second Edition (Vineland-II), and the Adaptive Behavior Assessment System-Second Edition (ABAS-2). Most adaptive behavior instruments have a number of subscales or subtests that measure four to six broad areas of independence. For example, the SIB-R has four factors (Motor Skills, Social Interaction and Communication Skills, Personal Living Skills, and Community Living Skills) that are combined to yield a Broad Independence score. The Vineland-II has four adaptive scales (Communication Skills, Daily Living Skills, Social Skills, and Motor Skills) that are combined to produce an overall Adaptive Behavior Composite. Several of the instruments have maladaptive scales to allow the clinician to better understand the individual's disruptive, uncooperative, or inappropriate behaviors needing targeted intervention. Results from the adaptive behavior instruments are reported in the form of standard scores that have a mean of 100 and a standard deviation of 15. Typically, scores in the range of 85 to 115 are considered age appropriate or "average."

## Applications

Adaptive behavior assessment has been used in conjunction with intellectual assessment in the diagnosis of mental retardation for decades. The American Association on Mental Deficiency (now the American Association on Mental Retardation) included deficits in adaptive functioning in its first definition of mental retardation in 1959. Similarly, in public schools, according to the Individuals with Disabilities Education Act (IDEA), children are diagnosed with mental retardation and provided specialized programming when both their intellectual functioning and their

adaptive behavior functioning fall at least two standard deviation units below the mean. For most IQ and adaptive behavior tests, this involves standard scores 70 and below. In nonschool settings, such as mental health, Mental Retardation/Developmental Disabilities (MRDD) facilities, and community living settings, the clinicians are obligated to use the *Diagnostic and Statistical Manual, Fourth Edition, Text Revision (DSM-IV-TR)* criteria for mental retardation before assigning the diagnosis. This definition requires both intellectual and adaptive behavior functioning two standard deviations below the mean. In both settings, the adaptive behavior test results are used diagnostically (i.e., to determine whether there is a diagnosis of mental retardation), descriptively (i.e., to determine the person's strengths and limitations), and prescriptively (i.e., to determine the appropriate goals for intervention programming).

While adaptive behavior assessment historically has been employed with persons suspected of having mental retardation, it is used to obtain valuable information for many students and adults referred for cognitive, academic, and/or behavioral assessment. For example, adaptive behavior testing provides valuable insight into the manifestations of developmental delay, pervasive developmental disorders, autism, and various behavior disorders. The results can be helpful in establishing intervention goals and in guiding treatment efforts. Ultimately, adaptive behavior testing is useful in helping a wide range of individuals achieve more satisfying, productive, and independent lives.

Mardis D. Dunham

**See also** Attention Deficit/Hyperactivity Disorder (v1); Autism/Asperger's Syndrome (v1); Cognition/Intelligence, Assessment of (v2); *Diagnostic and Statistical Manual of Mental Disorders (DSM)* (v2); Functional Behavioral Assessment (v1); Mental Retardation and Developmental Disabilities (v1); School Psychology (v1)

## Further Readings

- American Association on Mental Retardation. (2007). *The AAMR definition of mental retardation*. Retrieved January 16, 2008, from [http://www.aamr.org/Policies/faq\\_mental\\_retardation.shtml](http://www.aamr.org/Policies/faq_mental_retardation.shtml)
- American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed., Text rev.). Washington, DC: Author.



- Bruininks, R., Woodcock, R., Weatherman, R., & Hill, B. (1996). *Scales of Independent Behavior-Revised*. Chicago: Riverside.
- Harrison, P., & Boney, T. (2002). Best practices in the assessment of adaptive behavior. In A. Thomas & J. Grimes (Eds.), *Best practices in school psychology IV*. Bethesda, MD: National Association of School Psychologists.
- Harrison, P., & Oakland, T. (2000). *Adaptive Behavior Assessment System*. San Antonio, TX: The Psychological Corporation.
- Harrison, P., & Oakland, T. (2003). *Adaptive Behavior Assessment System-Second Edition*. San Antonio, TX: The Psychological Corporation.
- Sparrow, S., Cicchetti, D., & Balla, D. (2006). *Vineland Adaptive Behavior Scales, Second Edition*. Bloomington, MN: Pearson Education.

---

## ADLERIAN THERAPY

---

Adlerian therapy refers to counseling and psychotherapeutic interventions that are associated with the individual psychology of Alfred Adler (1870–1937), a Viennese psychologist and contemporary of Sigmund Freud. *Individual psychology* emphasizes an examination of the individual's social and cultural embeddedness, a holistic view of personality, taking personal responsibility, striving to achieve life goals, growth towards a sense of completion and belonging, and a practical approach to meeting life's challenges. Because these values are so universally shared, a wide variety of mental health professionals use classical and contemporary expressions of Adlerian therapy in their work.

### Theoretical Basis of Adlerian Therapy

Adler believed that people's pursuit of their overarching life goals pulled them from positions of inferiority, inactivity, and inertness to positions of mastery and completion. Many factors affect the nature of people's life goals and the manner in which they pursue them, including heredity, pre- and perinatal influences, socioeconomic and cultural contexts, health, the family emotional environment, and school experiences. In the process of negotiating these goals, Adler contended, all people must address three tasks: how to find a productive work role in life, how to establish

and maintain an emotionally close relationship with a life partner and family members, and how to contribute meaningfully to the community of humankind.

Adlerian therapists believe that *social interest* leads to and is a marker of psychological health. The essence of social interest involves striving to achieve one's life goals while meeting life's tasks in a socially responsible and supportive manner. Some individuals, however, strive so single-mindedly after particular goals, which offer only a fleeting sense of efficacy or esteem, that life tasks go unmet and other people are viewed as obstacles that must be manipulated, mastered, or vanquished. This approach is the antithesis of healthy mental functioning.

Adler believed that the roots of unhealthy goal striving developed during childhood from a confluence of variables such as dysfunctional family environments that were discouraging and disempowering, undiagnosed or untreated psychological or medical conditions, and lack of encouragement. Such conditions overwhelm the child's ability to develop a healthy lifestyle and a sense of belonging. Rudolf Dreikurs, an Adlerian scholar, observed that under these circumstances children may act out or misbehave as a means of seeking attention, becoming more powerful, exacting revenge, or withdrawing from a task or interaction. Adults also may develop self-defeating life goals that give rise to physical or psychological symptoms and to interpersonal difficulties. Adlerian therapy seeks to determine the early-in-life causes of unhealthy, self-defeating life goals, and to reorient the individual toward a healthy style of life.

### Processes of Adlerian Therapy

Dreikurs identified four phases that characterize Adlerian therapy. The initial phase involves establishing the therapeutic relationship. This is done by enlisting the client's cooperation, addressing and resolving immediate crises, understanding the presenting problem, and identifying possible goals for the therapy.

The second phase of therapy involves the use of semistructured interview and standardized measures to assess the client's lifestyle (i.e., personality). The lifestyle assessment process provides the clinician with essential information and creates an experience of self-discovery for the client. A successful lifestyle assessment will reveal the client's *private logic* (i.e., the reasons underlying the client's thoughts, emotions, and behaviors). Adlerian therapists sometimes



use genograms to explore the structure and emotional atmosphere of the client's family of origin and to understand the client's early goals and sense of belonging. The client's perceived position in his or her family may provide an indication of how he or she relates to others. Early recollections of childhood events and the analysis of dreams can reveal the client's implicit life goals. Knowledge of the client's goal striving provides an overarching framework for understanding the finer details of the client's life.

The insight phase of Adlerian therapy involves helping clients build a deeper, intuitively-based awareness of their private logic so that behavior change can be implemented. Adlerian therapists use a variety of techniques at this stage of therapy, including challenge, confrontation, prescribing the use or display of a client's symptom, and "spitting in the soup" (i.e., making a preferred but dysfunctional goal or behavior less palatable to the client and thus making it less salient for dealing with life challenges). This phase culminates with the client's understanding how his or her life goals and subsidiary behaviors lead to problems and dysfunctional relationships.

The objective of the final phase of Adlerian therapy is to help clients reorient themselves from dysfunctional positions in life to individually healthy and meaningful life goals that embody social interest. A variety of techniques are used to help clients achieve this objective. For instance, Harold Mosak's pushbutton technique helps clients see that they have a choice about the particular thoughts they entertain, along with the ensuing emotions and behaviors that stem from them. Clients also can be taught to "catch oneself" and to change course when they realize they are pursuing a goal or enacting a behavior that has been identified as dysfunctional. Clients can experiment with new modes of being and new life roles by "living as-if" in progressively wider settings outside of therapy. Adlerian therapy concludes when presenting problems have been resolved and the client is able to derive the positive psychological benefits of pursuing healthy and meaningful life goals.

### Forms of Adlerian Therapy

Adlerian therapy is widely used in the treatment of adults, children, couples, families, and groups. Although many variations of Adlerian therapy exist, they differ primarily with respect to the duration of therapy, the focus and scope of treatment goals, and

the strategies and techniques that are afforded by the therapeutic modality. Adlerian therapy has traditionally been long term and comprehensive in focus, but clinicians have successfully adapted the approach for short-term and brief therapy.

Adlerian therapy with couples emphasizes how *complementarity* (i.e., compatibility) in the life goals and lifestyle of the partners can perpetuate relational discord. Therapy with couples is aimed at increasing the partners' awareness of the way in which their choices lead to disagreements and unhappiness instead of goal alignment, mutual support, and encouragement.

Adlerian therapy with families emphasizes the importance of a democratic and supportive family atmosphere, the role of the parents as leaders and caregivers, the individual responsibility of each family member, and the necessity for each person to contribute meaningfully within the family system. Adlerian therapists often include the Systematic Training for Effective Parenting (STEP) model that was created by Don Dinkmeyer, Sr., Gary McKay, and Don Dinkmeyer, Jr. as an important component in primary and secondary prevention efforts with families.

Adlerian therapy with children uses a variety of play and other nonverbal techniques to examine the sources of a child's symptoms and goals. In addition to resolving symptoms (e. g., school refusal or aggressiveness), Adlerian therapy emphasizes the importance of orienting children toward cooperation (versus competition), and of encouraging them to become socially interested (versus self-interested). Adlerian interventions with children frequently involve parents and family members.

Adlerian group therapy, with suitably-screened clients, provides an active therapeutic forum in which the social manifestations of client's problems (e.g., goals for dominating others, hesitating lifestyle tendencies) can be explored and changed. Adlerian groups accentuate the client's social embeddedness, the interpersonal nature of problems, and ways in which social interest can be cultivated.

### Current Status and Future Trends

The breadth of Adlerian therapy makes it conceptually and clinically resonant with classic therapeutic approaches (e.g., those of Karen Horney, George Kelly, Abraham Maslow), with modern cognitive-behavioral approaches (e.g., those of Albert Ellis,



Aaron Beck) and with the newer postmodern and constructivist perspectives on therapy (e.g., that of Robert Neimeyer). The latter group has found Adlerian therapy of particular interest because of a shared epistemological heritage in the work of Hans Vaihinger's *Philosophy of the As-If*.

Mental health professionals continue to find Adlerian therapy and individual psychology highly useful to their work. The *Journal of Individual Psychology* is the primary forum for disseminating the conceptual and clinical scholarship of the field. Books summarizing the Adlerian literature or focusing upon specific topics continue to appear regularly. For example, Henry Stein and his associates have undertaken a comprehensive project to translate Adler's papers on theory and practice from their original German into English. The North American Society for Adlerian Psychology organizes an annual international convention dedicated to the advancement of Adlerian theory and therapy. The International Committee for Adlerian Summer Schools and Institutes (ICASSI, [www.icassi.net](http://www.icassi.net)) provides training in Adlerian methods and offers a framework for advocating positive social change in accordance with the work of Adler and Dreikurs. A number of local Adlerian societies and training institutes exist throughout the world.

Alan E. Stewart

**See also** Couple and Marital Counseling (v1); Family Counseling (v1); Outcomes of Counseling and Psychotherapy (v2); Parenting (v1); Personality Theories, Psychodynamic (v2); Person–Environment Fit (v4); Person–Environment Interactions (v2); Psychoanalysis and Psychodynamic Approaches to Therapy (v2); Self-Efficacy/Perceived Competence (v2)

### Further Readings

- Adler, A. (1927). *Understanding human nature*. Garden City, NY: Garden City Publishing.
- Ansbacher, H. L., & Ansbacher, R. R. (1956). *The individual psychology of Alfred Adler*. New York: Basic Books.
- Carlson, J., Watts, R. E., & Maniaci, M. (2005). *Adlerian therapy: Theory and practice*. Washington, DC: American Psychological Association.
- Dreikurs, R., & Soltz, V. (1964). *Children: The challenge*. New York: Hawthorn Books.
- Kottman, T. (1995). *Partners in play: An Adlerian approach to play therapy*. Alexandria, VA: American Counseling Association.
- Mosak, H. (1999). *Primer of Adlerian psychology: The analytic-behavioural-cognitive psychology of Alfred Adler*. Philadelphia: Brunner-Mazel.
- Oberst, U. E., & Stewart, A. E. (2003). *Adlerian psychotherapy: An advanced approach to individual psychology*. London: Brunner-Routledge.
- Rule, W. R., & Bishop, M. (2006). *Adlerian lifestyle counseling: Practice and research*. New York: Routledge.
- Shulman, B. H., & Mosak, H. H. (1988). *Manual for lifestyle assessment*. Muncie, IN: Accelerated Development.
- Sonstegard, M. A., Bitter, J. R., & Pelonis, P. (2004). *Adlerian group counseling and therapy: Step-by-step*. New York: Brunner-Routledge.
- Sweeney, T. (1998). *Adlerian counseling: A practitioner's approach*. Philadelphia: Accelerated Development.

### Web Sites

North American Society of Adlerian Psychology:  
<http://www.alfredadler.org>

## AFFECT (MOOD STATES), ASSESSMENT OF

In psychology, the term *mood* refers to a person's emotional state. Mood is central to psychological health, and disturbances in mood are related to subsequent psychological maladjustment. Moods such as elation, joyfulness, and excitement, when experienced within normal ranges, enhance a person's life and are associated with well-being. Moods such as anger, hostility, depression, and mania are negative emotions. When these moods are experienced outside of the normal range or when a person no longer has control over these moods, psychological disturbances appear in behavior. While it is normal for persons to experience anger, irritation, or sadness based on external events, these emotions can become extreme, leading to the need for psychological intervention.

A client's mood permeates almost any aspect of psychological intervention, and hence a reliable assessment of mood is part of the psychologist's armamentarium. The most common methods of assessing mood are the clinical interview and the use of a self-report inventory, but some psychologists use projective tests to assess mood. Although there are psychologists who tend to rely on their own clinical judgments and avoid more formal assessments, a



formal and organized assessment typically provides more accurate information than interviewing a patient in an unstructured manner. A systematic assessment evaluates all aspects of mood, whereas an unstructured assessment guided by clinical judgment can become sidetracked on a particular line of inquiry and fail to assess all aspects of the problem.

This entry reviews the instruments and scales most commonly used by psychologists to assess disturbances in mood. Some of these use a true/false format, others have a checklist format, and still others have a multiple-choice format, but the format is less important than the range of content included in the instrument. Some of these instruments are referred to as *broad-band* instruments because they assess a variety of emotions. Others are referred to as *narrow-band* tests, signifying that they assess only a single specific mood.

When assessing moods, psychologists consider whether the respondent is reporting honestly or is faking a response (i.e., exaggerating or underreporting his or her problems and emotional state). Inaccurate or “faked” responses are more likely when an evaluation is conducted to decide about employment, child custody, or prison release, or to obviate or attenuate a court verdict.

Some tests and scales include items that are both obvious and subtle to control for faking. An obvious item is one where the content of the item is logically related to the mood being assessed. For example, “I feel blue most of the time” is an obvious item when assessing depression. A respondent motivated to fake a response could do so easily on such an item. However, if research has found that depressed respondents often answer, “False” to the item “I like to eat candy,” the item is not obviously related to depression (i.e., provides a subtle assessment of depression). In general, tests and scales that have ways to detect tendencies toward inaccurate or inconsistent responding are more valid than those without such means.

Finally, psychologists evaluate the psychometric properties of tests and scales prior to using an instrument. *Psychometric properties* refer to the reliability, validity, internal structure, and correlations with external behavior of scores on the scale. All of the measures reviewed in this entry have acceptable reliability and validity.

The temporal reliability of an instrument is particularly important when assessing mood, because the respondent’s score at different times is often important. If the construct is a trait, temporal stability is

expected. If the construct is a mood, the pattern of change provides information about the improvement or lack of change in the emotional state.

## Methods of Assessing Mood

The most common way to assess mood is the clinical or assessment interview. Mood is an element in the overall assessment process in almost every published recommendation on interviewing and is a routine part of both a psychiatric and a mental status examination. These can be structured clinical interviews or “naturalistic” interviews. The latter are more commonly referred to as *unstructured interviews*, in which the psychologist talks with the client about a variety of topics and in so doing ascertains the level of mood (also referred to as *affect*).

Two types of structured interviews have been published. In a *structured clinical interview*, such as the Structured Clinical Interview for DSM–IV, the psychologist asks a predetermined set of questions. No additional questions are permitted. The client’s responses are scored according to diagnostic criteria. In a *semi-structured clinical interview*, such as the Structured Interview for DSM–IV Personality, the psychologist asks a set of predetermined questions, but supplements them with unscripted follow-up questions—referred to as *probes*—to gain a more complete understanding of the client’s response. In conducting an unstructured or semistructured interview, psychologists also take into account the client’s body language.

A clinical interview may appear to be unstructured because the psychologist does not appear to ask a set of predetermined questions. Nevertheless, the skilled interviewer will make sure to ask questions about each of the areas regarded as relevant to the question, problem, or disorder at hand.

There are many published self-report inventories that assess mood. Following is an overview of some of the more popular broad-band and narrow-band instruments that assess moods that have particular relevance to client functioning and behavior (i.e., anxiety, depression, mania, and hostility).

## Broad-Band Mood Survey

The Guilford Zimmerman Temperament Survey (GZTS) is a 300-item self-report survey designed for use with individuals 16 years of age and older who have at least an eighth-grade education. It takes from



30 to 60 minutes to complete and can be scored via local software, mail-in scoring, or optical scan scoring. It provides scores on 10 aspects of personality and temperament (e.g., energy versus inactivity, impulsivity versus restraint, friendliness versus hostility, and stability versus irritability). A computer-derived interpretive report is available from the publisher. The GZTS was designed for use in counseling, career planning, personnel selection, and placement with nonclinical populations.

### **Broad-Band Measures of Anxiety**

The scales discussed below are embedded in larger instruments. They are rarely extracted from the parent instrument for administration independent of the larger test.

#### ***Anxiety-Related Scales From the Minnesota Multiphasic Personality Inventory-2 (MMPI-2)***

Four scales of the MMPI-2 assess the respondent's anxiety level—one clinical scale (Psychasthenia, or Pt), two content scales (Anxiety and Fears), and one supplemental scale (Welsh's Factor A).

*Psychasthenia* is an older term that means neurotic anxiety, as opposed to realistic anxiety. It has been removed from psychiatric nomenclature, but the scale remains on the MMPI-2 as scale Pt. It is a 48-item scale that assesses trait anxiety, self-dissatisfaction, and psychic distress. The scale provides a reliable measure of both state anxiety (i.e., temporary anxiety due to some external circumstance) and trait anxiety (i.e., a lasting personality characteristic).

The Anxiety content scale consists of 23 items that assess physiological symptoms of anxiety (e.g., shortness of breath, sleep disturbances, and heart palpitations) and cognitive signs of anxiety (e.g., edginess, tension, and a fear that you are losing your mind). Persons who obtain a high score on this scale are described as ruminative, intellectualizing, and engaging in ritualistic behaviors. They often report problems with concentration, worry needlessly, and are troubled by disturbing thoughts. Scores on this scale are quite consistent when the test is administered more than once within a short period of time, such as a week.

The 23-item Fears content scale assesses apprehension about a particular object or circumstance and a fear of harm or injury. It has two components. The

Generalized Fears component measures respondents' feelings of persistent danger, and the potential harmfulness of objects or environmental circumstances. The Multiple Fears component assesses more specific fears such as fears of common objects or circumstances.

Welsh's Factor A scale represents one of the primary components underlying responses to the MMPI-2. It assesses situational stress rather than generalized trait anxiety measured by the Pt scale, and is commonly interpreted as a measure of generalized anxiety. The scale is sometimes described as measuring lack of ego resiliency or general maladjustment.

#### ***Anxiety Clinical Scale From the Millon Clinical Multiaxial Inventory***

The Anxiety Clinical Scale from the Millon Clinical Multiaxial Inventory (MCMI-III) contains a 14-item scale that correlates positively with items dealing with general distress and is useful in diagnosing patients with an anxiety disorder. Item content deals with nervous tension, intrusive thoughts (particularly over upsetting or traumatic events), sweating, compulsive behaviors, excessive worry, and fears of being alone. Persons scoring high on this scale have symptoms associated with physiological overarousal. They are described as anxious, apprehensive, restless, unable to relax, edgy, jittery, and indecisive. They often report symptoms that include insomnia, muscular tightness, headaches, nausea, cold sweats, undue perspiration, clammy hands, and palpitations. Phobias may or may not be present.

#### ***Anxiety Scale From the Personality Assessment Inventory***

The Anxiety Scale from the Personality Assessment Inventory (PAI) scale measures the cognitive, affective, and physiological aspects of anxiety. PAI items deal with subjective feelings of apprehension, ruminative worries, and physical signs of tension and stress.

#### ***Anxiety-Related Scales From the Sixteen Personality Factors Questionnaire***

The 5th revision of Raymond Cattell's Sixteen Personality Factors (16 PF) contains two factor scales, Apprehension—(Factor O) and Tension—(Factor Q4), that measure anxiety and a secondary factor referred



to as Anxiety. Elevations on the Apprehension scale describe a person who complains about excessive worries, apprehension, guilt, and insecurities. Elevations on the Tension scale describe someone who is tense, driven, and frustrated and feels overwrought. The Anxiety secondary factor includes items that assess emotional stability and vigilance.

### **Anxiety Scales From the Symptom Check-List-90 Revised**

The Symptom Check-List-90 R (SCL-90-R) consists of a list of items that describe mood states (e.g., nervous, apprehensive). Respondents are instructed to check all of the items that describe them. The test is designed for use with adult patients and nonpatients and takes about 12 to 15 minutes to complete. The items are written at the sixth-grade reading level, and those on the anxiety scale assesses typical symptoms of anxiety, such as feelings of dread and terror, apprehension, tension, trembling, and general nervousness and panic. The Phobic Anxiety scale of the SCL-90-R measures persistent fears—of persons, places, objects, or situations—that are deemed irrational and that lead to avoidance or escape behaviors.

## **Narrow-Band Measures of Anxiety**

### **Beck Anxiety Scale**

The Beck Anxiety scale has 21 obvious items that are rated by the respondent on a 4-point scale. For example, the scale asks such questions as whether the respondent feels like a failure, cries a lot, or feels like killing him- or herself. Consequently, the scale is more susceptible to faking than are the scales mentioned above. Administration time is approximately 5 to 10 minutes.

## **Broad-Band Measures of Depression**

### **The Depressive Adjective Check List**

Adjective checklist methodology directs respondents to endorse an adjective if it describes them and to leave the item blank if it does not. Among the more popular instruments of this kind is the Depression Adjective Check List (DACL). The DACL was developed to measure transient moods, feelings, and emotions related to depression. It requires an eighth-grade reading level and has been translated into many foreign languages. There are several available lists to

choose from with each list taking from 2 to 3 minutes to complete. Thus an assessment can be performed quickly and with minimal client resistance. Norms have been published for both depressed patients and normal individuals reporting no symptoms requiring attention. Items pertain to positive (e.g., happy) and negative (e.g., hostile) moods.

The Multiple Affect Adjective Check List-Revised (MACL-R) consists of 132 adjectives that ask respondents about their present state (i.e., “How do you feel today?”) and their more enduring trait (i.e., “How do you generally feel?”). It requires a sixth-grade reading level and measures both positive affect (e.g., friendliness, affectionate, and loving) and negative affect (e.g., anxiety, depression and hostility). It comes in two alternate forms.

These adjective checklists have the advantage of brevity and rapid administration. They consist of non-intrusive items that use words that are familiar to clients and a nonthreatening test format. They possess high face validity (i.e., they look like they are measuring what they claim to measure), and thus they stimulate little client test-taking resistance.

### **The Depression-Related Scales of the MMPI-2**

Two scales of the MMPI-2 provide measures of depression. The Depression (D) clinical scale is a 57-item scale that contains items dealing with subjective depression, psychomotor retardation, physical malfunctioning, mental dullness, and brooding. The major theme in this scale is psychic distress. This scale is sensitive to mood changes—a feature that makes it useful for detecting actual variations in mood.

The Depression (DEP) content scale consists of 33 obvious items that deal with distressed mood. The scale items assess lack of drive, self-depreciation, exaggerated feelings of discontent, and suicidal ideation.

The D and DEP scales differ in the emphasis they give to different symptoms of depression. The items on D refer predominantly to vegetative symptoms (e.g., problems with lack of energy, sleep, and poor appetite). Items that ask about cognitive symptoms of depression (e.g., feeling like a failure, feeling useless, and feeling lonely) have a secondary role. Scale DEP does not contain any items dealing with vegetative symptoms. All of the items assess cognitive symptoms of depression such as feelings of worthlessness, inadequacy, and inferiority.



### ***The Depression-Related Scales From the MCMI-III***

The MCMI-III contains three scales that assess for problematic mood. The 14-item Dysthymia scale asks about the absence of pleasure, loss of energy, guilt feelings, sadness, changeable moods, and general disparagement. The 17-item Major Depression scale assesses loss of energy and appetite, problems sleeping, general fatigue, absence of pleasure, feelings of emptiness, intrusive memories, suicidal thoughts, admission of past suicide attempt(s), and reports of repression. Finally, the Bipolar: Manic scale contains 13 items dealing with overactivity, elation and inflatedness, flight of ideas, variable moods, overtalkativeness, and impulsivity. The Depressive Personality Disorder scale assesses a clinical personality pattern rather than mood, but there is much redundancy between the personality disorder and mood scales.

### ***The Depression Scale of the PAI***

The PAI Depression scale (24 items) is designed to measure clinical depression. Item content pertains to both cognitive symptoms (e.g., unhappiness, pessimism, apathy, and negativism) and physical symptoms (e.g., problems with sleep, appetite, and energy). There are three subscales dealing with cognitive, psychological, and affective aspects of depression.

### ***The Depression Index From the SCL-90-R***

The Depression scale from the SCL-90-R measures common symptoms of depression, such as lack of interest, lack of motivation (apathy), suicidal ideation, withdrawal, extreme discontent and negative affect, and various bodily symptoms of depression.

### ***The Depression Index From the Rorschach Inkblot Test and Other Measures of Affect***

The Rorschach inkblot test can be scored to yield scores that pertain to the affect of depression and one major index that assesses depression.

One ratio is the relationship of form-color responses to color-form and pure color responses. A form-color response is one that describes an object that has a distinct shape and which also uses color to describe the percept. An example would be “a yellow banana.” This measures controlled emotions. A color-form response is one where the object seen is dominated primarily by its

color rather than by its form. An example would be “looks like a blue sky.” When the respondent refers only to the colors of the inkblot in forming the response, then a pure color response is scored. The last two types of responses measures impulsivity. The Affective ratio is the number of responses to the last three Rorschach cards compared to the number of response to the first seven cards. This measures the degree to which the client tends to become impulsive and drawn into emotional situations. Pure color is scored when the respondent only uses color to form the percept and indicates a failure to modulate an experienced emotion. Because many of the inkblots are black appearing on a white background, sometimes the respondent uses the white space rather than the black inkblot to form a response. This is called a space response. Space responses are scored when the test taker only uses this white space in the card to form the response. Depending on the frequency of occurrence, they can mean pessimism and negativism. The Depression Index (DEPI) clusters these and other scores into an overall index of depression. Since extensive training is required to reliably score and interpret the Rorschach, most psychologists use quicker and more objective means to assess mood.

## **Narrow-Band Measures of Depression**

### ***The Beck and Hamilton Depression Index***

The Beck Depression Inventory is a 21-item scale designed to assess clinical depression. Respondents rate each item using a 4-point scale. Since all of the items are obvious, the scale is prone to a faked-bad response set. That means that it is easy for respondents to fake responses to appear depressed when, in fact, they are not depressed, and vice versa. The Hamilton Depression Scale contains primarily items dealing with more vegetative symptoms of depression (i.e., sleep, appetite, and energy). The instrument can be used to screen for the more severe forms of depression.

### ***Measures of Mania***

Mania refers to an abnormally elevated mood that is often accompanied by both excessive cheerfulness and irritability. During a manic episode there is a decreased need for sleep, increased energy, rapid thought processes, excessive grandiosity, and distractibility. Depending on the severity of the condition, delusional



thinking may also be present. Mania differs from impulsivity in that there is a loss of self-control and a disturbance in emotions. Usually a period of deep depression follows the manic episode. This condition was known as manic depression but is now known as bipolar disorder.

### **Scale Ma From the MMPI-2**

The Hypomania clinical scale contains 46 items with four major content areas: amorality, psychomotor acceleration, imperturbability, and ego inflation. The major theme underlying these items is impulsivity.

### **Scale N From the MCMI-III**

The MCMI-III contains a 13-item Bipolar: Mania scale. Item content pertains to overactivity, elation and inflatedness, flight of ideas, variable moods, overtalkativeness, and impulsivity. Clinically elevated scores suggest a patient with labile emotions and frequent mood swings. During the manic phase, symptoms can include flight of ideas, pressured speech, overactivity, unrealistic and overexpansive goals, impulsive behavior, and a demanding quality in their interpersonal relationships.

### **The PAI Mania Scale**

The PAI Mania scale (24 items) assesses both mania and hypomania (i.e., an abnormality of mood resembling mania but of lesser intensity). Content addresses elevated mood, irritability, impatience, expansiveness, grandiosity, and exaggerated activity. The scale has three subscales addressing Activity Level, Grandiosity, and Irritability.

## **Measures of Hostility**

### **The Hostility Scale From the SCL-90-R**

The SCL-90-R Hostility scale addresses such things as anger, aggression, rage, and resentment, and more attenuated feelings such as thoughts of anger.

### **Cook-Medley Hostility Scale From the MMPI-2**

A hostility scale (Ho) based on the original item pool of the MMPI has been extensively researched as

a predictor of health outcomes and the physiological mechanisms underlying the association between hostility and health. These emotions play a role in coronary artery disease and the Type A personality style.

### **Megargee's Overcontrolled Hostility Scale**

This scale, developed from the MMPI item pool, was designed to differentiate between two types of violent criminal. Undercontrolled offenders are the type of aggressive, angry, physically violent individuals most readily recognized as dangerous by individuals and society in general. In contrast, overcontrolled offenders are seen as passive. They inhibit their aggressive impulses and generally are highly constrained until they engage in a violent physical assault. Those who knew these individuals viewed them as nice, polite members of society and are often stunned when learning of their violent behavior. The MMPI items that differentiated the undercontrolled individual reveal a passive and nonaggressive personality. Hence, the scale is labeled "overcontrolled hostility." The validity of this scale has been limited to an offender population.

## **Evaluation of Scales**

All of the scales discussed in this entry are psychometrically sound. They have acceptable internal consistency and test-retest reliabilities across a 1-week interval. Most of these scales are susceptible to faking because they contain obvious items dealing with the circumscribed mood. Some are embedded as scales in a large omnibus inventory. The effects of extracting these scales from their omnibus inventory and administering them separately are not yet well understood.

Some of these scales have a general mood scale that contains the major content components or dimensions of the mood, while others have subscales that assess specific components scale of these construct. The latter type of scale allows psychologists to check for differential endorsement of specific symptoms within a domain (e.g., endorsing cognitive but not physiological item). However, such differential endorsement is usually atypical.

These scales generally are quite adequate in doing what they are designed to do. There are very little differences between them that would warrant choosing one over the other. The choice of the scale depends on the needs of the psychologist, time considerations, the



setting and context in which the assessment occurs, and the motivation of the client.

*Robert J. Craig*

**See also** Beck, Aaron T. (v2); Bipolar Disorder (v2); Clinical Interview as an Assessment Technique (v2); Depression (v2); *Diagnostic and Statistical Manual of Mental Disorders (DSM)* (v2); Panic Disorders (v2); Psychometric Properties (v2); Psychopathology, Assessment of (v2); Test Interpretation (v2)

### Further Readings

- Beck, S. T., & Steer, R. A. (1993). *Beck Anxiety Inventory manual*. San Antonio, TX: The Psychological Corporation.
- Beck, S. T., & Steer, R. A. (1993). *Beck Depression Inventory manual*. San Antonio, TX: The Psychological Corporation.
- Conn, S. R., & Rieke, M. L. (Eds.). (1994). *16 PF 5th edition technical manual*. Champaign, IL: Institute for Personality and Ability Testing.
- Craig, R. J. (1999). *Interpreting personality tests: A clinical manual for the MMPI-2, MCMI-III, CPI-R, and 16PF*. New York: Wiley.
- Craig, R. J. (2003). Assessing personality and psychopathology with interviews. In I. B. Weiner (Editor-in-Chief) & J. R. Graham & J. A. Neglieri (Eds.), *Handbook of psychology: Vol. 10. Assessment psychology* (pp. 487–508). New York: Wiley.
- Craig, R. J. (2005). Assessing personality and mood with Adjective Checklist Methodology: A review. *International Journal of Testing*, 5, 177–196.
- Craig, R. J. (Ed.). (2005). *Clinical and diagnostic interviewing* (2nd ed.). Lanham, MD: Rowman & Littlefield.
- Craig, R. J. (2005). The clinical process of interviewing. In R. J. Craig (Ed.), *Clinical and diagnostic interviewing* (2nd ed., pp. 21–41). Lanham, MD: Rowman & Littlefield.
- Guilford, J. P., & Zimmerman, W. S. (2005). *Guilford-Zimmerman Temperament Survey*. Minneapolis, MN: Pearson Assessments.
- Megargee, E. I., Cook, P. E., & Mendelsohn, G. A. (1967). Development and validation of an MMPI scale of assaultiveness in overcontrolled individuals. *Journal of Abnormal Psychology*, 72, 519–528.
- Morey, L. C. (1991). *Personality Assessment Inventory*. Lutz, FL: Psychological Assessment Resources.
- Millon, T. (1994). *Millon Clinical Multiaxial Inventory-III: Manual*. Minneapolis, MN: Pearson Assessments.
- Millon, T. (1997). *Millon Clinical Multiaxial Inventory-III: Manual* (2nd ed.). Minneapolis, MN: Pearson Assessments.
- Pfohl, B., Blum, N., & Zimmerman, M. (1997). *Structured interview for DSM-IV personality (SIDP-IV)*. Washington, DC: American Psychiatric Press.
- Zuckerman, M., & Lubin, B. (1985). *Manual for the Multiple Affect Adjective Check List*. San Diego, CA: Educational and Industrial Testing Service.

---

## ANXIETY DISORDERS

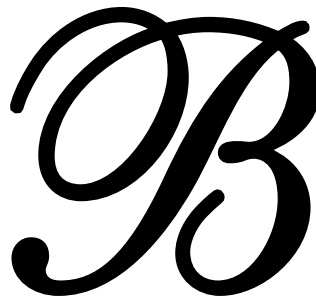
---

**See** PANIC DISORDERS









---

## **BANDURA, ALBERT (1925– )**

---

Albert Bandura was born in 1925 in a small town in northern Alberta, Canada. He was the youngest of six children and the only son. The local schools he attended were very short of teachers, so the young students had to be self-directed in their learning. This may have been where the young Bandura began to learn what would become a central theme in his later research on human development and functioning, that of *self-directedness*, or *agency*. Bandura earned his B.A. in psychology at the University of British Columbia and his M.A. and Ph.D. at the University of Iowa. After receiving his doctoral degree in 1952, under the direction of Arthur Benton, he joined the faculty of the Department of Psychology at Stanford University where he has spent his entire professional career.

### **Early Social Learning Theory: The Importance of Observational Learning**

Albert Bandura is one of the founders of behaviorally-oriented approaches to behavior change, including behaviorally-oriented psychotherapy. The psychodynamic drive model dominated the field of psychotherapy when he began his academic career, so his early work was met with skepticism and resistance from the established psychotherapy community. Beginning with his landmark 1963 book *Social Learning and Personality Development*, coauthored with R. Walters, he proposed a learning model based on the important role of observational learning and the consequences of behavior. He then began a major program of research

focusing in particular on the role of *observational learning* (also known as *imitation* or *modeling*) on the behavior of children.

Bandura soon applied his work to the treatment of adults with phobias, first snake phobia and later the broader family of agoraphobias. The treatment that evolved was based on the idea of *guided mastery* and designed to decrease fears by gradually increasing the client's sense of confidence or mastery in the behavioral domain in question. This guided mastery involved successful exposures to the feared stimuli through modeling, for example, of the therapist successfully engaging in the feared behavior, along with exposure to a graded series of "approach" tasks.

### **The Emergence of Self-Efficacy**

While evaluating these guided mastery treatments, Bandura found that they often generalized to other domains of behavior. For example, clients successfully treated for an animal phobia often showed gains in social confidence and public speaking confidence. Bandura concluded that the success of the treatment was actually the result of increased *self-efficacy expectations* (i.e., an increased sense of confidence in one's own behavioral competencies) with respect to the target behavior (and often other domains of behavior). In the 1970s he proposed a theory of behavior change with self-efficacy as the underlying causal mechanism. He theorized that psychological treatments worked because and to the extent that they were successful in increasing clients' perceptions of self-efficacy with respect to target behaviors. Based on the assumption of self-efficacy as the underlying mechanism of change,



the counselor could design interventions designed to increase self-efficacy expectations.

Bandura noted in his 1977 book, *Social Learning Theory*, that *perceived self-efficacy* refers to “beliefs in one’s capabilities to organize and execute the courses of action required to produce given attainments” (p. 3). Higher levels of self-efficacy are postulated to lead to “approach” rather than “avoidance” behavior, to better performance of enacted behaviors, and to persistence in the face of obstacles and disconfirming experiences. Bandura’s theory identifies four sources of efficacy information that both lead to the initial development of efficacy expectations and can be used to increase them: *performance accomplishments*, *vicarious learning* (modeling), *emotional arousal* (anxiety), and *social persuasion and encouragement*.

The concept of self-efficacy expectations is now widely used to develop counseling interventions to help with a variety of types of problems, including low social confidence, difficulties in educational and career decision making, development and maintenance of healthy behaviors, and avoidance of risky behaviors such as drug and alcohol abuse and unsafe sexual behaviors. In adolescents, perceived self-efficacy for affect regulation has been found to be related to higher self-efficacy in managing academic development and resisting pressure to engage in anti-social behaviors. Perceived coping self-efficacy also has been found to be related to recovery from traumatic experiences such as natural disasters, terrorist attacks, and sexual and criminal assaults. Self-efficacy concepts have been used to facilitate exercise programs in the elderly, and to assist people with disabilities, female offenders, and battered women. Such interventions require, in essence, that the counselor design a program including elements of the four sources of efficacy information—new performance accomplishments (successes), modeling of new behaviors, anxiety management, and verbal persuasion, encouragement, and social support.

### **Social Cognitive Theory: An Agentic Perspective**

As his work evolved, Bandura expanded his focus to what he called *social cognitive theory*. This represents Bandura’s attempt to understand the core element of what it means to be human, which for Bandura is the quality of *human agency* (i.e., the capacity to exercise control over the quality and directions of one’s life).

There are four features of agency—intentionality, forethought, self-reactiveness, and self-reflectiveness.

*Intentionality* is the formulation of plans for future action. Intentions are action plans directed toward some future desired goals. In some situations, intentions must involve a collective or community if collective agency is to be served. *Forethought* is the anticipation of future events—projected goals toward which individuals guide their behavior and the anticipated outcomes of their behavior. These can also be called *outcome expectations* or *incentives*.

*Self-reactiveness* is individuals’ capacity to monitor and modify their behavior to serve goals and desired outcomes. *Self-reflectiveness* involves self-observation and self-examination, but those alone are insufficient. Plans require action in order to be realized. Self-reflectiveness also requires changes in behavior based on the self-observations. The individual’s self-efficacy beliefs are the most important basis for determining whether the individual will engage in the effective self-regulation of behavior.

Bandura and others are now applying social cognitive theory, including these four central elements, to a wide range of individual and societal issues that require agentic responses for adaptive functioning and adjustment. In addition, Bandura has written that the concept of agency can be applied beyond personal agency to agency by proxy and collective agency. *Agency by proxy* occurs when we rely on others to act in agentic ways to help us meet our goals. *Collective agency* occurs when we rely on socially coordinated and interdependent actions. Central to collective agency is *collective efficacy*, essentially the shared belief that a group can work together to achieve its goals. Bandura has discussed the usefulness of collective efficacy in understanding the effective functioning of the family unit, educational systems, business organizations, athletic teams, the military, and political systems.

### **Awards and Honors**

It is difficult to overestimate the impact of Albert Bandura’s work on the field of psychology in general and counseling in particular. His work on collective efficacy is now influencing fields such as political science, economics, and business. Not surprisingly, Bandura has received much recognition and many honors in his career. He has been elected president of the American Psychological Association and Western Psychological Association, and honorary president of the Canadian Psychological Association. He has been



awarded the Distinguished Scientific Contributions Award of the American Psychological Association, the William James Award of the American Psychological Society, the James McKeen Cattell Award for Distinguished Achievement in Psychological Science from the American Psychological Society, election to the American Academy of Arts and Sciences, and, most recently, the Gold Medal Award for Lifetime Achievement in the Science of Psychology from the American Psychological Foundation. He is the author of nine books and hundreds of journal articles and has served on the editorial boards of more than 30 journals. He continues to publish actively.

Nancy E. Betz

*See also* Behavior Therapy (v2); Career Decision Scale (v4); Personality Theories, Social Cognitive (v2); Self-Efficacy/Perceived Competence (v2); Self-Esteem (v2); Social Cognitive Career Theory (v4)

### Further Readings

- Bandura, A. (1977). *Social learning theory*. Englewood Cliffs, NJ: Prentice Hall.
- Bandura, A. (1986). *Social foundations of thought and action: A social cognitive theory*. Englewood Cliffs, NJ: Prentice Hall.
- Bandura, A. (1997). *Self-efficacy: The exercise of control*. New York: Freeman.
- Bandura, A. (2000). Exercise of human agency through collective efficacy. *Current Directions in Psychological Science*, 9, 75–78.
- Bandura, A. (2001). Social cognitive theory: An agentic perspective. *Annual Review of Psychology*, 52, 1–26.
- Bandura, A. (2001). Swimming against the mainstream: The early years in chilly waters. In W. T. Donohue, D. A. Henderson, S. C. Hayes, J. E. Fisher, & L. J. Hayes (Eds.), *A history of the behavioral therapies: Founders' personal histories*. Reno, NV: Context Press.
- Bandura, A., & Walters, R. H. (1963). *Social learning theory and personality development*. New York: Holt, Rinehart, & Winston.

---

## BECK, AARON T. (1921– )

---

Aaron Temkin Beck is an American psychiatrist and the father of *cognitive therapy*—the most empirically supported form of psychotherapy to date. Beck was

born on July 21, 1921, in Providence, Rhode Island. He attended Brown University, majoring in English and political science. Beck graduated magna cum laude in 1942. He attended Yale Medical School and attained his M.D. in 1946. In 1954, Beck joined the Department of Psychiatry at the University of Pennsylvania. He is currently a Professor Emeritus at the University of Pennsylvania. He also serves as director of the Center for the Treatment and Prevention of Suicide, President of the Beck Institute for Cognitive Therapy and Research, and Honorary President of the Academy of Cognitive Therapy. Beck has published over 450 research articles and more than 17 books. He is listed among the 10 individuals who shaped American psychiatry and is considered one of the five most influential psychotherapists of all time.

In the 1960s, Beck was interested in validating various psychoanalytic concepts to make them more accessible to the scientific community. He made depression the focus of his research. Rather than finding evidence supportive of the psychoanalytic formulation that depression was a result of anger turned inward, Beck instead documented themes of rejection, defeat, deprivation, and sensitivity to failure in the thoughts and dreams of depressed individuals. Beck also noticed that depressed mood was typically preceded by very rapid negative thoughts and that by helping people to become aware of these thoughts, test their validity, and modify unhelpful cognitions, their depression would improve. This research spawned the beginning developments of cognitive therapy.

Cognitive therapy was originally developed for the treatment of depression but has now been applied successfully to a number of psychiatric conditions, including anxiety disorders, eating disorders, schizophrenia, personality disorders, substance abuse and dependence, bipolar disorder, couples therapy, and crisis management. The main assumptions underlying cognitive therapy are that cognition affects behavior, cognition may be monitored and altered, and helping individuals to alter the way that they interpret information can effect long-term change on their emotional and behavioral functioning and prevent the recurrence of psychopathology.

In addition to his contributions to the development and validation of cognitive theory and therapy, Beck has also firmly established himself in the area of test construction. Along with his colleagues, Beck has developed some of the most well-known and frequently utilized self-report instruments available for



research and practice. The most popular of these measures is the Beck Depression Inventory-II, which assesses the severity of depressive symptoms.

Beck's theory, research, and practice have garnered tremendous support in both the scholarly and therapeutic communities. Although they originated in attempts to understand psychopathology and personality problems, Beck's theory and therapeutic approach also have important implications for understanding everyday normative psychological functioning and for counseling psychology.

David J. A. Dozois

*See also* Affect (Mood States), Assessment of (v2); Cognitive-Behavioral Therapy and Techniques (v2); Cognitive Therapy (v2); Depression (v2); Personality Theories, Cognitive (v2); Psychoanalysis and Psychodynamic Approaches to Therapy (v2); Psychopathology, Assessment of (v2)

### Further Readings

Beck, A. T. (2005). The current state of cognitive therapy: A 40-year retrospective. *Archives of General Psychiatry*, 62, 953–959.

Dozois, D. J. A., Frewen, P. A., & Covin, R. (2006). Cognitive theories. In M. Hersen & J. C. Thomas (Series Eds.), J. C. Thomas & D. L. Segal (Vol. Eds.), *Comprehensive handbook of personality and psychopathology: Volume 1. Personality and everyday functioning* (pp. 173–191). New York: Wiley.

### Web Sites

Academy of Cognitive Therapy: <http://www.academyofct.org>

---

## BEHAVIOR THERAPY

---

Behavior therapy does not assume that, at their core, humans are inherently positive or negative. Behavior therapy assumes that, within biological constraints, humans are complex learners. Sometimes rich repertoires of positive behaviors are learned. Sometimes excesses (e.g., high anxiety or anger) or dysfunctional behaviors (e.g., substance use, aggressiveness, or inappropriate avoidance) are learned. Sometimes people have not learned needed behavior (e.g., job

interviewing or assertion skills). Human functioning is heavily influenced by past learning and the requirements of current environments. The nature of the fit of the person and situation is critical. People who have the requisite cognitive, emotional, and behavioral skills needed in the current environment are likely to function well, but problems occur when the fit of the person to the environment is poor. If learning is the primary source of difficulty, then new learning can be the solution. Therefore, the goal of behavior therapy is to help the client learn to stop behaving in a certain manner and start behaving in a more effective way.

Behavior therapy is rooted in models of learning. The client's current concerns are concretely assessed and learning-based interventions are designed for effective cognitive, emotional, and behavioral functioning. Behavior therapy is action oriented and most appropriate for clients with behaviors that need to be changed, rather than those seeking self-exploration or help with decision making. Behavior therapy can be integrated with other approaches (e.g., cognitive or family therapy). An extensive body of research evidence documents the status of behavior therapy as an empirically supported intervention. This entry describes three types of learning—classical conditioning, instrumental conditioning, and vicarious learning—and explains how these types of learning are applied in behavior therapy.

## Types of Learning

### *Classical Conditioning*

In classical conditioning, new situation-response associations are developed through temporal pairing of new situations with events that currently elicit a response. With repetition, people come to react with the old response in the new situation. Many counseling-relevant examples of classical conditioning involve emotional conditioning. For example, initially a person might find that public speaking arouses only mild anxiety. Then, while making a presentation, this person makes mistakes that lead to great fear and embarrassment. Oral presentations become paired with strong negative emotional reactions such that now the person is strongly fearful when preparing or giving a speech. Classically-conditioned fear has strong motivational properties, causing escape, avoidance, and other dysfunctional behavior.



## Operant Conditioning

In operant conditioning, behavior is learned and maintained by the consequences that follow the behavior. Some consequences are external (e.g., praise from another), whereas others are internal (e.g., anxious feelings). Consequences also differ in a temporal dimension; some occur immediately, while others are delayed. Sometimes a conflict between the immediate and delayed contingences is part of the problem (e.g., avoiding a test brings a student immediate anxiety reduction but later academic difficulties). Behavior that leads to positive events (positive reinforcement) or a reduction of aversive events (negative reinforcement) will be maintained or increased. Behavior that consistently fails to lead to reinforcement (extinction) will decrease. Behavior that inconsistently or intermittently leads to reinforcement will be highly resistant to extinction and likely to persist. Behavior leading to negative, unpleasant outcomes (punishment) tends to decrease. Punishing consequences can involve the presentation of something aversive (e.g., being yelled at) or the loss of something positive or pleasant (e.g., loss of privileges).

Events co-occurring with or preceding consequences (antecedents) trigger and guide behavior because they signal likely consequences. In summary, in operant conditioning, antecedent events (internal and external) activate a person's learned behavior. The positive, negative, or neutral consequences that follow the behavior strongly influence the person to continue or change the behavior.

## Modeling or Observational Learning

In modeling, information about behaviors and their consequences is learned vicariously through observations of the situations, behaviors, and consequences experienced by others. Modeling can lead to the acquisition of new behavior (response acquisition), an increase of available behavior presently not performed (response facilitation), or a decrease in behavior (response inhibition) due to the adverse consequences to the model.

These learning processes often operate interdependently. For example, a fear might be developed through classical conditioning or modeling. Defensive, avoidant, and other dysfunctional behavior may be strengthened due to powerful negative reinforcement effects of the fear reduction produced by these behaviors.

## Characteristics of Behavior Therapy

Behavior therapists attempt to understand behavior within these learning models and employ learning-based strategies to bring about positive change. This learning-based understanding of human behavior leads to some broad characteristics of behavior therapy.

### Behavioral Specificity

Learning can be very situation specific. A person may respond effectively in one situation and poorly in another. For example, clients may not be "unassertive." They may respond respectfully and appropriately with coworkers, anxiously and acquiescently with supervisors, and aggressively with intimate partners. A corollary is that behavior therapists do not conceptualize client concerns in terms of broad intrapersonal characteristics (e.g., low self-esteem or chronic anxiety). Instead, they see problems as happening in specific contexts. Sometimes, the range of contexts is quite broad, but behavior therapists try to understand client concerns in terms of specific contexts, forms of responding, and outcomes or consequences.

Because learning histories are so varied, behavior therapists do not assume that the same stated client concern results from similar factors in different clients. For example, three clients might present with social anxiety. One may have conditioned strong emotional/physiological arousal that interferes with functioning and leads to avoidance. Another may never have developed needed social skills and consequently suffers interpersonal rejection. A third may have adequate skills but excessively high performance expectations and be highly demanding and self-critical, thereby being overly vigilant and anxious. Similar problems may be due to very different factors and require quite different interventions.

### Behavioral Assessment†

Behavior therapists approach client concerns with a careful assessment of *antecedent-response-consequence cycles* to understand the meaning of the client's stated concerns. Behavioral assessment often involves detailed interviewing and exploration of specific examples. Since not all issues can be understood by talking about them, assessment often involves observation during *naturalistic conditions* (e.g., marital discussion), *simulations* (e.g., role-play of giving negative feedback), or *imagery review* (e.g., visualization of a recent social



encounter). With client permission, information may be obtained from others (e.g., parents, employers, teachers, or intimate partners). *Archival information* (e.g., nursing notes, school records) also may be sought. *Issue-specific questionnaires* (e.g., a speech anxiety or assertiveness questionnaire) may be administered. The results of these are not used normatively, but as samples of the person's report about responses in the situation.

Information from these various sources is integrated, and clients and therapists develop a detailed, shared behavioral understanding of the antecedent-behavior-consequence sequence that forms the client's concerns. This understanding also leads to ways of monitoring key elements (e.g., frequency of behavior, anxiety intensity ratings on 0–10 scale, daily completion of the Beck Depression Inventory), which furthers ongoing understanding and assists in evaluating therapy effectiveness.

### **Behavioral Interventions**

If behavior is primarily learned responding, then learning-based interventions that alter one or more element of the antecedent-behavior-consequence sequence should increase desired outcomes. Since internal responding (i.e., feelings, imagery, self-talk) follows the same learning processes, learning-based interventions also can be brought to bear on internal responses.

*Modifying Antecedents.* Problematic behavior often exists in complex chains of behavior, so altering antecedents can change behavior in a number of ways. One strategy is for the person to avoid cues for problem behavior (e.g., someone with a drinking problem not socializing with an alcohol-abusing friend, couples not discussing problems when they are tired or consuming alcohol). Another strategy is building in a pause or a time-out, thereby interrupting the chain of events leading to problem behavior. When clients are about to engage in the problem behavior (e.g., yelling at their children), they remove themselves from the environment so that they interrupt their automatic, overlearned behavior and it does not continue. The clients may rehearse effective behavior (e.g., calmly making a request of their children) during this pause as well.

A variant is for the client to record undesired behavior before engaging in it. The act of recording breaks up the chain of antecedents and provides greater control over the behavior. Some environments

trigger multiple, conflicting behaviors. For example, an insomniac may read, ruminate, worry, do work, watch television, and eat in bed, making falling asleep difficult. Such insomnia may respond to stimulus narrowing in which all behaviors, other than sleep and sexual activity, take place in other environments. Other problem behaviors that occur in many environments (e.g., overeating, sulking, worrying) respond to stimulus narrowing (e.g., engaging in them only at a specific place and time).

Another way of modifying antecedents is to explain to clients how to systematically present cues for the desired behavior. For example, depressed clients might place a colored dot on their watch and rehearse realistic, positive self-appraisals whenever they look at the watch. The social environment may be reprogrammed so that friends and family prompt desired behavior. Clients can also preprogram the environment to reduce problem-eliciting antecedents (e.g., removing alcohol or high calorie foods). The person's internal environment may be altered so that negative self-talk or feelings such as anxiety do not trigger problem behavior. Developing specific self-instructions for initiating desired behavior also can be effective. In summary, undesired behaviors can be decreased and desired behaviors increased by clients' systematically changing the antecedent events that prompt them.

*Modifying Behavior.* Sometimes the goal is developing new, effective behaviors (e.g., job seeking or parenting skills). Behavior therapists focus on identifying needed skill components and providing experiences in which those skills are rehearsed until clients can use them naturally. Two examples, relaxation coping and assertiveness skills training, are described below.

Highly anxious, stressed, or angry clients may not know how to calm themselves and use skills they have to cope with the situation. Relaxation coping skills programs address these deficits.

First, clients are taught to recognize the internal and external cues for problem emotions so they know when to employ relaxation. Sensitivity to distress cues is developed by activities such as keeping diaries on emotional experience, attending to areas of greatest tension during relaxation practice, and attending to arousal during in-session coping practice. Simultaneously, clients learn a basic relaxation response, usually through progressive relaxation training. As clients become proficient at relaxing, they learn ways to initiate relaxation quickly (e.g., relaxation without tension, cue-controlled



relaxation). Then they are provided in-session training in applying relaxation for emotional control. For example, anxious clients might visualize anxiety arousing situations, experience anxiety for 30 to 60 seconds, and then initiate relaxation to lower arousal.

During early therapy sessions anxiety arousal is mild to moderate, and therapists provide assistance in initiating relaxation. As clients experience success, the anxiety level is increased and the therapist assistance decreased so clients gain full self-control over their initiation of relaxation. Clients also practice the application of relaxation coping skills in external problem situations so they can employ relaxation whenever needed. Relaxation coping skills programs are effective with anxiety, fear, stress, anger, headaches, pain, and related forms of emotional discomfort.

Some clients' difficulties involve problems in assertiveness. Assertiveness requires an active, positive, expression of self, while respectfully entertaining and supporting the expression of others. Assertiveness is not a single behavior. For shy, inhibited individuals, assertiveness may mean giving voice to thoughts, feelings, and preferences; making reasonable requests of others; standing up for one's rights; setting interpersonal limits; expressing positive feelings toward others; and doing so without anxiety and reticence. For angry, aggressive individuals who express themselves but override and disrespect others, assertiveness may mean slowing down, not jumping to conclusions, actively listening to others, expressing themselves in calmer ways, sharing preferences without demand and intimidation, and respectful negotiation.

When assertiveness deficits and situations in which they occur are identified, therapist and client discuss appropriate behaviors for the situation. The therapist may model examples. Then, one or two aspects of the desired responding are specified (e.g., content of response, voice volume, or nonverbal behavior) and the client role-plays and rehearses those behaviors. The rehearsal is then debriefed; the client describes the experience, and the therapist reinforces and supports gains and clarifies remaining issues. The experience is repeated with attention to old and new behavioral elements.

Assertive behaviors are practiced in a natural setting with positive elements reinforced and troublesome behavior addressed in subsequent sessions. Over time, clients develop general principles and strategies of assertiveness and a flexible repertoire of assertive behaviors. Assertiveness training is effective

with timid, acquiescent individuals and with angry, aggressive individuals, and it is used in psychoeducational experiences for enhancing the well-being of nonclients.

*Modifying Consequences.* The law of effect draws attention to the fact that we can modify the consequences that follow behavior to develop desired behavior. Therapists, clients, and others can deliver consequences. Client and therapist can arrange for positive events to follow desired behavior (positive reinforcement). For example, parents might allow their youngster extra time with friends for expressing displeasure in a nonaggressive manner, or depressed clients might provide themselves with contingent amounts of video watching for initiating and engaging in social and physical activity.

Following a low-frequency but desired behavior with a higher-frequency, nonproblem behavior is also positively reinforcing. For example, a depressed person could follow a subvocal repetition of positive self-statements with a sip of coffee or tea.

Negative reinforcement (strengthening behavior by the reduction of negative outcomes) also can be employed. For example, a problem drinker might visualize starting to drink followed by an intense sensation of being about to vomit, and then visualize throwing the drink into the sink and experiencing relief of these aversive feelings. Initially, desired behaviors are reinforced every time they occur to maximize success. Over time, however, the frequency of reinforcement is reduced to make the behavior more likely to persist.

Punishment is another contingency that can be used to suppress behavior. For example, a man who ruminates obsessively about his ex-partner could self-administer a strong rubber band snap to decrease rumination. Punishment is used sparingly to prevent negative side effects. Where possible, removal of positive events is preferred over contingent presentation of painful stimuli. Every effort is made to combine punishment with the reinforcement of desired behavior. For example, smokers or alcoholics might visualize initiating problem consumption immediately followed by a noxious event such as vomiting (punishment). In other visualizations, they visualize initiating problem behavior, but stopping before consumption followed by a great sense of relief from not vomiting, thereby negatively reinforcing the desired behavior (i.e., resistance to temptation).



*Extinction* (not following a behavior with reinforcement) can reduce undesired behavior. One example is the use of exposure and response prevention in treating anxiety. Initially, certain situations elicit strong anxiety in the client, leading to dysfunctional avoidance and escape. These undesirable behaviors are strengthened by the negative reinforcement of anxiety reduction. To reverse this, clients are exposed to the cues that cause anxiety, but they are not allowed to avoid or escape, thereby preventing reinforcement of the undesirable behavior. With repetition, the association between the eliciting cues and anxiety is extinguished, as is the connection between anxiety and avoidance. Generally, exposure is gradual (i.e., it starts with low levels of anxiety and increases over time). Exposure and response prevention is often combined with interventions to enhance effective behavior. Exposure-based interventions are highly effective with phobic, panic, posttraumatic, and obsessive-compulsive issues.

### ***Flexible Structure***

Behavior therapy may not follow a regularly scheduled hour in the office. For example, exposure and response prevention and parenting skills training often require greater time. Intervention may take place in naturalistic settings (e.g., in a store with an unassertive client returning an item) or in simulated environments (e.g., in front of a camera for speech-anxious people). Behavior therapists employ homework and contracted tryouts outside counseling to extend and solidify clients' behaviors in their natural environments. Clients keep records of the assignments they complete outside the counseling sessions, and these are reviewed and used in planning further intervention efforts. Behavior therapists construct learning experiences to be efficacious, rather than limit them to an office hour.

### ***Maintenance and Relapse Prevention***

Behavior therapists expect difficulty in maintaining gains for many reasons. New behaviors are fragile and old behaviors are often highly reinforced. Environments and reinforcement contingencies shift. Times of stress may reinstate old conditions and reactions. Behavior therapists inform clients to expect slips and discuss maintenance and relapse prevention in the late stages of therapy. For example, conditions that often contribute to relapse are identified, and

strategies to minimize them are rehearsed. Clients may continue recording behaviors to keep a focus on maintenance. Therapists review records, reinforce maintenance, and troubleshoot problems. Later sessions might be scheduled further apart so clients have greater opportunity for relapse, which is addressed in subsequent sessions. Brief intervals of new counseling might be initiated to address relapse. Whatever the format, maintenance and relapse prevention are anticipated, normalized, and addressed.

### ***Client Readiness***

Behavior therapists expect resistance to change. Clients may not wish to give up reinforcement. Clients may have learned to externalize the source of behavior and blame others. Change may be avoided because it is associated with anxiety. Clients may not understand the nature of their issues, much less be ready to change. Such things lower client readiness for change.

When behavior therapists accept a client who is not yet ready for change, readiness for change becomes the initial focus of intervention. For example, rather than trying to convince angry, externalized clients to reduce their anger and aggression, behavior therapists might focus on an exploration of the consequences of client behavior. They could explore whether the clients are getting everything they want from their behavior or have their clients collect information from others regarding the impact of their behavior. Change may become the focus of therapy, but only when the clients are ready for change.

### ***Behavioral Groups***

Behavior therapy is often provided in groups. Groups are time limited, issue focused (e.g., anxiety reduction or assertiveness training), and sequentially structured to provide learning experiences that maximize success and minimize anxiety. For example, a group of unassertive, timid clients could be introduced to the notion of assertiveness and assisted in a series of graded steps to identify, rehearse, and employ assertive responding in daily life.

Behavioral groups offer the efficiency of group counseling and other benefits. Groups provide many different models and styles for behavioral rehearsal. Groups also provide different opinions about effective behavior, thereby leading to uniquely satisfying definitions of behavior for the individual. Modeling



effects may be enhanced by group work. In individual therapy, the therapist may be perceived as an expert, thereby making the gap between therapist and client too large for effective modeling. This problem is reduced in behavioral groups, because other group members serve as models during behavioral rehearsal. Other members also serve as powerful prompts for the desired behavior, and they can reinforce the desired behavior both within and between sessions (e.g., in a group of displaced workers, group members can call each other and support each other's job search behaviors). Behavioral groups can also occur in psychoeducational contexts in which nonclient participants are brought together to develop desired behaviors (e.g., stress or anger management).

### ***Behavioral Consultation***

Behavior therapists often consult with other professionals by conducting behavioral assessments and by designing and evaluating interventions. For example, behavior therapists might consult with school staff to design and implement interventions to diminish students' problem behavior. They might consult with nursing home staff to identify behavioral strategies that will increase client activity level and self-sufficiency and decrease depression. In this role, behavior therapists are a resource to the primary agents of change.

### ***Self-Directed Change***

Behavioral interventions can be highly self-directed. People may take classes on general principles of behavioral analysis and change or topic-specific classes (e.g., weight management or parenting skills). Instructors provide learning strategies and serve as consultants in the design and implementation of self-change projects. People may undertake self-directed change without professional assistance by using some of the detailed behavioral self-help materials that are available.

## **Other Therapy Issues**

### ***Therapeutic Relationship***

Behavior therapy regards the counseling relationship and alliance as very important, but not necessarily as the central factor in change. Clients may

withdraw from therapy if the behavior therapist is not a warm, supportive, empathic listener, because the client does not feel safe and trusting. A positive relationship allows clients to feel safe enough to reveal details about their lives from which collaborative conceptualization and intervention can be developed. Without a positive relationship, behavior therapists cannot conduct a thorough analysis of client concerns and clarify examples of critical antecedent-behavior-consequence sequences. Moreover, a positive relationship is very powerful in encouraging and reinforcing clients as they undertake new behaviors or take steps toward trying out anxiety-laden behaviors. For these reasons, the counseling relationship is considered a necessary condition for successful behavior therapy. The relationship supports and makes possible changes in environmental and learning conditions, which are the necessary conditions for lasting change.

### ***Attention to Emotion***

Behavior therapy is sensitive to feelings and emotions. Sometimes feelings (e.g., fear, depression, resentment, shame, and/or guilt) are primary issues and the target of intervention (e.g., anxiety or anger reduction). Learning to use a facilitative emotional tone is often an important part of a client's skill development. For example, emotional tone and paralinguistic characteristics are important elements of rehearsed behavior in assertiveness training (e.g., requests should be initiated in a calm, firm, respectful manner and compliments should be given with a positive voice inflection). Furthermore, behavior therapy may focus on behaviors and activities that increase positive emotions. Interventions may help clients scan for and take advantage of naturally occurring positive events or increase behaviors leading to positive feelings and a sense of mastery and self-efficacy.

Emotional reactions may be involved in another way. Clients are not likely to engage in new behavior that is culturally incongruent or generates conflict with their important attitudes and values (e.g., angry clients may initially be unwilling to try assertive behaviors because they interpret assertiveness as a sign of weakness or vulnerability). In behavior therapy such interpretations and feelings become the focus of intervention (e.g., helping clients understand how the behavior fits positively valued constructs and is therefore a sign of strength and self-empowerment).



Thus, behavior therapy is very emotionally focused, even if some of its language is not.

### **Insight**

Behavior therapy does not assume that deep cognitive and emotional exploration of family of origin or early traumatic issues is necessary for change. Behavior therapy may focus on earlier life issues to learn what they can teach about current problems and their maintenance and change. If the client's anxieties or dysfunctional behaviors are linked strongly to earlier issues, therapy may focus on these issues. The goal is not to provide insight, however, but to reduce anxiety and develop alternative, positive coping strategies. Behavior therapists do not believe that a deep understanding of earlier life issues is sufficient to affect a resolution of current concerns.

### **Cultural Sensitivity**

Behavior therapy is very sensitive to culture. In a general sense, culture is a broad set of norms, expectations, and sanctions for behavior. Behavior therapists assess these cultural norms and sanctions and make interventions consistent with the person's cultural experiences. Failure to do so would encourage clients' dysfunctional behavior and resistance to change, in addition to increasing the likelihood that clients will drop out of therapy. For example, relaxation interventions may be inconsistent with the beliefs of certain ethnic or religious groups. In a situation where the client belongs to such a group, a form of relaxation that fits with the client's cultural beliefs would be sought and integrated into therapy.

Culture may be a focus of behavioral intervention in at least two other ways. First, people may experience a cultural conflict where settings call for different behaviors (e.g., the client's culture of origin encourages deference to authority, whereas a current work environment encourages challenges to authority and an open, animated expression of ideas). Conflict, ambivalence, and avoidance may ensue. Therapy explores different cultural expectations and reinforcement structures and how to behave differently, yet comfortably, in different cultural contexts.

On other occasions, a change in culture may be considered. For example, delinquents and substance abusers often exist in subcultures that model and reinforce deviant, self-defeating behavior. Intervention

may focus on the client's changing environments, developing skills to resist reentering deviant environments, and developing new skills and reinforcement structures.

### **Conclusion**

Behavior therapy emphasizes the action-oriented psychological interventions based on learning theory that are most useful for clients who wish to change behaviors. The underlying premise of behavior therapy is that dysfunctional behaviors are learned and that clients can learn to discontinue those dysfunctional ways of behaving and substitute more effective ways of behaving in their place. Behavior therapy can be used by itself or integrated with other therapeutic approaches. An extensive body of research documents the effectiveness of behavior therapy.

*Jerry L. Deffenbacher*

**See also** Cognitive-Behavioral Therapy and Techniques (v2); Counseling Theories and Therapies (v2); Dialectical Behavior Therapy (v2); Homework Assignments (v2); Personality Theories, Behavioral (v2); Personality Theories, Social Cognitive (v2); Person-Environment Interactions (v2); Rational Emotive Behavior Therapy (v2); Skinner, B. F. (v2)

### **Further Readings**

- Alberti, R. E., & Emmons, M. L. (2001). *Assertiveness and social skills training: A practical therapist guide*. Atascadero, CA: Impact.
- Alberti, R. E., & Emmons, M. L. (2001). *Your perfect right: Assertiveness and equality in your life and relationships* (8th ed.). Atascadero, CA: Impact.
- Best practices for therapy: Empirically based treatment protocol series* (a series of behavior therapy manuals for issues such as anxiety, depression, phobias, obsessive-compulsive disorder, and anger). Oakland, CA: New Harbinger.
- Hays, P. A., & Iwamasa, G. Y. (2006). *Culturally responsive cognitive-behavioral therapy: Assessment, practice, and supervision*. Washington, DC: American Psychological Association.
- Watson, D. L., & Tharp, R. G. (2001). *Self-directed behavior: Self-modification for personal adjustment* (8th ed.). Belmont, CA: Wadsworth.
- Wolpe, J. (1992). *The practice of behavior therapy* (4th ed.). New York: Allyn & Bacon.



---

## BIPOLAR DISORDER

---

Bipolar disorder (previously known as manic depression or manic depressive illness) is a psychiatric disorder marked by extreme shifts in mood from severe depression to mania (a highly activated state). The cyclical mood fluctuations that characterize this disorder can be devastating for the individual and family members and often result in significant impairment in social, interpersonal, and occupational functioning. Bipolar disorder is a serious illness that requires ongoing psychiatric and psychological treatment. Untreated individuals with bipolar disorder have a significantly higher lifetime rate of attempted suicide (25%) and completed suicide (10%–15%).

### Common Symptoms

The most severe form of the disorder, *bipolar I disorder*, is characterized by one or more manic or mixed (simultaneously manic and depressed) episodes of sufficient severity to cause marked impairment in social and occupational functioning, often resulting in a psychiatric hospitalization. Typically, people with bipolar I disorder experience extreme fluctuations in mood ranging from severe depression to mania. During manic episodes people experience euphoric, elevated, or irritable moods in which they may become highly energized, have an inflated sense of self-esteem, experience a reduced need for sleep, become very talkative, have racing thoughts, take on multiple projects at once, and become easily distracted.

People in a more severe state of mania may lose their normal sense of judgment and may undertake risky behaviors with the potential for painful negative consequences. In the most severe stages of acute mania individuals will become disorganized in their behavior and thought processes. These individuals may appear bizarre to others, and they may experience strange or unusual ideas.

*Bipolar II disorder* is distinguished from bipolar I disorder by the presence of a milder form of mania called hypomania. Hypomanic episodes are characterized by a shorter duration (4 days versus 7 days) than manic episodes and less severe impairment in social and occupational functioning. Hypomanic episodes do not terminate in grossly disorganized behavior or psychotic features that typically require hospitalization. While bipolar II disorder is often thought of as a

“milder form” of the disorder, individuals with this disorder have a high risk of suicide and a severe depressive course just as devastating as that experienced in bipolar I disorder. Individuals with bipolar II disorder may have significant interpersonal and occupational problems due to ongoing fluctuations in mood.

Individuals with bipolar I and bipolar II disorders also experience significant periods of depression. These periods are characterized by a depressed mood and loss of interest or pleasure as well as the following symptoms: significant weight loss or decrease or increase in appetite; sleeping too much or too little; and being agitated, slowed down, or feeling fatigued. During depressed periods, individuals often report feelings of worthlessness, excessive or inappropriate guilt, diminished ability to think or concentrate, indecisiveness, or suicidal thoughts or plans. A significantly elevated risk of suicide occurs during the depressed phase of bipolar and bipolar II.

The mildest form of bipolar disorder is cyclothymic disorder, a chronic fluctuating mood disorder characterized by numerous periods of hypomanic and depressive symptoms over at least 2 years. Individuals with cyclothymic disorder are at increased risk to develop bipolar I or bipolar II disorder.

### Age of Onset

The typical age of onset of bipolar disorder is at 20 years of age in both men and women. However, 50% of individuals experience an earlier onset (some as early as late childhood). About 10% of individuals experience a late-life (post-50) onset. Women are more at risk for depression (about 2 times the rate for men), but for bipolar disorder the gender ratio of male to female is about equal. There are no known differences in the rate of bipolar disorder in different ethnic groups or cultures.

In about 60% of cases, the disorder presents initially as a severe depression, but individuals may also experience an initial severe episode of mania. The symptoms of a severe bipolar I manic episode may include extreme agitation, disorganization, and psychotic features (hearing voices or believing in strange ideas). For the individual and family members, the onset of these symptoms can be extremely confusing and profoundly disturbing, especially if the young person has never before exhibited any significant problems. Diagnosis may be complicated because these symptoms overlap with signs of drug abuse and



schizophrenia, an illness also characterized chiefly by hearing voices (auditory hallucinations) and having strange ideas (delusions).

### Prevalence

The prevalence of bipolar I disorder is estimated to be between 1% and 1.2%, significantly lower than that of depression. However, taking into account both bipolar II (less severe mania) and other “less than manic” forms of the disorder, the overall prevalence rate of bipolar disorder may be closer to 4% to 5%.

### Etiology

Bipolar disorder is one of the psychiatric disorders known to have a very strong biological and genetic basis, substantially more so than depression. The probability of developing the disorder when a close biological relative has bipolar disorder is about 15% to 20% (i.e., 15–20 times the population risk). The probability is in the 50% to 70% range when both parents have the disorder. Environmental factors also play a significant role in the timing of the initial onset, the course of the disorder (as described below), and the prognosis of the disorder.

### Course and Prognosis

There is a great deal of variability in the course of bipolar disorder. About 90% of individuals who have an initial episode of mania have a second episode. In a high percentage of cases, manic episodes occur directly after a period of depression. Individuals may experience significant periods of wellness between episodes of mania and depression or, in many cases, may experience unremitting periods of continuing low-level depression. Approximately one third have residual symptoms that interfere with their social, interpersonal, and occupational functioning. Ongoing treatment, especially adherence to medication, greatly enhances quality of life and overall outcomes for these individuals.

### Assessment of Bipolar Disorder

The current prevailing scientific view of bipolar disorder conceives of the illness dimensionally rather than categorically. That is, bipolar disorder may be viewed as a part of a spectrum of disorders ranging from depression through cyclothymic disorder to

bipolar I disorder. This view has important implications for the assessment and treatment of the disorder in that the clinician must be alert to “less than manic” forms of the illness. Careful assessment before prescribing medication is important because people with bipolar disorder experience significant periods of depression as well as distinct periods of elevated mood. About 60% of people who present initially with mainly depressive symptoms may go on to experience a manic or hypomanic episode. People who receive an antidepressant may experience a medication-induced manic or hypomanic episode. While the severe symptoms associated with bipolar I disorder are easily recognized, milder forms of the illness can be easily overlooked with significantly negative consequences.

Assessment must always include a careful screening for past indications of either hypomania or mania with or without a history of depression. Longitudinal assessments rather than one-time assessments are preferred because of the episodic nature of the illness. Finally, because of the heritability of the illness, assessment should include a careful family history.

### Treatment of Bipolar Disorder

#### *Biological Treatment*

Treatment of bipolar disorder is complex and often involves several different classes of medication, including antidepressants, anticonvulsants, antipsychotics, and mood stabilizers. Lithium continues to be the gold standard for treatment, due to research that has been conducted confirming its long-term effectiveness.

Treatment can be divided into acute and maintenance phases. For acute mania or mixed states, a first-line treatment would be lithium, valproate, carbamazepine, haloperidol, aripiprazole, olanzapine, risperidone, or quetiapine. Any of these first-line treatments may be combined with adjunctive treatments that are intended to reduce symptoms of agitation, insomnia, or anxiety. For acute bipolar depression, a first-line treatment would be lamotrigine, olanzapine, or quetiapine. For individuals with rapid cycling (more than four mood episodes in 12 months), lamotrigine is the first-line choice. For maintenance with a mood stabilizer, lithium, valproate, lamotrigine, or aripiprazole may be considered. There is some debate as to the relative risk versus benefit of continuing treatment with antidepressants, which may in some cases exacerbate the illness.



Because of rapid changes in knowledge and practice in this area, the reader is cautioned that this discussion of biological treatment is not intended to substitute for professional medical consultation and advice.

Even the best pharmacological treatment rates are completely effective in less than 50% of patients. Significant problems with adherence to treatment (i.e., taking medication consistently as prescribed) greatly limit the overall effectiveness of medication-only approaches.

### **Psychotherapy or Psychosocial Treatment**

Some people are able to remain relatively stable on a long-term medication regimen. However, adjunctive psychotherapeutic treatment should be considered for individuals experiencing continuing episodes or significant periods of mood instability marked by breakthroughs of depression, mania, or hypomania. This is especially important if marked suicidal ideation, severe hopelessness, or mood instability is causing significant problems in an individual's living and quality of life.

Treatments that have demonstrated specific evidence of effectiveness include cognitive and cognitive-behavioral therapy, developed by Albert Ellis, Aaron Beck, and others, interpersonal and social rhythm therapy (IPSRT), developed by Ellen Frank; and family-focused treatment (FFT), developed by David Miklowitz. Effective treatments appear to share several common characteristics, including education about the disorder, emphasizing medication adherence, helping patients maintain lifestyle regularity, helping patients recognize early warning signs of illness, and helping patients develop specific coping plans in order to anticipate and minimize the impact of future episodes.

*Robert P. Reiser*

**See also** Affect (Mood States), Assessment of (v2); Cognitive-Behavioral Therapy and Techniques (v2); Depression (v2); *Diagnostic and Statistical Manual of Mental Disorders (DSM)* (v2); Psychopathology, Assessment of (v2); Psychopharmacology, Human Behavioral (v2)

### **Further Readings**

Akiskal, H. S. (2005). Mood disorders: Clinical features. In B. J. Sadock & V. A. Sadock (Eds.), *Comprehensive textbook of psychiatry* (8th ed., Vol. 1, pp. 1611–1652). Philadelphia: Lippincott Williams & Wilkins.

- American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed., Text rev.). Washington, DC: Author.
- Basco, M. R., & Rush, A. J. (1996). *Cognitive-behavioral therapy for bipolar disorder*. New York: Guilford Press.
- Frank, E. (2006). *Treating bipolar disorder: A clinician's guide to interpersonal and social rhythm therapy*. New York: Guilford Press.
- Goodwin, F. K., & Jamison, K. R. (1990). *Manic-depressive illness*. New York: Oxford University Press.
- Lam, D. H., Jones, S. H., Hayward, P., & Bright, J. (1999). *Cognitive therapy for bipolar disorder: A therapist's guide to concepts, methods, and practice*. Chichester, UK: Wiley.
- Miklowitz, D. J., & Goldstein, M. J. (1997). *Bipolar disorder: A family-focused treatment*. New York: Guilford Press.
- Reiser, R. P., & Thompson, L. W. (2005). Bipolar disorder. In D. Wedding (Series Ed.), *Advances in psychotherapy: Evidence-based practices*. Göttingen, Germany: Hogrefe & Huber.

---

## **BRIEF THERAPY**

---

Brief therapy is a type of counseling that is time limited and present oriented. Brief therapy focuses on the client's presenting symptoms and current life circumstances, and it emphasizes the strengths and resources of the client. The therapist in brief therapy is active and directive. Termination of counseling is a major focus from the initial session.

### **History**

Brief therapy began to gain attention in the 1950s, following the increase in popularity of behavior therapy and family therapy. Behavior therapy emphasizes the correction of immediate problem behaviors and employs numerous behavioral techniques to facilitate change in the individual. Family therapy emphasizes the individual in the context of the family. In both therapies, the therapist is direct and active. These two therapies differ from earlier dominant therapies rooted in psychoanalytic thought that focus on the individual's insight and past, and in which the therapist is nondirective and passive. Thus behavior therapy and family therapy set the stage for the acceptance of active short-term therapeutic approaches.

The popularity of brief therapy increased in the 1980s, following empirical research on the process



and outcomes of psychotherapy. Researchers used meta-analysis, a statistical method allowing the results of many studies to be compared, to make the following conclusions about psychotherapy: (a) most clients stayed in therapy for six to eight sessions, (b) 75% of clients who reported improvement experienced benefits within the first 6 months of therapy, and (c) time-limited psychotherapy had outcomes similar to those of long-term therapy.

In addition to these research findings, societal changes increased the need and demand for brief therapy. Insurance companies, Health Maintenance Organizations (HMOs), and Preferred Provider Organization (PPOs) routinely place restrictions on the number of sessions an individual can attend. Some people, unwilling to go through insurance, elect to pay outright for their psychotherapy. Many individuals do not have the time or personal income for long-term therapy. Finally, the demand for therapy has increased while the supply of therapists (in the face of reduced fees and increased workloads) has decreased. Therefore, in many community and university counseling centers, there are not enough therapists to see clients for long-term courses of therapy. Brief therapy has become an attractive method for meeting the increased demand for counseling services in a way that is timely and cost-efficient.

## Types

There are many approaches to brief therapy. Typically, existing long-term therapies have been adapted to a short-term context. Table 1 below provides a list of the most popular approaches followed by key concepts and suggested readings for each type of therapy.

### ***Single-Session Therapy***

#### **Theory of Single-Session Therapy**

In single-session therapy, the therapist and client meet only once. The goal of single-session therapy is to encourage new learning, enhance coping, and promote growth. Typically, a single session is used to help a client shift perspective or acquire skills. Single-session therapy is most effective for individuals with specific problems who (a) need a change in perspective, (b) need an evaluation or referral, (c) feel stuck about processing a past event, (d) are looking for reassurance, or (e) have a specific problem that is within

their power to solve. In contrast, individuals in inpatient care, individuals needing continuing support to process traumatic past events (e.g., childhood sexual abuse), individuals with eating disorders or chronic pain, and individuals with conditions caused by biological or chemical mechanisms (e.g., schizophrenia) are not as likely to benefit from single-session therapy or any of the brief therapies.

#### **Techniques of Single-Session Therapy**

Diverse techniques are employed in single-session therapy. For example, the therapist may contact the client by phone before meeting to obtain detailed information about the presenting problem and to ask the client to complete specific tasks before the session. A second popular technique is to focus on ambiguity during the session. Focusing on ambiguity allows the therapist to introduce new ways of looking at the same problem. Clients often practice possible solutions during the session. Rehearsing ideal outcomes or practicing new skills can help a client feel more able to transfer skills from the therapy session to everyday life. After the session is over, the therapist informs the client that he or she can return for another session if necessary.

### ***Cognitive-Behavioral Brief Therapy***

#### **Theory of Cognitive-Behavioral Brief Therapy**

Cognitive-behavioral brief therapy focuses on schemas. *Schemas* are templates that individuals use in order to make decisions, guide responses, or explain situations. Schemas develop from life experiences and become a standard of normal behavior. Thus, whenever a critical event occurs, the individual uses a schema to decide how to react. Schemas may not be based on accurate information, so relying on some schemas may result in cognitive distortions. For example, if a child were punished whenever interrupting an adult, that child may develop beliefs that make him or her hesitant to interrupt, even as an adult.

#### **Techniques of Cognitive-Behavioral Brief Therapy**

The focus in cognitive-behavioral brief therapy is to identify and replace distorted cognitions based on schemas. Goal setting is central to cognitive-behavioral



**Table 1** Summary of types of brief therapy

<i>Type of Therapy</i>	<i>Key Concepts</i>	<i>Suggested Readings</i>
Adlerian	Roots behavior in socially-constructed meaning Focuses on who the client is and what the client wants Shifts the underlying rules of interactions	Bitter & Nicoll (2004)
Cognitive-behavioral	Identifies and replaces the client's distorted cognitions Sets goals with specific objectives Emphasizes measuring treatment effectiveness	Dziegielewski (1997)
Depth-oriented	Uncovers the hidden emotional meaning behind issues Actively engages emotional, cognitive, somatic, behavioral, and unconscious aspects	Ecker & Hulley (1996)
Eclectic	Posits that no theory can work all the time with all clients Combines several theories and uses many techniques Focuses on optimism, enhancing coping skills, adapting to change	Wells (1994)
Ecosystemic	Focuses on social systems, strengths, and persuasion Emphasizes small changes that lead to larger systemic changes Maps social systems and behavior patterns	Miller (1997)
Family	Focuses on family system issue instead of individual problem Uses intermittent sessions and one-way mirror team Has clients rate the problem on a scale from "worst it's ever been" to "best I can imagine"; increases awareness of small improvements	Kisch (1997)
Gestalt	Focuses on fragmentation and reintegration of the self Stresses the importance of nonverbal behavior Uses the empty-chair technique	Williams (2001)
Group	Recreates patterns of client interpersonal difficulties in the group Allows the client to practice new behaviors, with group members giving feedback Focuses on task assignment and problem solving	Garvin (1990)
Interpersonal	Explores interpersonal problems to identify issues Uses client-therapist relationship as a tool Connects stressful events with client's current mood	Dziegielewski (1997)
Marital	Stresses conflict resolution and communication strategies Employs I-messages, active listening, and borrowing client's voice Examines intergenerational context of learning	Magnuson & Norem (1998)
Short-term dynamic	Explores the internal phobia of experiencing a specific feeling Utilizes triangle of conflict and triangle of person Restructures defenses, affect, and attachments	McCullough & Osborn (2004)
Single session	Includes presession contact Focuses on ambiguities Has clients practice skills in session	Hoyt (1995)



brief therapy. It serves as a mechanism for measuring treatment effectiveness. Each goal should have specific objectives, be worded positively, and be realistic. Cognitive-behavioral brief therapy focuses on meeting each goal, as opposed to focusing on client insight or the process of therapy.

### **Short-Term Dynamic Psychotherapy**

#### **Theory of Short-Term Dynamic Psychotherapy**

Short-term dynamic psychotherapy focuses on affect phobia. *Affect phobia* is an internal phobia in which individuals are afraid to experience a particular feeling (e.g., anger, shame). According to short-term dynamic theory, affect is the basic motivation that drives individuals, and affect phobias are the culprit of most behavior problems.

Triangles are used to diagram conflicts and people in short-term dynamic psychotherapy. The *triangle of conflict* is used to conceptualize the way an individual avoids a feeling and the *triangle of person* is used to conceptualize the recipient of that feeling. The triangle of conflict uncovers defenses, anxieties, and adaptive feelings. Each point on a triangle is called a *pole*. The *defense pole* consists of behaviors (e.g., avoidance), thoughts (e.g., “I’m incompetent”), or feelings (e.g., fear). These defenses can be adaptive and helpful, but they become harmful when they result in maladaptive behaviors. The *anxiety pole* consists of inhibitory feelings that lead individuals to become vigilant about their own or others’ behaviors. There are four major categories of inhibitory feelings: anxiety, shame/guilt, emotional pain, and contempt/disgust. The *feelings pole* represents normal adaptive behaviors that are motivated by underlying basic feelings and impulses (e.g., grief, anger, excitement, sexual desire). These feelings can be healthy, but individuals avoid them when the feelings are associated with a negative experience. The triangle of conflict helps the therapist to identify defensive patterns used by the client to avoid feelings, identify how and why a client is using inhibitory feelings, and help the client understand the underlying affect that is being avoided.

The triangle of person helps the therapist recognize the relationships where patterns of avoidance occur. These can include past relationships, current relationships, or the relationship between the client and therapist.

#### **Techniques of Short-Term Dynamic Psychotherapy**

The goal of short-term dynamic psychotherapy is to restructure defenses, affect, and attachments. There are several main objectives. First, the client should acknowledge and understand the defensive pattern. Second, the client should be motivated to change the defensive pattern. Third, in order to desensitize the affect phobia, the client must experience and express appropriate feelings. Fourth, the therapist must listen to the client and help identify healthy feelings that can help the client to behave more effectively and experience relief from his or her symptoms.

### **Gestalt Brief Therapy**

#### **Theory of Gestalt Brief Therapy**

From a Gestalt perspective, individuals are experiencing difficulty because they have become fragmented by disowning different parts of themselves. Therefore, the aim of Gestalt brief therapy is to reintegrate the fragmented parts of the individual. Once the reintegration process has occurred, the individual can successfully interact with him- or herself, others, and the environment. In Gestalt brief therapy, the focus is on growth and process. Nonverbal cues are a key part of Gestalt brief therapy. In fact, if the verbal content of the client is in conflict with the nonverbal content of the client, the nonverbal content is usually considered more important. For example, if a client reports feeling relaxed but fidgets constantly, then the therapist would assume that the client is not relaxed. The therapist may also point out this incongruence during the session.

#### **Techniques of Gestalt Brief Therapy**

Gestalt brief therapy uses Duey Freeman’s therapeutic circle as a guide for brief therapy. There are six stages in Gestalt brief therapy. First, therapy must begin with a present or here-and-now focus. Gestalt brief therapy helps the client to increase awareness of immediate feelings, experiences, and situations. Second, an issue is identified. The therapist does not direct the client to identify a particular issue. Instead, the therapist simply helps the client increase awareness of the here and now, and trusts the client to talk about an issue that is important.

Third, the therapist may conduct an “experiment” during the session. Gestalt therapy considers techniques



to be experiments. For example, the therapist may make a client aware of nonverbal cues throughout the session. Perhaps the most popular experiment is the empty chair technique. In this experiment, a client is asked to initiate a dialogue between the two parts of the self that are in conflict, or with another person with whom the client is experiencing conflict. Each time the client switches perspectives, the client switches chairs and talks to an empty chair as if the other part of the self or the other person were in the chair.

Fourth, the therapist identifies and discusses the behavior that is causing the problem. This moves the discussion from the present to the past, but in Gestalt brief therapy, the past is discussed in the context of how the client is currently experiencing issues from the past in the present. Therefore, the emphasis is not on discussing the past, but experiencing the past. Fifth, the client and therapist explore alternative behaviors. These alternate behaviors may be external or internal. Sixth, the therapist and client discuss how life is different when trying these alternate behaviors. The therapist assists the client in the integration of these new behaviors into daily life.

### Future Directions

The increase in cost-conscious managed medical care (i.e., HMOs, PPOs) and the need to deliver services to a growing population suggest that therapists will continue to be interested in brief therapy. As brief therapy increases in popularity, therapists will become more highly trained in brief therapy and research will be conducted that will better demonstrate which brief therapies are the most effective for which psychological problems. Importantly, there are some instances in which longer-term therapy will be more beneficial (e.g., treatment of severe traumas, eating disorders, personality disorders, schizophrenia). In general, though, brief therapy is cost effective and efficacious.

*Andrea J. Miller, Joshua N. Hook,  
and Everett L. Worthington, Jr.*

*See also* Behavior Therapy (v2); Clinical Presenting Issues (v2); Cognitive-Behavioral Therapy and Techniques (v2); Counseling Theories and Therapies (v2); Evidence-Based Treatments (v2); Facilitative Conditions (v2); Mental Health Issues in the Schools (v1); Psychoanalysis and Psychodynamic Approaches to Therapy (v2); Solution-Focused Brief Therapy (v2); Therapist Techniques/Behaviors (v2)

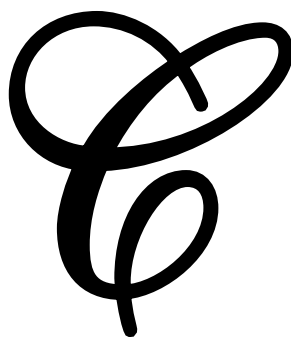
### Further Readings

- Bitter, J. R., & Nicoll, W. G. (2004). Relational strategies: Two approaches to Adlerian brief therapy. *Journal of Individual Psychology, 60*, 42–66.
- Dziegielewska, S. F. (1997). Time-limited brief therapy: The state of practice. *Crisis Intervention, 3*, 217–228.
- Ecker, B., & Hulley, L. (1996). *Depth-oriented brief therapy: How to be brief when you were trained to be deep—and vice versa*. San Francisco: Jossey-Bass.
- Garvin, C. D. (1990). Short-term group therapy. In R. A. Wells & V. J. Glanetti (Eds.), *Handbook of the brief psychotherapies* (pp. 513–536). New York: Plenum Press.
- Hoyt, M. F. (1995). Single-session solutions. In M. D. Hoyt (Ed.), *Brief therapy and managed care: Readings for contemporary practice* (pp. 281–332). San Francisco: Jossey-Bass.
- Kisch, E. H. (1997). Brief psychotherapy with children, adolescents, and their families. *Psychotherapy, 6*, 137–150.
- Magnuson, S., & Norem, K. (1998). Marital counseling: An integrated brief therapy approach. *Family Journal: Counseling and Therapy for Couples and Families, 6*, 235–238.
- McCullough, L., & Osborn, K. A. R. (2004). Short-term dynamic psychotherapy goes to Hollywood: The treatment of performance anxiety in cinema. *Journal of Clinical Psychology, 60*, 841–852.
- Miller, G. (1997). *Becoming miracle workers*. Hawthorne, NY: Aldine de Gruyter.
- Wells, R. A. (1994). *Planned short-term treatment* (2nd ed.). New York: Free Press.
- Williams, B. (2001). The practice of Gestalt therapy within a brief context. *Gestalt, 24*, 7–62.









---

## CLIENT ATTITUDES AND BEHAVIORS

---

The therapeutic process holds both majesty and mystery for its participants. Client knowledge about the process ranges from total unfamiliarity with and/or misinformation about therapy—and what to expect of it—to the unique sophistication of the client who has entered into episodic therapy with several therapists. Given that individuals bring the sum of their past experiences as well as their current state into the therapeutic process, it is appropriate to assume that client expectations, behaviors, and outcomes vary due to these and many other factors, such as temperament, early learning about relationships, capacity to trust, experience of trauma, current stress level, and cultural mores.

How, then, do therapists proceed to create a therapeutic alliance that allows the maximum gain for their clients? What client attitudes and behaviors mediate the outcome of successful therapy? How does the therapist accommodate these issues when inviting a relationship, determining a course of therapeutic action, or approaching a problem area? The American Psychological Association Division 29 Task Force on Empirically Supported Therapy Relationships has compiled information on client characteristics within the therapy relationship that have been shown to enhance therapeutic outcome. This entry addresses some of these factors.

### Meaning-Making and Attribution

The term *first impression* generally denotes an individual's immediate sense and understanding of an

encounter with a specific person or situation. Individuals may use many different pieces of information as evidence for making quick judgments about others that may become lasting beliefs. Researchers have suggested that humans have a unique ability to judge personality traits and complex social characteristics—such as dominance, hierarchy, warmth, fear, and threat—from their first impression of individuals they meet or see in a photograph.

The client's assessment of the personal character of the therapist, including the therapist's physical appearance and dress, professional reputation, assumed ethnicity, and gender, is influenced by the innumerable experiences the client has synthesized over his or her lifetime. Such impressions often lead to permanent judgments and emotional reactions to others, particularly those perceived to be in positions of authority or power. There is little a therapist can do to change clients' past experiences and how these experiences affect their relationships to the therapist and the experience of counseling. Therapists accept that some issues may be projected onto the therapist and create a distorted view of the interactions between client and therapist. Therapists then work to provide a way in which clients may be able to recognize their distortions when the distortions are pointed out by the therapist in a respectful, well-timed, and appropriate manner.

Different schools of therapy have different labels for these projective phenomena: transference and countertransference, products of early learning, personal schemas, or projective identification. The client's attribution of specific positive and negative qualities to the therapist and therapeutic process allows the therapist to understand how the client



views the world and to provide corrective emotional experiences through addressing the appropriateness and validity of the client's ascriptions. It also provides a platform for therapists to evaluate themselves and their own attributions and biases through self-reflection, supervision, or their own psychotherapy.

Clients may reenact in therapy their prior experiences in order to determine if there is truth to their beliefs or to verify that their past course of action was valid. Examples of this are clients who continually check that their therapists have scheduled the standing appointment that has been attended for months or those who will tell their therapists about others who have committed an error and then intently gauge their therapists' reactions in order to see how faults and/or past behavior may be accepted. Obviously, therapists' attention to language and the meanings of verbal and nonverbal interactions are essential for a positive therapeutic outcome.

Once therapists sense the distortions and biases of the client, they may modify their own behavior and dialogue in unique and distinctive ways. The ability to engage in conscious self-regulation varies among therapists and in different situations; clients appear to have inconsistent levels of awareness of personal schemas, scripts, value systems, cultural biases, and clinical expectations as well. An awareness of habitual ways of interpreting personal information is one of the significant benefits clients may derive from therapy. What appeared to the client to be an adaptive response to a prior problematic situation may now be seen as an irrational action or thought that is within the client's control to change if necessary.

### **Therapeutic Relationship**

Adam Horvath emphasized that a client's first impression and early therapeutic alliance or relationship may predict the outcome of psychotherapy. The therapeutic relationship is conceptualized as the quality and strength of the collaborative relationship between client and therapist in therapy and the positive affective bonds between client and therapist—mutual trust, liking, respect, and caring. It also includes the active establishment of and allegiance to the goals of therapy and the means by which these goals will be attained. The therapeutic alliance creates a sense of shared responsibility in therapy in which each participant is actively committed to his or her specific responsibilities in therapy, and

believes the other is equally committed to and invested in the process.

Clara Hill envisioned the therapeutic relationship as evolving over time as the result of the intersection of therapist techniques and client involvement. The therapist is able to employ theoretically appropriate techniques that lead to more intense client engagement and increasing therapist influence, strengthening the therapeutic relationship as it changes during the course of therapy. She viewed supportive and engaging therapist techniques as venues that permit the client to become involved in the therapy process.

### **Empathy**

Empathy is defined as the therapist's perceptive and sensitive ability and willingness to understand the client's thoughts, feelings, and struggles from the client's point of view. In a meta-analysis of empathy and psychotherapy outcome conducted by Leslie Greenberg, Jeanne Watson, Robert Elliott, and Arthur Bohart, four theoretical factors were identified as potential mediators linking empathy and therapeutic outcome. Three of the factors comprise the processes of empathy as a relationship condition, as a corrective emotional experience, and as a cognitive-affective processing condition. The fourth factor is associated with the role of the client as an active self-healer.

Relationally, empathy provides a positive bonding function. Empathy (i.e., feeling understood) increases client satisfaction with therapy and thereby increases compliance with therapist suggestions and/or homework (most often utilized in cognitive-behavioral therapy). Feeling understood has been related to increased feelings of safety in the relationship and comfort when self-disclosure occurred. In addition, clients who felt understood also felt safer when approaching difficult topic areas and appeared to stay longer in therapy rather than prematurely terminating it. Empathy offers a specific learning or corrective emotional or relational experience. Hypothetically, an empathic relationship may help strengthen the self, diminish isolation, and facilitate clients' experiences of personal value, including the possibility that they are worthy of respect and of being attended to and heard. Perceived empathy may validate the veracity of clients' feelings and behaviors. This empathic reflection and validation might eventually lead clients' to develop the ability to express their feelings and needs in relationships. Empathy may also promote exploration and creation of meaning. It helps



clients think more productively, raises levels of constructive experiencing, facilitates emotional reprocessing and decreases emotional angst due to anxiety and depression, as well as providing learning experiences.

Arthur Bohart and Karen Tallman suggested that therapy works fundamentally by supporting and encouraging clients' active self-healing efforts. Clients are seen as having innate capacities for growth and change, and therapy becomes the educational process that helps clients mobilize their resources. The therapist's empathy contributes to this process by furthering client involvement and openness to the process. In addition, it provides an "empathic workspace" where clients can draw on their capacities for self-healing. This perspective of client as "self-healer" differs from more medical views of psychotherapy wherein the therapist is viewed as the expert healer.

### Deference

Deference is commonly defined as individuals' submission of thoughts, opinion, and projected course of action to another person, who is recognized as superior in knowledge, skill, judgment, and so forth. In the therapy dyad, the therapist is generally considered more expert than the client—a situation that could be expected to exacerbate the client's deference to perceived therapist directives. This phenomenon has been overlooked in the literature on the counseling relationship. David Rennie noted that attention has been directed more to concepts presumed to relate to the process of improvement in therapy, particularly transference, resistance, empowerment, and the working alliance. Rennie postulated that clients' deference to the therapist consists of eight categories: concern about the therapist's approach, fear of criticizing the therapist, understanding the therapist's frame of reference, meeting the perceived expectations of the therapist, accepting the therapist's limitations, client's metacommunication, threatening the therapist's self-esteem, and indebtedness to the therapist.

The most direct effect of clients' deference appears to be on the establishment of a positive working alliance and, in a tangential way, the client's resistance. Being deferential to the therapist is seen as the client's way of protecting and fostering the alliance. However, deference may at times be costly for clients, sapping their energy and thereby creating difficulty with their commitment to the therapist's strategies and expectations. Nonetheless, whether clients would

appreciate a request to express dissatisfaction may be determined by the degree to which the discontent disturbs the clients' ability to focus constructively on their own processes. The awareness that many clients are extremely disposed to be deferential might increase therapists' awareness and influence their clinical judgment, and help them avoid the conflict that comes from a client's inner feelings of not being good enough, smart enough, or worthy of positive outcomes.

### Stages of Change

In the transtheoretical model of therapeutic change developed by James O. Prochaska and John Norcross, behavior change is seen as a process that unfolds over time and involves movement through a series of six stages: precontemplation, contemplation, preparation, action, maintenance, and termination. Each stage represents a period of time and a series of tasks that must be completed before movement to the next stage is possible. Although the amount of time an individual spends in each stage will vary, the tasks to be accomplished during each stage are assumed to be the same. The stages of change model provides a way of thinking about client readiness to change.

In the *precontemplation* stage, individuals do not intend to change their behavior in the near future. Most individuals in this stage are unaware or under-aware of their problems, although their intimates—family, friends, neighbors, and coworkers—are often aware of the precontemplator's problems. When precontemplators present for psychotherapy, they are likely to do so because of pressure from others. Precontemplators can wish or hope to change, but do not seriously intend or earnestly consider changing.

*Contemplation* is the stage where individuals are aware that a problem exists and are sincerely thinking about overcoming it, but have not yet committed to a course of action. Individuals often are in this stage for long periods of time. Those who state that they are seriously considering changing the problem behavior in the next 6 months are classified as contemplators. The *preparation* stage combines intention and behavioral criteria. Individuals in this stage intend to take action in the next month or so, as their past actions surrounding change have not been successful. Individuals in this stage have experienced a slight decrease in their problem, but have not yet reached a level of effective action such as the absence of anger or a decrease in their symptoms of anxiety.



During the *action* stage individuals transform their behavior, experiences, and environment in order to surmount their problems. Action involves explicit behavioral changes and requires a serious commitment of time and energy. Modifications of the problem behavior occurring during the action stage tend to be readily visible. Individuals are classified as in the action stage if they have successfully changed or seriously modified the dysfunctional behavior for a period from 1 day to 6 months.

*Maintenance* is the stage where individuals work to prevent relapse and consolidate their current gains. Remaining free of the problem behavior and consistently engaging in a positive incompatible behavior for more than 6 months are the criteria for considering someone to be in the maintenance stage. The final stage is termination. *Termination* means that individuals have completed the change process and no longer have to work consciously to prevent relapse. Termination is defined as total confidence or self-efficacy across all high-risk situations and no temptation to relapse.

At each stage of change, different processes of change generate progress. Formulating change processes to facilitate optimal change within the different stages necessitates that the therapeutic relationship correspond to the client's stage of change. As clients progress from one stage to the next, the therapeutic relationship also progresses. There is an increasing body of research evidence on how tailoring the therapy relationship to the stage of change can enhance outcome, since the various change processes are not equally effective in each stage of change.

The research by Prochaska and Norcross noted that therapists who tailored their interventions to the client's stage had clients with an increased completion rate for a course of therapy and who continued to implement and maintain change. Prochaska and Norcross's work suggested that change processes associated with experiential, cognitive, and psychoanalytic orientations appear to be most valuable during the earlier precontemplation and contemplation stages. Change processes traditionally associated with the existential and behavioral traditions, by contrast, are most useful during action and maintenance. Prochaska and Norcross recommended that therapists consider the following:

- Assess the client's stage of change; tailor therapy relationships and interventions accordingly.
- Beware of treating all clients as though they are in an action phase, as the majority of clients are not. An

estimated 10% to 20% are prepared for action, about 30% to 40% are in the contemplation stage, and 50% to 60% in the precontemplation stage.

- Set realistic goals; move one stage at a time and celebrate success as appropriate for the current stage. Helping clients move beyond the stuck phase of precontemplation is a therapeutic success. This likely doubles the chances of clients taking effective action in the next 6 months.
- Engage in interpersonal behaviors that tailor the therapeutic relationship to the client's change stage and use techniques that are consistent with the change processes that are most effective at that stage.
- Avoid mismatching stages and processes. Modifying behavior without awareness of the client's stage of change and prescribing overt action without insight into the change process and the client's stage most often engenders only temporary change.

## Self-Disclosure

Talking to others about difficult parts of themselves is a challenge for most individuals; nevertheless, it is important within the therapeutic relationship for clients to allow their therapist to know the hidden, misunderstood, even shameful parts of themselves. In general, research has shown that clients who are in moderate to long-term psychotherapy state that they view therapy as a safe place to disclose, particularly if they perceive the therapeutic relationship as good. For the most part, active participants in psychotherapy describe the disclosure process as principally generating shame and anxiety at the outset, but eventually as evoking feelings of safety, pride, and genuineness. They also note that keeping secrets inhibits their progress in therapy and disclosing produces a sense of liberation from physical and emotional tension. It is generally held that initial disclosures in therapy smooth the progress of subsequent disclosures to clients' family members and friends and the continued disclosure of difficult parts of themselves to their therapist. The consensus is that therapists should gently pursue material that is difficult to disclose.

It should be noted that therapists' self-disclosures to their clients might engender positive or negative results. The sharing of the therapists' personal and private experiences must be in the service of client understanding and comfort rather than for the therapists' self-aggrandizement. When the focus remains on the client and the disclosures (often in the form of stories)



remain pertinent to the issues at hand, they usually have positive effects in therapy, frequently helping clients feel understood and allowing clients to move on to other significant issues. When clients' issues are not addressed, however, a breach in the relationship occurs and may lead to negative outcomes such as premature termination or clients testing the relationship through various modes, which may include missing appointments or failing to invest in positive change.

Clients' reactions to therapist disclosure have been studied in laboratory settings using videotapes of client-therapist interaction. Research has shown that as long as the therapeutic alliance was positive, study participants rated sessions as more meaningful and the therapist as more expert when the therapist made general disclosures versus no disclosures at all. When the alliance was negative, clients rated the sessions where therapist disclosure occurred as more superficial and the therapist as less skilled when the therapist made either general or countertransference disclosures as opposed to no disclosures.

There are a number of factors that influence clients' willingness to disclose. The research of Barry Farber, Kathryn Berano, and Joseph Capobianco indicated that about half of clients keep secrets from their therapists. This occurs mostly in the areas of relationship issues, sexual problems, and perceived personal failures. The subjects of clients' parents and despised personal characteristics are the topics most addressed within the therapy session. Women and men seem to disclose equally. The longer a client is in therapy and the stronger the clients consider their therapeutic alliance, the more willing clients are to disclose to their therapist.

### Client Self-Observation as a Precursor to Change

The activation of self-observation is a collaborative feature of all psychotherapies. It differs from self-awareness and relies upon consciousness to provide context and reality. Self-awareness is the capacity to know one's self and one's self-in-context. Self-observation is the act of examining one's inner landscape (intentions, expectations, emotions, thoughts, and behaviors), processing this information, and exploring the ideas in other people's minds, as well as what others think of the self.

Clients become aware of and learn about their own functioning in order to change maladaptive responses and generate new responses for the future. In helping

clients focus attention on their own distinctive patterns, psychotherapists assist clients in activating their self-observation. This process is an implicit and multifaceted thread that runs through the different psychotherapies. It gives the client permanent tools to use during the process of change that is the object of psychotherapy.

Kathleen M. Kirby

*See also* Counseling Process/Outcome (v2); Defenses, Psychological (v2); Multicultural Counseling (v3); Multicultural Counseling Competence (v3); Relationships With Clients (v2); Self-Disclosure (v2); Therapist Techniques/Behaviors (v2)

### Further Readings

- Bohart, A. C., & Greenberg, L. S. (1997). Empathy: Where are we and where do we go from here? In A. C. Bohart & L. S. Greenberg (Eds.), *Empathy reconsidered: New directions in psychotherapy* (pp. 419–450). Washington, DC: American Psychological Association.
- Bohart, A. C., & Tallman, K. (1999). *How clients make therapy work: The process of active self-healing*. Washington, DC: American Psychological Association.
- Farber, B. A., Berano, K. C., & Capobianco, J. A. (2004). Clients' perceptions of the process and consequences of self-disclosure in psychotherapy. *Journal of Counseling Psychology, 51*, 340–346.
- Greenberg, L. S., & Pinsof, W. M. (Eds.). (1986). *The psychotherapeutic process: A research handbook*. New York: Guilford Press.
- Greenberg, L. S., Rice, L., & Elliott, R. (1993). *Facilitating emotional change: The moment-by-moment process*. New York: Guilford Press.
- Greenberg, L. S., Watson, J. C., Elliott, R., & Bohart, A. C. (2001). Empathy. *Psychotherapy: Theory, Research, Practice, Training, 38*, 380–384.
- Hill, C. E. (2005). Therapist techniques, client involvement, and the therapeutic relationship: Inextricably intertwined in the therapy process. *Psychotherapy: Theory, Research, Practice, Training, 42*, 431–442.
- Hill, C. E., & Knox, S. (2001). Self-disclosure. *Psychotherapy: Theory, Research, Practice, Training, 38*, 413–417.
- Horvath, A. O. (2001). The alliance. *Psychotherapy: Theory, Research, Practice, Training, 38*, 365–372.
- Levesque, D. A., Prochaska, J. M., & Prochaska, J. O. (1999). Stages of change and integrated service delivery. *Consulting Psychology Journal: Practice and Research, 51*, 226–241.



- Norcross, J., & Goldfried, M. (Eds.). (2005). *Handbook of psychotherapy integration* (2nd ed.). New York: Oxford University Press.
- Principe, J. M., Marci, C. D., Glick, D. M., & Ablon, J. S. (2006). The relationship among patient contemplation, early alliance, and continuation in psychotherapy. *Psychotherapy: Theory, Research, Practice, Training*, 43, 238–243.
- Prochaska, J. O., & Norcross, J. C. (2001). Stages of change. *Psychotherapy: Theory, Research, Practice, Training*, 38, 443–448.
- Rennie, D. L. (1994). Clients' accounts of resistance in counselling: A qualitative analysis. *Canadian Journal of Counselling*, 28, 43–57.
- Rennie, D. L. (1994). Clients' deference in psychotherapy. *Journal of Counseling Psychology*, 41, 427–437.

---

## CLINICAL INTERVIEW AS AN ASSESSMENT TECHNIQUE

---

A clinical interview involves counselors asking individuals questions to gather pertinent information. In interviewing, therapists attempt to help individuals feel comfortable so that candid and relevant information is revealed. Clinical interviewing occurs throughout the counseling process but is typically a major component of the initial session.

An initial interview focuses on gathering information. Therapists generally gather demographic information (e.g., marital status, race or ethnicity, and employment) and information about current problems (e.g., frequency of problem, degree problem affects functioning, and previous attempts to solve problems). Additional questions are asked about social support, medical history, and current medications. Furthermore, therapists may ask questions regarding suicide, substance use, and issues of violence. The information gathered during the initial clinical interview influences the treatment plan, so honest communication is essential to permit accurate assessment.

The initial interview and other interviewing assessments conducted during the counseling process can be useful in assessing client issues. The effectiveness of clinical interviewing is more dependent on counselors' communication skills than are more formal assessment techniques. Depending on the type of information sought, therapists may use formal assessments and behavioral observations to supplement the clinical

interview. These techniques help gather information in a systematic manner; however, many counselors believe there is no substitute for the wealth of information typically gained during the clinical interview.

### Types of Clinical Interviews

There are three types of clinical interviews: structured, unstructured, and semistructured. The type of interview used varies according to the setting and the theoretical or professional orientation of the therapist. A *structured interview* requires that the same questions be asked of each client in an identical manner. An *unstructured interview* allows the counselor to determine the questions and topics covered during the interview. A *semistructured interview* combines these formats. Specific questions are always asked, but these are coupled with opportunities to explore unique client circumstances.

There are advantages and disadvantages to each interview format. The questions asked in a structured interview have been researched to determine if they are reliable and whether they elicit useful and valid information. Consequently, the structured interview provides more consistent information. However, a structured interview may not be appropriate for clients with less common problems or clients from diverse cultures. Although the unstructured interview can be adjusted for individual clients, its effectiveness depends on the clinician's interviewing skills and ability to interpret the clients' answers.

Commonly used structured interviews are the Composite International Diagnostic Interviews: Authorized Core Version 1.0 (CIDI-CORE) and the Diagnostic Interview Schedule (DIS). Some typical semistructured interviews are the Psychiatric Research Interview for Substance and Mental Disorders (PRISM) and the Structured Clinical Interview for Axis I DSM-IV Disorders (SCID-I).

### Interviewing Techniques

Effective clinicians exhibit interpersonal warmth, refined skills, and attentiveness. They use open-ended questions that allow clients to elaborate on their thoughts and feelings and answer questions in "their own words." An example of a closed-ended question is, "Do you drink alcohol?" whereas an open-ended question might be, "Why don't you tell me about your drinking?"



The clinical interviewing process as an assessment technique continues well after the first session. Clinical interviewing also is used to monitor problem resolution, interpersonal development, daily functioning, and client progress. Clinical interviewing may also be used to evaluate the counseling process by asking clients questions concerning the degree to which counseling was helpful.

*Susan C. Whiston and Dawn Lindeman*

*See also* Affect (Mood States), Assessment of (v2); Clinical Presenting Issues (v2); Counseling Process/Outcome (v2); Counseling Skills Training (v2); Multicultural Counseling (v3); Multicultural Counseling Competence (v3); Personality Assessment (v2); Relationships With Clients (v2); Self-Disclosure (v2); Therapist Techniques/Behaviors (v2)

### Further Readings

- Morrison, J. (1995). *The first interview*. New York: Guilford Press.
- Okun, B. F. (2001). *Effective helping: Interviewing and counseling techniques* (6th ed.). Pacific Grove, CA: Brooks/Cole.

---

## CLINICAL PRESENTING ISSUES

---

The *presenting issue* is the brief description clients use to describe their reasons for seeking help when seeking psychological services. It is the initial clue encountered by psychologists in their efforts to help clients solve the problems that have brought them to therapy. The presenting issue may be complete and focused on the primary issue of concern to the client, vague and largely unrelated to the most pressing concerns of the client, or somewhere in between those extremes. This imperfect relation between the presenting issue and the focal issues upon which the client and psychologist will eventually work is reflected in the common clinical adage: "The career counseling referral is always a psychotherapy referral, and a psychotherapy referral is always a career counseling referral." Therefore, the presenting issue is best regarded as the opening statement in a dialogue between the psychologist and the person seeking help rather than as a statement of fact. As such, psychologists must give it their close attention and treat it with the respect it deserves while

understanding that it does not necessarily tell the entire story. Presenting issues tend to vary as a function of the helping professional being addressed (e.g., psychologist, counselor, psychiatrist, clinical social worker, or vocational counselor), the setting in which services are sought (e.g., college counseling center, community mental health center, or hospital), and the client's characteristics (e.g., mandated client or child, teen, or adult voluntarily seeking services). This entry reviews the presenting issues prominent in each of these.

### Helping Professional

The theoretical and empirical contributions of Stanley Strong, Charlie Gelso, and Howard E. A. Tinsley have been instrumental in demonstrating the influence of the helping professional on the presenting problem. The name by which the "helper" is known influences the likelihood an individual will seek assistance from that person. The typical individual is more likely to seek help for personal problems involving a spouse, family member, or member of the opposite sex from a counseling psychologist. Psychiatrists, clinical psychologists, and peer counselors are less likely to be seen by persons with those presenting problems. Psychiatrists and counseling psychologists are most likely to be seen by individuals who are troubled by thoughts of suicide or concern about their emotional stability. People who desire help with career plans, problems on the job, or developing a life plan are most likely to seek the assistance of a career counselor, a college counselor, a close friend, or a relative. In general, therefore, people tend to have a general idea of the relative areas of expertise offered by the different potential helpers and to base their help-seeking decisions on those beliefs.

Although this is a sound, common-sense approach, people seeking help do not always understand (or may not be ready to admit) the true nature of their concerns. For this reason, helping professionals must be broadly trained and stand ready to refer clients when they conclude that another helper is better prepared to help the client.

Clients are in a state of vulnerability or even crisis at the time they are stating their presenting problem. For this reason, Randolph Pipes and Donna Davenport have underscored the importance of therapist sensitivity and competence in crisis management. Skilled therapists understand that in addition to the pain caused by their personal situation, clients typically experience some trepidation about disclosing the



relevant personal information to a therapist (and many clients are troubled by the nagging doubt that no one—and especially not the therapist they do not yet know—could understand what they are experiencing.

A substantial number of clients do not return after their first interview with a therapist. For this reason, experiencing and communicating respect for clients and their experiences is a key therapeutic factor when considering the referral problem. Although that may sound like a fundamental social skill, skilled psychologists understand that respect is deeply embedded in a cultural context. Multicultural competency is critical clinical skill expected of therapists, and psychologists are called upon to exercise this competency from the clinician's first reading of a phone message to their more formal assessment of the reason for referral.

### Setting

The most systematic body of research on presenting issues has been conducted in university counseling centers. The evidence, of course, tends to yield answers that are somewhat typical of individuals at that developmental stage. Concerns about personal values, academic and emotional stress, body image, alcohol use, and adjustment to college life tend to be salient presenting issues on college campuses. For female students the 10 most distressing concerns, ranked in terms of their severity, are anxiety and worry, academic concerns, depression, stress management, concern about the future, self-esteem and self-confidence, procrastination and motivation, career and college major selection, finances, and concentration. In contrast to popular stereotypes of the college years, loss of relationships and dating concerns ranked relatively low. For males the same 10 problems were ranked as their most severe presenting concerns, but the order was slightly different. The men ranked concentration, procrastination, and motivation as more troublesome than the women did, and stress management, self-esteem, and self-confidence as less troublesome.

A different picture emerges from clients seeking services from the department of psychiatry in a university medical center. Their most frequent presenting issues involved mood disorders, substance abuse, anxiety disorders, psychotic disorders, and eating disorders.

Community mental health centers often see the broadest range of presenting problems, since these centers tend to be both the initial point of contact for the community, particularly those with few resources,

and the safety net or service provider of last resort. As a result, community mental health centers deal with mental health matters ranging from the crises of suicidal behavior to the chronic problems of schizophrenia and bipolar disorder.

### Help Seekers

#### *Children and Adolescents*

In general, parents initiate mental health services for their children. However, the agreement between parent and child identifications of the presenting problem is quite low. In one recent study more than 60% of the parent-child pairs failed to agree on a single problem for which the child needed help. Even when the presenting issues were grouped into broad categories, more than a third of the parent-child pairs failed to agree on even one general area in which the child needed help. It appears that parents and children see the presenting problems quite differently.

Parents and children are in better agreement regarding the child's need for help with externalizing behaviors than their need for help with internalizing behaviors. Externalizing behaviors such as fighting, arguing, and disruptive behaviors are readily observable, so it is not surprising that parents are more aware of the child's needs in this regard. In contrast, internalizing behaviors such as anxiety, depression, and low self-esteem are more subjective. It is more difficult for parents to become aware of the child's need for help with these issues, and their awareness of the child's needs is dependent in large part on the child's willingness to express these needs to his or her parents. It is also true that parents and children are in better agreement regarding the problems that bother the child than they are the problems that bother the parents. This is most likely due to the parents' decision to avoid burdening the child with knowledge of the stress and anxiety the child's problems are causing the parents.

A recent Surgeon General's Report on Mental Health stated that during the course of a year, one in five children and adolescents manifest the signs and symptoms of a disorder found in the fourth edition of the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV)*, and about 5% of all children experience an "extreme functional impairment." This estimate is consistent with the 2001 finding of the Policy Leadership Cadre for Mental Health in Schools



that more than 20% of the primary healthcare visits of children are prompted by mental health concerns.

A different perspective emerges from a large survey of regular and special education teachers, school counselors, and school psychologists who were asked to rate the severity of 10 presenting emotional/behavioral problems in their school. Impaired self-esteem was rated as the most serious problem. Suicidal thoughts or behaviors and inappropriate sexual behavior were generally rated as being of least concern. However, these findings may speak more to the prevalence and amenability to observation of adolescents' problems than to their severity. School personnel may be quite aware of the troublesome nature of common and observable problems. More severe problems may be more rare and not as readily observable (internalized). For example, even highly trained specialists are not able to predict with any degree of accuracy which child will commit suicide or bring a gun to school with the intent of harming others.

### Young Adults

Young adults form the predominant clientele of university counseling centers, so information on the presenting complaints that are most prominent in this age range is largely overlapping with that for university counseling centers presented earlier. One recent study compared the prevalence of presenting issues gathered from 50 university counseling centers on two occasions across a 6-year interval. The five main presenting problems were academic concerns, relationship/adjustment issues, depression/romantic relationships, sexual issues, and eating concerns. Comparison of the earlier and more recent years revealed that the presenting complaints of students had increased in severity and chronicity. For example, longstanding, persistent depression, bipolar disorder, and schizophrenia have become more common.

Even within a somewhat homogeneous group such as university students, subgroups of students can experience quite different concerns. For example, the major presenting issues of concern to gay, lesbian, bisexual, transgender, and questioning (GLBTQ) clients are development of their social identity, isolation, educational issues, family issues, and health risks.

### Adults

The clinical presenting issues of adults are as broad as the *DSM-IV*. Depression (e.g., suicidal ideation)

and anxiety (e.g., panic attacks) are often identified by screening instruments, but other presenting issues are more difficult to diagnose. Approximately 10% of the general population experiences a personality disorder (i.e., a chronic and frequently severe condition associated with high levels of impairment and suffering in social, occupational, and other important areas of life due to an enduring, inflexible personality pattern). Roughly half of the patients seeking services from a community-based clinical setting meet the diagnostic criteria for a personality disorder.

### Mandated Clients

Clients who are ordered to receive psychological services by the courts or some other authority pose particular challenges because they did not freely choose to seek the services of the mental health professional. However, therapists cannot assume that mandated clients are unwilling clients, or that their motivation to seek therapy is different from that of nonmandated clients. Some mandated clients are willing if not eager to see the mental health professional. It is also true that many nonmandated clients seek the services of a psychologist because someone else brought them or urged them to do it. For example, children and adolescents often seek the services of a therapist at the urging or direction of their parents, and oftentimes one of the persons in a marital dyad is an unwilling participant.

Many court-ordered mandated clients are more willing to participate in therapy than might be expected. While the presence of legal charges provides some information, this information cannot be taken at face value. For example, the juvenile who took the family car and is referred to therapy because of the stated offense of auto theft is different from the youth who stole a car from the streets. Nevertheless, many mandated clients are resistant to the notion of counseling. Given this, the main tasks of the mental health professional are to elucidate the choices the client has, explain how cooperation in the client's best interest, and treat the client with dignity. Mandated clients, like nonmandated clients, need to tell their story because the presenting problem makes little sense without context.

Brian Glaser

*See also* Client Attitudes and Behaviors (v2); Counseling Skills Training (v2); *Diagnostic and Statistical Manual of Mental Disorders (DSM)* (v2); Gay, Lesbian, and Bisexual



Therapy (v2); Gelso, Charles J. (v2); Help-Seeking Behavior (v3); Multicultural Counseling (v3); Multicultural Counseling Competence (v3); Relationships With Clients (v2); Self-Disclosure (v2); Strong, Stanley R. (v2); Therapist Techniques/Behaviors (v2); Tinsley, Howard E. A. (v4); University Counseling Centers (v1)

## Further Readings

- Achenbach, T. M., McConaughy, S. H., & Howell, C. T. (1987). Child/adolescent behavioral and emotional problems: Implications of cross-informant correlations for situational specificity. *Psychological Bulletin*, 101, 213–232.
- American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders* (4th ed.). Washington, DC: Author.
- Cooley, J. (1998). Gay and lesbian adolescents: Presenting problems and the counselor's role. *Professional School Counseling*, 1(3), 30.
- Critchfield, K. L., & Benjamin, L. S. (2006). *Principles for psychosocial treatment of personality disorder: Summary of the APA Division 12 Task Force/NASPR*. Salt Lake City: University of Utah Neuropsychiatric Institute and the University of Utah.
- Erdur-Baker, O., Aberson, C., Barrow, J., & Draper, M. (2006). Nature and severity of college students' psychological concerns: A comparison of clinical and nonclinical national samples. *Professional Psychology: Research and Practice*, 37(3), 317–323.
- Horwitz, S. M., Kelleher, K., Boyce, T., Jensen, P., Murphy, M., & Perrin, E. (2002). Barriers to health care research for children and youth with psychosocial problems. *Journal of the American Medical Association*, 288, 1508–1512.
- Howard, K. I., Moras, K., Brill, P. L., Martinovich, Z., & Lutz, W. (1996). Evaluation of psychotherapy: Efficacy, effectiveness, and patient progress. *American Psychologist*, 51, 1059–1064.
- Keown, P., Holloway, F., & Kuipers, E. (2002). The prevalence of personality disorders, psychotic disorders and affective disorders amongst the patients seen by a community mental health team in London. *Social Psychiatry & Psychiatric Epidemiology*, 37(5), 225.
- Pipes, R. B., & Davenport, D. S. (1999). *Introduction to psychotherapy: Common clinical wisdom*. Boston: Allyn & Bacon.
- Policy Leadership Cadre for Mental Health in Schools. (2001). *Mental health in schools: Guidelines, models, resources, and policy considerations*. Los Angeles: Author.
- Repie, M. (2005). A school mental health issues survey from the perspective of regular and special education teachers, school counselors, and school psychologists. *Education & Treatment of Children*, 28(3), 279–298.
- Rosenblatt, J. A., & Rosenblatt, A. (1999). Youth functional status and academic achievement in collaborative mental health and education programs: Two California care systems. *Journal of Emotional and Behavioral Disorders*, 7, 21–30.
- Samuels, J., Eaton, W. W., Bienvenu, O. J., Brown, C. H., Costa, P. T., & Nestadt, G. (2002). Prevalence and correlates of personality disorders in a community sample. *British Journal of Psychiatry*, 180(6), 536–542.
- Sartre, J. (1989). Existentialism is a humanism (1946 lecture). In W. Kaufman (Ed.), *Existentialism from Dostoyevsky to Sartre*. New York: Meridian.
- Sue, D., Arredondo, P., & McDavis, R. (1992). Multicultural counseling competencies and standards: A call to the profession. *Journal of Counseling & Development*, 70(4), 477–486.
- Waldman, F. (1999). Violence or discipline? Working with multicultural court-ordered clients. *Journal of Marital and Family Therapy*, 25, 503–515.
- Yeh, M., & Weisz, J. (2001). Why are we here at the clinic? Parent-child (dis)agreement on referral problems at outpatient treatment entry. *Journal of Consulting and Clinical Psychology*, 69(6), 1018–1025.

---

## CODE OF ETHICS AND STANDARDS OF PRACTICE

---

At the heart of the counseling profession is the all-important relationship between the professional counselor and the individual, couple, group, or family seeking help. Because the relationship itself is so central to the helping process, ethical concerns and obligations are especially salient and compelling. This relationship entails an important power differential between the professional and those seeking counseling assistance, thus making ethical behavior an essential responsibility of the professional. Many professional counseling organizations have ethics codes and standards of practice. These codes indicate the aspirations and values of the profession and provide professional and educational guidelines applicable to a wide range of counseling endeavors. Codes also have both legal and moral consequences that are not necessarily limited to any particular professional organization. In addition to the overarching codes for counseling in general, more specific codes exist for



many situations, including school counseling, mental health counseling, marriage and family counseling, pastoral counseling, rehabilitation counseling, and group counseling. These codes have much common ground, as well as specific guidance for the particular population in question.

### Why Ethics Codes?

Society accords professionals a distinct form of respect and power that necessitates a high level of moral responsibility to avoid exploiting those who are served. Just as basic morality is necessary for the healthy functioning of the human community, ethical conduct is necessary for safe, effective professional counseling. Certain moral principles have been identified by those working in the area of bioethics that have been adopted as principles relevant to most helping professions, including counseling. The most common of these are:

- *Beneficence*: the principle that one must do good when it is in one's power to do so
- *Nonmaleficence*: the principle that one must avoid doing all unnecessary harm
- *Justice*: the principle that one must avoid partiality and seek to enact equal benefits and treatment for all those seeking assistance
- *Autonomy*: the principle that one should honor the right of human beings to have authority over decisions affecting their health and well-being

In addition to these principles, specific ethics codes have been in place for many decades in most of the counseling-related professional organizations. While they vary in length, purpose, and specificity, these ethics codes, behavioral guidelines, and standards of practice have many related functions. Often, the preface of a code will include a description of the highest, most morally admirable traits of the profession, and may detail principles similar to those mentioned above. This section alerts both the professional and the public to the parameters of the truly moral professional. Codes also serve an educational function for the counselors and clients. Since they evolve and are revised over time, codes provide the community with the contemporary standard of practice that can be expected from counselors.

Ethics codes do not necessarily carry the weight of state or federal law. Nevertheless, a violation of the

code can result in professional sanctions or removal of membership in a professional organization. Often times, laws are enacted that reflect the essence of a particular ethical mandate. Thus, ethical codes can be influential in the formation and enforcement of criminal and civil law. Having an ethics code is a hallmark of a profession. It is a defining feature that provides ideals to aspire toward, guidance for sorting out conflicting demands, and rules to obey.

### The Essence of Counseling Ethics

The ethics codes of the American Counseling Association, the American Psychological Association, and the National Association of Social Workers are relevant to those providing professional counseling. Generally, the codes address three important domains: (1) responsibilities to clients (or the recipients of professional counseling services), (2) responsibilities to other professionals, and (3) responsibilities to society at large.

#### *Responsibilities to Clients*

The welfare of the client is the predominant ethical concern of the helping professions. Ethics codes emphasize this reality by delineating the domains considered to be essential to a healthy counseling relationship. Most importantly, clients are entitled to an informed consent process that allows them to understand the helping (or therapeutic) process, make decisions regarding their participation, and have a reasonable understanding of the expected process and outcome of counseling. Clients have a right to know the theories and techniques that guide their counselor, the price of the services they will receive, the limits of confidentiality, the training and professional memberships of their counselor, and the likelihood that the counseling they will receive will be helpful. Even when counseling is involuntary, counseling ethics codes encourage practitioners to find ways to empower clients and assist them in making small informed choices.

Because the professional counseling relationship involves an inherent power imbalance, the responsibility to the client is absolute. Clients are never to be exploited for the betterment of the counselor. Anything that might threaten the counselor's objectivity and impartiality is ethically questionable. Therefore, counselors must avoid engaging in or carefully manage other roles in their clients' lives.



### ***Responsibilities to Other Professionals***

Counselors interact with other mental health professionals, school or hospital personnel, law enforcement professionals, healthcare professionals, and administrators of public or private organizations. Counselors have an ethical duty to work for the welfare of their clients while maintaining mutually respectful relationships with colleagues and employers. When policies or other professional expectations conflict with client welfare, the counselor is ethically bound to work for a solution that satisfies all parties. This is a complex mandate, and satisfying it may on occasion require consultation or mediation. However, in the end, ethics codes guide counselors to protect their clients' welfare as their most sacred trust.

Many institutions, agencies, and insurance companies have confidentiality policies that require disclosure of certain information obtained in counseling, or that allow for consultation with other professionals. This is not necessarily unethical, but clients must be informed of these policies at the beginning so they can make an informed decision about the information they are willing to disclose to the counselor.

### ***Responsibility to Human Society***

Counseling professionals are accountable to society at a number of levels. At the individual and immediate level, counselors have a duty to protect intended victims from violence threatened by clients, but must do so in a way that minimizes potential harm to the client. Professional counselors also have a duty to represent themselves and their professions accurately, and to use societal resources wisely and efficaciously.

In the aspirational section, recent editions of ethics codes are urging counseling practitioners to attend to concerns of social justice and the root causes of human distress and disability. Many writers have called for increased multicultural sensitivity in ethical counseling practices. Becoming competent to work with clients from varied cultural backgrounds is an important goal for ethical counselors, as professionals are expected to limit their practice to those areas within which they have competence.

### **Current Controversies and Future Directions**

Ethical concerns in counseling must be responsive to community parameters, cultural trends, and societal

needs. For instance, rural settings or specialized practices might necessitate a different kind of multiple-role management than larger urban settings. The challenges presented by HIV/AIDS and end-of-life choices have stimulated specific evolutionary changes in ethical guidelines for counselors. Under certain circumstances, counselors can choose to warn unaware sexual partners of clients with HIV/AIDS. They can also choose to maintain confidentiality if a terminally ill client wishes to talk about the possibilities of enacting an assisted suicide.

As healthcare costs continue to spiral out of control, stringent and limiting policies within managed care and state-funded policies present numerous challenges to ethical counseling treatment. Often, the money allocated for treatment is not sufficient to cover the costs of effective counseling. Further, counselors cannot abandon their clients without providing at least some possible alternatives for care.

These current concerns illustrate the necessity for ethics codes to evolve in response to changes in the needs and demands of the culture in which the counselor practices and the clients reside. Ethics committees and task forces within all of the major professional counseling organizations deal on a continuing basis with the daunting task of keeping ethical guidelines coherent, reasonable, current, and relevant.

*Rita Sommers-Flanagan*

**See also** Confidentiality and Legal Privilege (v2); Consultation (v2); Credentialing Individuals (v1); Duty to Warn and Protect (v2); Ethical Codes (v1); Ethical Dilemmas (v1); Ethics in Research (v1); Evidence-Based Treatments (v2); Expectations About Therapy (v2); Impairment (v1); Informed Consent (v2); Outcomes of Counseling and Psychotherapy (v2); Relationships With Clients (v2); Suicide Potential (v2); Supervision (v1); Specialization Designation (v1); Therapy Process, Individual (v2); Underdiagnosis/Overdiagnosis (v2); Virtue Ethics (v1); Working Alliance (v2)

### **Further Readings**

- Beauchamp, T., & Childress, J. (2001). *Principles of biomedical ethics*. New York: Oxford University Press.
- Cottone, R. R., & Tarvydas, V. M. (2003). *Ethical and professional issues in counseling* (2nd ed.). Upper Saddle River, NJ: Merrill, Prentice Hall.
- Handelsman, M., Gottlieb, M., & Knapp, S. (2005). Training ethical psychologists: An acculturation model.



- Professional Psychology: Research & Practice*, 36(1), 54–65.
- Pope, K., & Vasquez, M. (1998). *Ethics in psychotherapy and counseling: A practical guide* (2nd ed.). San Francisco: Jossey-Bass/Pfeiffer.
- Remley, T., & Herlihy, B. (2005). *Ethical, legal, and professional issues in counseling*. Upper Saddle River, NJ: Pearson.
- Smith, D. (2003, January). *Ten ways practitioners can avoid frequent ethical pitfalls*. Retrieved November 14, 2005, from <http://www.apa.org/monitor/jan03/10ways.html>
- Sommers-Flanagan, R., & Sommers-Flanagan, J. (2006). *Becoming an ethical helping professional: Cultural and philosophical foundations*. Hoboken, NJ: Wiley.
- Stone, C. B. (2005). *School counseling principles: Ethics and law*. Alexandria, VA: American School Counselor Association.
- Welfel, E. R. (2006). *Ethics in counseling and psychotherapy*. Belmont, CA: Thomson Brooks/Cole.

### Web Sites

American Counseling Association: <http://www.counseling.org>

---

## COGNITION/INTELLIGENCE, ASSESSMENT OF

---

The assessment of intelligence has a long and colorful history, and its development mirrors the development of psychology as a field. From the early work of Francis Galton and James McKean Cattell to the seminal contributions of Charles Spearman and David Wechsler to the contemporary work of Alan and Nadeen Kaufman, Jack Naglieri, and many others, the assessment of intelligence has facilitated the growth of scientific and clinical psychology. The purpose of this entry is not to provide a comprehensive review of current and promising instruments but rather to highlight important approaches to and key issues involving the assessment of intelligence.

### Assessments

There are numerous ways to classify the diverse range of intellectual assessments, but this entry uses two basic categories to facilitate the treatment of the topic: classic assessments (those based on classic theoretical and conceptual approaches to intelligence) and

contemporary approaches (those based on more recent theoretical approaches).

### Classic Assessments

#### *Stanford-Binet Intelligence Scale*

The goal of the French psychologists Alfred Binet and Theodore Simon was to examine the mental abilities of children in comparison with their average-level achieving peers. In the first couple of decades of the 20th century, Binet and Simon defined intelligence as a fundamental faculty that is of the utmost importance for practical life. They referred to this faculty variously as judgment, good sense, practical sense, initiative, and the ability to adapt one's self to circumstances. A person who lacks judgment may be a moron or an imbecile, but a person who has good judgment cannot be either. Indeed, Binet and Simon believed that the rest of the intellectual faculties were of little importance in comparison with judgment. The Binet-Simon scale required children to complete a series of mental activities until the items consistently became too difficult for them to answer correctly. The tests were normed to allow an estimate of "mental age" for each student based on the types of items they were able to answer correctly.

Lewis Terman revised and extended the Binet-Simon scale in 1912, standardized it using a large American sample, and renamed it the Stanford-Binet Intelligence Scale. Terman defined intelligence as the ability to engage in abstract thinking. Terman was well known for his work in assessing children to predict whether they would be successful later in life. He found that children who were gifted tended to be healthier, taller, better developed physically and advanced in leadership and social adaptability compared to their average-level peers.

The Stanford-Binet Scale, which was revised for its fifth edition (SB5) by Gale Roid, can be used across the lifespan. It has been normed with 4,800 participants including 1,400 children ages 2 to 5. The Stanford-Binet assesses two Domains (verbal and nonverbal reasoning) and five Factors (fluid reasoning, visual-spatial processing, quantitative reasoning, working memory, and knowledge). Each of the Factors is assessed through different subtests in each of the Domains. For example, there are verbal and nonverbal subtests for fluid reasoning. The Stanford-Binet provides a number of objects such as blocks



and colorful toys that must be manipulated to increase the attention and enjoyment of young children. The assessment takes about 5 minutes per subtest to administer.

### **Wechsler Scales**

Working primarily in the mid- to late 20th century, David Wechsler viewed intelligence as an individual's global capacity to act purposefully, think rationally, and deal effectively with the environment. Wechsler also believed that intelligence is affected by nonintellective factors such as personality. The Wechsler Intelligence Scale for Children (WISC-IV), now in its fourth edition, has been normed with 2,200 children who were matched closely to the diversity of the 2000 United States Census. The WISC-IV can be used to assess children from the age of 6 to 16 years, 11 months. It yields a full-scale IQ score and four index scores: Verbal Comprehension, which includes similarities, vocabulary, and comprehension activities; Perceptual Reasoning, which includes matrix reasoning, block design, and picture concepts; Working Memory, which includes letter-number sequencing and digit-span; and Processing Speed, which includes symbol search and coding. The subtests have not been arranged in order of importance, but instead are compiled to gauge general mental ability.

Wechsler also designed the Wechsler Preschool and Primary Scale of Intelligence, now in its third edition (WPPSI-III). The present version has been normed with 1,700 children and can be used with children ages 2 years, 6 months to 7 years, 3 months. Children under 4 years of age are administered a shorter assessment of four subtests (e.g. receptive vocabulary, information, block design, and object assembly), which measure perceptual organization and verbal comprehension. Older children are administered seven subtests (e.g., information, vocabulary, word reasoning, block design, matrix reasoning, picture concepts, and coding) to measure perceptual organization, verbal comprehension, and processing speed abilities. In its latest revision, the WPPSI-III was revised with the goal of being more enjoyable for young children and better able to sustain their attention, and to remove any ethnic, gender, regional, or socioeconomic bias.

The Wechsler Adult Intelligence Scale, currently in its third edition (WAIS-III), is administered to those 16 years old or older. The latest edition was normed in the United States during the early 1990s with a group of

2,450 people deemed to be representative of the adult population. The WAIS-III is divided into Verbal and Performance Scales. The six standard subtests found in the Verbal Scale are Information, Digit Span, Arithmetic, Vocabulary, Similarities, and Comprehension. The five standard subtests found in the Performance Scale are Block Design, Picture Arrangement, Matrix Reasoning, Picture Completion, and Digit Symbol-Coding.

### **Woodcock-Johnson Test of Cognitive Abilities**

The Woodcock-Johnson III Test of Cognitive Abilities (WJ III) offers a different perspective of cognitive assessment. The WJ III is one of the only assessments based on the Cattell-Horn-Carroll (CHC) theory of cognitive abilities. CHC theory views intelligence in a three-stratum hierarchy. The first stratum is composed of 69 narrow cognitive abilities, including memory, fluency, and coding. The second stratum is composed of seven clusters of cognitive ability, including short-term memory, processing speed, fluid reasoning, auditory processing, visual-spatial thinking, long-term retrieval, and comprehension-knowledge. The third stratum, known as General Intellectual Ability, represents a combination of all cognitive abilities. The WJ III can also be used to assess working memory and executive functioning.

The WJ III has been normed with 8,818 people in the United States and it can be administered to anyone from 2 to over 90 years old. This assessment has been normed along with the Woodcock-Johnson III Tests of Achievement, which together form the complete battery that practitioners will often administer together. The assessment is computer scored, and its results can be reported in terms of standard scores, percentile ranks, age and grade equivalent scores, and general intellectual ability. There are 10 subtests in the Standard Battery, including Verbal Comprehension, Visual-Auditory Learning, Spatial Relations, Sound Blending, Concept Formation, Visual Matching, Numbers Reversed, Incomplete Words, Auditory Working Memory, and Visual-Auditory Learning-Delayed. There are also 10 subtests on the Extended Battery. All 20 subtests are not needed at one time, but the assessment is designed to combine selected subtests to obtain the most pertinent and suitable information. The manual offers various ways to combine subtests to discern the exact information the psychologist is seeking. This assessment usually takes between 40 minutes and 2 hours to administer.



## Contemporary Approaches

### **Kaufman Batteries**

Alan and Nadeen Kaufman created two major assessments of intelligence, both of which are innovative due to their strong theoretical foundations. The Kaufman Assessment Battery for Children, Second Edition (KABC-II) has been normed with 3,025 children, and it is administered to children ages 3 years to 18 years, 11 months. The KABC-II is based on two theories of intelligence. First, the CHC model for assessment is based on a theoretical approach to intelligence that distinguishes between fluid and crystallized abilities. In the KABC-II, the CHC model is used more often because it is designed for children who speak English as a first language and would, therefore, be less disadvantaged by tests of language abilities and word knowledge. The second model, based on the neuropsychological work of Russian scientist A. R. Luria, de-emphasizes verbal processes by not including the assessments of language ability or word knowledge. This makes the Luria model more accessible to children who do not speak English as a first language, or who have an expressive or receptive language disorder.

The KABC-II was revised to provide an assessment that is more impartial when working with diverse children from various backgrounds, which resulted in less significant score variations among ethnic groups. This assessment has been standardized, adapted, and translated in more than 15 countries, and administration time typically ranges from 30 to 60 minutes.

The Kaufman Adolescent and Adult Intelligence Test (KAIT) has been normed with 2,000 people in the United States, and it is appropriate for people over the age of 11. The norm sample considered such characteristics as gender, ethnicity, examinee or parental education, and geographic region. The KAIT contains 11 subtests that compose three scales, the Crystallized, Fluid, and Delayed Recall scales. Administration takes approximately 1 hour.

### **Cognitive Assessment System**

J. P. Das, Jack Naglieri, and John Kirby proposed a planning-attention-simultaneous-successive (PASS) model of human intelligence that is partly based on Luria's neuropsychological research. Based on PASS theory, Das and Naglieri developed the Cognitive Assessment System (CAS). The CAS assesses four

aspects of basic cognitive functioning. Planning assesses cognitive control, setting goals, knowledge, and the effectiveness of one's planning strategies. Attention assesses the ability to focus on certain stimuli while ignoring others. Simultaneous processing assesses the ability to perceive stimuli as a whole. Successive processing assesses the ability to remember certain phrases and use them to better understand concepts.

The Cognitive Assessment System was standardized in 1990 on 2,200 children from diverse backgrounds. The composition of the norm group mirrors the general population in terms of gender, race, age, region, community setting, ability level, classroom placement, and parental education. The CAS can be used with children aged 5 years to 17 years, 11 months.

### **Differential Ability Scales (DAS)**

Collin Elliot has avoided the term *intelligence* and did not use it in the Differential Ability Scales (DAS-II), because of his belief that there are multiple definitions and considerable misunderstanding surrounding the term. The DAS was designed to assess cognitive strengths, weaknesses, and other abilities of children. It has been normed with 3,475 children and adolescents living in the United States, who were stratified on sex, ethnicity, age, parental educational level, region, and preschool enrollment. It is appropriate for children ages 2 years, 6 months to 17 years. The DAS was designed to reduce examinee frustration and testing time because of specific beginning and end points used for different age levels.

Two different batteries are available for administration to children: the Preschool Level is suitable for ages 2 years, 6 months to 5 years, 11 months, and the School-Age Level is intended for ages 6 years to 17 years, 11 months. The 17 subtests are divided into 12 core and 5 diagnostic subtests. The core subtests are used to compute the General Conceptual Ability composite, which assesses an individual's ability to perform complex mental tasks. The subtests are also used to compute the Verbal Ability, Nonverbal Ability, Nonverbal Reasoning Ability, and Spatial Ability scores.

### **Nonverbal Tests**

The creation and use of nonverbal tests, such as the Raven's Matrices, has played a role in intelligence testing for decades. Nevertheless, increased concern



about the confounding of language with intelligence testing has led to the development of additional nonverbal approaches to intelligence testing. Nonverbal assessments now exist for use with gifted and talented students and those who do not speak English as a first language or who have special needs.

Researchers have offered several cautions about the use of nonverbal tests. First, nonverbal assessments should be used after other assessments have first been administered. Second, although the goal is for nonverbal assessments to be helpful in assessing non-English speakers, it is difficult to find an assessment that does not have some sort of cultural bias in it. Third, the assessment procedures are nonverbal, but the cognitive processes a person uses to answer the questions may involve drawing on vocabulary words or mathematical skills. Fourth, if a nonverbal assessment is administered orally, it can no longer be considered nonverbal, because verbal skills are required to comprehend the directions. As a result, many psychologists prefer to use nonverbal assessments that involve directions that are pantomimed. For all of the reasons listed above, some psychologists prefer the use of standard, verbal assessments, such as the CAS or KABC-II, that hold promise for reducing demographic differences, but this topic remains controversial.

### **Raven's Progressive Matrices**

The Raven's Progressive Matrices (1998) is a form of nonverbal assessment that was originally designed in 1938 to assess an individual's ability to view abstract figural stimuli, reason using analogies, and draw conclusions. The Coloured Progressive Matrices is designed for children ages 5 to 11 years. The most widely used version, the Standard Progressive Matrices, is designed for those age 6 to 17 years old, but it can be used with adults also. The Advanced Progressive Matrices is designed for older adolescents and adults who have a higher intellectual ability. All three versions were constructed based on Spearman's unitary theory of intelligence.

### **Comprehensive Test of Nonverbal Intelligence**

The Comprehensive Test of Nonverbal Intelligence (CTONI) is a commonly used nonverbal assessment that consists of six subtests designed for those ages 6 to 89 years old. It has been standardized using a group of 2,901 people from 30 different states. Included in this

sample were people of diverse gender, ethnicity, age, and geographic region. The sample also included some students with disabilities who were enrolled in general education courses. The instrument measures abstract thinking abilities, problem solving, and reasoning, using a series of visual problems that need to be solved using analogical thinking, sequencing, or categorization. It requires 40 to 60 minutes to administer and can be administered orally or using pantomime.

### **Naglieri Nonverbal Ability Test**

The Naglieri Nonverbal Ability Test (NNAT) is designed for administration to children in kindergarten through Grade 12 and it has been normed on more than 100,000 students. The NNAT is useful for any students who may benefit from a nonverbal assessment, including students who are gifted and talented, learning disabled, or hearing impaired. The assessment is administered by showing diagrams of progressive matrices, so no verbal instructions are needed. This helps to ensure that the assessment is completely nonverbal to decrease the chance of any confounding variables. The NNAT takes about 30 minutes to administer and it can be administered in a group setting.

### **Universal Nonverbal Intelligence Test**

The Universal Nonverbal Intelligence Test (UNIT) is suitable for administration to children ages 5 to 17. It was standardized with a sample of 2,100 children from across the United States, and on an additional 1,765 children who were used to test its validity and reliability. The UNIT is administered by using eight language-free gestures (i.e., thumbs up, hand waving, stop, head nodding, head shaking, open-hand shrugging, palm rolling, and pointing). The UNIT consists of six subtests that assess Analogic Reasoning, Spatial Memory, Cube Design, Object Memory, Symbolic Memory, and Mazes. The UNIT, similar to other nonverbal assessments, includes matrices, but it also includes items that require the manipulation of objects and the use of gesturing, and pencil and paper.

## **Key Issues in Intellectual Assessment**

### ***Flynn Effect***

In the early 1980s, the sociologist James Flynn noted that intelligence test scores show a gradual rise in average performance over the previous several



decades. This phenomenon, which has become known as the *Flynn effect*, has been observed in almost every country and on almost every assessment (although the effect appears to be pronounced on nonverbal assessments). The increase is small (roughly 1–2 IQ points a generation) but appreciable over extended periods of time. Causes of the Flynn effect are widely debated and are beyond the scope of this entry, but the effect's primary implication for psychologists is the need to ensure that scores on intelligence tests are calculated and compared to updated norms. Flynn has documented several cases in which scores have been compared to outdated norms, leading to conclusions of superior IQ or large IQ gains when current norms would have led to more moderate conclusions.

### Giftedness

A cutoff score on an intelligence or, occasionally, an achievement test has traditionally been used to identify intellectual giftedness. For example, a school district might define a gifted student as one who scores in the top 3% to 5% on a specific intelligence assessment (e.g., the WISC-IV, SB5, or WJ III). However, in many countries a broadened definition of giftedness has emerged over the past quarter century. This change has been stimulated, in part, by recognition that giftedness can be multifaceted, that traditional intellectual assessments are limited in their ability to identify intellectual talent, and by the underrepresentation of minorities in gifted programs (i.e., the belief that current tests are biased against minority students). This has led to the development of nontraditional assessments of giftedness, including teacher and parent ratings, performance-based assessments, and peer nominations. Increasingly, the nonverbal assessments described above are also used in gifted identification systems. The impact of these alternatives appears to be limited, but a great deal of research and evaluation on the development and use of alternative assessments is needed.

### Creativity

The past decade has seen an explosive growth in research on creativity because of a growing awareness of the relationship of creativity to psychological well-being and problem-solving ability. Most conceptualizations of creativity include both cognitive and noncognitive factors, so cognitive assessment provides information on an important but limited aspect of

creativity. Divergent thinking (DT) is the most commonly assessed cognitive aspect of creativity. Historically, the Torrance Tests of Creative Thinking (TTCT) have been the most widely used divergent thinking tests. The TTCT has two versions, Verbal and Figural, and two forms (A and B) of each version. Scores can be calculated for Fluency (number of responses), Originality (statistical infrequency of the responses), Flexibility (extent to which responses appear to be from different categories), and Elaboration (extent to which responses go beyond the typical answer). The Consensual Assessment Technique, in which students produce products that can be evaluated for creativity, is a popular alternative to divergent thinking tests, but it has been the subject of limited study in applied settings.

### Major Developments

The assessments reviewed in this entry represent the main themes in cognitive assessment over the past 50 to 60 years, but there are hundreds of additional cognitive assessments available to counseling psychologists. The major developments over the past century have been the reliance on stronger theoretical models and research in the development of tests, the acknowledgment of the role of language (as both an advantage and disadvantage to certain test takers), and the realization of the need to restandardize tests on a routine basis to account for the Flynn effect.

*Jonathan A. Plucker and Rachel Oxnard*

**See also** Academic Achievement (v2); Academic Achievement, Nature and Use of (v4); Achievement, Aptitude, and Ability Tests (v4); Achievement Gap (v3); Intelligence (v2); Intelligence Tests (v3); Psychometric Properties (v2); School Counseling (v1); Test Interpretation (v2); Thurstone, Louis L. (v2); Wechsler, David (v2)

### Further Readings

- Carroll, J. B. (1993). *Human cognitive abilities: A survey of factor-analytical studies*. New York: Cambridge University Press.
- Fancher, R. E. (Ed.). (1985). *The intelligence man: Makers of the IQ controversy*. New York: Norton.
- Flynn, J. R. (2006). Tethering the elephant: Capital cases, IQ, and the Flynn Effect. *Psychology, Public Policy, and Law*, 12, 170–189.
- Neisser, U., et al. (1996). Intelligence: Knowns and unknowns. *American Psychologist*, 51, 77–101.



Sattler, J. M. (1990). *Assessment of children* (3rd ed., rev.). San Diego, CA: Sattler.

### Web Sites

Human Intelligence: <http://www.indiana.edu/~intell>

---

## COGNITIVE-BEHAVIORAL THERAPY AND TECHNIQUES

---

Cognitive-behavioral therapy derives from the research protocols of hundreds of active scholars focused on a wide array of specific clinical problems. They cumulatively conclude that dysfunctional human behavior is caused or at least accompanied by irrational thinking and behavioral skill deficits; thus treatments focused on producing more reasonable thought patterns and personal-social coping skills provide the most efficient solution.

To be sure, the etiology of all human disturbances may someday be traced to biological defects, but currently such views are long on theory and short on data. Moreover, even when a pharmacological intervention may be warranted, the incremental benefits of cognitive-behavioral therapy are generally conceded.

At the core of cognitive-behavioral therapy lies the concept that people's interpretations of experiences are *beliefs* rather than *facts*, and as such, they may be accurate, rational, or irrational to varying degrees. The focus of cognitive-behavioral treatment rests on identifying and directly altering cognitions and behaviors that maintain a pattern of distress, rather than on probing into early developmental factors that may have set the stage for these cognitions and behaviors. Thus, cognitive-behavioral therapies clearly differ from the traditional psychodynamic and insight-driven psychotherapies that preceded them.

More specifically, cognitive behavior therapists posit: (a) an internal cognitive process, or "thinking," directly influences behavior; (b) this cognitive activity may be monitored and altered; and (c) desired behavior change may be mediated through a process of cognitive change. Thus external situations do not ultimately determine individuals' emotions or behavior, but rather their *interpretations* of those situations dictate their feelings and actions. An identical event may trigger disparate views among a group of

individuals, leading to dramatically different emotions and behavior. For example, two students may receive the same low score on an exam. One student interprets this event as a sign that he or she is insufficiently bright and feels a sense of failure, perhaps even contemplates a career change. The other student attributes the low grade to an unfair level of test difficulty, and feels only resentment toward the instructor. Thus, depending on how an event is interpreted and evaluated, the same external experience may lead to a wide range of eventual emotions and behaviors.

Cognitive-behavioral therapy encompasses a wide array of techniques and strategies. Cognitive-behavioral therapists argue that individuals respond to cognitive representations of environmental events rather than to the events themselves, so their interventions focus on the intricate yet functional interrelationships among cognitions, emotions, and behaviors. Although cognitive-behavioral therapy is empirically grounded and based on a manual of effective interventions, it is not a rigid approach to psychotherapy. When optimally employed, cognitive-behavioral therapy is a pragmatic and flexible process that may be tailored to the presenting needs of each client. From its origins in behavior therapy and cognitive learning science, cognitive-behavioral therapy continues to emerge as an efficient set of tools for aiding clients as they address the specific challenges of everyday life.

### Historical and Theoretical Underpinnings

The origins of cognitive-behavioral therapy can be traced to movements in the 1950s and 1960s within the existing fields of cognitive psychology and behavioral science. Growing dissatisfaction with traditional psychoanalysis and a heightened interest in learning theory led to a notable rise in behaviorally oriented therapies during the 1950s. Fortified by an arsenal of empirical findings, behavior therapy became an established mode of treatment that included techniques based on classical, operant, and observational learning.

However, by the late 1960s, discontent with strict tenets of behaviorism began to appear, even among those with behavioral proclivities. Initial attempts to include "thinking" behaviors aped the existing paradigms for modifying observable behaviors: Coverant (a contraction of *covert operant*) control, covert sensitization, and covert modeling, for example, all focused on increasing or decreasing specific thoughts, images,



and feelings deemed desirable or problematic. When Albert Ellis, Donald Meichenbaum, and Aaron T. Beck all began writing about the treatment of chronically and severely distressed individuals through cognitive approaches, the tide turned from behaviorism to cognitive therapies. Researchers demonstrated the effectiveness of cognitive therapy through tightly controlled outcome studies using random assignment and placebo controls. Soon cognitive explanations for learning-based phenomena began to be blended with the once-dominant paradigm of behaviorism, and cognitive-behavioral theories were born.

Researchers in the 1970s and 1980s began to develop specific cognitive-behavioral protocols that included strategies from forms of both cognitive and behavioral treatments. During this period, cognitive-behavioral therapy (CBT) began to be used more frequently as a manner of structured treatment for a variety of client concerns. Examples of typical CBT protocols included manualized approaches to panic control, depression, anxiety, and specific phobias. Researchers and clinicians alike began reporting that cognitive factors could be viewed as a form of behavior and, therefore, could be manipulated using previously established conventional behavior therapies. For example, behavioral techniques such as modeling, reinforcement, and problem solving were reconceptualized as tools for implementing various cognitive strategies; they were also used to explore the viability of inferences. Additionally, the cognitive-behavioral therapies involved learning experiences that were designed to change cognitions in order for behavior to become more appropriate, and, eventually, facilitate social or emotional functioning. Mounting evidence continues to support the effectiveness of cognitive-behavioral therapy for certain psychological problems.

### **Basic Features of Cognitive-Behavioral Therapy**

Although a variety of different models and interventions have been developed under the rubric of cognitive-behavioral therapy, all share certain features that are common to CBT.

#### ***Empirical Grounding***

Cognitive-behavioral therapy grew out of a precedent set by radical behaviorism that established the strong empirical verification of all clinical

procedures. Consequently, an empirical, hypothesis-testing approach is a trademark of modern cognitive-behavioral therapy. Literally hundreds of controlled clinical trials have been performed using CBT to address a wide range of problems, with the continued evaluation of specific, standardized cognitive-behavioral protocols a salient goal in the field.

#### ***Problem Focused and Goal Oriented***

In simplest form, the cognitive-behavioral case conceptualization of client concerns envisions people seeking treatment for problems they want to solve and goals they hope to attain. The cognitive-behavioral therapist works with a client to identify these problems, prioritize which ones to address in therapy, and together develop a concrete means of measuring regular progress. The process of treatment is designed to alleviate the identified problem and to assist clients in accomplishing the goals they seek. For example, a primary treatment goal for an individual suffering from panic disorder might be eliminating the symptoms of panic; secondary goals may address modifying the client's dysfunctional beliefs and thoughts so that episodes of panic will not emerge if multiple stressors accumulate in the future.

#### ***Time Limited***

Cognitive-behavioral treatments are typically brief, ranging in duration from 6 to approximately 30 sessions. However, treatment rarely exceeds 7 or 8 months in total. Treatment approaches are often based on established CBT manuals that identify specific goals for each session while recommending various techniques to accomplish these goals. The time-limited approach of cognitive-behavioral therapy has contributed to its popularity, because third-party and managed care providers place challenging limits on billing for therapy yet require a solid justification for payment in brief psychotherapy treatment.

#### ***Collaborative***

Cognitive-behavioral therapists actively collaborate with their clients, helping them solve acute problems and identify effective strategies for coping with challenges. The therapist and client communicate in a direct, straightforward manner to develop treatment goals and strategies. Discussion of problems takes



place in a transparent style that highlights any conceptual steps underlying the tactics employed. Clients play an active role and contribute to the treatment process throughout the course of cognitive-behavioral therapy.

### ***Action Oriented***

Cognitive-behavioral therapies require clients to behave in new ways in order to alter maladaptive patterns of interpreting and interacting with their environments. Novel interventions and activities are developed and performed by the client both in session and beyond in an attempt to address and eventually modify dysfunctional distortions, behaviors, and beliefs.

### ***Structured Homework Assignments***

Consistent with the active, teaching role of the therapist, homework is an important component of cognitive-behavioral treatments. Homework may include such activities as practicing specific techniques (e.g., relaxation or breathing), conducting personal experiments, rehearsing behavioral skills, or completing cognitive journals and assessments. Homework is viewed as a structured mechanism for both learning and rehearsing new skills and behaviors that require consistent practice for mastery. Homework is a cornerstone of the action-oriented approach epitomized by many cognitive-behavioral interventions.

### ***Directive Role of Therapist***

Under CBT protocols, the therapist provides active, direct assistance to clients who must confront problems they feel unable to address on their own. Irrational thoughts and cognitions are confronted by an active cognitive-behavioral therapist, who often argues the logic of these beliefs through various exercises aimed at fostering change. A therapist may also employ active modeling, role-playing, and other corrective interpretation strategies when working with a particular client. Although the process of cognitive-behavioral therapy is ultimately collaborative in nature, the therapist plays an active and directive role in many exchanges that take place in session.

### ***Emphasis on the Present***

Unlike its psychotherapeutic predecessors, cognitive-behavioral therapy is primarily focused on a client's

present-day concerns rather than mining through what has since passed. Although an understanding of the pathogenesis of problems may be helpful when considering optimal solutions to present-day concerns, the cognitive-behavioral therapist does not dwell on early etiological assertions of how problems may have developed in childhood. The CBT protocol most often addresses the cognitions and subsequent behaviors that are contributing to the client's present dysfunction, rather than the pursuit of developmental insight.

## **Overview of Cognitive-Behavioral Therapies**

### ***Rational-Emotive Therapy***

Ellis developed rational-emotive therapy in the 1950s in reaction to various aspects of traditional psychoanalysis. He proposed that irrational beliefs regarding the self and the world were cause for much suffering, including the expressions of psychopathology. Ellis identified cognitive processing errors that he described as irrational thoughts (e.g., "awfulizing," believing "I must be perfect," and jumping to conclusions). Rational-emotive therapy focuses on behavioral change, yet emphasizes cognitive persuasion and actively disputing irrational beliefs. An important contribution follows from the ABC model, wherein emotional consequences are thought to be caused by beliefs about unsettling events, not by the events themselves. These emotional consequences (C) are targeted for change by disputing the beliefs (B) about the situation (A). Ellis later moved away from a strictly cognitive approach, and his rational-emotive therapy evolved into rational emotive behavior therapy (REBT). Nonetheless, the central intervention of Ellis's work remains the identification and disputation of irrational thoughts that are deemed responsible for an identified emotional upset. Therapy involves actively persuading the client to adopt more rational cognitions through modeling of appropriate thoughts, monitoring the content of existing thoughts, and developing an awareness of the frequency of irrational thoughts and their subsequent impact on emotions and behavior.

### ***Cognitive Therapy***

Aaron Beck has played a central role in the development of cognitive-behavioral therapy. Second only to Sigmund Freud in the number of citations to his work



in the psychiatric literature, Beck published a cognitive theory of depression in the 1960s that has since grown to address anxiety, phobias, personality disorders, substance abuse, suicide, bipolar disorder, and other specific psychological problems. Beck identified a collection of faulty mental processing mechanisms to which humans are susceptible. These cognitive distortions include all-or-nothing thinking, overgeneralization, negative prediction, arbitrary inference, and selective negative focusing. In working with clinical patients, Beck noted that depressed individuals experienced a set of negative thoughts about themselves, about the world around them, and regarding the future. He labeled this negative pattern the *cognitive triad*. Beck described these damaging thoughts as both omnipresent and automatic; so much so that the patient is unaware of his or her biased cognitive processing. Beck sought to elicit a client's automatic thoughts through focused questioning and actively challenging dysfunctional attitudes. Beck also described schematic representations and beliefs that further create individuals' characteristic interpretation of everyday events. In sum, Beck asserted that depression and other psychopathology is caused by automatic and negative thoughts, such as devaluing the self or viewing the future in a reliably pessimistic way.

### **Social Learning Theory**

Albert Bandura was originally a behaviorist, but is most known for asserting the view that humans learn to fulfill their needs through active observation and evaluation of events, including social behavior. He alleged that individuals develop cognitive expectancies about what will happen in their environment, as well as beliefs about their own abilities to effectively perform tasks. Bandura's social learning theory purports that external conditions, in conjunction with individuals' thoughts about the situations, determine individuals' behaviors and emotions. Bandura developed the principle of reciprocal determinism, which suggests that individuals not only are shaped by their environment but also act upon and impact the environment with an influence that is far from unidirectional. Additionally, social learning theory states that perceived reinforcers may be more reinforcing than actual reinforcers. Likewise, in social learning theory, direct reinforcement for performing a behavior is unnecessary for the behavior to occur, as observation of a modeled performance that incurs a positively

evaluated reward is sufficient to create the behavior. Thus, in Bandura's social learning theory, cognitive processes are responsible for mediating the relationship between behavioral reinforcers and personal response.

### **Stress Inoculation Training**

Stress inoculation training (SIT) was popularized by Meichenbaum as a psychotherapeutic analogy to vaccination against a disease. SIT utilizes many of the specific cognitive-behavioral therapies previously described. It prepares clients for dealing with demanding future events by providing instruction in applying coping skills at gradually increasing levels of stress. Augmenting clients' repertoire of coping responses to milder stressors is intended to build their skills and confidence when handling more severe levels of stress. The three phases of SIT involve education about the clinical problem, coping skills training, and exposure to simulated stressors. Clients are initially exposed to low levels of stressful situations through imagery techniques, and gradually practice coping skills with the stressful events encountered in daily life.

### **Problem-Solving Therapy and Decision-Making Counseling**

Problem-solving therapy rests upon the assumption that symptoms of psychopathology are inversely related to effective problem solving, and that training in problem-solving techniques may ameliorate many maladaptive behaviors. Thomas D'Zurilla and Marvin Goldfried outlined a model of efficient problem solving that relies upon teaching clients to specify and define the problems in their lives, to generate possible solutions, and to implement those solutions judged best. Clients are trained to self-monitor their cognitive processes and to evaluate their choices and behaviors. One key component of problem solving involves the process of decision making. Decision-making counseling targets a number of tools for the collaborative generating of alternatives, gauging their relative utility, estimating probabilities of likely effects, and so forth. The literatures of problem solving and decision making overlap considerably, and some authors use the terms interchangeably. They may perhaps be distinguished in that problem solving focuses on discovering the single solution, whereas decision making weighs the trade-offs of competing alternatives.



Overall, the literature of problem-solving therapy asserts that at least one source of individual distress is a deficiency in ordinary problem-solving skills. Fundamentally, some form of problem solving is involved in any approach to psychotherapy.

## Strategies and Techniques

### ***Psychoeducation***

Individuals who receive cognitive-behavioral counseling are typically provided with educational information to facilitate the process of working on their presenting problems. Psychoeducation involves teaching individuals the key tenets of cognitive-behavioral therapy, from defining and identifying negative thoughts to understanding the impact these cognitions have on emotions and behavior. Although psychoeducation takes place throughout the process of counseling, it is used most extensively during early sessions and may be supplemented with bibliotherapy (reading materials), videos, and other educational resources. For example, in treating an individual suffering from an eating disorder, psychoeducation would likely entail exposure not only to the CBT model, but also to supplemental information addressing proper nutrition, healthy diet, and the possible medical complications associated with restricting, bingeing, or purging. In addressing issues of panic or anxiety dysregulation, the therapist must explain to the client the normal, biological elements involved in the stress process. The content of cognitive-behavioral psychoeducation may take many forms depending on the client's presenting concerns, but understanding the process of change is integral to the success of CBT.

### ***Cognitive Restructuring***

At its core, the methodology of cognitive-behavioral therapy involves identifying and changing maladaptive cognitive processes as they relate to problematic emotions and behavior. Cognitive restructuring entails teaching clients to become aware of their automatic negative thoughts, to evaluate the extent to which these thoughts are accurate or rational, and to replace irrational thoughts with more reasonable interpretations, evaluations, and assumptions. Clients are encouraged to systematically seek out and test the evidence upon which they base their predictions and views. Initially, the therapist may actively question the client's beliefs

in an attempt to uncover automatic thought processes. Various forms of self-monitoring are also utilized to aid clients in identifying, disputing, and acting against their own negative thoughts that lead to problems with depression, anxiety, anger, and other distressing psychological symptoms. Several strategies for challenging irrational thinking include examining previous experiences, exploring objective data, shifting perspectives and role playing, combating catastrophic or biased thinking, and becoming educated about relevant facts. The therapist may provide examples of more adaptive cognitive patterns while reinforcing the client's constructive efforts to develop new sets of rational schema. Cognitive restructuring is a collection of techniques that attempt to loosen and modify a client's biased perceptions in favor of more functional and constructive ways of viewing the self, the world, and the future.

### ***Social and Communication Skills Training***

Depending on the areas of identified deficit, cognitive-behavioral therapy may involve teaching clients specific strategies for increasing the efficiency of their social and relational behaviors. Modeling, practice, and performance of new skills, videotaping, and group exposure may be used to facilitate social skills training. For example, eye contact may be practiced and targeted for improvement, along with other assertiveness skills. Interpersonal conflicts may be role-played, and methods of approaching confrontation or boundary setting may be brainstormed and discussed collaboratively. Training in social and communication skills is generally considered an indispensable part of cognitive-behavioral therapy for treating social anxiety and marital distress. These strategies have also been employed when addressing depression, discontent, and conflict in a variety of interpersonal systems.

### ***Behavior Rehearsal***

Introduced by Arnold A. Lazarus in 1966, the term *behavior rehearsal* identified a specific procedure that sought to replace deficient or ineffective social and interpersonal responses with more adaptive behavioral patterns. The cognitive-behavioral therapist might play the role of some person(s) with whom the client is inhibited, under the assumption that through role-playing progress is made toward dealing with actual people and events. The therapist may also train the client to become knowledgeable about other



stressful situations or fear-provoking objects, to plan coping skills and alternate behaviors, and to rehearse these new modes of expression. Lazarus equated being rehearsed with being prepared, both of which were associated with successful spontaneous effects and the genesis of change.

### **Imagery Rehearsal**

Imagery rehearsal therapy is conceptualized as a therapeutic process that employs the human imagery system in an effort to change and rehearse new outcomes. The use of mental reproductions in an attempt to generate change is a current topic in cognitive-behavioral therapy. Imagery treatments are used in CBT to mentally rehearse behavioral alternatives that contribute to burgeoning coping skills. For instance, positive imagery may be practiced to aid with relaxation or anxiety-reduction techniques. The rehearsal of imagery also shows preliminary promise for the treatment of trauma symptoms and chronic nightmares in a variety of populations. Aspects of imagery rehearsal therapy include practicing imagery skills, selecting images for change, and manipulating or rearranging the visualization in an attempt to change the frightening thoughts into a preferred context. These new images are then rehearsed in a structured effort to enhance control of bothersome mental scenes.

### **Relaxation**

Relaxation strategies are commonly used with disorders having a basis of arousal or anxiety, but training in relaxation also serves as an adjunct to facilitate other forms of cognitive-behavioral therapy. In the 1930s, Edmund Jacobson developed a method of deep relaxation that depended upon a series of muscular tension and release exercises. This technique, known as progressive muscle relaxation (PMR), involves moving through the major muscle groups of the body in a sequence of directed tension and relaxation. The client is instructed to notice the difference between tautness and release, and to develop awareness of the sensations of relaxation. Other common forms of relaxation training include breathing retraining, meditation, and guided imagery. Various approaches to relaxation may be combined in a simultaneous or sequential approach. The overarching goal of relaxation training is for the individual to enhance his or

her awareness of unnecessary tension in the body, and to develop an ability to release it.

### **Flooding**

The process of flooding involves prolonged exposure to stimuli that evoke strong levels of anxiety or fear. This technique differs from other forms of exposure-based anxiety reduction in that flooding begins with intense exposure to highly feared situations, where other procedures allow for gradual contact. Flooding entails systematic, prolonged, and repeated exposure to fear-evoking stimuli until the anxiety and fear associated with the situation have been reduced. Flooding may take place in vivo, where exposure is to an actual, tangible stimulus, or a mental representation may be used in a second technique called *imaginal flooding*. The latter intervention is employed when it is neither feasible nor practical to conduct in vivo flooding (e.g., a therapist may have great difficulties accessing the feared situation). Flooding has typically been conceptualized as a procedure for eliminating fear, anxiety, phobias, and panic. High levels of discomfort are invariably induced in the client, yet many therapists view extended exposure to feared yet harmless stimuli as important and even essential conditions for extinction of the fear response.

### **Systematic Desensitization**

Systematic desensitization is another exposure therapy that emphasizes less intense and more gradual contact with distressing stimuli. Developed by Joseph Wolpe, systematic desensitization aims to maintain clients in a nonanxious state during the process of graduated exposure. Wolpe adopted and streamlined the technique used in progressive muscle relaxation as a method of counterconditioning, what he termed *neurotic anxiety response habits*. The client collaborates with the therapist to develop a hierarchy of anxiety-producing situations. Then, the client is induced into a deeply relaxed state and presented with a series of gradually escalating anxiety-provoking images from the hierarchy. This hierarchy might include items such as hearing that someone vomited, watching a movie where a character vomits, seeing someone vomit in real life, feeling nauseated and needing to vomit oneself, and so on. These graded visualizations are then paired with relaxation procedures, and discomfort is addressed with self-calming. When certain thresholds



of anxiety are experienced during the intervention, images are terminated and relaxed states reproduced. With continued systematic exposure, the client's levels of fear and anxiety are said to progressively weaken until the client no longer experiences anxiety in response to the once aversive circumstances.

*Kristine Goto and John J. Horan*

**See also** Bandura, Albert (v2); Beck, Aaron T. (v2); Behavior Therapy (v2); Brief Therapy (v2); Cognitive Therapy (v2); Counseling Theories and Therapies (v2); Dialectical Behavior Therapy (v2); Ellis, Albert (v2); Homework Assignments (v2); Psychoeducation (v2); Rational Emotive Behavior Therapy (v2); Social Cognitive Career Theory (v4); Solution-Focused Brief Therapy (v2); Stress Management (v2)

### Further Readings

- Bandura, A. (1969). *Principles of behavior modification*. New York: Holt, Rinehart & Winston.
- Bandura, A. (1977). *Social learning theory*. Englewood Cliffs, NJ: Prentice Hall.
- Barlow, D. H. (Ed.). (2001). *Clinical handbook of psychological disorders* (3rd ed.). New York: Guilford Press.
- Beck, A. T. (1976). *Cognitive therapy and the emotional disorders*. New York: International Universities Press.
- Beck, A. T., Rush, A. J., Shaw, B. F., & Emery, G. (1979). *Cognitive therapy of depression*. New York: Guilford Press.
- D'Zurilla, T. J., & Goldfried, M. R. (1971). Problem solving and behavior modification. *Journal of Abnormal Psychology*, 78, 107–126.
- Ellis, A. (1962). *Reason and emotion in psychotherapy*. New York: Lyle Stuart.
- Goldfried, M. R. (1977). The use of relaxation and cognitive relabeling as coping skills. In R. B. Stuart (Ed.), *Behavioral self-management: Strategies, techniques, and outcomes*. New York: Brunner/Mazel.
- Jacobson, E. (1938). *Progressive relaxation*. Chicago: University of Chicago Press.
- Janis, I. L. (1971). *Stress and frustration*. New York: Harcourt, Brace.
- Lazarus, A. A. (1966). Behavior rehearsal vs. nondirective therapy vs. advice in effecting behavior change. *Behavior Research and Therapy*, 4, 209–212.
- Meichenbaum, D. (1977). *Cognitive behavior modification: An integrative approach*. New York: Plenum.
- Meichenbaum, D. (1985). *Stress inoculation training*. Elmsford, NY: Pergamon Press.

O'Donohue, W., Fisher, J. E., & Hayes, S. C. (Eds.). (2003). *Cognitive behavior therapy: Applying empirically supported techniques in your practice*. Hoboken, NJ: Wiley.

Wolpe, J. (1958). *Psychotherapy by reciprocal inhibition*. Stanford, CA: Stanford University Press.

---

## COGNITIVE THERAPY

---

Cognitive therapy is based on the idea that beliefs determine feelings and behavior. Albert Ellis, who along with Aaron Beck pioneered the cognitive approach to therapy, favored this quote by the Stoic philosopher Epictetus (first century A.D.): “What disturbs people's minds is not events but their judgments on events.” Cognitive therapists use a variety of techniques and approaches to identify and then modify the cognitive distortions and irrational beliefs that clients bring to counseling. Thoughts are typically defined as distorted or irrational when they do not square with reality or cannot be supported with objective evidence, and when they cause emotional problems such as depression and anxiety.

Cognitive therapists utilize the counseling relationship to educate their clients about how thinking affects feelings and behaviors. Cognitive therapists formally or informally assess clients' patterns of thinking and how their beliefs have contributed to their current problems. A variety of techniques can then be employed to help clients challenge and modify problematic cognitions. For example, the counselor and client often discuss the veracity of the client's beliefs and whether they can be defended rationally. Clients also may be asked to keep records of irrational thoughts, read books or articles about the principles of cognitive therapy, and participate in role-plays with the therapist that challenge beliefs about inadequacies clients perceive in their relationships with other people. The underlying goal of these interventions is to modify the irrational or distorted thoughts that are causing problems for the client.

Over the past several decades, cognitive therapy has been increasingly integrated with behavior counseling into a broad category labeled cognitive-behavioral therapy (CBT). Both cognitive and behavioral counseling were developed during the mid-20th century, in part because of the dissatisfaction by some with Sigmund Freud's psychoanalysis and because of emerging research on human cognition and behavior.



Classic behavioral approaches initially rejected any attempt to incorporate the role of clients' thoughts into counseling, but eventually were strongly influenced by the science of cognitive psychology. In a similar way, cognitive therapists such as Ellis and Beck initially focused very little attention on their clients' behaviors and increasingly incorporated more and more behavioral elements into their approaches.

Ellis pioneered cognitive therapy with his original formulation of what he called *rational-emotive therapy* because of what he saw as the limitations and myths associated with psychoanalysis. He has gradually reshaped it to be an integration of both cognitive and behavioral counseling, and fittingly relabeled it *rational emotive behavior therapy* (REBT). Beck initially developed his brand of cognitive therapy to explain the psychological processes that led to depression. While Aaron Beck acknowledged Ellis's influence in the development of cognitive therapy, today Beck's approach remains unique in its primary emphasis on cognitive factors in therapy. Many theorists have influenced the development of cognitive therapy in addition to Ellis and Beck, so it has much less historical cohesion than theories dominated by a single theoretician. The remainder of this entry will focus on the counseling models of Ellis and Beck, cognitive therapy's two most prominent theorists, and will conclude with a brief review of research and current trends in cognitive therapy.

### Albert Ellis's Rational Emotive Behavior Therapy

Ellis turned to philosophy, especially the philosophy of happiness, early in his own life because of anxieties in social situations. In some of his later writings, Ellis identified himself as having moved from a logical positivist point of view (a modern, scientific approach emphasizing what exists and is knowable) to a constructivist and postmodern philosophy (in which there is no absolute truth). Meaning is created, at least partly, by the individual observer. Despite our often strongly-held convictions, Ellis believes that we do not know reality, nor what reality will be, with absolute certainty.

Two general principles are prominent in REBT. First is the notion that thoughts play a major role in determining how an individual feels and behaves, and are the primary cause of emotional and psychological disturbances. Ellis worked with a client's current thought patterns and spent little time exploring the history of

how these thoughts developed. Central to REBT is the idea that specific types of irrational beliefs are particularly likely to lead to human misery. Some examples of irrational beliefs are those pertaining to

- *Competence and success*: the irrational belief that in whatever we strive to do, we must be completely successful all the time
- *Love and approval*: the irrational belief that our love must be returned by others completely and without reservation
- *Being treated unfairly*: the irrational belief that if we believe we are treating someone fairly, they must reciprocate by treating us with absolute fairness at all times
- *Safety and comfort*: the irrational belief that because we seek to live a safe and comfortable life, we cannot tolerate the inconveniences and setbacks that life presents

A second important principle of REBT concerns the active role played by the therapist. REBT counselors educate the people they work with about the basic principles of REBT, and they do not hesitate to confront irrational and dysfunctional beliefs displayed by the client. REBT is synonymous with the ABC method Ellis used to work with clients. The A refers to an activating event that caused a client to feel a certain way, the B refers to the beliefs that the client has about the event, and the C refers to the consequences that those beliefs have in terms of emotional and behavioral responses.

After ABCs are identified at the outset of counseling, the main curative effort in REBT is for the counselor to help the client dispute and change the irrational beliefs so that new effects will be realized. According to Ellis, when irrational beliefs are successfully disputed, effective new philosophies emerge and lead to healthy emotions and effective functional behaviors.

### Aaron Beck's Cognitive Therapy

Aaron Beck was originally trained as a psychoanalyst, but was influenced by both George Kelly and Albert Ellis in formulating cognitive therapy (hereafter referred to as CT). Kelly was a psychologist who developed personal construction theory, which posited that the world is perceived according to whatever meaning a person attaches to it, and that each person is free to choose different meanings in understanding the world.



Beck's early theorizing was primarily based on an information-processing model that emphasized understanding systematic distortions of external events and internal stimuli that ultimately result in depression. He categorized and discussed these distortions in his writings, and in many ways they are similar to the types of irrational beliefs Ellis identified in REBT. Examples from cognitive therapy include *arbitrary inference*, coming to a conclusion, when there is no evidence, or even contrary evidence, for the conclusion; *selective abstraction*, paying attention to a selective piece of information, without looking at the other information or considering the situation as a whole; and *overgeneralization*, drawing a conclusion from very limited information.

Beck noted that underlying these distorted interpretations of events are relatively enduring cognitive structures called *schemas*. Schemas are core beliefs, developed throughout life, that affect people's interpretation of events at a fundamental level. A person's schemas dictate the types of information he or she pays attention to, and lead to the cognitive distortions and automatic thoughts about the situations a person encounters in life. Based on these ideas, Beck described the presence of a negative cognitive triad that he believed is present in depression-prone individuals: negative views about the world, negative ideas about the future, and negative thoughts about the self. Beck labeled this the *cognitive specificity hypothesis*, and expanded it to postulate a distinct cognitive profile for each psychiatric disorder. For example, the cognitive profile of depressed individuals may include self-devaluation, which is evident in the negative cognitive triad, while the cognitive profile for anxious individuals may include fears about their vulnerability to future threats.

As with REBT, raising the clients' awareness of the influence that thoughts have on negative feelings is viewed as essential. One notable difference between CT and REBT is Beck's emphasis on what he termed the *collaborative empiricism* between the counselor and client. Whereas an REBT counselor may take a more directive, educational stance with a client, Beck favored a more collaborative process. The counselor and client work together using whatever evidence they have to determine if a given belief is distorted.

Thought stopping, positive imagery, and positive self-talk are also often used in cognitive therapy. *Thought stopping*, which can be as simple as saying "stop" to oneself, is used as a way to break the negative thought cycle. *Positive imagery*, asking the client

to imagine a positive outcome, can help challenge negative automatic thoughts. *Positive self-talk*, which involves saying positive, affirming things to oneself, is also a way to interrupt the negative thought cycle. Beck also suggested giving clients homework by having them attempt to modify thoughts in everyday life situations between sessions.

## Research Support

There is considerable research evidence documenting the effectiveness of CT, which explains in part the strong continued interest in developing and refining both cognitive and cognitive-behavioral therapy. For example, support for the efficacy of REBT was found in reviews of 70 and 28 outcome studies. The efficacy of CT was the subject of a review of 14 meta-analyses, a statistical method of summarizing the results of numerous studies on the same topic. Another research review of an aggregate of 325 studies involving more than 9,000 subjects indicated that CT was effective with a number of different psychological problems including adult and adolescent depression, anxiety disorder, social phobia, and marital distress. The research support for CT and REBT is one of the reasons it is often labeled an *evidence-based treatment* for disorders such as anxiety and depression.

## Future Directions

A number of theorists have taken core features of cognitive therapy and expanded both its theoretical underpinnings and its applicability to different types of clinical issues. Jeffrey Young and colleagues developed *schema therapy*, an application of CT for clients with personality disorders. They noted that personality disorders represent rigid and inflexible traits that are enduring. The general goal of schema therapy is to help clients with personality disorders repair maladaptive schemas developed early in life and to change maladaptive coping styles.

Donald Meichenbaum's *stress inoculation training* (SIT) represents an important integration of cognitive and behavioral therapies. This approach attempts to "inoculate" a person from stress in a manner analogous to the way the body reacts to a virus or bacteria by forming antibodies after a vaccination. Meichenbaum uses a three-stage approach. During the conceptual phase the counselor establishes a collaborative relationship with clients, gathers information about their



concerns, and provides education about the role of thinking and emotion in maintaining stress. In the skills acquisition phase clients are taught coping skills that can be used in stressful situations. For example, a client may be taught relaxation strategies and the use of positive self-statements. In the application and follow-through stage, clients implement what they have learned in life, and they work with the counselor to evaluate their effectiveness.

Zindel Segal, J. Mark G. Williams, and John D. Teasdale developed mindfulness-based cognitive therapy (MBCT) by integrating cognitive therapy with Jon Kabat-Zinn's mindfulness-based stress reduction (MBSR) in order to prevent relapses of depressive episodes. Mindfulness in contemporary psychology has been conceptualized as nonjudgmental, present-centered awareness. Mindfulness entails acknowledging each thought, feeling, or sensation that arises nonjudgmentally and with acceptance. Kabat-Zinn's MBSR consists of a program of eight weekly 2-hour sessions and includes such elements as meditation and yoga. In MBCT, Segal suggested that mindfulness practices be used to help individuals shift their relationship to the thoughts, feelings, and bodily sensations that contribute to depression. Rather than attempt to change the content of thoughts, as suggested in Beck's CT, participants in MBCT are trained to view their thoughts as transient mental events that are not necessarily fundamental parts of themselves or accurate depictions of reality.

Cognitive approaches to therapy are widely used and researched. The vitality of this approach is evidenced in an extensive body of research, and in continued developments in its applicability to a wide of clinical concerns. Ellis and Beck have training institutes that offer extensive training in REBT and cognitive therapy, respectively. These institutes continue to produce trained therapists and teachers, to play an important role in establishing credentialing standards, and to provide direction for continued research on these approaches.

*Christopher J. McCarthy and James A. Archer, Jr.*

**See also** Beck, Aaron T. (v2); Behavior Therapy (v2); Cognitive-Behavioral Therapy and Techniques (v2); Constructivist Theory (v2); Counseling Theories and Therapies (v2); Depression (v2); Dialectical Behavior Therapy (v2); Ellis, Albert (v2); Evidence-Based Treatments (v2); Panic Disorders (v2); Positivist Paradigm (v2); Rational Emotive Behavior Therapy (v2); Relationships With Clients (v2); Social Cognitive Career Theory (v4)

## Further Readings

- Beck, J. (1995). *Cognitive therapy: Basics and beyond*. New York: Guilford Press.
- Butler, A. C., & Beck, A. T. (2000). Cognitive therapy outcomes: A review of meta-analyses. *Journal of the Norwegian Psychological Association*, 37, 1–9.
- Ellis, A., & Dryden, W. (1997). *The practice of rational emotive behavior therapy*. New York: Springer.
- Engles, G. I., Garnefsky, N., & Diekstra, F. W. (1993). Efficacy of rational-emotive therapy: A quantitative analysis. *Journal of Consulting and Clinical Psychology*, 6, 1083–1090.
- Kabat-Zinn, J. (1990). *Full catastrophe living: Using the wisdom of your mind to face stress, pain and illness*. New York: Dell.
- Lyons, L. C., & Woods, P. (1991). The efficacy of rational-emotive therapy: A quantitative review of the outcome research. *Clinical Psychology Review*, 11, 357–369.
- Meichenbaum, D. (1985). *Stress inoculation training*. New York: Pergamon Press.
- Segal, Z. V., Williams, J. M. G., & Teasdale, J. D. (2002). *Mindfulness-based cognitive therapy for depression*. New York: Guilford Press.
- Young, J. E., Klosko, J. S., & Weishaar, M. E. (2003). *Schema therapy: A practitioner's guide*. New York: Guilford Press.

---

## COMMON FACTORS MODEL

---

The study of psychotherapy has yielded important insights into the predictors of clinical improvement. One major focus of the psychotherapy outcome literature has been to determine the most efficacious treatment models or techniques. For example, is cognitive therapy (CT), in which therapists focus on helping clients identify and challenge irrational thoughts, more effective in treating depression than interpersonal psychotherapy (IPT), in which therapists encourage clients to discuss and troubleshoot problems in their social relationships?

Reviews indicate that the number of psychotherapies has increased approximately 600% since 1960 and the number of psychotherapeutic treatments models is greater than 200. Are each of these therapies fundamentally different, offering clients help in separate ways, or might they share more in common than one might expect? While proponents of the various models claim that techniques and strategies specific to their models account for client change, research indicates



that the *mechanisms* responsible for change may not differ according to theoretical approach. The *common factors* theory stems from the contention that much of the effect of the various psychotherapies is due to factors that psychotherapies share, rather than those that are unique to a particular type of therapy. Researchers estimate that common factors account for between 45% and 70% of the effects of psychotherapy. This is in comparison to an upper bound of 8% accounted for by specific techniques.

### The Dodo Bird

Seventy years ago, Saul Rosenzweig introduced the concept of common factors in what has become a classic article, noting that apparently diverse forms of psychotherapy appear to be similarly successful. Attempting to capture the peculiarity of this phenomenon, Rosenzweig invoked Lewis Carroll's *Alice in Wonderland*, noting the dodo bird's proclamation that "Everyone has won, and all must have prizes." The finding that most psychotherapies tend to have similar rates of efficacy has subsequently been labeled *the dodo bird conjecture*.

Ironically, the empirical basis of common factors research was spurred by Hans J. Eysenck's controversial outcome study, in which he found minimal, custodial treatment to be more effective than psychotherapy. In response to Eysenck's work, researchers set about rigorously demonstrating the beneficial effects of psychotherapy. Mary L. Smith and Gene V. Glass used meta-analysis, a statistical method that allows for the findings of many research studies to be combined, to establish the therapeutic effect of psychotherapy. They combined the results of more than 375 studies and provided compelling evidence in support of the efficacy of psychotherapy. Subsequent meta-analyses have confirmed the efficacy of psychotherapy over no treatment. Most striking, however, is that meta-analytic findings are consistent with Rosenzweig's original proposition that different psychotherapies have approximately similar effects. In the most extensive meta-analysis of psychotherapy treatment studies to date, Bruce E. Wampold and colleagues found no evidence of differential treatment effects.

This finding leads to a paradox. Treatments with different theorized mechanisms of change yield quite similar results. Thus, psychotherapies could be like radiation and chemotherapy, completely different, yet similarly effective treatments for the same illness.

Alternatively, they could be quite similar in their active ingredients, like two aspirin-containing pain relievers marketed under different brand names. Common factors researchers investigate hypotheses related to the latter.

### The Common Factors

The lack of a consensual operational definition of the term *common factors* has posed a problem for researchers, and there are three widely cited organizational schemes for categorizing the factors. Rosenzweig's original model included four common factors: (1) catharsis, (2) the personality of the good therapist, (3) the therapeutic ideology, and (4) the alternative formulation of psychological events. Julia D. Frank and Jerome B. Frank also listed four components as necessary: (1) a healer in whom faith is placed, (2) a conceptual scheme or myth consistent with the assumptive world of the client and therapist that makes sense of the symptoms, (3) a locality that is imbued with the power of healing (e.g., hospital, psychologist's office), and (4) a task or procedure that demands effort and is a vehicle for maintaining the therapeutic relationship. The final organizational approach identifies five broad categories of common factors: (1) client characteristics, (2) therapist qualities, (3) the therapeutic relationship, (4) change processes, and (5) treatment structures. Although these categories are not mutually exclusive (e.g., therapist qualities are likely not independent of the quality of therapeutic relationship, and the therapeutic relationship may be considered a change process by some), this approach is useful for the purposes of succinctly describing the extant literature on common factors.

### Therapist Factors

Although recent outcome research has primarily focused on determining the most effective treatments for specific groups of clients, reanalyses of these studies indicate that the therapist may be a more important factor in determining outcome than the type of treatment. On the average, the therapist accounts for approximately 6% to 9% of the variability in outcomes. This is in contrast to the variability among treatments, which is approximately 1% at most. This finding is consistent with the common factors hypothesis, since if the most important determinants of change are shared across therapies, then the qualities of the



person implementing the therapy should be of more importance than variations in type of treatment.

Although the therapist appears important in determining psychotherapeutic change, empirically clarifying the qualities of an effective therapist has been a challenging task. This question remains important in regard to the common factors hypothesis. Although therapist variability may indicate that certain pantheoretical therapist characteristics are critical to helping clients, the finding that the therapist accounts for differences in client outcome may be related to differential skill in implementing or fidelity to a particular therapy's techniques.

Findings consistent with the latter explanation noted above would be inconsistent with the common factors hypothesis and lend support to specific theoretical explanations of psychotherapy. However, *treatment adherence*, or the degree to which a therapist faithfully performs the techniques of a particular therapy (and does not perform the techniques of other therapies), has not consistently predicted clinical outcome. Furthermore, analyses indicate that therapist demographic variables (type of training, years of training, theoretical orientation) do not differentially contribute to client outcome. It is important to note how this differs from what one might expect in more traditional medical settings. For example, one would expect that a surgeon who more closely follows the accepted protocol for an appendectomy would be more successful than one who does not.

Instead, the most commonly cited beneficial therapist trait is the rather generic *positive descriptors*. More specifically, a recent meta-analysis demonstrated that client ratings of therapist empathy were significant predictors of therapy outcome, accounting for approximately 7% to 10% of variance in outcomes. Reanalyses from a large clinical trial indicate that more effective therapists: (a) tended to focus on the psychological versus biological aspects of depression, (b) were more likely to be psychologists than psychiatrists, (c) used psychotherapy only rather than in combination with medication, and (d) expected treatment to take longer. Thomas M. Skovholt and Len L. Jennings analyzed the interviews of 10 psychotherapists who were nominated by colleagues as *master therapists* and reported that such therapists described a number of common traits. Among these were descriptors such as (a) a desire for lifelong learning, (b) valuing cognitive complexity and ambiguity, (c) attention to their own emotional well-being and

how it may influence their work, and (d) relational competence that is utilized in therapy. Although it remains unclear how these descriptors influence therapeutic change, it seems clear that therapist qualities that cut across convenient theoretical boundaries are among the most important predictors of psychotherapeutic change.

### ***Client Factors***

Although among the least cited factors, the characteristics of the client may be among the most important ingredients in effective therapy. Positive expectation and hope are the most frequently cited of these client factors. E. Fuller Torrey noted that faith in the institution (e.g., seeking treatment or merely walking in the door) may lead clients to improve.

Specifically, expectation can be operationalized as cognitions regarding the likelihood that an event will occur. A significant body of research has addressed the construct of client expectations, and findings confirm that expectancies are significant predictors of psychotherapy outcome. If clients believe they are likely to improve by engaging in therapy, they often do. Expectations about counseling have an important impact on decisions to begin or remain in psychotherapy and on the effectiveness of psychotherapy in general. Those with positive expectations are more likely to begin psychotherapy, invest more fully in the therapeutic process, remain in therapy even when it is difficult, and experience positive outcomes.

### ***Relationship Factors***

The relationship between therapist and client is the most widely cited and researched common factor, revealing robust findings and generating a significant body of literature. The genesis of the therapeutic alliance can be traced back to Sigmund Freud's early papers in which he noted the importance of positive attachment between the analyst and the patient. In 1975, Edward S. Bordin formally presented the first pantheoretical notion of alliance in his presidential address to the Society of Psychotherapy Research. He argued that the alliance was composed of three related components: (1) bonds, (2) tasks, and (3) goals. Specifically, *bonds* referred to the interpersonal attachment in psychotherapy; *tasks* were the agreement surrounding what is to be done in therapy; and *goals* were the degree of consensus between therapist



and client relative to long- and short-term outcome expectations. Recent meta-analyses indicate that measures of the therapeutic relationship derived from this construct are moderate predictors of treatment outcome. There is also evidence supporting the *tear and repair hypothesis*, which holds that therapeutic relationships that involve a period of decline (i.e., tear) that is followed by periods of improvement (repair) may actually be more indicative of successful therapy than therapeutic dyads with static or even steadily increasing relationship quality.

Researchers such as Carl R. Rogers held that the empathic bond between a client and therapist was sufficiently powerful to induce change in and of itself. In Rogers's view, the role of the therapist is to facilitate a collaborative and genuine interpersonal relationship with the client and unlock the client's own natural tendency toward growth and development. Psychodynamic theories (the most direct descendents of Freud's psychoanalysis) include direct discussion of the relationship between client and therapist as the central ingredient central in successful therapy. More specifically, psychodynamic therapists contend that clients tend to repeat the maladaptive patterns of past relationships in the therapy session and that is the role of the therapist to make these patterns explicit so that they can be discussed openly and be changed.

Others, such as Aaron T. Beck, the founder of cognitive therapy, argued that an adequate therapeutic alliance is important in that it allows for the client and therapist to engage in the primary work of cognitive approaches, namely, examining the validity of irrational automatic thoughts and determining problematic cognitive schemas. Integrative therapists such as James P. McCullough, the developer of the *cognitive-behavioral analysis system of psychotherapy* (CBASP), have argued for a more robust discussion of the therapeutic relationship in cognitively oriented therapies.

Research provides no clear answers in regard to the respective validity of the above claims. Thus, it remains possible that the therapeutic relationship has an impact on clinical outcome in different ways across therapies (as suggested by the various theories above). However, it is important to note that, as yet, findings do not support significant differences in the effect of the therapeutic alliance in regard to therapy type (e.g., interpersonal, cognitive behavior, active, and placebo pharmacotherapy with clinical management). Consistent with the common factors hypothesis, this finding indicates that despite divergent theories regarding

the therapeutic relationship, the mechanisms mediating its effects on clinical outcome may be quite similar.

## Change Processes

Change processes are the means through which therapeutic change is thought to occur. Approximately 30 commonalities have been identified under this subheading, the most frequent of these being: (a) opportunity for catharsis, (b) acquisition and practice of new behaviors, (c) provision of rationale, (d) fostering insight/awareness, and (e) emotional or interpersonal learning.

Numerous findings illustrate the importance of providing a therapeutic rationale that is acceptable to clients. The rationale addresses both the cause of the presenting concern and the approach chosen to address that concern. Participants prefer counseling theories that are congruent with their personal epistemology, and congruence of client worldview and psychotherapeutic theory is positively related to outcome.

## Treatment Structures

Treatment structure is the specific implementation of the rituals and techniques particular to a certain treatment. All effective treatments have rituals and related techniques. The most frequently cited factors related to treatment structure are: (a) use of techniques/ritual, (b) a focus on the "inner world"/exploration of emotional issues, (c) adherence to theory, (d) interacting participants, (e) communication (verbal/nonverbal), and (f) explanation of therapy and participant roles. Research on treatment structures suggests that it does not matter which specific treatment approach is followed as long as the chosen approach includes the above factors. Thus, although evidence supporting the importance of *specific* structures or techniques is lacking, the presence of structure and techniques *in general* appears to be an important common factor.

Zac E. Imel

**See also** Client Attitudes and Behaviors (v2); Cognitive-Behavioral Therapy and Techniques (v2); Counseling Process/Outcome (v2); Counseling Theories and Therapies (v2); Counselors and Therapists (v2); Evidence-Based Treatments (v2); Expectations About Therapy (v2); Facilitative Conditions (v2); Feedback in Counseling, Immediate (v1); Relationships With Clients (v2); Therapist Techniques/Behaviors (v2); Working Alliance (v2)



### Further Readings

- DeRubeis, R. J., Brotman, M. A., & Gibbons, C. J. (2005). A conceptual and methodological analysis of the non-specifics argument. *Clinical Psychology: Science & Practice, 12*, 174–183.
- Frank, J. D., & Frank, J. B. (1991). *Persuasion and healing: A comparative study of psychotherapy* (3rd ed.). Baltimore: Johns Hopkins University Press.
- Grencavage, L. M., & Norcross, J. (1990). Where are the commonalities among the therapeutic common factors? *Professional Psychology: Research and Practice, 21*, 374–376.
- Norcross, J. C. (2002). *Psychotherapy relationships that work*. New York: Oxford University Press.
- Rosenzweig, S. (2002). Some implicit common factors in diverse methods of psychotherapy. *Journal of Psychotherapy Integration, 12*, 5–9. (Original work published 1936)
- Skovholt, T. M., & Jennings, L. (Eds.). (2004). *Master therapists: Exploring expertise in therapy and counseling*. Boston: Allyn & Bacon.
- Smith, M. L., & Glass, G. V. (1977). Meta-analysis of psychotherapy outcome studies. *American Psychologist, 32*, 752–760.
- Wampold, B. E. (2001). *The great psychotherapy debate*. Mahwah, NJ: Lawrence Erlbaum.

---

## COMPUTER-ASSISTED TESTING

---

Computer-assisted testing is the use of computers to support assessment and testing processes. This entry focuses on the history, varieties, and future directions of computer-assisted testing.

### History

Computer-assisted testing began in the early 1950s when optical scanners were adapted to read special answer sheets and score tests. This resulted in the widespread use of multiple-choice tests in a variety of testing applications. As mainframe computers became more available, the use of computers in testing expanded.

The first expansion focused on extracting more information from scores on tests with multiple scores. Thus, in addition to scoring tests, computers began to interpret test scores and analyze test data. Score profiles on a number of tests were interpreted by experts,

and their knowledge was embodied into computer-generated interpretive reports for instruments scored on multiple scales. Notable examples include the Minnesota Multiphasic Personality Inventory and the Strong Interest Inventory. Interpretive reports have been expanded and improved over the years and are in prominent use today for a number of educational and psychological instruments.

The second expansion occurred in the late 1960s. As computers became more accessible in education, mainframe computers were equipped with multiple terminals that could display information on cathode-ray terminals and accept responses by keyboard. These “dumb” terminals were connected to mainframe computers by dial-up modems that functioned at speeds of 10 to 30 characters per second. Rudimentary “time-sharing” software polled the terminals for responses and transmitted information to the terminals. These hardware configurations gave rise to the first generation of computer-assisted instruction (CAI).

CAI in the 1960s and 1970s consisted of computers functioning as “page turners,” with very basic branching logic to support the instructional process. A screen was presented to the student, the student made a response, and rudimentary computer software determined the next screen to present to the student. Computer-based testing, using the same page-turning approach, was a natural result of this process.

Initially, time-shared computers administered tests on a question-by-question basis. However, communication between terminals and mainframe computers was very slow. The response times of the time-shared systems were unpredictable, and sometimes delays of a minute or more occurred between test questions. This problem seriously affected the standardization of the testing process and the acceptability of CAI. As a consequence, neither CAI nor computer-based testing was very successful in those years.

The development of the minicomputer in the early 1970s was the major hardware advance that allowed computer-assisted testing to flourish. Minicomputers were small (relative to mainframes, but large by today’s standards) and provided a single user with complete access to the hardware and software. As a consequence, software dedicated to the testing process could be written and run independently of other applications. This allowed almost complete control over the system response time between test questions and faster



throughput time, resulting in better standardization of the testing process. These capabilities were further enhanced as the personal computer (PC) became widely available in the mid-1980s. Today's PCs using multithreading and high-speed microchips allow computers to perform extensive computations in fractions of a second.

## Varieties of Computer-Assisted Testing

### **Conventional Testing**

The simplest application of computers in test delivery is the administration of conventional tests in which all examinees receive the same test questions in the same order, usually a question at a time. Although this seems like a trivial advance over paper-and-pencil tests, it has a number of advantages. First, all instructions are presented by computer, prior to the examinee receiving the test questions, typically along with some practice questions. This insures that each examinee has read and understood the instructions. Second, scores can be made available to the examinee or test administrator immediately after completion of the test. Furthermore, all examinee responses are recorded electronically, thus eliminating the need to optically scan test answer sheets. The amount of time it takes the examinee to respond to each question can be recorded. This information can be useful in evaluating the examinee's attention to the task, and it provides information about the examinee's processing time that might be useful for evaluating his or her performance. No paper is used in the testing process, thereby reducing the expense of reproducing the test materials and filing paper records. Finally, the testing process can be enhanced with audio, video, and color, thus making it possible to measure traits not easily measured in paper-and-pencil test administration.

### **Branched or Response-Contingent Testing**

Branched or response-contingent testing is useful in measuring variables that can be evaluated through a problem-solving scenario or sequence of steps. In this approach, a problem situation is presented to the examinee with a number of alternatives. Each alternative "branches" to a different second stage in the problem-solving process. Subsequent branches for each subsequent question continue to lead to different changes in the situation presented to the examinee. As

a consequence, each examinee can follow a different pathway through the problem-solving process, some of which lead to an appropriate solution to the problem whereas others do not.

These "situational" tests are typically scored in terms of the adequacy and efficiency with which an examinee arrives (or does not arrive) at a solution to the presenting problem. Perhaps the most successful implementation of computer-assisted branched tests is in medical training. In this application, hypothetical patients are presented to medical students, along with information that they can access about the "patient." The student attempts to "cure" the patient by ordering various medical tests and evaluations, drawing conclusions from the information made available interactively through the test, and requesting additional information as needed. The exercises vary in level of difficulty and in the information supplied to challenge the student's knowledge and skills.

### **Partially Adaptive Testing**

Adaptive tests are designed to adapt to each examinee as the testing process is implemented. Branched or response-contingent tests are adaptive in that sense, but partially and fully adaptive tests take this process further.

Partially adaptive tests operate from a bank of questions that is structured by difficulty. The simplest of these tests consists of subsets of questions grouped into short tests, or *testlets*, comprising questions of differing average difficulty levels. A testlet of medium difficulty is administered, one question at a time, and immediately scored. Examinees who score high on the testlet then receive a more difficult testlet. Those who score low are then administered an easier testlet. If only two testlets are given to an individual, the test is a *two-stage* test. A *multistage* test involves the administration of three or more testlets, with the difficulty of each subsequent testlet based on the examinee's score on the previous testlet.

In the testlet approach, *branching* is based on the examinee's score on each testlet. One variation of this approach involves branching after each question is administered. This allows examinees to move more quickly toward questions that are consistent with their ability level. Other possible partially adaptive structures have also been developed, but they are seldom used because they do not make good use of a question bank. The exception is branched testlets that are used



for measuring skills such as reading comprehension, where a number of questions are asked about a given reading passage.

### ***Fully Adaptive Testing***

Fully adaptive testing, based on a family of mathematical models called item response theory (IRT), is currently the most used approach to adaptive testing. A fully adaptive computerized adaptive test (CAT) has the five following requirements and characteristics:

1. It uses a question bank in which all questions have been calibrated by an appropriate IRT model. The IRT family includes models for questions that are scored in two categories (e.g., multiple choice scored as correct or incorrect, true or false, yes or no) and rating scale questions that are scored as multiple categories.
2. Preexisting information about each examinee (e.g., his or her school grade) can be used as a starting point for selecting questions.
3. Questions are administered one at a time, and the examinee's score is estimated after each question is answered.
4. After each question is administered, the entire question bank is searched and the question that will provide the most precise measurement of that examinee (given the examinee's score at that point in the test) is selected for administration.
5. This process of selecting and administering a question and rescoring is repeated until a suitable termination criterion is reached. Fully adaptive CATs can be terminated when the examinee's score reaches a prespecified level of precision, when there are no more useful questions in the bank for measuring a given examinee, or when the examinee has been reliably classified with respect to one or more cutting scores.

Fully adaptive CATs based on IRT are dramatically shorter than conventional tests, and they reduce the time required for test administration by 50% to 90%. They can measure individuals at much higher levels of precision than conventional tests of the same length. Furthermore, for tests with questions scored in one of two categories (e.g., correct or incorrect), most examinees will answer about 50% of the questions correctly regardless of how high or low their score is. Low-ability examinees are likely to experience the test as

“easier” than similar tests that they have taken, because the CAT will have adapted to their ability level by giving them easier questions. Conversely, high-ability examinees will experience the test as more difficult than many they have taken. As a consequence, the “psychological environment” of the test is better equated for all examinees, resulting in an appropriately challenging testing environment. Fully adaptive CAT has been implemented in a number of major testing programs.

### ***Sequential Testing***

Many have referred to sequential tests as CATs, but they are a separable set of procedures. Sequential tests are typically used to make a classification decision (e.g., to hire or not to hire, to graduate or not to graduate, or whether someone is or is not depressed) using one or more prespecified cutoff scores. Typically, the questions in the test are ranked in order of how much precision they contribute to making the classification decision. Then, the questions are administered in ranked order until a classification can be made. In contrast to fully adaptive CAT, questions are not selected based on the examinee's trait level—indeed, sequential tests generally are not designed to measure continuous traits. Since test termination is individualized in sequential testing, however, sequential tests might differ in length among a group of examinees.

### ***Current Issues and Future Directions***

Since the advent of the Internet in the late 1990s, a considerable number of tests are delivered through the Internet. Although 20 years of research demonstrated that rigorously designed computer-administered tests were equivalent to or superior to paper-and-pencil tests, the developers of most Internet or Web-based tests have given little thought to equivalence (i.e., Internet or Web-based tests have not been rigorously designed). Consequently, substantial differences might exist between tests delivered on a PC and those delivered through the Web. These differences can affect the standardization and validity of some tests. Some of these factors include:

- Different browsers use different settings for fonts, colors, and other display characteristics to deliver Web-based tests. These potentially render a given question differently to different examinees. In addition, differences in screen size and resolution reduce the



equivalence of Web-delivered tests to PC-delivered tests. On a PC, the test administration software standardizes the display for all examinees, and a standard monitor can be used throughout a testing room.

- Web access and response time vary greatly from question to question. Some of the factors that affect response time include the speed of the examinee's connection and the amount of traffic on the Web at the instant the examinee responds and receives a new question. Response time is further affected by the speed of the Web server and the other demands on the Web server. For CATs, the computational server time necessary to estimate trait level and select the next question is yet another factor that affects response time. By contrast, on a PC, only a single person is being tested at a time and between-question response time is virtually instantaneous, thus better standardizing test delivery.

- When tests are administered in an uncontrolled environment, such as might occur with Web delivery, environmental variables present during test delivery can affect the test performance of individuals. A basic principle of well-standardized testing is that paper-and-pencil tests are to be administered in a quiet and comfortable environment. For the most part PC-based tests also have been administered in testing rooms with a carefully controlled environment. When tests are delivered through the Web, however, a wide variety of extraneous factors might be present that interfere with—and potentially invalidate—the resulting scores. In addition, when individuals take tests without supervision, it is impossible to know who is actually taking the test, what materials they were accessing during test administration, and who was assisting them during testing.

Clearly, considerable research needs to be done to evaluate the comparability of Web-delivered tests to PC-delivered and paper-and-pencil tests. Before Web-delivered tests can be assumed to be replacements for other testing modes, the effects of their lack of standardization and of the physical conditions of testing on test scores must be evaluated. Furthermore, Web-delivered tests must be delivered under supervised conditions to ensure test integrity and validity.

Although computer-assisted testing has made possible the development of new kinds of tests that can take advantage of the multimedia capabilities of PCs,

that promise has yet to be realized. Very few computer-administered tests focus on the measurement of new abilities, skills, and personal characteristics that cannot be measured by paper-and-pencil tests. Unrealized possibilities include the development of tests to measure personality characteristics in new ways (e.g., using interactive scenarios and video) and new approaches to measuring individual differences in traits such as memory, reasoning, and complex perceptual skills. These developments, combined with fully adaptive CAT, will help computer-assisted testing to realize its full potential.

David J. Weiss

**See also** Academic Achievement (v2); Academic Achievement, Nature and Use of (v4); Achievement, Aptitude, and Ability Tests (v4); Affect (Mood States), Assessment of (v2); Assessment (v4); Cognition/Intelligence, Assessment of (v2); Intelligence Tests (v3); Language Difficulties, Clinical Assessment of (v2); Memory, Assessment of (v2); Personality Assessment (v2); Psychometric Properties (v2); Psychopathology, Assessment of (v2); Test Interpretation (v2)

### Further Readings

- Bartram, D., & Hambleton, R. (2005). *Computer-based testing and the Internet: Issues and advances*. New York: Wiley.
- Dragow, F., & Olson-Buchanan, J. B. (1999). *Innovations in computerized assessment*. Mahwah, NJ: Lawrence Erlbaum.
- Mills, C. N., Potenza, M. T., Fremer, J. J., & Ward, W. C. (2002). *Computer-based testing: Building the foundation for future assessments*. Mahwah, NJ: Lawrence Erlbaum.
- Parshall, C. G., Spray, J. A., Davey, T., & Kalohn, J. (2002). *Practical considerations in computer-based testing*. New York: Springer-Verlag.
- Wainer, H., Dorans, N. J., Eignor, D., Flaugher, R., Green, B. F., Mislevy, R., et al. (2000). *Computerized adaptive testing: A primer* (2nd ed.). Mahwah, NJ: Lawrence Erlbaum.
- Weiss, D. J. (2004). Computerized adaptive testing for effective and efficient measurement in counseling and education. *Measurement and Evaluation in Counseling and Development*, 37(2), 70–84.

### Web Sites

C. A. T. Central: <http://www.psych.umn.edu/psylabs/catcentral>



---

## CONFIDENTIALITY AND LEGAL PRIVILEGE

---

### Confidentiality

Confidentiality is the legal and ethical duty of therapists not to reveal information about their clients to unauthorized individuals. Legally and ethically, therapists are bound by statute and by the profession's code of professional conduct not to reveal information about their clients to unauthorized individuals. Legally and ethically, clients have the right to prevent their therapist from disclosing information shared by them in counseling without their consent.

In counseling, two types of confidentiality are commonly recognized: content confidentiality and contact confidentiality. *Content confidentiality* requires that the substance or content of the client's discussion with a counselor not be revealed by the professional. Disclosures of confidential client information to individuals with no right to that information are called *content breaches*. Such breaches of confidentiality may result in civil liability to the therapist or licensure revocation. *Contact confidentiality* requires that the professional not reveal the fact that the client is being seen by the professional. Disclosures to an unauthorized party that the client is seeing the therapist are referred to as *contact breaches*. Although therapists often make strenuous efforts to avoid disclosures of the identities of their clients, the law generally does not address matters of contact confidentiality.

The ethics codes of both the American Psychological Association (APA) and the American Counseling Association (ACA) provide a set of standards and code of conduct to guide the professional activities of their members, including the provision of counseling and psychological services. In both codes, the duty of counselors and therapists to protect and uphold their clients' right to privacy is fundamental, and both generally are interpreted as including the protection of contact confidentiality. Nevertheless, it is important that counselors and their clients understand the distinction between content and contact confidentiality, as most laws governing the confidentiality of counselor–client communications do not protect contact confidentiality.

Therapists' obligations to protect their clients' confidentiality derives from the client's right to privacy, which itself derives from the more general, but central, ethical value of personal autonomy—a person's right to

“self-determination.” In this case, it is the right to determine with whom personal information may be shared. Confidentiality in this sense can be understood as the counselors' duty or obligation to support clients' right to privacy by not repeating to or sharing with others information shared privately with them by their clients. What clients consider to be private must stay private, and it is the duty of therapists to assure that this is the case with respect to disclosures made by clients in counseling. If a client's private information is to be shared with another, it should be shared by the client—or at least with the consent or authorization of the client. In this regard, a client's right to privacy and a client's right to confidentiality in relation to communications shared in counseling are one and the same.

Because confidentiality and privacy are a client's right, the client may waive that right if he or she chooses. In making such a waiver, it must be demonstrated that such waiver is undertaken knowingly and voluntarily. That is, counselors may ethically and legally reveal a client's confidences with the *informed consent* of the client.

It is often suggested that the protection of another's privacy through the maintenance of confidentiality is a way to build trust within the counseling relationship—trust necessary for clients to share productively and personally with their counselors and therapists. In this regard, it is not uncommon to find it argued that an assurance of confidentiality is indispensable for effective therapy. In keeping with this view, counselors and the counseling profession generally assume that an assurance of confidentiality is essential for effective therapy and that most clients would not feel safe discussing personal and intimate aspects of their lives with a counselor without such assurance. Even the courts have embraced this assumption, with the U.S. Supreme Court writing in *Jaffee v. Redmond* (1996),

Effective psychotherapy depends upon an atmosphere of confidence and trust in which the patient is willing to make a frank and complete disclosure of facts, emotions, memories and fears . . . For this reason, the mere possibility of disclosure may impede development of the confidential relationship necessary for successful treatment.

This may be the case for some clients; however, both experience and research demonstrate that many clients are quite willing to talk personally and intimately with their counselor or therapist without



assurances of confidentiality. While some studies suggest that assurances of confidentiality are essential to productive counseling, overall the results of research on this topic are mixed, with other studies indicating that such assurances have little effect on encouraging disclosures, or that assurances of confidentiality matter only to some clients in some circumstances.

For this reason, the protection of client privacy and the maintenance of confidentiality cannot rest on their necessity to the effectiveness of therapy or as critical therapeutic tools or strategies. Rather, privacy protection and confidentiality must be justified on ethical and legal grounds. Both the APA and the ACA include the therapist's duty to protect the confidentiality of client disclosures made in counseling as a fundamental ethical principle and duty in their respective ethics codes. With regard to law, state and federal law also protect the (content) confidentiality of communications between clients and their therapists. Importantly, state and federal laws also address how such confidential communications are stored (e.g., the maintenance and management of case records) and how that information can be released—specifically, the restricted circumstances under which such information may or must be shared, and the mechanism by which that information is shared. Thus, under the law, clients' rights to privacy and therapists' obligations to protect that privacy through their maintenance of confidentiality are enforceable. However, those rights and obligations are not without limits. Exceptions to confidentiality will be discussed momentarily.

## Legal Privilege

### *Privileged Communication*

Statutes that accord protection to clients from therapists' sharing with others information that was shared privately in therapy also may include provisions exempting counselors and therapists from the requirement to reveal privileged information about a client and client disclosures in court. These laws are called privileged communication laws.

Privileged communication refers to the statutory or judicial protection extended to certain "special relationships" whose existence is considered important to the community and to be dependent on assurance of the confidentiality of communications. More specifically, in the case of therapy, it is a right, granted by statute to the client, that confidences originating in the therapeutic relationship will be safeguarded (i.e., not

be revealed) during certain court proceedings. In other words, when a client invokes privilege, the therapist is legally and ethically bound to not reveal in court information obtained during the professional relationship.

Privileged communication is understood to be rooted in early Elizabethan law, where certain individuals had the right or privilege to refuse to testify about embarrassing matters. In time, this individual privilege conferred to attorney–client relationships prohibited an attorney from testifying against his or her client. Under U.S. law, the privileged nature of communications shared by clients with their attorneys can be understood within the context of the Fifth Amendment to the Constitution—the right to avoid self-incrimination.

Over time, legislatures cautiously have passed laws extending privileged status to communications originating in other, special, socially important relationships. Such relationships include those between physicians and their patients, husbands and wives, priests and penitents or confessors. In order for legislatures to pass such laws they must be convinced that making an exception to the rule of evidence is vital to the well-being of society and that an individual citizen's need to privacy outweighs the need for evidence in a court case.

In 1961, jurist John Wigmore proposed four criteria to be used as guides to decision making regarding the according of privileged communication: (1) the communications must originate in confidence that they will not be disclosed, (2) confidentiality must be essential to the full and satisfactory maintenance of the relationship, (3) the relationship must be one that is strongly supported and fostered by the community, and (4) the harm to the relationship as a result of disclosure of the communications must be greater than the benefit from the proper disposal of the litigation.

Extension of the privilege to communications originating in therapy relationships (i.e., those occurring between psychologists or counselors and their clients) is a relatively recent development. Although it is now almost universal that *psychologist*–client communications are treated as privileged, the extension of privileged status to the communications occurring within the *counselor*–client relationship remains limited.

Even where such privileged communication is recognized, it is important for counselors to be aware that there are exceptions to this privilege that may require otherwise protected or privileged information to be revealed. Common exceptions include requirements to testify regarding client threats to the health and safety of the client or others; a client's intent to commit



a crime; knowledge of child abuse, elder abuse, or disabled adult abuse committed by the client; and a client's mental condition or state in an involuntary commitment proceeding or if the client has raised an issue of her or his mental state in a legal proceeding.

### **Qualified Privilege**

When invoked and accepted by the court, the doctrine of qualified privilege provides protection against charges of defamation. *Defamation* is an act of communication that causes someone to be shamed, ridiculed, held in contempt, lowered in the estimation of the community, or to lose employment status or earnings or otherwise suffer a damaged reputation. More specifically, defamation is the making of false statements about a person that injure his or her reputation or that deter others from associating with him or her. Libel and slander are the legal subcategories of defamation. *Libel* is defamation in print, pictures, or any other visual symbols. *Slander* is defamation by oral communication.

Of relevance to issues of confidentiality and legal privilege, defamation involves instances in which a counselor or therapist shares with another information about a client that may be or is damaging to that client's reputation. An example of this would be when therapists break confidentiality to share with the appropriate authorities (e.g., local child-protection services) their suspicion that a client is being (or has been) sexually abused or molested by an adult or, if the client is an adult, is molesting a child. Both are instances in which counselors may be required by law to break confidentiality to report their suspicions to protect a child. It is important to note that counselors are not required to be certain that abuse has taken place; rather, they are required to report their suspicions—leaving determination of facts of the matter to the appropriate authorities. Regardless of the truth or falsity of such a communication to the authorities, such a communication or revelation can be understood to be damaging to the reputation the suspected abuser, and it is understandable that such person might take legal action against the therapist for breach of confidentiality and for defamation and damage to the person's reputation and standing in the community.

In legal proceedings, the general avenues of defense in defamation suits are (1) that the communication or revelation is true, and (2) that the person gave consent to the release of the information. Qualified privilege is a third avenue of defense. The notion of there being a privilege that qualifies some communications as

exemptions from defamatory characterization rests on the notion of an overarching social duty to share or release information, even if that information may be false. There are four conditions that must be met under the doctrine of *qualified privilege*: (1) the information must be presented in good faith—not in malice, (2) there must be a legitimate social duty to release the information, (3) the disclosure must be limited in scope to what is necessary to discharge the duty, and (4) the disclosure must be made only to the appropriate parties with a right to know. Most states with mandatory abuse-reporting laws include a qualified privilege provision in their reporting statute, thereby protecting counselors from defamation suits so long as their report of suspected abuse was made out of sincere concern for the protection and welfare of the child, the information shared related only to the suspicions of abuse, and the information was shared only with the appropriate authorities.

### **Limits and Exceptions to Confidentiality and Privilege**

As noted earlier, a client's right to privacy and confidentiality, is not without limits. There are exceptions to rules of privacy and confidentiality; neither is absolute. Specific exceptions to privacy and confidentiality vary by jurisdiction, and counselors are well advised to become familiar with the exceptions that are relevant to their practice jurisdiction and professional practice setting.

In addition to previously noted client waivers of confidentiality with their informed consent, other circumstances may permit and require disclosures by counselors of otherwise confidential disclosures to supervisors and others involved in the treatment of the client. Disclosures to the parent or guardian of a minor client and disclosures to share in the interest of the operation of the system in special settings (e.g., the penal system) are additional instances when confidentiality is limited.

Even where privileged communication is recognized, counselors need to be aware of statutory exceptions to this privilege that may require them to reveal otherwise confidential and privileged information. Such exceptions may include requirements to testify regarding client threats to the health and safety of the client or others (including when a client has a fatal, communicable disease and the client's behavior is putting others at risk), a client's intent to commit a crime, reporting of suspected abuse or neglect of a child or other persons



presumed to have limited ability to care for themselves (e.g., the elderly or a disabled adult), and a client's mental condition or state in an involuntary commitment proceeding or if the client has raised an issue of her or his mental state in a legal proceeding.

Other exceptions include death of the client, sharing information with subordinate and fellow professionals in coordinating client care (e.g., within-agency or within-institution sharing of information), working under supervision, the use of clerical staff and other assistants who handle confidential information, and clinical and legal consultation with colleagues or experts. Additionally, privilege and confidentiality are waived when clients bring law suits claiming emotional damage, when clients raise issues of their mental health in legal proceedings (e.g., in custody suits), when counselors provide services to multiple clients (e.g., when a third party is present during the communication, such as in couples, family, or group counseling), and to permit counselors or therapists the ability to defend themselves against charges of negligence or malpractice charges raised by their clients.

*James W. Lichtenberg and Pamela L. Knox*

**See also** Code of Ethics and Standards of Practice (v2); Duty to Warn and Protect (v2); Ethical Codes (v1); Ethical Dilemmas (v1); Informed Consent (v2); Relationships With Clients (v2)

### Further Readings

- American Counseling Association. (2005). *ACA code of ethics*. Alexandria, VA: Author.
- American Psychological Association. (2002). *Ethical principles of psychologists and code of conduct*. Washington, DC: Author.
- Bersoff, D. N. (Ed.). (2003). *Ethical conflicts in psychology* (3rd ed.). Washington, DC: American Psychological Association.
- Jaffee v. Redmond, 518 U.S. 1 (1996).
- Welfel, E. R. (Ed.). (2006). *Ethics in counseling and psychotherapy: Standards, research, and emerging issues* (3rd ed.). Belmont, CA: Thomson Brooks/Cole.

---

## CONSTRUCTIVIST THEORY

---

The influence of postmodernism's challenge of the "objectivist" position in psychology has been central

in the evolution of constructivist therapies. The abandonment of the certainty of modernist positions for the tentative, constructed meanings in the postmodern world has given rise to a number of therapeutic approaches that eschew well-established, contemporary icons in psychology. Objective assessment of personality, abilities, and psychopathology has given way to a more interpretive, hermeneutic approach to understanding the world in which we live. The spirit of uncertainty that pervades postmodern discourse is evident when trying to provide a fundamental definition of constructivism.

Robert A. Neimeyer noted that there are numerous positions in postmodernism and that they are sometimes discordant with each other. He and Donald E. Polkinghorne, among others, have argued that the constructivist movement in psychotherapy is characterized by a truly postmodern lack of foundationalism, a lack of agreement on many of the particulars of how individuals construct reality. In general, constructivist theorists have an intellectual allergy to the metaphysical realist position that sets forth an understanding of the world that is independent of our own, human experiences of the world. According to the 2007 *APA Dictionary of Psychology*, *constructionism* is

the theoretical perspective, central to the work of Jean Piaget, that people actively build their perception of the world and interpret objects and events that surround them in terms of what they already know. Thus their current state of knowledge guides processing, substantially influencing how (and what) new information is acquired. (p. 221)

There are several points of view that are based on constructivist ideas; two of the best known are *radical constructivism* and *social constructionism*. Radical constructivists such as philosopher Ernst von Glasersfeld and psychotherapy pioneer Paul Watzlawick of the Mental Research Institute hold that all we can know of the world are the products of sensory/perceptual processes that take place within our bodies. The radical constructivists do not deny, in a solipsistic way, the existence of reality outside. Rather, they argue that there is no eidetic correspondence between what is "out there" and our internal perceptual constructions. Paul Watzlawick's well-known metaphor invites the reader to imagine he or she is piloting a large ocean liner through an impenetrable fog at night. In such circumstances, the ship's captain has no direct visual



representations of the rocks or icebergs that might lurk in the darkness. The captain must rely on the iconic representations given by radar and sonar and other electronic sensing devices, to make interpretations about what is “out there.” Successful adaptation, under these circumstances, is not measured by how accurately the captain was able to describe what was “out there,” but by whether or not the ship crashed into the rocks. So, for the radical constructivist, sensory/perceptual habits that endure are regarded as reality.

Another constructivist approach is that of social constructionism. It owes an intellectual heritage to Peter L. Berger and Thomas Luckman’s early work, *The Social Construction of Reality*. There are several more recent extensions of that early work by Kenneth J. Gergen, Theodore R. Sarbin, Donald E. Polkinghorne, John Shotter, and others. Sarbin and John I. Kitsuse open their collection of essays on social constructionism with the story of three baseball umpires reflecting on their professional practice of calling balls and strikes.

The first, a self-confident realist, says, “I call ’em the way they are,” to which the second who leans toward phenomenological analysis says, “I call ’em as I see ’em,” and the third closes the discussion with “They ain’t nothin’ until I call ’em.” (p. 1)

The third umpire illustrates the central premise in constructionism—that human beings are active agents in processing information and creating knowledge rather than passive organisms who simply respond to the environment. Although most constructivists acknowledge there is a “real world” outside of human consciousness, they are more interested in people’s constructions of their worlds than how close those constructions are to any objective “truth.” Social constructionism moves the interpretive act of reality construction away from people’s interior constructions to a social endeavor heavily reliant on language, customs, culture, and other contextual factors. The social constructionists move beyond the constructivism of von Glaserfeld, Watzlawick, and George Kelly by invoking the social nature of human meaning making. Social constructionism, then, adds a layer to the radical constructivist’s formulation by including the social nature of reality construction.

The social constructionist view owes its early intellectual heritage to the work of Lev Vygotsky and others. Gergen is perhaps the most well-known American psychologist writing about social constructionism. The

essential feature of social constructionism is the notion that reality construction is the result of meaning-making activities that take place in relationships with other people and in cultural/environmental/linguistic contexts. Although language is frequently seen as the primary constituent of social constructionism, language is but one aspect of the cultural/biological context that influences meaning construction. Social constructionists are interested in epistemological understandings of how we come to adapt to the varieties of realities we construct.

### Therapeutic Approaches Based on Constructivist Theory

Constructionism has found expression in a variety of psychotherapeutic approaches. Kelly is usually identified as an early example of the application of constructivist theories to therapy. He developed personal construct theory and elaborated the idea that people approach their phenomenological world much like scientists: generating theories, testing hypotheses, and revising their expectations of the world based on these experiences. Kelly did deny the existence of a reality “out there”; he thought that we all construct a different “out there” based on our experiences and expectations. Kelly called his particular philosophy *constructive alternativism* to reflect that everyone constructs an alternate reality based on his or her unique experiences. The Repertory Grid interview he developed allows clinicians to understand the unique constructs of their clients and how those constructs influenced their perceptions and behaviors.

At the same time that Kelly was developing his personal construct theory, the anthropologist Gregory Bateson was developing an approach to treatment of disorders based on radical constructivism. Bateson’s team originated the seminal idea in American psychology that the origin of psychological difficulties was in the interactions between people. The well-known double-bind theory of schizophrenia was an early attempt to explain the effect of interpersonal communication on psychological development.

The solution-focused therapies of Steven de Shazer’s group and the solution-oriented variations of William H. O’Hanlon and Michele Weiner-Davis arose in the 1980s and represented a move away from radical constructivism to a more pragmatic focus on problem resolution. The rising influence of social constructionism has enabled therapists to develop



approaches based on contextual formulations of problems and their resolutions.

The most dramatic example of this trend is seen in the work of therapists who employ a narrative metaphor in their work. Although there is a group of therapists that refer to themselves as *narrative therapists*, there is a strong narrative tradition in psychoanalysis as well. Narrative therapists, for the most part, derive their working metaphors from literary criticism and hermeneutics. The influence of narrative therapists can be seen in their influence on more conventional therapies. Recently, some cognitive-behavioral therapists have begun to describe their work as having a basis in constructionism.

### Research Support

A body of research support for constructivist therapies is growing. Practitioners of constructivist theories are generally unsympathetic to positivist approaches to research. Accordingly, the tradition of empirical studies involving carefully constructed experimental controls on treatment is sparse for constructivist therapies. Empirical support for constructivist therapies has come largely from case studies and anecdotal reports.

Solution-focused brief therapies (SFBT) have been more widely researched in recent years than any other approach. A recent review of 15 controlled studies of the effectiveness of SFBT found that SFBT provided significant benefits. Solution-focused brief therapy has been demonstrated to be effective in working with at-risk junior high school students, high school bullies, juvenile offenders, older adults, adolescent substance abusers, and university counseling center clients.

Empirical evidence for narrative approaches also exists. Narrative therapy has been reported to be successful in treating abuse, older adults, and athletes. Robert G. Malgady and Giuseppe Costantino and their colleagues have demonstrated the usefulness of narrative therapy in working with Hispanic children and adolescents.

Monte Bobele

**See also** Adaptation (v3); Barriers to Cross-Cultural Counseling (v3); Constructivist Career Counseling (v4); Counseling Theories and Therapies (v2); Meaning, Creation of (v2); Narrative Career Counseling (v4); Narrative Therapy (v2); Personality Theories, Phenomenological (v2); Person–Environment Interactions

(v2); Positive Psychology (v2); Positivist Paradigm (v2); Solution-Focused Brief Therapy (v2)

### Further Readings

- American Psychological Association. (2007). *APA dictionary of psychology* (G. R. VandenBos, Ed.). Washington, DC: Author.
- Costantino, G., Dana, R. H., & Malgady, R. G. (2007). *TEMAS (Tell-Me-A-Story) Assessment in multicultural societies*. Mahwah, NJ: Lawrence Erlbaum.
- Gergen, K. J. (2001). *Social construction in context*. London: Sage.
- Kelly, G. A. (1955). *The psychology of personal constructs*. New York: Norton.
- Neimeyer, R. A. (1995). Constructivist psychotherapies: Features, foundations, and future directions. In R. A. Neimeyer & M. J. Mahoney (Eds.), *Constructivism in psychotherapy* (pp. 11–38). Washington, DC: American Psychological Association.
- O'Hanlon, W. H., & Weiner-Davis, M. (1989). *In search of solutions: A new direction in psychotherapy*. New York: Norton.
- Polkinghorne, D. E. (1992). Postmodern epistemology of practice. In S. Kvale (Ed.), *Psychology and postmodernism. Inquiries in social construction* (pp. 146–165). London: Sage.
- Sarbin, T. R., & Kitsuse, J. I. (Eds.). (1994). *Constructing the social*. London: Sage.
- Shotter, J. (1992). Social constructionism and realism: Adequacy or accuracy? *Theory and Psychology*, 2(2), 175–182.
- Watzlawick, P. (1984). *The invented reality: How do we know what we believe we know?: Contributions to constructivism*. New York: Norton.

---

## CONSULTATION

---

The defining moment for most products that have reached an iconic status is the generic application of the product's name, such as the use of "Kleenex" to indicate any brand of tissue. Similarly, the practice of consulting has reached a comparable level of renown and one is able to find it in almost every aspect of our present society. Today, in any given business or academic arena, one can locate listings for financial consulting, international consulting, executive sales and marketing consulting, and even nutritional consulting. Historically, the term *consulting* existed more frequently as a verb and



predates society's current trend toward life coaches who "consult" on issues such as career, relationships, and communication styles. This entry on consultation emanates from a psychological frame of reference that addresses different forms of consultation and the competent and ethical practice of consulting.

## Consulting Defined

The act or art of consulting is typically tied to solution seeking. It can be thought of as a set of helping behaviors in which one party is seeking input, advice, or feedback from another related to a problem, question, or dilemma. Several authors within the field of counseling psychology, such as Sandra Shullman and John M. Whiteley, have traced the origins of consulting to the early guidance days of Frank Parsons during which counselors and psychologists worked diligently in business settings and industrial organizations to solve vocational problems for groups, as well as individuals.

Perhaps most notable in the early life of psychological (mental health) consultation is the seminal work of Gerald Caplan with his prevention-based book titled *The Theory and Practice of Mental Health Consultation*. This work presented prevention- and developmental-based intervention options for mental health professionals that would take place outside of the therapy room. By doing so, it created the opportunity to apply psychological principles through assistance or advice in outreach types of activities. An outline of Caplan's four types of consultation would typically include client-centered case consultation, consultee-centered consultation, program-centered consultation, and administrative consultation. Since Caplan's work, consultation has been broadened to include school counseling and education, advocacy, group, and process consultation. Work in these arenas may be theoretically based on behavior-oriented, (industrial) organizational, or social justice-based solutions. Their underpinnings, though, can be connected to the early works of Caplan.

## Types of Consultation

### *Collegial Consultation*

One common form of consultation is the informal or formal exchange of information that occurs in the professional lives of counselors as they move toward refining their own clinical techniques; establishing expertise

in a particular faction of study; or improving upon a design, method, or approach. In the field of counseling, practitioners are taught to seek consultation when faced with complicated issues that are not always well defined in textbooks or evidenced-based research. A common situation that requires consultation is the realization of a potential ethical dilemma involving clients, colleagues, or students. Thus, consulting with another professional allows for the translation of what may appear abstract or unknown into observations or behaviors that others have studied and/or experienced, and for which solutions have been developed.

### *Agency Consultation*

In more formal settings, such as businesses, consultation often occurs in the context of a contractual relationship between the consultant, who holds some expertise in a specified area, and the consultee, who has identified a need or potential need but does not have the knowledge or skills required to address the issue. The consultant is held in the role of "expert" and proceeds to clarify the consultee's goals or referral questions and then sets out to analyze the situation through the study of a group, system, or process. This can incorporate direct assessment of a person or groups as well as indirect observation and data collection from others. Subsequently, the consultant interprets and outlines the results for the consultee in an effort to assist in potential problem solving or identification of structural issues, concerns, or conflicts. In most instances the consultant is collaborating with the consultee to arrive at the point of problem resolution. This mode of consultation is the essence of the scientist-practitioner model of counseling psychology. The science is manifest in the methods of investigation and research of the issues at hand, while the practice is applied through the skills of the counseling psychologist as he or she intervenes and facilitates the process.

## Stages of Consulting

The literature has demonstrated that, similar to the therapy process, the consultation experience includes different stages or phases that originate with a well-grounded working relationship. The importance of a working relationship in counseling may seem self-evident, but it is equally important in the consultation process. If rapport is not present, productivity is limited. As with therapy, the phases of assessment, conceptualization, and



solution development are often taking place as the consultant continues to build the consultation relationship. Once a working relationship has been established, clearly defining the problem, concern, or issue at hand becomes paramount to the success of the consultation process. Whether the identified need is an organizational issue of reduced productivity or a work group's difficulty in successful management of differing opinions, the participants must have a common definition of the concern as they begin their process.

Once such groundwork is clarified and understood by the engaged parties, the goal setting and problem solving may begin. It is important to remember that parallel to therapy, this understanding should be reviewed often as the consultation proceeds. Clarifying the consultation process, in addition to evaluating ongoing progress or assessing outcomes, is crucial to the successful maintenance and completion of the consulting relationship. The positive termination of a consulting relationship is dependent on a cooperative understanding of the tasks at hand and the skillful facilitation of an accountable, working relationship.

### Competency Standards

Perhaps one way to ensure competent consulting in today's mental health professions is to better quantify and define the basics of competency-based training, course work, and field experiences. As noted, there has been a proliferation of consulting "professionals" in today's job arenas. One can easily locate a number of corporate- or business-related consulting career titles available in any given phone directory or Better Business Bureau listing. Additionally, there are now persons from fields outside of psychology who promote themselves as consultants in a multitude of areas, such as retirement, spirituality, personal fitness training, athletic activities, and fashion.

The need for increased professional clarification in psychology-based consultation has been recognized through the timely efforts of the American Psychological Association's (APA) educational workgroups. The workgroups propose and outline benchmarks in an attempt to delineate boundaries of practice, developmental progress, educational requirements, internship, and practice and supervision needs. Such efforts point to a desire for more quality control in the area of consultation and a more systematic approach to the training of psychologists in the area of consultation. Likewise, Stewart E. Cooper, and numerous authors from industrial/organizational, school psychology,

military, and counseling psychology backgrounds, organized a special issue of the *Consulting Psychology Journal of Practice and Research* in 2002. This collection offered a summary of training needs and proposed working definitions of consultation as well as competency standards. These authors also called for increased research and ethics to be applied to consulting. If indeed the area of consultation is unique from the process of therapy, then it stands to reason there should be a set of skills, related literature, research, and standards that can be employed to measure a trainee's ability development. Continued APA workgroup involvement throughout each of psychology's areas will address the uniqueness of consulting and guidelines to ensure quality delivery of services.

Pamela Cogdal

**See also** Code of Ethics and Standards of Practice (v2); Counseling Skills Training (v2); Expectations About Therapy (v2); Industrial/Organizational Psychology (v1); Relationships With Clients (v2); Scientist-Practitioner Model of Training (v1)

### Further Readings

- Archer, J., & Cooper, S. (1998). *Counseling and mental health services on campus: A handbook of contemporary practices and challenges*. San Francisco: Jossey-Bass.
- Caplan, G. (1970). *The theory and practice of mental health consultation*. New York: Basic Books.
- Lowman, R. L., Alderfer, C., Atella, M., Garman, A., Hellkamp, D., Kilburg, R., et al. (2002). Principles for education and training at the doctoral and postdoctoral level in consulting psychology/organizational. *Consulting Psychology Journal: Practice and Research*, 54, 213–222.
- Shullman, S. L. (2002). Reflections of a consulting counseling psychologist: Implications of the principles for education and training at the doctoral and predoctoral level in consulting psychology for the practice of counseling psychology. *Consulting Psychologist Journal: Practice and Research*, 54, 242–251.
- Whiteley, J. M. (1984). Counseling psychology: A historical perspective. *The Counseling Psychologist*, 12, 3–109.

---

## COPING

---

Coping refers to a complex set of behaviors and cognitions that individuals use to deal with stress and adversity. The concepts of stress and adversity are explicitly



linked to coping. Understanding coping is fundamental to understanding how stress affects people.

## The Nature of Coping

Since the 1980s the most widely accepted definition of coping has described coping as (a) constantly changing, (b) involving both cognitions and behavior, (c) effortful, (d) concerned with the management of specific demands, and (e) present when demands from within or outside of a person are evaluated as taxing or exceeding that person's resources.

Key features of this definition focus on the process of coping, noting that coping is not traitlike. Coping fluctuates across situations, although there is also stability in coping. The management aspect of this definition also is emphasized. Coping efforts may not always be successful. Some of the cognitive and behavioral strategies individuals use to manage stress lead to better adjustment, while other strategies result in worse adjustment. A third feature of the definition is that coping is a psychological construct, in that it involves evaluations or appraisals of a situation as exceeding a person's resources to manage the situation. Finally, coping involves voluntary and effortful responses. Individuals respond in broad ways to stress, and those responses include both voluntary and involuntary (automatic) reactions. Coping refers to the effortful responses people make to manage a situation or their emotional responses to it.

Coping behavior is only one part of a broader set of constructs referred to as *coping processes*. Richard Lazarus, Susan Folkman, and their colleagues describe the coping process as consisting of appraisal, behavior, and reappraisal. Appraisal involves an evaluation of the extent to which a situation is challenging, benign, or harmful, and an assessment of the internal and external resources available to deal with the situation. Coping behavior follows this appraisal, and then a reappraisal is made to determine the extent to which the coping behavior had the desired effect.

## Functions of Coping

One way of classifying coping behaviors, now regarded as overly simplistic, is as having either an emotion-focused or a problem-focused function. *Emotion-focused coping* refers to people's efforts to manage their emotional responses to stress. Examples include reframing the problem, venting, distracting oneself, and denial. *Problem-focused coping* refers to

efforts to solve the problem. These efforts can be directed inward or outward. Examples of problem-focused coping strategies include thinking about solutions, taking direct action to solve the problem, shifting one's focus, and seeking help from others. Both types of coping can be adaptive and both can be harmful, depending on the precise behavior enacted and the nature of the situation.

Recently, researchers have suggested that the functions of coping be considered in light of challenges and threats to the basic human needs for competence, relatedness, and autonomy. From a motivational perspective, all individuals have basic needs to feel competent, to relate and be connected to others, and to make independent decisions. When viewed from this perspective, the function of coping is distinguished not by the coping behavior used but by the extent to which it is a response to attacks on core needs.

## Structure of Coping

Two primary ways of thinking about types of coping are whether the coping behaviors involve active or approach (sometimes called engagement) strategies or avoidant (sometimes called disengagement) strategies, and whether the behaviors involve cognitive or behavioral strategies. *Active* coping behaviors are characterized by a willingness to interact with the stress, either internally or externally. Coping efforts that fall into this framework include cognitive reframing (thinking about the problem situation differently), acceptance, problem solving, and emotion regulation. In contrast, avoidant coping behaviors reflect an unwillingness or inability to confront the problem. *Avoidant* coping behaviors include denial, avoidance, and wishful thinking. Involuntary responses to stress (e.g., emotional or physiological arousal, intrusive thoughts, and emotional numbing) are not regarded as coping per se. Proactive coping is an additional form of coping that is not assessed by most coping inventories. *Proactive* coping consists of efforts undertaken in advance of a potentially stressful event to prevent it or to modify it before it occurs.

Recently some psychologists have suggested that a hierarchical system be developed for grouping coping strategies, but no such system has been forthcoming to date.

## Measurement of Coping

Questionnaires are the most frequently used method of assessing coping. Observational methods and



interviews are used rarely. The Ways of Coping Checklist and the COPE are the two measures of coping most often used with adults. Popular options for assessing coping in children and adolescents include the Adolescent Coping Orientation for Problem Experiences Scale (A-COPES), the Children's Coping Strategies Checklist (CCSC), the Coping Response Inventory, and the Responses to Stress Questionnaire (RSQ). Theoretically driven measures that were developed and validated using Confirmatory Factor Analysis are preferable to measures developed using other strategies. The COPE, CCSC, and RSQ are excellent examples of such measures.

Most general measures of coping have both dispositional and situation-specific versions. Dispositional measures ask about the coping strategies the individual uses with a broad array of stressors. Situation-specific measures assess coping strategies used to deal with a specific event or class of events (e.g., peer rejection or job loss). Both dispositional and situation-specific measures of coping tap some forms of active and avoidant coping. For example, problem solving, positive reframing, support seeking, distraction, and avoidance are common coping behaviors on many inventories. Additionally, some inventories assess humor, religious coping, or drug or alcohol use as a means of coping.

In addition to measures that assess a wide array of coping behaviors, there are measures designed to assess very specific types of coping in great detail. For example, a number of measures are specifically designed to assess religious coping. These measures are designed to capture subtle differences within the broad category of religious coping, and are useful for in-depth study in a particular area. Other coping inventories are designed for specific stressors such as health conditions (e.g., cancer, depression, infertility or chronic pain), and life situations (e.g., marital problems, job loss, or death of a family member).

The choice of measure used in a study of coping should depend on both the quality of the measure and the specific aims of the study. With the exception of proactive coping, which may go unstudied because it is hard to detect, many coping inventories assess the most commonly observed coping behaviors.

### **Why Coping Matters: Links to Adjustment**

A key reason for psychologists' concern about how best to categorize and measure coping is that people's

success in dealing with situations that tax their resources affects their mental and social adjustment. The goal underlying attempts to group coping strategies is to determine which coping strategies are most adaptive. Although definitive conclusions are premature, it appears that both youth and adults who use active coping strategies and versatile coping behaviors in response to stress demonstrate better psychological and physical health. In contrast, individuals who rely on avoidant coping demonstrate worse adjustment. Avoidance may be necessary in the short term to permit the individual to achieve some distance from the stress; ultimately it is harmful to psychological and physical well-being.

### **Influences on Coping**

Given the importance of coping, psychologists are engaged in an effort to understand what influences coping, particularly if changing coping as a way of improving adjustment is the goal of the counselor. Coping behaviors are influenced by a broad set of factors, including qualities of the individual, aspects of the specific situation, and pressures in the environment.

#### ***Individual Influences on Coping***

Qualities of the individual that influence coping include age, gender, socioeconomic status, temperament or personality, beliefs, and values. Girls and women are more likely than boys and men to seek social support when confronted with stress. Cognitive coping strategies increase over time; adolescents are more likely than school-age children to use cognitive coping strategies. Optimistic adults and Type A individuals (i.e., those who are hard-driving, achievement oriented, and impatient or hostile) are more likely to use active strategies and less likely to disengage from stressors than individuals who are pessimistic or not Type A.

Personality factors can serve as coping resources in times of stress. Individuals for whom religion is important are more likely to endorse spiritual forms of coping than individuals who do not hold religious values. Individuals who place a high value on maintaining relationships with others will engage in coping that repairs relationships to a much greater degree than individuals for whom this is not a salient value.



### ***Situational Influences on Coping***

Aspects of the situation that affect coping include the extent to which the stressor is acute versus chronic in nature, is familiar or novel, is controllable, involves threat as opposed to loss, involves a conflict situation, and is interpersonal in nature. For interpersonal situations, the power difference of those involved is another relevant factor. For example, individuals use religious coping much more frequently in situations that are chronic and involve loss than in situations that involve more mundane everyday stress. Situations that can be changed evoke greater use of problem-focused coping strategies than situations that cannot be changed. For example, a layoff might evoke coping focused on managing affect, whereas a conflict with a friend might stimulate coping focused on repairing the relationship. Even in situations that are not controllable, however, individuals do have a choice in how they think about and respond to the stress.

Some forms of coping are influenced by qualities of the situation to a greater degree than others. Across a variety of situations, there is much greater consistency in the use of coping strategies that involve religion, avoidance via alcohol and drug use, and seeking emotional support than there is in the use of denial, disengagement, and some aspects of active coping.

### ***Environmental Influences on Coping***

Familial, cultural, and social aspects of the environment also influence coping behavior. Family socialization plays a large role in shaping how individuals respond to stressors, particularly for youth. Coping styles and strategies develop over the course of childhood and adolescence, and are heavily influenced by parents. For example, parental reactions to differences in temperament (an individual influence) can transform natural coping tendencies.

Parents influence the development of coping strategies in three ways. First, parents coach youth to engage in particular coping behaviors via direct suggestion. For example, parents might suggest that children come talk to them when they have a problem, or parents might suggest that children engage in physical activity to take their minds off a situation. Second, parents model coping behaviors. Children observe both the behavior and the consequences of the coping choices, and when confronted with a similar situation tend to enact that coping strategy. Third, parents create an environment that encourages or

discourages specific coping activities. For example, children feel freer to talk about their feelings in families that model open communication than in families where honest discourse is discouraged. The influence of these three mechanisms in teaching youth coping strategies is apparent even when individuals become adults.

Peer, work, and neighborhood contexts also shape coping responses, largely by way of the values that are reinforced in those contexts and the resources that are available. For example, in neighborhoods with high levels of collective efficacy—that is, where neighbors support one another and share child discipline—individuals are more likely to seek tangible support to cope with specific problems. In contrast, support seeking is less likely to occur in neighborhoods lacking cohesiveness.

Culture influences how parents socialize their children's coping, but it also has independent effects via the values it espouses. For example, cultures that value the needs of the group over the needs of the individual are more likely than other cultures to support coping efforts that take group needs into account.

In addition, the environment, including culture, provides tangible (e.g., money, information or specific help) and emotional coping resources. The availability of coping resources influences individuals' perceptions of the coping options that are open to them.

### **Future Directions**

Psychologists regard an understanding of coping as critically important in their efforts to help people improve their lives. Research on coping will continue to investigate how coping should be conceptualized, the ways in which coping relates to appraisal, how the coping process unfolds, individual and environmental contributions to coping, and the contexts in which particular coping behaviors are adaptive or maladaptive. The next decade is likely to see increased attention given to ways of assessing coping that capture individuals in their daily experience, and to qualitative assessments of coping.

*Wendy Kliever*

*See also* Defenses, Psychological (v2); Help-Seeking Behavior (v3); Meaning, Creation of (v2); Person–Environment Interactions (v2); Problem-Solving Appraisal (v2); Resilience (v2); Social Support (v2); Stress (v2); Stress Management (v2)



### Further Readings

- Aspinwall, L. G., & Taylor, S. E. (1997). A stitch in time: Self-regulation and proactive coping. *Psychological Bulletin*, 121, 417–436.
- Connor-Smith, J. K., Compas, B. E., Wadsworth, M. E., Thomsen, A. H., & Saltzman, H. (2000). Responses to stress in adolescence: Measurement of coping and involuntary stress responses. *Journal of Consulting and Clinical Psychology*, 68, 976–992.
- Lazarus, R. S., & Folkman, S. (1984). *Stress, appraisal, and coping*. New York: Springer.
- Skinner, E. A., Edge, K., Altman, J., & Sherwood, H. (2003). Searching for the structure of coping: A review and critique of category systems for classifying ways of coping. *Psychological Bulletin*, 129, 216–269.
- Wolchik, S. A., & Sandler, I. N. (Eds.). (1996). *Handbook of children's coping: Linking theory and intervention*. New York: Plenum.

---

## COSTA, PAUL T. (1942– ), AND McCRAE, ROBERT R. (1949– )

---

Paul T. Costa, Jr., and Robert R. (Jeff) McCrae are an extraordinarily productive research team that has worked together since they first met in Boston in 1975. Their more than 250 publications on personality traits and the Five Factor model have had a profound effect on personality assessment, theory, and research.

Costa was born in 1942 in Franklin, New Hampshire. After completing undergraduate work at Clark University (1964), he went to graduate school at the University of Chicago (1966–1970), where he studied human development. He taught for 2 years at Harvard and 5 years at the University of Massachusetts, Boston (1973–1978), before moving to the National Institute of Aging in Baltimore, where he and McCrae have been ever since. He is a fellow of the Gerontological Society of America and the American Psychological Association, and a past president of the International Society for the Study of Individual Differences.

McCrae was born in 1949 in Maryville, Missouri. He studied philosophy at Michigan State University (1967–1971), but switched to psychology for his graduate work at Boston University (1971–1976). He gravitated to personality measurement and psychometrics because of his interest in mathematics and the works of

Raymond Cattell. He met Paul Costa while still in graduate school, and they worked together for 2 years in Boston before moving their research team to Baltimore. He is a fellow of the American Psychological Association, the American Psychological Society, and the Gerontological Society of America.

Costa and McCrae's research reflects their enduring interest in the scientific study of personality and of the ways in which people differ from one another. Hans Eysenck had theorized that the important dimensions underlying differences among people were neuroticism and extraversion. Costa and McCrae added Openness as a primary dimension of personality and developed the NEO (i.e., neuroticism, extraversion, openness) personality inventory for use in their research on the stability of the adult personality. They later revised the inventory to add Agreeableness and Conscientiousness and named the revised instrument the NEO-PI-R. This instrument is somewhat time consuming because it assesses multiple facets for each broad trait domain, so Costa and McCrae also developed a shorter form, the Five Factor Inventory (NEO-FFI), for quick assessment at the broad domain level.

Their work at NIA has focused primarily on a longitudinal sample of aging adults in Baltimore. They have been able to demonstrate striking consistency, long-time stability, and important consequences of the traits measured by the NEO and NEO-PI-R. This was a controversial finding in the late 1970s and early 1980s. Many in psychology (particularly social psychology) had dismissed the importance or even the existence of traits. The Five Factor model has become a consensus representation in personality assessment and theory partly because of the consistency of Costa and McCrae's findings, and the agreement of their findings with results from investigations of the lexical hypothesis (e.g., Lewis R. Goldberg).

*William Revelle*

**See also** Adult Development (v1); Aging (v1); Multicultural Personality (v3); Personality Assessment (v2); Personality Assessment and Careers (v4); Personality Theories (v2); Personality Theories, Five-Factor Model (v2); Personality Theories, Traits (v2); Quantitative Methodologies (v1)

### Further Readings

- Costa, P. T., Jr., & McCrae, R. R. (1988). Personality in adulthood: A six-year longitudinal study of self-report and spouse ratings on the NEO Personality Inventory. *Journal of Personality and Social Psychology*, 54, 853–863.



- Goldberg, L. R. (1981). Language and individual differences: The search for universals in personality lexicons. In L. Wheeler (Ed.), *Review of personality and social psychology* (Vol. 1, pp. 141–165). Beverly Hills, CA: Sage.
- McCrae R. R., & Costa, P. T., Jr. (1996). Toward a new generation of personality theories: Theoretical contexts for the five-factor model. In J. S. Wiggins (Ed.), *The five-factor model of personality: Theoretical perspectives* (pp. 51–87). New York: Guilford Press.

---

## COUNSELING PROCESS/OUTCOME

---

Counseling process refers to events, characteristics, or conditions that occur during or as a result of the interaction between counselor and client. The therapeutic relationship that develops during counseling sessions is an example of counseling process; completing homework outside of session also constitutes an event that fits within counseling process. *Process* can refer to what the counselor does with the client as well as how change occurs within the client. In contrast, *counseling outcome* refers to the results or effects of counseling. Outcomes are those phenomena that change in the client as a direct or indirect result of counseling. Presumably, process influences outcome, although research has been unsuccessful at demonstrating consistent links between measures of process and measures of outcomes.

Measurement of counseling process and outcome has been one of the most vexing tasks in the history of counseling and psychotherapy research. One of the key problems in process and outcome measurement is that while hundreds of process and outcome measures have been created, no consensus exists about what measures or how these measures should be employed in practice or research. Researchers refer to this as the *units of measurement* issue: With any particular client, or in any particular study, *what* should be measured? Process researchers have investigated such variables as the amount of talking by counselors or clients, counselor competence, therapist adherence to a role or treatment manual, client experiencing of affect, the strength of the therapeutic bond, client defensiveness or resistance, severity of client problem(s), and language use. As researchers have noted, process clearly signifies many different things.

The remainder of this entry discusses how psychological tests are typically evaluated, describes and evaluates a representative sample of counseling

process and outcome measures, and then discusses future directions for research about process and outcome measures.

### General Measurement Principles

Process and outcome measures can be evaluated using traditional standards of reliability and validity. *Reliability* refers to the consistency of measurement and is frequently evaluated through statistical tests of internal consistency, test-retest reliability, and interrater reliability. Coefficient alpha, the statistic usually employed to assess *internal consistency*, indicates the extent to which scores on individual test items contribute consistently to the total score. *Test-retest reliability* refers to the consistency of measurement over time; if the test measures a stable psychological trait, it should yield consistent scores across repeated administrations. *Interrater reliability* refers to the ability of two or more judges to assess some psychological characteristic or event similarly. The intraclass correlation and kappa statistic are used to indicate the degree of interrater reliability.

*Validity* has been described both as (a) the extent to which a test measures the construct it is intended to measure and (b) the extent to which evidence exists that test scores can be employed for a particular purpose. The first definition focuses on whether scores on a particular test reflect a particular construct (e.g., depression) as opposed to other constructs (e.g., stress) or systematic sources of error. *Social desirability* is a frequently noticed source of error for many tests and refers to the tendency to present one's self in a favorable light. In a counseling setting, for example, a new client might underreport such negative behaviors as smoking, drinking, or unsafe sexual behaviors.

Regarding the second definition of validity, organizations such as the American Educational Research Association (AERA), the American Psychological Association (APA), and the National Council on Measurement in Education (NCME) emphasize the purpose of testing as a critical factor. Given that the primary purpose of an outcome measure is to assess change, an instrument's sensitivity to change is directly related to its construct validity.

Validity can be evaluated using numerous methods. For example, researchers often examine the correlations between a test of a particular construct and a second test of the same or a similar construct (i.e., an evaluation of convergent validity). Correlations between a test of a construct and a dissimilar construct



represent an evaluation of discriminant validity. In addition, test developers frequently create tests by administering a large pool of items to a large group of respondents and then subjecting the resulting scores to a factor analysis. In factor analysis, test developers assume that any large collection of items or tests actually measures a smaller number of more basic factors or traits; these factors consist of a group of highly intercorrelated variables. *Factor analysis* refers to a set of statistical procedures used to examine the relations among items or tests and produce an estimate of the smaller number of factors that accounts for those relations.

## Process Measures

This section reviews a representative sample of five counseling process measures. The description of each measure includes an overview of the test, brief information about reliability and validity findings, a counseling-related research result found with this measure, and at least one potential problem or issue with the measure.

### Five Process Measures

*Working Alliance Inventory (WAI)*. This 36-item scale includes parallel forms that are completed by client, counselor, and observer; a short-form of 12 items has also been recently developed. The WAI measures aspects of the working alliance that Bordin suggested would grow out of an agreement between client and therapist on counseling goals and tasks. The WAI produces scores on 3 subscales of 12 items each (tasks, goals, and the therapeutic bond) and a total score. Sample items include, "I believe (my counselor) likes me" and "(My counselor) and I are working toward mutually agreed-upon goals." More than 100 studies employing the WAI have appeared in the literature, with many confirming that WAI scores evidence high internal consistency and at least modestly predict therapy outcome. Some studies have raised questions about the constructs the WAI measures, how to explain the high correlations among the three subscales, and which source (client, counselor, observer) better predicts outcome. Research also indicates that a better working alliance is associated with a client's willingness to express negative affect, a potentially important component of a successful counseling process.

*Session Evaluation Questionnaire (SEQ)*. The SEQ was developed to measure clients' perceptions of a counseling session's impact on them in terms of post-session mood and immediate effects. Twenty-four items, rated on a 7-point semantic differential scale, produce a total score and four subscale scores (Depth, Smoothness, Positivity, and Arousal). With a semantic differential scale, the two extremes of the construct are presented with the numbers between them (e.g., Safe–1 2 3 4 5 6 7 Dangerous, or Quiet–1 2 3 4 5 6 7 Aroused). Raters choose the number that best expresses their feeling. Depth items refer to the client's in-session perception of the session's value and impact, while Smoothness items assess in-session perceptions of safety and distress. Positivity measures client's postsession confidence and happiness, and Arousal refers to postsession level of activity and excitement. Research indicates that the in-session Depth and Arousal measures correlate highly with the postsession Positivity (but not Arousal) scale. Like all process measures, questions remain about the SEQ's relation to outcome, that is, to what extent does a single counseling session affect counseling outcome?

*Expectations About Counseling-Brief Form (EAC-B)*. Clients' expectations about counseling form a potentially important explanation for why clients seek counseling and what they expect to occur. The Expectations About Counseling-Brief Form (EAC-B) has been the most widely employed measure in this area for research purposes. The EAC-B contains items answered on a 7-point Likert scale that ranges from *not true* to *definitely true*. Responses to the 66 items are employed to produce scores on 17 scales that are grouped in four general areas of Client Attitudes and Behaviors, Counselor Attitudes and Behaviors, Counselor Characteristics, and Counseling Process and Outcome. Studies of the internal consistency and test-retest reliability of the subscales found support for most of the scales. Construct validity studies have demonstrated that the scale assesses expectations about counseling as opposed to perceptions about counseling. The scale has also been found to be useful with Hispanic and rural samples. Although one of the technically most sophisticated of the process measures, little published research has appeared with the EAC-B since the early 1990s.

*Client Reactions System (CRS)*. Hill and colleagues developed the CRS, a measure that contains 21



categories of reactions (14 positive and 7 negative categories) that clients experience in response to counselor interventions. Examples of the positive categories include Feelings, where the client felt more deeply; Supported, where the client feels that the counselor liked or cared for the client; Relieved, with decreased feelings of anxiety or depression; and Responsibility, where the client blamed others less and took more responsibility for events. In negative categories, Misunderstood refers to situations where the client believes that the counselor did not listen accurately, judged the client, or made false assumptions, and Scared, where the client feels overwhelmed or afraid to admit some problem. To employ the CRS, clients watch a videotape of their session, stopping the tape after each counselor intervention and then rating their reaction. Although researchers have raised questions about the reliability and validity of similar measures, relatively few studies have been completed with the CRS.

*Counseling Self-Estimate Inventory (COSE).* Bandura's self-efficacy theory forms the theoretical basis for more recent process-oriented measures. The theory's basic idea is that expectations of personal competence strongly influence the initiation and persistence of behavior. To create the COSE, Larson and colleagues administered the Likert-format items to 213 students enrolled in master's level counseling courses and performed a factor analysis on the resulting responses. Five factors resulted from the analysis. Microskills items refer to course content related to basic counseling and communication skills training. Process items describe an integration of counselor responses when working with a client. The sum of the Difficult Client Behaviors items indicates high self-efficacy for dealing with silent or unmotivated clients. Cultural Competence items refer to behaving competently with clients of different ethnic or cultural groups. Awareness of Values items assess counselors' tendency to impose their values and biases on the client.

COSE scales have demonstrated moderate to high internal consistency and test-retest reliability, and they correlate moderately in expected directions with measures of self-concept, anxiety, problem-solving appraisal, and counseling performance. A significant problem with the Process and Microskills subscales is that the content of each scale is confounded with positive or negative item wording.

### **Additional Process Measures**

Other process scales more frequently employed in the counseling literature include the Expectations about Counseling scale, Counselor Rating Form, Counselor Effectiveness Scale, Barrett-Lennard Relationship Inventory, Counselor Effectiveness Rating Scale, Personal Attributes Inventory, Counselor Evaluation Inventory, and Structural Analysis of Social Behavior. These measures tap into just a few of the many process constructs noted above.

### **Outcome Measures**

While many process measures are employed primarily in research studies, both researchers and practicing counselors use outcome measures. Counseling researchers use outcome measures to conduct efficacy and effectiveness studies. Efficacy studies are studies typically conducted in experimental settings (such as university clinics) in which a particular therapeutic approach (e.g., cognitive-behavioral therapy) is employed with counseling and control groups that are relatively homogeneous (e.g., all clients are depressed). With efficacy studies, researchers choose measures focused on the particular targets of counseling, such as depression or anxiety. In contrast, effectiveness studies occur in field settings, such as community mental health settings, where a diverse group of clients (in terms of age, gender, and race) presents with a wide range of psychological problems.

In practice settings, managed care companies and other funding sources often require counselors to employ outcome measures to offer evidence that counseling services are effective. Community mental health agencies, hospitals, and schools employ outcome measures to demonstrate that their services provide benefits to clients and their families. Outcome measures in effectiveness studies and in most practice settings are more likely to be comprehensive measures that assess a broad range of problem domains.

A corresponding set of problems to those found with process measures occurs with counseling outcome measures. For example, outcome measures differ in terms of their

1. *Content*, such as a focus on intrapsychic (e.g., feelings of anxiety and depression), interpersonal (e.g., conflict with others), and social role (e.g., student or employee) functioning



2. *Source of information*, including the client, counselor, significant others, trained observers, expert judges, and societal agents (e.g., teachers)
3. *Methods*, including self-reports, ratings by others, behavioral observations, physiological measures, and projective methods

As with process measures, no agreement exists among researchers or counselors about which combinations of content, source, or method should be employed in any particular situation. What is known is that each of these elements can influence the results of outcome investigations. Researchers have found that the degree of apparent change in counseling can be significantly influenced by the assessment method as well as the specific measure chosen. These findings include:

1. Counselor and expert ratings produce larger estimates of change than client self-reports.
2. Global ratings (e.g., an overall assessment of client functioning) typically show larger effects than assessments of specific symptoms.
3. Measures based on specific short-term targets of therapy (e.g., reduction in alcohol consumption) produce greater effects than more general long-range targets (such as future mental health status).
4. Measures of negative affective states (e.g., depression and anxiety) show larger, more immediate effects from counseling than measures of interpersonal conflict or social role functioning.

#### Four Outcome Measures

Many well-known scales employed for outcome measurement with children, adolescents, and adults, such as the Child Behavior Checklist, Conners Rating Scales, and the Minnesota Multiphasic Personality Inventory-2 (MMPI-2), are lengthy measures initially designed to perform diagnostic and screening purposes. Many of these measures are too long, are too expensive, and contain too many items that are insensitive to change to be realistic outcome measures in practice settings. Research participants may be willing to spend an hour or more completing a battery of measures. However, actual clients whose primary motivation is to obtain relief from a troublesome condition typically will not complete tests that are more than 1 page in length, tasks that require more than 5 minutes to complete, or activities that

appear to be unrelated to the actual provision of counseling services.

This section provides four examples of outcome measures: Two are specific to depression and anxiety, while the remaining two measures represent examples of a global outcome measure and a comprehensive outcome measure.

*Beck Depression Inventory (BDI)*. Developed on the basis of observations of depressed and nondepressed individuals, the BDI contains 21 multiple-choice items that assess 21 different aspects of depression. Completed by clients, each item contains four statements that range from *no indication of depression* to *severe*. A sample item might ask respondents to choose among statements ranging from “I do not feel sad” to “I am so sad or unhappy that I can’t stand it.” Depression symptoms and attitudes include mood, guilt feelings, suicidal wishes, irritability, sleep disturbance, and loss of appetite.

Research suggests that scores on the BDI evidence high internal consistency, correlate highly with other measures of depression, and are sensitive to change resulting from a variety of medication and counseling interventions. On the other hand, some research indicates that more than 50% of individuals classified as depressed by the BDI change categories when retested, even when the retesting period consists of only a few hours or days. The instability of some BDI items raises questions about whether changes in BDI scores reflect improvements resulting from counseling or a methodological influence.

*State-Trait Anxiety Inventory (STAI)*. The STAI consists of two 20-item self-report scales that are based on a conceptual understanding of anxiety as a signal to an individual of the presence of danger. The State Anxiety scale assesses more transient emotional states that can vary by situation, while the Trait Anxiety scale focuses on more stable aspects of anxiety. Sample items include “I feel content” and “I feel nervous.” Research evaluations of the two scales show expected differences; the State Anxiety scale, for example, evidences lower test-retest reliability. Both the State and Trait Anxiety scales evidence high internal consistency across most samples. The State Anxiety scale has been shown to be treatment sensitive, particularly in detecting the effects of counseling interventions aimed at decreasing test anxiety. Although the STAI was developed with the intent to produce scores that better reflect anxiety than



depression, most measures of anxiety and depression correlate moderately to highly. This finding has not been explained satisfactorily, and it raises questions about the validity of measures of anxiety and depression.

*Global Assessment of Functioning (GAF).* Over the past several decades, the GAF has been the most widely used brief outcome measure. Its popularity is attributable in part to the fact that it consists of a single-item 100-point rating scale that clinicians complete to estimate a client's overall functioning and symptomatology. The global rating is intended to summarize symptoms and functioning across diverse domains from work functioning to suicide potential over daily, weekly, or monthly periods. GAF ratings employed for outcome assessment are typically completed at intake and termination. However, managed care companies often require counselors to report such ratings for individual clients over more frequent time intervals while counseling is ongoing.

Researchers have reported modest test-retest reliability values in the .60 to .80 range. Despite its widespread use, little additional psychometric data are available. The most fundamental problem with the GAF is its transparency: The counselor can easily manipulate the rating, making the client appear as distressed as necessary to justify treatment, but at a potential cost of validity. A recent survey found that counselors considered global GAF-type data to be among the least useful information for outcome assessment.

*Outcome Questionnaire (OQ-45).* One of the newest comprehensive outcome scales is the Outcome Questionnaire-45 or OQ-45. Intended for persons 18 and older, the 45-item test can be completed in about 5 minutes. The OQ produces a total score and three subscale scores. The *Symptom Distress* subscale contains items related to anxiety and depression (e.g., "I feel blue"). Interpersonal Relations items assess satisfaction with and problems in interpersonal functioning (e.g., "I am satisfied with my relationships with others"). Social Role Performance items relate to satisfaction and competence in employment, family, and leisure roles (e.g., "I find my work/school satisfying").

Studies indicate that the OQ-45 has adequate test-retest reliability and internal consistency. Scores on the OQ correlate in expected directions and magnitudes with scores on related scales such as the SCL-90-R, Beck Depression Inventory, State-Trait Anxiety Inventory, and Inventory of Interpersonal Problems. Furthermore, OQ-45 scores can distinguish between clinical

and nonclinical groups. A source of concern is that research with college students found that students show improvement on OQ items even when they are not in counseling, although not at the same rate as treated individuals. An additional issue is that all three subscales of the OQ-45 are highly intercorrelated, suggesting that the total score on the scale provides an indication of general distress. Nevertheless, some of the most interesting outcome research now being conducted has demonstrated that using OQ scores to provide ongoing feedback to counselors about client progress reduces the rate of client treatment failures.

## Future Directions

Traditionally, test developers have sought items that discriminate among individuals on relatively stable traits (e.g., intelligence or vocational interests). A more challenging task is to measure change. Test developers are now at work developing a second generation of tests to measure changes that occur as a direct or indirect result of counseling. Empirical studies of methodologies that can be used to evaluate and enhance change-sensitive measures have only recently begun to appear in the professional psychological literature. A major assumption guiding these approaches is that different test construction and item analysis procedures are necessary to select items that reflect counseling effects. These item-analysis procedures test the competing claims that an observable change at the item level results from counseling, or that change results from factors that are unrelated to counseling. These efforts may enable researchers and counselors to eventually obtain better answers to such important questions as "What changes in counseling?" and "What is the nature of the process that produces beneficial change in counseling?"

Scott T. Meier

*See also* Bandura, Albert (v2); Beck, Aaron T. (v2); Career Counseling Process (v4); Client Attitudes and Behaviors (v2); Depression (v2); Expectations About Therapy (v2); Hill, Clara E. (v2); Homework Assignments (v2); Outcomes of Counseling and Psychotherapy (v2); Process and Outcome Research (v4); Psychometric Properties (v2); Therapy Process, Individual (v2); Tinsley, Howard E. A. (v4); Working Alliance (v2)

## Further Readings

Bandura, A. (1977). Self-efficacy: Toward a unifying theory of behavioral change. *Psychological Review*, 84, 191-215.



- Bordin, E. S. (1979). The generalizability of the psychoanalytic concept of the working alliance. *Psychotherapy: Theory, Research, and Practice*, 16, 252–260.
- Hill, C. E., & Lambert, M. J. (2004). Methodological issues in studying psychotherapy processes and outcome. In M. J. Lambert (Ed.), *Bergin and Garfield's handbook of psychotherapy and behavior change* (5th ed., pp. 84–135). New York: Wiley.
- Hoffman, B., & Meier, S. T. (2001). An individualized approach to managed mental health care in colleges and universities: A case study. *Journal of College Student Psychotherapy*, 15, 49–64.
- Horvath, A. O., & Greenberg, L. S. (1989). Development and validation of the Working Alliance Inventory. *Journal of Counseling Psychology*, 36, 223–233.
- Kendall, P. C., Hollon, S. D., Beck, A. T., Hammen, C. L., & Ingram, R. E. (1987). Issues and recommendations regarding use of the Beck Depression Inventory. *Cognitive Therapy and Research*, 3, 289–299.
- Martin, D. J., Garske, J. P., & Davis, M. K. (2000). Relation of the therapeutic alliance with outcome and other variables: A meta-analytic review. *Journal of Consulting and Clinical Psychology*, 68, 438–450.
- Maruish, M. E. (1999). *The use of psychological testing for treatment planning and outcome assessment* (2nd ed.). Mahwah, NJ: Lawrence Erlbaum.
- Meier, S. T. (2004). Improving design sensitivity through intervention-sensitive measures. *American Journal of Evaluation*, 25, 321–334.
- Orlinsky, D. E., Ronnestad, M. H., & Willutzki, U. (2004). Fifty years of psychotherapy process-outcome research: Continuity and change. In M. J. Lambert (Ed.), *Bergin and Garfield's handbook of psychotherapy and behavior change* (5th ed., pp. 307–389). New York: Wiley.
- Spielberger, C. D., & Sydeman, S. (1994). State-Trait Anxiety Inventory and State-Trait Anger Expression Inventory. In M. Maruish (Ed.), *The use of psychological testing for treatment planning and outcome assessment* (pp. 292–321). Hillsdale, NJ: Lawrence Erlbaum.
- Stiles, W. B., Honos-Webb, L., & Knobloch, L. M. (1999). Treatment process research methods. In P. C. Kendall, J. N. Butcher, & G. N. Holmbeck (Eds.), *Handbook of research methods in clinical psychology* (2nd ed., pp. 364–402). New York: Wiley.
- Stiles, W. B., & Snow, J. S. (1984). Counseling session impact as viewed by novice counselors and their clients. *Journal of Counseling Psychology*, 31, 3–12.
- Vermeersch, D. A., Whipple, J. L., Lambert, M. J., Hawkins, E. J., Burchfield, C. M., & Okiishi, J. C. (2004). Outcome Questionnaire: Is it sensitive to changes in counseling center clients? *Journal of Counseling Psychology*, 51, 38–49.

## COUNSELING SKILLS TRAINING

Training in counseling skills originated in 1966 and resulted in the microcounseling training approach to teaching interviewing skills and the publication in 1968 of the first monograph separate in the *Journal of Counseling Psychology*. Since that time the microcounseling approach to teaching single skills of counseling, interviewing, and psychotherapy has become the standard and more than 450 databased studies have examined its efficacy. Meta-analyses have concluded that microcounseling is effective for teaching a wide variety of helping skills to a variety of populations.

Forty years of research and theorizing has demonstrated microcounseling's merit as an educational paradigm for counselor and therapist education. Microcounseling has since evolved into a comprehensive generic framework that describes not only the training process but the skills, dimensions, and processes of therapy and effective communication in general. Microcounseling sees the training process and therapy not necessarily as separate entities, but as part of a larger whole, the goal of which is to help people lead intentional, effective, and positive lives.

### Origins and Development of Skills

The identification of the first microskill of attending behavior is illustrative of the theory and practice orientation of the counseling skills approach. In 1966, video was new to the helping profession and few had ideas on how to use this new medium. Allen Ivey and Weston Morrill asked a volunteer “counselor trainee” to conduct a videotaped interview. Fortunately, the trainee was ineffective and the team review of the video revealed that the beginning counselor (1) failed to maintain eye contact, (2) moved her hands and legs nervously, (3) had a tense vocal tone, and (4) awkwardly changed topics and ended up talking about herself. The opposite of these four behaviors were named *attending behavior*; now a generic part of the language of the helping field. The trainee was returned to the interviewing room with feedback and then conducted a vastly improved session with another client. Furthermore, 2 days later the trainee commented joyously that she had attended to her husband and that they had enjoyed a “beautiful weekend.”

The next skill to be identified was the skill of reflection of feeling (“You feel . . . because . . .”), and other listening and influencing skills soon followed. These



first identified counseling skills became the basis of social skills training. Skills training in communication is often the basis for management training, nutrition counseling, AIDS peer counseling, medical interviewing, and many other types of counseling. From 1968 to 1970 Ivey demonstrated the effectiveness of teaching hospitalized patients basic communication skills. Patients who had been in a Veteran's Administration (VA) hospital for years were successfully trained and released to the community without further therapy.

Microcounseling instruction in each skill is followed by practice sessions with feedback and a focus on generalization of each to the "real world" of interviewing practice.

Critical to this entire process is the identification of observable, countable behavioral skills that are verifiable and that produce predictable results in client verbal and nonverbal behavior. B. F. Skinner lauded the microcounseling approach as indicative of how reinforcement patterns could affect the counseling and therapy process, while humanistically-oriented counselors decried the scientific orientation of the system.

During the next decade many contributors added skills, and by the mid-1970s a comprehensive Microskills Hierarchy of skills and dimensions was formulated. Conceptually, the Hierarchy rests on a foundation of ethics, multicultural issues, and wellness. Built on this foundation, in successive layers, are attending behavior skills, the basic listening sequence, five-stages of interviewing, and influencing skills. The Hierarchy (see Figure 1) represents the cumulative impact of years of clinical teaching experience and research.

### **Predicting Results From Intentional Use of Interviewing Skills**

Experienced counselors who use questioning skills can reliably predict the kind of response their clients will next make. However, trainees are encouraged to intentionally flex and be prepared with a new skill when the skill they are using does not produce the expected results in the client. Two example skills are presented below that exemplify intentional prediction.

#### **Open and Closed Questions**

Open questions often begin with *who*, *what*, *when*, *where*, and *why*. Closed questions may start with *do*, *is*, or *are*. Questions beginning with *could*, *can*, or *would* are open, but they are somewhat closed in that

they permit the client to more easily say that they don't want to respond.

The predicted result is that clients will give more detail and talk more in response to open questions. Closed questions elicit specific information, but they also discourage extended client responses. Effective questions encourage more focused client conversations with more pertinent detail and less wandering. A danger of questions, of course, is that the counselor may take too much direction and control in the session.

#### **Reflection of Feeling**

This involves identification by the interviewer of the key emotions of a client and a restatement of them back to the client to clarify and focus attention on the client's affective experience. With less verbal or reluctant clients and children, the brief acknowledgment of feeling may be more appropriate than detailed exploration of complex feelings, as exploration of emotions may be uncomfortable.

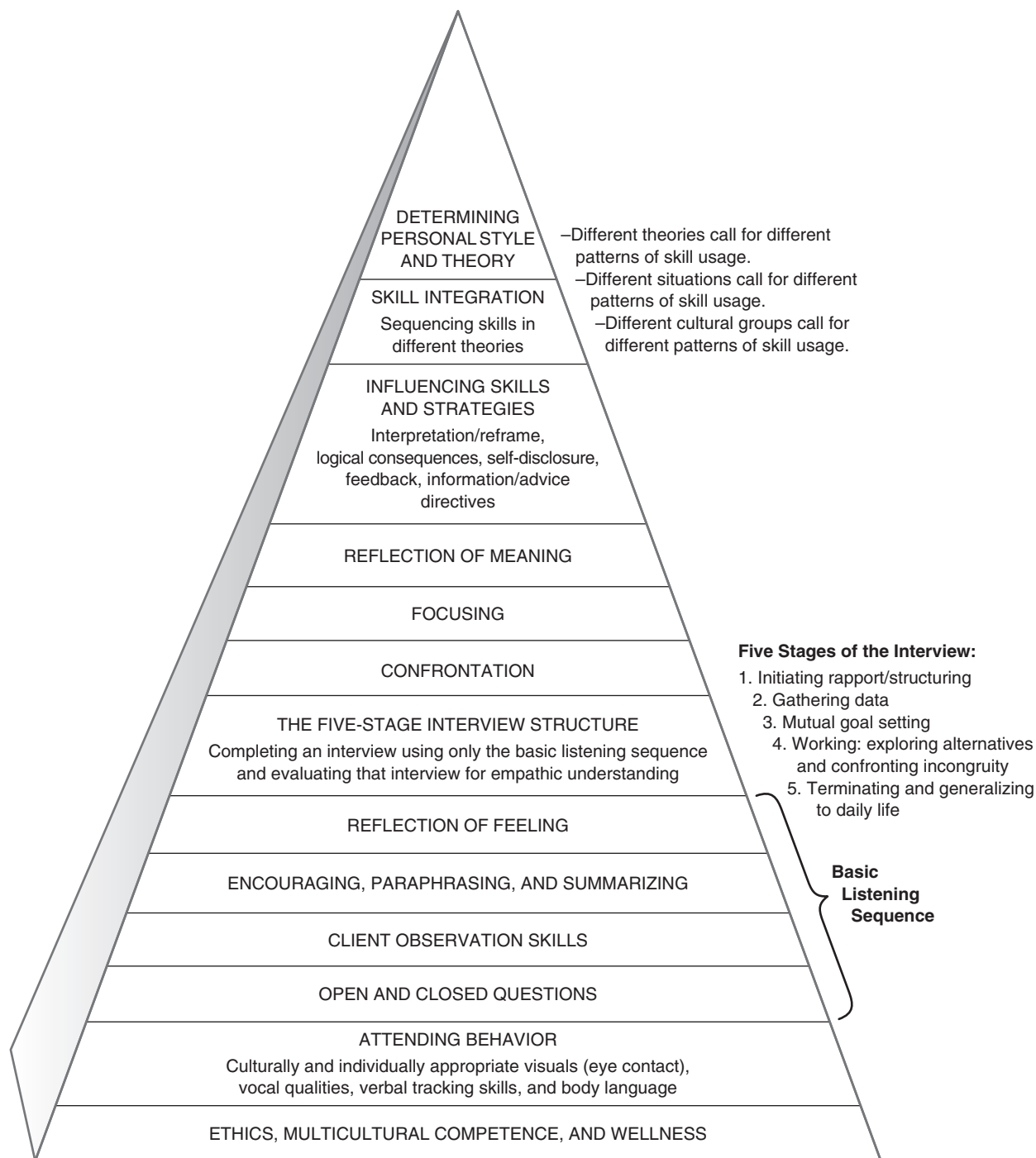
The predicted result is that clients will understand their emotional states more clearly and will correct the interviewer with a more accurate description of their emotional state if the counselor's reflection is not accurate.

### **Stages of Interview**

The microskills hierarchy proposes a five-stage organization of the interview that focuses on goals and results. The stages require that the practitioner

1. *Initiate the Session.* Establish rapport and structure the session so that clients know what to expect from the counseling or therapy process.
2. *Gather Data.* Define the problem and identify client strengths by drawing out stories, concerns, problems, or issues.
3. *Set Mutual Goals.* Determine what the client wants to happen.
4. *Explore and Create.* Generate alternatives, confront the client's conflict and incongruities, generate alternative resolutions for conflict, and help the client create a new way of thinking, feeling, or behaving.
5. *Conclude.* Plan for the generalization of the learning that has occurred in the counseling interviews to "real life" and for the eventual termination of the counseling relationship.





**Figure 1** Microskills hierarchy

Source: © 1982, 1987, 2003, 2007 Allen E. Ivey. Reprinted with permission.

The five stages may occur sequentially, particularly in decisional and career counseling, but different theories give varying attention to the skills. Brief counseling, for example, sets goals early and spends considerable time focusing on generalization

throughout the session. By way of contrast, a traditional psychoanalytic interview spends virtually the entire session focusing on the third phase of exploration of issues and concerns and gives little attention to goal setting.



Different theoretical approaches to the interview also have vastly different patterns of skill usage. For instance, practitioners of brief counseling often focus on questions, while client-centered practitioners avoid questions as much as possible and prefer reflection of feeling, paraphrasing, and summarization.

### The Multicultural Connection

In 1972, Ivey observed that Alaskan Natives had a unique pattern of eye contact and body language. Many Alaskan Natives consider direct eye contact to be rude and intrusive and, at times, consider it to be an invitation to a direct confrontation. In 1974 Ivey and Norma Gluckstern advocated the need to adopt different counseling approaches and styles with clients from different cultures.

Awareness of multicultural differences was soon expanded with awareness of the culturally unique patterns of Aboriginal Australians, African Americans, Asian Americans, Latinas and Latinos, First Nation and Native Americans, and other groups. The definition of multiculturalism was extended to include issues of gender, sexual orientation, social class, and other factors. As awareness of multicultural differences has increased over the years, the use of microskill training and theories in multicultural courses has increased to better teach students about the important individual and cultural differences that require careful attention in counseling.

### Adaptations of the Microskills Model

Multiple adaptations of the original approach to microcounseling skills are now available. For example, Gerard Egan combined the listening microskills with Carkhuff's popular model of helping. Clara Hill generated the Hill Taxonomy, a variant of the original Ivey Taxonomy of microskills, based on her extensive research coupled with her adaptation of the Egan interview structure.

The language and teaching style of the microcounseling model has become generic to the profession. Unfortunately, the culture-centered emphasis of microcounseling has not yet been generalized to the field nor to textbooks discussing counseling skills. However, guidelines for multicultural psychology have now been approved by the American Psychological Association, and the American Counseling Association has now adopted multicultural competencies, and it can be expected that counseling

skills training will eventually become more culturally sensitive.

*Allen E. Ivey and Thomas Daniels*

**See also** Client Attitudes and Behaviors (v2); Clinical Interview as an Assessment Technique (v2); Counseling Process/Outcome (v2); Expectations About Therapy (v2); Facilitative Conditions (v2); Hill, Clara E. (v2); Individual Therapy (v2); Ivey, Allen E. (v1); Iven, Allen E.: Counseling Theory and Skills Training (v3); Multicultural Counseling Competence (v3); Reframing (v2); Skinner, B. F. (v2); Taxonomy of Helpful Impacts (v2); Therapist Techniques/Behaviors (v2); Therapy Process, Individual (v2)

### Further Readings

- Daniels, T. G., & Ivey, A. E. (2007). *Microcounseling: Making skills training work in a multicultural world*. Springfield, IL: Charles C Thomas.
- Egan, G. (2006). *The skilled helper: A problem-management and opportunity-development approach to helping* (8th ed.). Belmont, CA: Wadsworth.
- Hill, C. E. (1992). Research on therapist techniques in brief individual therapy: Implications for practitioners. *The Counseling Psychologist*, 20, 689–711.
- Ivey, A. E. (1971). *Microcounseling: Innovations in interviewing training*. Springfield, IL: Charles C Thomas.
- Ivey, A. E., & Bradford, M. B. (2007). *Intentional interviewing and counseling: Facilitating client development in a multicultural world* (6th ed.). Belmont, CA: Thomson/Brooks/Cole.
- Ivey, A. E., & Bradford, M. B. (2008). *Essentials of intentional interviewing: Counseling in a multicultural world*. Belmont, CA: Thomson/Brooks/Cole.
- Ivey, A. E., D'Andrea, M., Ivey, M. B., & Simek-Morgan, L. (2007). *Theories of counseling and therapy*. Boston: Thomson/Allyn & Bacon.
- Ivey, A. E., & Gluckstern, N. (1974). *Basic attending skills*. North Amherst, MA: Microtraining Associates.
- Ivey, A. E., Normington, C., Miller, C., Morrill, W., & Hasse, R. (1968). Microcounseling and attending behavior: an approach to prepracticum counselor training. *Journal of Counseling Psychology*, 15, 1–12.

---

## COUNSELING THEORIES AND THERAPIES

---

Theories and therapies of counseling are the building blocks of the profession. Probably every counselor



has had at least one course in theories of counseling, and the names of the leading theorists, such as Sigmund Freud, Albert Ellis, Carl Rogers, and others, are both legendary and familiar. This entry will address what constitutes a theory of counseling, why counseling theories and therapies are so important, and how these theories have evolved.

### Common Characteristics of Theories of Counseling

Estimates are that more than 350 counseling theories and therapies have been advanced. Although most of these have received little attention or validation, a core group of about 10 major theories, and fewer than 50 secondary approaches or modifications of the major theories, dominate the counseling profession. Most of these theories are characterized by the following important ingredients:

- A concept of how people develop throughout the life span. Typically, this involves a sequence of stages and describes important factors that are likely to influence development.
- Criteria for mental health, with characteristics of unhealthy or disordered emotional functioning either explicitly or implicitly stated. This information is important in helping people set realistic treatment goals and in assessing progress.
- Information on how to promote healthy development and help people reduce symptoms and enhance their coping skills and satisfaction with their lives.
- A description of the role of the effective counselor and the desired relationship between client and counselor. Nearly all theories of counseling currently recognize the powerful impact of the therapeutic alliance and offer clinicians ways to collaborate effectively with their clients. A safe and healing environment and a caring, skilled, and trustworthy counselor are essential to successful treatment.
- Strategies and interventions that counselors can use to help people achieve their counseling goals. Examples include reflections of feeling, modification of cognitive distortions, and systematic desensitization.
- Information on treatment parameters such as duration and frequency of sessions; whether to use individual, group, or family treatment; and benefits of medication and other adjunct services.
- Delineation of those people who are most likely to benefit from this treatment approach. This is most likely to be presented in terms of symptoms and disorders that are amenable to treatment via this approach, but might also discuss such factors as gender, age, cultural background, and other factors.

### Purposes of Counseling Theories and Therapies

Although, of course, counselors cannot master all the important counseling theories and therapies, most counselors have a few preferred theories that they use with confidence and competence. Their skills in those therapeutic approaches enable them to do the following:

- Decide whether they are likely to be able to help a particular person with a given set of concerns.
- Collaborate with clients in establishing goals that are realistic in terms of the treatment approach that is being used.
- Develop an overall plan for helping people achieve their goals.
- Individualize treatment by emphasizing and selecting interventions and strategies that are most likely to be helpful to a particular person.
- Assess a person's progress against that made by other people who received similar treatment and modify treatment if it does not seem effective.
- Deepen their knowledge of and skill in their chosen theory through experience, reading, training, and supervision.

### Four Categories of Counseling Theories and Therapies

Although counseling theories and therapies overlap considerably, they can be organized into four broad groups. Each group is characterized by its primary emphasis (background, behavior, emotions, thoughts), as well as its theoretical rationale.

#### *Theories and Therapies Emphasizing Background*

Freud, viewed as the father of psychotherapy, advanced the first widely studied theory of therapy. Although Freud's work dates back to the late 19th century, well before the advent of the counseling profession, Freud's ideas established the groundwork for all the mental health professions. Freud viewed the first 5 years of life, along with the parent-child



connection and interactions during those years, as the major determinants of a person's subsequent psychological development. Therapy sought to make the unconscious conscious and, through the transference relationship, to rectify shortcomings of the child's early connection to the parent.

Freud's followers, as well as those who later expanded and revised his concepts and strategies, include many of the early and seminal thinkers in mental health. In addition, current conceptions of brief psychodynamic therapy developed by Gerald Klerman, Hans Strupp, and others, also are rooted in Freudian thinking.

Although relatively few counselors today practice Freudian psychoanalysis, many view people from a psychodynamic perspective and believe that understanding of people's early histories is essential to their personal growth. Strategies such as interpretation, analysis of repetitive patterns, free association, exploration of transference and countertransference, modification of defense mechanisms, and discussion of early recollections all reflect the influence of Freud and others who emphasized the importance of people's history and background.

### **Theories and Therapies Emphasizing Behavior**

Theories emphasizing behavior and behavioral change represent the second wave of counseling theories and therapies. Gaining attention during the 1950s and 1960s and becoming a powerful force in the mental health professions, these approaches presented both an alternative and a challenge to psychoanalysis. Behavior therapy takes the stance that behavior is learned through exposure, modeling, conditioning, experiences, rewards, and punishments. In light of this, behavior that is unhealthy, nonproductive, or harmful to the self or others can be unlearned and replaced with new and more effective behaviors.

The foundations of behavior counseling can be found in the work of Ivan Pavlov and John W. Watson. Others, including B. F. Skinner, John Dollard and Neal Miller, Joseph Wolpe, and Albert Bandura, used both research and theory to develop strategies to promote behavioral change. More recent theorists, including Arnold Lazarus, Donald Meichenbaum, Albert Ellis, Aaron Beck, and William Glasser, have further expanded on the application of behavior counseling by combining that approach with cognitive therapy.

The popularity of solution-focused therapy also has promoted the importance and power of behavioral change.

Behavior counseling focuses on present manifestations of observable behaviors and targets a broad range of behaviors, including substance use, eating, interpersonal skills, self-care, study habits, executive functioning, exercise, parenting, working and playing, and many others. Behaviors are viewed in context and a collaborative alliance of counselor and client is viewed as essential. Treatment typically begins by establishing a baseline or clear picture of the nature and severity of the undesirable behavior. Goal setting promotes motivation, facilitates development of change strategies, and helps people move forward. Behavior counseling incorporates a wide range of strategies to facilitate change, such as education, skill training, reinforcement, desensitization, relaxation, behavioral rehearsal, and many others. Peer and group support, as well as relapse prevention, often help to solidify gains.

### **Theories and Therapies Emphasizing Emotions**

Carl Rogers, through his development of what is now called *person-centered counseling*, deserves most of the credit for bringing the third wave of counseling theories to the fore. With his emphasis on people's emotions and his deep respect for people's ability to grow and change in positive ways, Rogers humanized the counseling profession. He believed that counseling would be more effective if counselors could join with their clients on an emotional level, feel appreciation and empathy for them, help them express their emotions fully, and use their own resources to enhance their self-esteem and improve their lives. Rogers's work brought attention to the importance of the human potential and actualization, self-esteem, and the client-counselor relationship. Most counselors now appreciate the importance of the therapeutic alliance and the facilitative conditions that enhance that relationship. In addition, Rogers's deep respect for each person led to an appreciation of the importance of phenomenological approaches, those that seek to understand people's views of the world and their unique perspectives.

Although adherence to a pure person-centered treatment approach seemed to decline after Rogers's death, his emphasis on emotions had a profound impact on counseling theories and therapies. During his lifetime, other approaches emphasizing feelings, such as Gestalt



therapy, developed by Fritz and Laura Perls, and existential therapy also garnered attention. Important current treatment approaches such as narrative therapy, constructivist therapy, feminist therapy, and motivational interviewing reflect Rogers's emphasis on empathy, phenomenology, and the therapeutic alliance. These newer approaches have contributed to a deeper appreciation for the tenets of person-centered counseling.

### **Theories and Therapies Emphasizing Thoughts**

Albert Ellis, who initially developed rational emotive behavior therapy in the 1950s, led the way in the development of cognitive theories and therapies of counseling. His efforts to help people identify dysfunctional thoughts or irrational beliefs and replace them with thoughts that are valid, logical, flexible, and helpful gave counselors yet a fourth perspective on the process of change. The subsequent work of Aaron Beck provided more structure, as well as additional effective tools, to counselors who emphasized cognitions in their work.

Ellis, Beck, and other cognitive therapists hold that thoughts are the most powerful and successful route to effect change. They suggest that people's emotions and behaviors, as well as their views of the world, grow out of their thoughts and that, if they can change those thoughts in positive and healthy ways, they will be more likely to make positive changes in emotions and actions. Like behavior counseling, cognitive therapy is a structured but flexible approach that usually focuses on the present, seeks to effect fairly rapid change, and involves client-counselor collaboration. Cognitive therapy also draws heavily on a wide range of treatment strategies, such as affirmations and self-talk, thought stopping, imagery, and, most important, transformation of dysfunctional and unhealthy thoughts into healthy and helpful ones.

### **Integrated and Eclectic Counseling Theories and Therapies**

This entry on counseling theories and therapies has focused on four broad approaches to treatment, distinguished by whether they emphasize background, emotions, behaviors, or cognitions. Counselors also should keep in mind the growing trend toward eclectic and integrated approaches. Examples include Arnold Lazarus's multimodal therapy, developmental

counseling and therapy (DCT) developed by Allen Ivey and his colleagues, and the transtheoretical model developed by James Prochaska and others. Most integrated counseling theories and therapies are still in the formative stages. However, this is a growing area of the profession, and we can anticipate expansion and refinement of integrated approaches.

*Linda Seligman*

**See also** Adlerian Therapy (v2); Beck, Aaron T. (v2); Behavior Therapy (v2); Brief Therapy (v2); Career Counseling (v4); Cognitive Therapy (v2); Cognitive-Behavioral Therapy and Techniques (v2); Ellis, Albert (v2); Freud, Sigmund (v2); Humanistic Approaches (v2); Integrative/Eclectic Therapy (v2); Multicultural Counseling (v3); Psychoanalysis and Psychodynamic Approaches to Therapy (v2); Rational Emotive Behavior Therapy (v2); Rogers, Carl R. (v2); Skinner, B. F. (v2); Solution-Focused Brief Therapy (v2)

### **Further Readings**

- Capuzzi, D., & Gross, D. R. (2005). *Introduction to the counseling profession*. Boston: Allyn & Bacon.
- Prochaska, J. O., & Norcross, J. C. (2003). *Systems of psychotherapy: A transtheoretical analysis*. Pacific Grove, CA: Brooks/Cole.
- Seligman, L. (2006). *Theories of counseling and psychotherapy: Systems, strategies, and skills*. Columbus, OH: Pearson Merrill Prentice Hall.

---

## **COUNSELORS AND THERAPISTS**

---

There has been considerable professional debate, in the United States and elsewhere, regarding the precise nature of the functions and roles fulfilled by counselors, therapists, psychotherapists, and others who provide mental health services. Professionals using different names, such as counseling psychologist, counselor, and therapist, are viewed quite differently by the lay public. Much of the confusion centers on *who* provides *what* services, in *what* contexts, and to *what* end or goal.

A common differentiation is that counselors concern themselves more with normative stresses, adjustment difficulties, and life transitions, whereas therapists focus primarily on mental illnesses and psychological disorders. A more comprehensive view recognizes the extensive overlap in the work of the professionals using



these designations, while, at the same time, acknowledging differences in the relative emphasis they afford to some issues. Increased clarity in this regard can facilitate an enhanced sense of professional identity for mental health practitioners and greater awareness among consumers of mental health services.

### Similarities and Differences

A crucial question underlying this issue is whether the type of work performed by the various helping professionals (e.g., counselors, therapists, and clinical social workers) is essentially the same, or whether each “camp” has a unique contribution to offer when assisting clients with their problems. There have been many attempts, at times highly politicized and market driven, to articulate the services provided by the various mental health professions. These attempts have escalated, as the historical progression of these specialties has proceeded and as these groups have sought to professionalize their services. Thus, whereas some impart a distinct meaning to the term *counseling* or *therapy*, others use the two terms more or less interchangeably.

The basic roles and functions of helping are by no means new phenomena. The desire to help others with their personal and emotional problems has a long history that can be traced to ancient western and non-western civilizations and that entails the use of very diverse methods. As noted by Colin Feltham, some of counseling’s “cousins” include advising and influencing; friendship; co-counseling; teaching and coaching; consciousness-raising; self-analysis and self-help; psychotherapy; the application of basic helping skills by social and welfare workers, probation officers, nurses, and occupational therapists; and other charismatic and fortuitous encounters (e.g., religious conversion) that may lead to healing or change. However, the more formalized or stylized practices of modern counselors and therapists have developed separately and under different sets of influences that initially shaped their functions in somewhat divergent ways.

### Perspectives Emphasizing the Distinctiveness of Counselors and Therapists

Use of the term *therapist* (or *psychotherapist*) to denote a helping relationship in the form of a “talking therapy” can be traced largely to the work of Sigmund Freud and his pioneering of psychoanalysis around

the dawning of the 20th century. Thus, therapists preceded counselors in the establishment of a professional identity and came to enjoy some recognition and status among the medical establishment of psychiatry. *Counseling*, in contrast, is a more recent label first applied to professional helping activity in the early 1900s by Frank Parsons who used it to characterize his vocational guidance movement. Then, in the 1930s and ’40s, Carl Rogers popularized the term when he sought to promote his person-centered helping techniques and to circumvent restrictions reserving the term *psychotherapist* for psychiatrists.

Because of their different origins, counselors and therapists have historically placed a different relative emphasis on certain key issues or concerns. Counseling came to be associated predominantly with the enhancement and promotion of optimal functioning and decision making among relatively normal individuals. Therapy came to be associated primarily with the remediation of actual mental illness or psychopathology. This early difference in emphasis also gave rise to a number of other perceived differences in the roles and functions of counselors versus therapists.

The work of a counselor is viewed as a shorter-term, developmental, cognitive or informational, surface-level, conscious-oriented, future-focused, acceptance-based, and positive enterprise for less-serious and extrapsychic problems. The work of a therapist, in contrast, is viewed as a longer-term, remedial, affective or emotional, in-depth, unconscious-oriented, past-focused, change-based, and pessimistic endeavor for more serious and intrapsychic issues. As suggested by the aforementioned list of adjectives, the word *counseling* is often associated with more humanistic perspectives, such as that of Carl Rogers, whereas the terms *therapy* and *psychotherapy* have sometimes been used to connote the psychoanalytic orientation of Sigmund Freud, and its derivatives. Correspondingly, therapists may be perceived as having more expertise than counselors, attributable to the common misperception that they undergo a longer and more intensive professional training that may include participating as a patient in psychoanalysis.

The recent proliferation of training programs and influx into the system of many different kinds of helping disciplines that seek professional recognition and the ability to be competitive in today’s market economy has stimulated a renewed focus on this issue. Discussions about the differences attributed to counselors and therapists have at times been framed as a



debate concerning which of the two services is more helpful, prestigious, or generally superior. Some argue that counseling is a subcomponent of the more comprehensive set of therapeutic skills, and thus counseling should be subsumed under the term *therapy*. They view counseling and therapy as lying on a continuum, with counseling representing a more circumscribed or less intense process and therapy representing a more thorough or intensive process. Others view counseling as more comprehensive than therapy because of the inclusion of specific vocational, occupational, and educational competencies in counseling training that are lacking in other training paradigms. Changes in the training of therapists and counseling psychologists and in the provision of mental health services in the last two decades render many of these issues obsolete. Nevertheless, it is likely that some associations and expectations concerning the work of counselors and therapists still persist today.

### Perspectives Emphasizing the Similarity of Counselors and Therapists

As the practice of counseling and therapy has progressed, one notable phenomenon has been the diversification of counselors into new and multiple settings, including hospitals, clinics, correctional institutions, and private practices. Some of these were previously viewed as the exclusive domain of therapists. Given these developments, many professionals today view the work of counselors and therapists as virtually indistinguishable. Recent empirical studies of the training and functions of helping professionals, the nature and severity of client issues, and the treatment goals and strategies emphasized by the practitioner reveal that there is no essential difference between what is referred to as counseling and what is referred to as therapy.

### Future Directions

It would appear that there are more similarities between the work of counselors and therapists than there are differences, and that the differences between the two are relative rather than absolute. In fact, as pointed out by J. Vincent Peterson and others, proposed distinctions between the roles of counselors and therapists are likely to be rooted more strongly in the perceptions and expectations of the corresponding professional organizations or of the general public than they are in any actual rigid state of affairs.

Although there is a strong precedent for counselors as a group to focus more on mental health and therapists as a group to focus more on mental illness, this pattern will not necessarily hold true for any given individual who identifies as a counselor or therapist.

This extensive overlap has led some leaders to call for one unified type of helping professional, often referred to as a “psychological counselor,” rather than exaggerating rather minor differences into an ever-expanding array of competing specialties and subspecialties.

*Noelle S. Giffin Wiersma*

**See also** Common Factors Model (v2); Counseling, Definition of (v1); Counseling Psychology, Definition of (v1); Counseling Psychology, History of (v1); Counseling Skills Training (v2); Counseling Theories and Therapies (v2); Therapist Techniques/Behaviors (v2); Therapy Process, Individual (v2)

### Further Readings

- American Psychological Association, Division of Counseling Psychology, Committee on Definition. (1956). Counseling psychology as a specialty. *American Psychologist*, 11, 282–285.
- Crago, H. (2000). Counselling and psychotherapy: Is there a difference? Does it matter? *Australian and New Zealand Journal of Family Therapy*, 21, 73–80.
- Farwell, G. F., Gamsley, N. R., & Mathieu-Coughlan, P. (1974). *The counselor's handbook*. New York: Intext Educational Publishers.
- Feltham, C. (1995). *What is counselling? The promise and problem of the talking therapies*. Thousand Oaks, CA: Sage.
- Gladding, S. T. (2004). History of and trends in counseling. In S. T. Gladding, *Counseling: A comprehensive profession* (5th ed., pp. 4–25). Upper Saddle River, NJ: Pearson Education.
- Peterson, J. V., & Nisenholz, B. (1999). *Orientation to counseling* (4th ed.). Needham Heights, MA: Allyn & Bacon.

---

## CRISIS COUNSELING

---

There are many definitions of what constitutes a crisis sufficient to bring a person to counseling. Richard K. James and Burl E. Gilliland defined a crisis as the



perception of an event or situation as intolerable and one that exceeds the immediately available resources and coping mechanisms of the person. Unless the person obtains relief, the crisis has the potential to cause severe affective, cognitive, and behavioral malfunctioning. Crisis is both universal and idiosyncratic. No matter how resilient one is, if the duration and intensity of the crisis is severe enough, no one is immune from breaking down. Crisis is also idiosyncratic because what one person may successfully overcome, another may not, even though the circumstances are virtually the same.

For most people, crises are time limited, lasting from 6 to 8 weeks. At the end of this time, people should regain a sense of equilibrium. However, this does not mean the fallout from the crisis is resolved. It simply means people should recover the capacity to function on a day-to-day basis. If resolution of the crisis does not continue or is impeded, the problems stemming from the crisis can become pervasive. The problems will change from an acute state to a chronic state wherein the individual is constantly at risk to fall back into a continuous cycle of crisis. If this happens, the person will be in a transcrisis state.

## History of Crisis Counseling

It has only been within the past 60 years that crisis intervention has grown into a field of its own with specific theories and techniques. Groundbreaking work by Erich Lindemann with the survivors of the Boston Cocoanut Grove fire of 1942 and Gerald Caplan's extension of that work forms much of the foundation for crisis intervention. Two historical events in the 1970s hallmark the birth and evolution of crisis intervention as a clinical specialty. The first was the Vietnam War and the perplexing psychological trauma that veterans carried out of it. The second was the women's movement that exposed domestic violence in its many forms. It became clear that no one is immune from the severe emotional distress and psychological disequilibrium that could result from exposure to traumatic events.

There are numerous factors that stand out as influencing the growth of crisis intervention as a clinical subspecialty.

1. *Suicide.* The possibility of dealing with suicidal clients is ever present and is prevalent in all age and racial/ethnic groups. The resulting development of

early research on the causes of suicide and suicide intervention techniques by Edwin Shneidman has been one of the seedbeds from which the fertile field of crisis intervention has grown.

2. *Crisis lines.* The advent of telephone crisis and hotlines and, recently, the Internet, has made mental health services available to vast numbers of people who would otherwise be unable or unwilling to avail themselves of mental health services. The ease of access, constant availability, lack of cost, and anonymity of the caller have made the crisis line the most used form of crisis intervention in the world.

3. *Interpersonal violence.* The discovery that more unreported or underreported interpersonal violence takes place than what was previously thought has brought this large crisis population to the attention of counselors. Interpersonal violence has far-reaching effects for the survivors that occur long past the original incident itself and form the basis for what may be called *transcrisis states*.

4. *Substance abuse and drug addiction.* The rise of substance abuse and the smorgasbord of both prescription and illicit drugs are a fertile breeding ground for personal, interpersonal, and community crisis.

5. *Posttraumatic stress disorder.* In the last four decades, posttraumatic stress disorder (PTSD) has become identified as a major mental health problem. In a world where natural disasters and human-made traumatic events occur on an everyday basis, counselors have realized that those events leave a long and wide wake of residual stress.

6. *The mentally ill on the streets.* With the advent of psychotropic drugs in the 1960s, it was believed that a significant turning point had occurred in the world of mental illness. It was felt that the antipsychotic drugs would allow the large, residential, state mental hospitals to be replaced with less-restrictive community mental health clinics and halfway houses. Unfortunately, this has not happened. The negative side effects of antipsychotic medication and the lack of adequate supervision have influenced the chronically mentally ill to stop taking their medication. Psychotic symptoms quickly resurface and are further compounded when individuals use alcohol or illicit street drugs. These "dual diagnosis" clients may then have very severe and violent psychotic breaks with reality. They also may become a large part of the homeless population. As a result, police departments have become unwilling participants



in the community mental health business as they attempt to contain these mentally ill individuals. Indeed, one of the largest groups of professionally trained crisis interventionists is specially trained police officers who operate on Crisis Intervention Teams.

## Theories of Crisis Intervention

Crisis intervention theory is in its infancy. To date, emphasis has been on helping people recover from crisis situations rather than on theory development. However, a number of experts in the field have recognized this shortcoming and are beginning to build theoretical models for understanding crisis intervention. Their research focuses on including and using contextual issues that influence individuals' reactions in crises. These researchers are integrating ideas from systems, adaptional, interpersonal, and ecological approaches to understand crisis intervention.

*Systems crisis theory* is based on the interrelationships among people and events and how they reciprocally interact with one another when a crisis occurs. The crisis of addiction, its compounding effect on the family of the addict, and the family's enabling tactics to keep the system in maladaptive homeostasis is a classic example of systems theory in operation. Crisis intervention usually means disrupting and breaking down the old system by directly confronting the behaviors that sustain it.

*Adaptional theory* operates on the premise that a crisis is sustained through maladaptive behaviors. Just as maladaptive behaviors are learned, they may be unlearned and new, more constructive behaviors that are more reinforcing to the individual may replace them. The battered wife who finally leaves the abusive relationship for a shelter, completes her education, and becomes financially and emotionally independent from her abusive and controlling spouse is an example of adaptional theory at work.

*Interpersonal theory* is based on the belief that as long as people believe that their reference of self-evaluation is placed in others, they cannot escape the crisis. By establishing or reestablishing the locus of self-evaluation within themselves, people are able to gain or regain control of their lives and take appropriate action to overcome the crisis. The grief-stricken parents of a dead child who condemn God, or the doctors, remain stuck in their grief and cannot marshal their own intrapersonal resources to overcome the traumatic event. Regaining personal control is one of

the major central axes on which crisis intervention revolves.

*Ecological theory* reaches beyond closed systems such as the family, school, or job site into the environment at large. Urie Bronfenbrenner's model for human development forms the cornerstone for this influence. Ecological theory deals with the multifaceted impact of large-scale natural and human-made disasters such as hurricanes, earthquakes, bombings, and nuclear reactor meltdowns, as well as the effects these events have not only for the people themselves, but also across the environment. Ecological theory calls for crisis intervention on a massive scale in a multitude of ways that deal with the psychological and physical needs of the survivors along with repair of the environment itself.

## Typologies of Crises

Crises can be categorized into four types. Although these overlap, each has unique characteristics setting it apart from the others. An understanding of these characteristics can increase counselors' abilities to provide the appropriate intervention.

*Developmental crises* occur when events in the normal flux and flow of human growth are disrupted by a dramatic shift that precipitates an abnormal response. Graduation from college, marriage, a first child, job change, or retirement are all key developmental benchmarks that call for dramatic shifts in how a person operates and may occasion a crisis event. Cultural variances may play a large part in whether these developmental issues are seen as crises or not.

*Situational crises* occur when an uncommon event occurs that the individual has no way of forecasting or controlling. Automobile accidents, rapes, shootings, sudden illnesses, the unexpected death of a child or spouse, job loss, and divorce are all examples of unforeseen, sudden, and intense traumatic events that are far out of the realm of normal functioning. These crises generally do not have a cultural component. The crisis of being a victim of a violent crime is a crisis regardless of the culture.

*Existential crises* are those inner conflicts that accompany the important human issues of joy, happiness, love, responsibility, goal orientation, and self-concept. Existential crises occur when individuals suddenly realize that some important intrapersonal aspect of their lives will never be fulfilled. Finding out that a major league baseball career is beyond one's



skills after a great collegiate career, never taking a risk or having an adventure before being bedridden with arthritis, and a death bed review of one's life as meaningless are examples of crises of self-purpose and self-worth.

*Systemic crises* ripple out into large segments of the population and the environment itself. Natural disasters such as Hurricane Katrina and the Indonesian tsunami wreak havoc on all parts of the ecological system across wide geographic areas. They result in death and injury, as well as the loss of basic human necessities such as food and shelter. Infrastructure services are destroyed, and the means of employment are lost because the businesses where people worked are no longer in existence. Natural and human-made disasters such as the Oklahoma City Federal Building bombing, the September 11 attacks, and school massacres not only affect the immediate victims but also psychologically impact people throughout the world via extensive media coverage. As a result, the kinds of psychological intervention applied to these crisis domains tend to be very different from those used in the normal course of psychotherapy.

### Basic Crisis Intervention

Crisis intervention targets temporary affective, behavioral, and cognitive distortions generated by traumatic events and helps people recognize and correct their perceptions, feelings, and behaviors to approximate more normal precrisis functioning. Crisis intervention is based on an equilibrium/disequilibrium paradigm that has four stages: (1) disturbed equilibrium from the trauma, (2) brief therapy targeted at the trauma and disequilibrium, (3) the client's working through the trauma, and (4) and restoration of equilibrium.

### Crisis Intervention Models

There are numerous crisis intervention models now available to the counselor. Probably the most common is the *equilibrium/disequilibrium model* that views people as in a state of disequilibrium in comparison to their precrisis coping ability. Its aim is to use previous client coping mechanisms or new counselor-generated coping mechanisms to help clients regain equilibrium and bring maladaptive responses under control. It is most often used in early intervention when the person is out of control, disoriented, emotionally distraught, and unable to function.

A specific adaption that is representative of this model for crisis intervention is a six-step model proposed by Richard James and Burl Gilliland. In this model, the steps do not necessarily function as discrete entities. Rather, some of the steps may be transposed or they may be integrated as a smoothly flowing process. Overarching the six steps is a constant and dynamic triage assessment of affective, behavioral, and cognitive functioning as proposed by Rick Myer. This continuous assessment allows counselors to evaluate the clients' past and present situational crises in regard to their ability to cope, response to personal threat, amount of lethality, degree of mobility, and type and amount of direct action needed by the counselor. The six-step model may be loosely divided into two major categories of Exploration and Acting. In the first three steps of Exploration (i.e., defining the problem, determining safety needs, and providing immediate physical and psychological support), the emphasis of the counselor will be on exploration and assessing by attending, empathizing, and being nonjudgmental, caring, respectful, and genuine. However, counselors may also become confrontive, directive, assertive, and guiding when clear threats to the client's or others' safety emerges. In the second three steps (i.e., examining alternatives, making plans, and obtaining commitment), the emphasis of the counselor will be on acting by becoming involved in the intervention at a nondirective, collaborative, or directive level according to the assessed needs of the client and the availability of environmental supports and coping mechanisms. It is likely that the second three steps will have a higher degree of counselor involvement, responsibility, information giving, guidance, and directiveness than would normally be seen in a typical counseling encounter.

### Crisis Counseling Skills

To deal with both crisis and transcrisis states calls for a variety of skills from the counselor that do not fit neatly into what might be expected of a more traditional therapist. Unlike traditional, long-term therapy, the creation of a cure or the movement of a client to more self-actualized behavior is not an end goal. The immediate and overriding objective of the crisis worker is to contain the situation, stabilize the client, stop the escalation of emotional disequilibrium and disorganization, and, it is hoped, return the client to as close to precrisis functioning as possible. Such intervention will typically be on a very time-limited basis



that may be measured in minutes, hours, or days, rather than weeks, months, or years. After stabilization, the client may be referred, if needed, to long-term therapy where systemic change and increased functioning are the goals.

The ability to use accurate listening and responding skills; assess, synthesize, diagnose, explore alternatives; and plan and solve problems are all as important in crisis intervention as they would be in traditional therapy. However, the crisis worker will typically have little time, support, or resources to do these activities. Because of rapidly changing conditions and the volatile atmosphere that surrounds a crisis, the worker will have to be exceedingly adaptive. At times, when clients are clearly out of control, crisis intervention is much more directive and closed ended than traditional therapy. It is likely that owning or "I" statements that use assertion, positive reinforcement, limit setting, and here-and-now responses are used much more than in typical counseling. The same may be said of closed questions that ask clients for "Yes" or "No" responses to determine their degree of physical mobility, psychological equilibrium, personal safety, and potential lethality towards themselves or others.

*Richard K. James and Rick A. Myer*

**See also** Critical Incident Stress Debriefing (v2); Disasters, Impact on Children (v1); Life Transitions (v2); Posttraumatic Stress Disorder (v2); Resilience (v2); Sexual Violence and Coercion (v1); Stress Management (v2); Substance Abuse and Dependence (v2); Suicide Postvention (v1); Suicide Potential (v2)

### Further Readings

- Bronfenbrenner, U. (1979). *The ecology of human development*. Cambridge, MA: Harvard University Press.
- Figley, C.R. (Ed.). (1985). *Trauma and its wake: The study of post-trauma stress disorder*. New York: Brunner/Mazel.
- Finkelhor, D. (1984). *Child sexual abuse: New theory and research*. New York: Free Press.
- Fujimura, L. E., Weis, D. M., & Cochran, J. R. (1985). Suicide: Dynamics and implications for counseling. *Journal of Counseling and Development*, 63, 612-615.
- James, R. K., & Gilliland, B. E. (2004). *Crisis intervention strategies* (5th ed.). Pacific Grove, CA: Brooks/Cole.
- Myer, R. A. (2002). *Triage assessment for crisis intervention*. Pacific Grove, CA: Brooks/Cole/Wadsworth.
- Ochberg, F. M. (Ed.). (1988). *Post-traumatic therapy and victims of violence*. New York: Brunner/Mazel.

## CRITICAL INCIDENT STRESS DEBRIEFING

Critical incident stress debriefing (CISD) is a specific, seven-phase, small-group crisis intervention technique. It is a structured discussion of a significant traumatic event, commonly referred to as a *critical incident*. A critical incident stress debriefing is a supportive crisis-focused tool that is employed by a specially trained crisis intervention team after a small, homogeneous group has encountered a disturbing traumatic experience.

### The Nature of Critical Incident Stress Debriefing

#### Perspective

A critical incident stress debriefing is not a form of psychotherapy, nor does it constitute a substitute for psychotherapy. Instead, it is small group "psychological first aid." The primary emphasis in a critical incident stress debriefing is to inform and empower a homogeneous group after a threatening or overwhelming traumatic situation. A CISD attempts to enhance resistance to stress reactions, build resiliency, and facilitate both a recovery from traumatic stress and a return to normal, healthy functions.

A critical incident stress debriefing is one of many crisis intervention techniques within a larger, comprehensive, integrated, systematic, and multicomponent crisis intervention program known as *critical incident stress management*. The critical incident stress debriefing is not a stand-alone process, and it is only employed within a package of crisis intervention processes under the critical incident stress management umbrella. A CISD should be linked and blended with numerous crisis support services including, but not limited to, preincident education; individual crisis intervention; family support services; follow-up services; referrals for professional care, if necessary; and postincident education programs. Its best effects, which are enhanced group cohesion and performance, are always achieved when it is part of a broader crisis support system.

#### Historical Synopsis

Critical incident stress debriefing was developed by Jeffrey T. Mitchell in 1974 for use with small homogeneous groups of paramedics, firefighters, and



law enforcement officers who were distressed by an exposure to some particularly gruesome event. It is firmly rooted in the crisis intervention and group theory and practice of such notables as Thomas Salmon, Eric Lindemann, Gerald Caplan, Howard Parad, Lillian Rapoport, Norman Faberow, Calvin Frederick and Irving Yalom. The first article on CISD appeared in 1983.

Over time, the use of critical incident stress debriefing spread to other groups outside of the emergency services professions. The military services, airlines, and railroads find the process helpful, particularly when it is combined and linked to other crisis intervention processes. Businesses, industries, hospitals, schools, churches, and community groups eventually adopted the critical incident stress debriefing model as an integral part of their crisis support programs.

### **Objectives**

A critical incident stress debriefing has three main objectives. The first is the mitigation of the impact of a traumatic incident. The second is the facilitation of the normal recovery processes in psychologically healthy people who are distressed by an unusually disturbing event. Third, a CISD functions as a screening opportunity to identify group members who might benefit from additional support services or a referral for professional care.

### **Conditions**

The critical incident stress debriefing requires the following conditions: (1) the small group (about 20 people) must be homogeneous, *not* heterogeneous; (2) the group members must not be currently involved in the situation (i.e., their involvement is complete or the situation has moved past the most acute stages); (3) the group members should have had about the same level of exposure to the experience; (4) the group members should be psychologically ready and not so fatigued or distraught that they cannot participate in the discussion.

### **The Intervention Team**

A critical incident stress debriefing relies on a team approach. Several team members work together to conduct a CISD. One team member is required for every five to seven participants. A unique feature of

CISD is that Critical Incident Stress Management-trained peer support personnel (firefighters, paramedics, police officers, military personnel, etc.) work with a mental health professional when providing CISDs to personnel from law enforcement, fire service, emergency medical, military, medical, aviation, and other specialized professions.

## **The Critical Incident Stress Debriefing Process**

### **Timing**

The critical incident stress debriefing is often *not* the first intervention to follow a critical incident. A brief group informational process may have taken place, and distressed individuals may have been supported individually. Typically, 24 to 72 hours after the incident, the small, homogeneous group gathers for the CISD. Intervention delays may occur in disasters. Personnel may be too involved in the event to hold the CISD earlier. Depending on the circumstances, a CISD may take between 1 and 3 hours to complete.

### **Phases in the Critical Incident Stress Debriefing**

A CISD is a structured process that includes the cognitive and affective domains of human experience. The phases are arranged in a specific order to facilitate the transition of the group from the cognitive domain to the affective domain and back again. Although primarily a psychoeducational process, emotional content can arise at any time in the CISD.

#### **Phase 1—Introduction**

In this phase, the team members introduce themselves and describe the process. They present guidelines for the conduct of the CISD and motivate the participants to engage actively in the process. Participation in the discussion is voluntary and the team keeps the information confidential.

#### **Phase 2—Facts**

Only brief overviews of the facts are requested. Excessive detail is discouraged. This phase helps the participants to begin talking. It is easier for them to



speak of what happened before they describe how the event affected them. The fact phase, however, is not the essence of the CISD. The usual question is, “Can you give our team a brief overview of what happened in the situation?”

### Phase 3—Thoughts

The thought phase is a transition from the cognitive domain toward the affective domain. It is easier for people to speak of their thoughts than to focus immediately on the most painful aspects of an event. The typical question in this phase is, “What was your first thought or your most prominent thought once you realized you were thinking?”

### Phase 4—Reactions

The reaction phase is the heart of a critical incident stress debriefing. It focuses on the impact of the event on the participants. Anger, frustration, sadness, loss, confusion, and other emotions may emerge. The trigger question is, “What is the very worst thing about this event for you personally?”

### Phase 5—Symptoms

Team members ask, “How has this tragic experience shown up in your life?” or “What cognitive, physical, emotional, or behavioral symptoms have you been dealing with since this event?” The team members listen carefully for common symptoms associated with exposure to traumatic events. The team will use the signs and symptoms of distress presented by the participants as a kicking-off point for the teaching phase.

### Phase 6—Teaching

The team conducting the critical incident stress debriefing normalizes the symptoms brought up by participants. They provide explanations of the participants’ reactions and provide stress management information. Other pertinent topics may be addressed during the teaching phase.

### Phase 7—Reentry

The participants may ask questions or make final statements. The CISD team summarizes what has

been discussed in the CISD. The teams present final explanations, information, action directives, guidance, and thoughts to the group. Handouts may be distributed.

## Follow-Up

The critical incident stress debriefing is usually followed by refreshments to facilitate the beginning of follow-up services. The refreshments help to “anchor” the group while team members make contact with each of the participants.

Other follow-up services include telephone calls, visits to work sites, and contacts with family members of the participants if that is requested. At times advice to supervisors may be indicated. One to three follow-up contacts are usually sufficient to finalize the intervention. In a few cases, referrals for professional care may be necessary.

Jeffrey T. Mitchell

*See also* Brief Therapy (v2); Crisis Counseling (v2); Group Therapy (v2); Posttraumatic Stress Disorder (v2); Resilience (v2); Social Support (v2); Solution-Focused Brief Therapy (v2); Stress (v2); Stress Management (v2)

## Further Readings

- Mitchell, J. T. (1983). When disaster strikes . . . The critical incident stress debriefing process. *Journal of Emergency Medical Services*, 13(11), 49–52.
- Mitchell, J. T. (2004). Characteristics of successful early intervention programs. *International Journal of Emergency Mental Health*, 6(4), 175–184.
- Mitchell, J. T. (2007). *Group crisis support: When and how to provide it*. Ellicott City, MD: Chevron.

---

## CSIKSZENTMIHALYI, MIHALY (1934– )

---

Mihaly Csikszentmihalyi has spent his career researching creativity, happiness, subjective well-being, and fun. He is currently the C. S. and D. J. Davidson Professor of Psychology and Management at Claremont Graduate University in California. He received his Ph.D. at the University of Chicago in 1965. Csikszentmihalyi (pronounced “chick-SENT-me high”) was born in Hungary



in wartime Europe. His theories about “flow” and the psychology of optimal experience have transformed psychology as well as other fields, such as business management and leisure sciences. Csikszentmihalyi’s most important books include *Flow: The Psychology of Optimal Experience*, *Creativity*, *Finding Flow*, and *Good Business: Leadership, Flow and the Making of Meaning*.

Csikszentmihalyi’s research has had wide influence. He has served on boards and commissions such as the Department of Labor, Department of Education, and Social Science Research Council. He also has served on editorial boards and reviewed manuscripts for journals in areas such as psychology, sociology, anthropology, business management, and leisure sciences. Csikszentmihalyi has held visiting professorships in the United States, Canada, Brazil, Italy, United Kingdom, and Finland. He is also a member of the American Academy of Education, the American Academy of Arts and Sciences, the Academy of Leisure Sciences, and the Hungarian Academy of Sciences. He was the 1990 recipient of the National Recreation and Park Association’s Theodore and Franklin Roosevelt Excellence in Research Award and has received two Senior Fulbright Fellowships.

Csikszentmihalyi is well known for his forays into positive psychology and the examination of constructs like happiness, creativity, and flow. *Flow* is the term he coined to describe the state of being that results in an ardent involvement in life. Flow has been reported by people in all areas of work and leisure. It is often cultivated through artistic involvements, sports, and meditation arts, but it also can occur in work. Flow is associated with happiness and a desire for a meaningful life. People want to replicate this intrinsic mental state of flow as often as possible. Time changes, slows, and becomes different. People in flow are totally focused on what they are doing. For flow to occur, however, goals, feedback about progress toward the goals, and challenge must be appropriate to an individual’s skills. Csikszentmihalyi demonstrated how work or leisure activities that are enjoyable provide a feeling of accomplishment and competence. If a task is too easy, boredom may occur. If it is too difficult, the result is anxiety. The happiest people spend a good deal of time in a state of flow in which they are so involved in an activity that nothing else seems to matter.

Karla A. Henderson

**See also** Affect (Mood States) Assessment of (v2);  
Happiness/Hardiness (v2); Job Satisfaction and General

Well-Being (v4); Leisure (v2); Positive Psychology (v2);  
Seligman, Martin E. P. (v2)

### Further Readings

- Csikszentmihalyi, M. (1975). *Beyond boredom and anxiety*. San Francisco: Jossey-Bass.
- Csikszentmihalyi, M. (1990). *Flow: The psychology of optimal experience*. New York: Harper & Row.
- Csikszentmihalyi, M. (1997). *Creativity*. New York: HarperCollins.
- Csikszentmihalyi, M., & Csikszentmihalyi, I. S. (2006). *A life worth living: Contributions to positive psychology*. New York: Oxford University Press.

---

## CURRENT PROCEDURAL TERMINOLOGY

---

Current Procedural Terminology (CPT) is a listing of descriptive terms and codes that are used to describe a medical procedure or service. CPT was developed and published by the American Medical Association (AMA) in 1966. The original four-digit codes were expanded to five-digit numeric (or five-character alphanumeric) codes in 1970.

The purpose of the CPT codes is to provide a uniform language that accurately describes a service (diagnostic, medical, or surgical), to serve as a method of communication among physicians, patients, and third parties.

In 1987, the Centers for Medicare and Medicaid Services (CMS), formerly the Health Care Financing Administration (HCFA), mandated that hospitals report CPT codes for outpatient hospital procedures. In August 2000, the CPT codes were named as the national standard under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Although originally designed as a form of communication, CPT codes are now used to provide the basis for physician and hospital reimbursement for outpatient hospital services received by Medicare patients.

The CPT Editorial Panel of the AMA updates the CPT nomenclature on a yearly basis to reflect

---

Current Procedural Terminology (CPT®) is copyright 2006 American Medical Association. All Rights Reserved. No fee schedules, basic units, relative values, or related listings are included in CPT®. The AMA assumes no liability for the data contained herein. Applicable FARS/DFARS restrictions apply to government use. CPT® is a trademark of the American Medical Association.



advances in medicine and technology. New CPT books are available in late fall of each year preceding their implementation, and January 1 is the effective date for using new CPT codes. Using a deleted code could cause the denial of a claim for physician or hospital outpatient services.

The Healthcare Common Procedure Coding System (HCPCS), developed by CMS in 1983 as a way to standardize the coding system used to process Medicare outpatient claims, also makes use of the CPT codes. The HCPCS has three levels, each consisting of a unique coding system. Level I is the AMA's CPT codes, and these codes make up the majority of the procedures and services performed by physicians and other health care professionals.

Level II codes are five-character codes and consist of a letter (A through V, except I and S) followed by four numeric digits. The American Dental Association owns the copyright on the "D" codes. Level II codes describe services and supplies not found in Level I codes. They include drugs, orthotics and prosthetic devices, surgical supplies, dental procedures, vision services, ambulance services, and medical equipment. Level II codes are also known as alphanumeric codes.

Level III codes are known as local codes and are assigned by local medical carriers to describe procedures and services not identified in the other two

levels. Local codes can vary from state to state. These five-digit codes begin with an alphabetic character (W through Z) followed by four numeric digits.

Category III codes, a subset of CPT, became effective in January 2001. Category III codes are temporary codes used to describe emerging technology. Category III CPT codes are alphanumeric. Category III codes are not assigned a dollar value. These codes are reported to describe new technology or new procedures that are not described by the Level I CPT codes. A procedure note is submitted to the payer when a Category III code is used. The payer will determine the appropriate reimbursement. Typically, a code is deleted after 5 years if the code has not been accepted for placement in the Category I section of CPT.

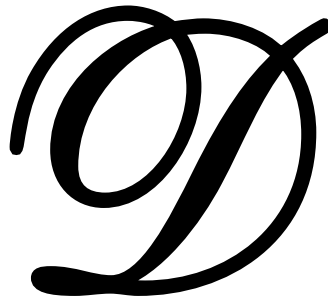
*Suzanne Forrest*

**See also** Chronic Illness (v1); Health Belief Model (v1); HIV/AIDS (v1); Physical Health (v2)

### **Web Sites**

American Medical Association: <http://www.ama-assn.org>  
U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services: <http://www.cms.hhs.gov>





---

**DECI, EDWARD L. (1942– ),  
AND RYAN, RICHARD M. (1953– )**

---

Edward Deci and Richard Ryan are professors in the Department of Clinical and Social Sciences in Psychology at the University of Rochester. Their extremely productive 30-year collaboration has led to the development and continuing evolution of self-determination theory (SDT). Deci received his Ph.D. from Carnegie Mellon University in 1970, and Ryan received his Ph.D. from the University of Rochester in 1981. Their work has been focused on the effects of social contexts on motivation, particularly factors that enhance or undermine self-determination and intrinsic motivation. Together and with other collaborators, Deci and Ryan have isolated basic social cognitive processes underlying motivation. Applications of SDT have been tested in many areas dealing with parenting, sport and exercise, work, leisure, health care, mental health, education, and psychotherapy. A testament to the importance of Deci and Ryan's contributions is the substantial amount of debate and controversy that has been generated about empirical support for the theory and the implications of its various applications.

SDT is based on the assumptions that human beings actively respond to their world, are naturally inclined toward growth and development, and have a set of basic psychological needs that are culturally universal. These innate needs include autonomy, competence, and social relatedness, and their satisfaction is thought to be critical for human development and well-being. Social contexts that support the satisfaction of these

needs facilitate intrinsic motivation and consequently natural growth processes. Contexts that interfere with them are associated with poorer motivation, performance, and well-being. These contexts are characterized by external regulation that often takes the form of rewards, and since people feel controlled by rewards, these contexts can have the unintended consequence of decreasing intrinsic motivation and preventing the development of self-regulatory processes. However, Deci and Ryan have argued that even externally motivated actions can be brought under the control of self-regulatory processes if an individual engages in an active process of internalization and integration.

Since the basic psychological need for autonomy is central to effective self-regulation and well-being, autonomy is seen as being of critical importance for promoting long-term behavior change and well-being. Fostering intrinsic motivation for engaging in healthy behavior and learning in educational settings are two areas that have received a considerable amount of attention by Deci and Ryan as well as other researchers and stakeholders. SDT has been used to develop strategies to foster mental health, personal growth, and healthy behavior change in psychotherapy and population health contexts. Examples include adherence to treatment regimes for managing physical health problems, overcoming behavioral problems including abuse and eating disorders, and tackling mood disorders such as depression and phobias.

With respect to educational issues, Deci and Ryan have argued that autonomy-supportive classroom teaching approaches foster motivational styles that facilitate students' progression from an unmotivated



to a more intrinsically-motivated approach to learning. They also have addressed performance testing in schools. Although performance testing is advocated as a means of motivating students and improving school performance, Deci and Ryan have cautioned that when it is used indiscriminately it can undermine students' feelings of autonomy and a sense of personal control. Ultimately, this can lessen students' intrinsic motivation to learn, diminish their sense of well-being, and jeopardize the quality of student learning.

*Roger Mannell*

**See also** Academic Achievement (v2); Constructivist Theory (v2); Developmental Counseling and Therapy (v2); Exercise and Sport Psychology (v1); Happiness/Hardiness (v2); Intrinsic Motivation (v2); Leisure (v2); Positive Psychology (v2); School Counseling (v1); Self-Efficacy/Perceived Competence (v2); Self-Esteem (v2)

### Further Readings

- Brown, K. W., & Ryan, R. M. (2004). Fostering healthy self-regulation from within and without: A self-determination theory perspective. In A. Linley & S. Joseph (Eds.), *Positive psychology in practice* (pp. 105–124). Hoboken, NJ: Wiley.
- Ryan, R. M., & Deci, E. L. (2000). Self-determination theory and the facilitation of intrinsic motivation, social development, and well-being. *American Psychologist*, 55, 68–78.

---

## DEFENSES, PSYCHOLOGICAL

---

Use of the term *defense* within psychology and counseling has a long and complex history beginning in the late 19th and early 20th centuries with the revolutionary and, at the time, controversial theoretical contributions of Sigmund Freud. Freud is considered the founder of the psychoanalytic movement within psychology and psychiatry. As theoretical advances, modifications, and challenges to the metatheory of psychoanalysis emerged through the latter half of the 20th century, this central construct of Freudian thinking evolved and developed through the works of such seminal writers as Anna Freud, Carl Jung, Heinz Hartmann, Ronald Fairbairn, Melanie Klein, Jacques Lacan, D. W. Winnicott, Otto Kernberg, and a host of other contributors to, and critics of, psychoanalytic theory.

### Basic Formulation

Psychoanalytic theory emerged onto the historical stage at the end of the Victorian era, a time that viewed human sexuality with both horror and fascination. When Freud advanced his theory of sexuality in 1905, his ideas were met with a storm of controversy, the echoes of which can still be heard today. Freud proposed that fundamental human behavior is organized largely by biological forces, chief among which is the sexual drive. Within the contemporary context of Victorian morals and mores that were predominant in Western Europe, the open expression of sexual feelings and desires was considered unacceptable in the social milieu of the time. Freud suggested that an internal war was being waged between the basic biological urge to express our sexual needs and the conservative nature of societal expectations to suppress them. Freud believed the mind generated internal psychological barriers to protect itself from the anxiety these dangerous and unacceptable sexual thoughts, images, and impulses would create if we were to become conscious of them. He called the psychological activity of building and maintaining such barriers the *defense mechanism*. In order for a defense mechanism to operate, two key functions must obtain: it must distort reality to some degree, and the psychological activity that accompanies this distortion will operate unconsciously. Freud's accompanying theory of the unconscious is perhaps his most distinctive, profound, and influential contribution to modern and postmodern thought. It is a contribution that has permeated virtually every level of philosophical, scientific, social, and popular culture.

### Post-Freudian Development of the Construct

Anna Freud, nearly as famous as her father, Sigmund Freud, made her own significant and far-reaching contribution to psychoanalytic theory by exploring the second element of her father's tripartite theory of mind, the ego. The ego houses the conscious sense of self and shapes the power of will and choice in everyday life. Key to Anna Freud's conceptualization of the ego is her elaboration of a series of psychological activities she called *ego defense mechanisms*. Although Sigmund Freud had originated the idea of the defense mechanism, Anna Freud is generally credited with the full exploration and development of this central



psychoanalytic idea. It is her work on the subject, published in 1937, which is commonly cited when referring to psychological defense.

### **Defense Mechanisms**

Anna Freud's model of psychological defense includes the following specific mechanisms: regression, repression, reaction-formation, isolation, undoing, projection, introjection, turning against the self, and sublimation. Each mechanism operates in specific ways to protect the ego from unwanted and disturbing impulses, generally thought to reflect the basic biological drives and urges including sexuality and aggression. The name of each mechanism more or less describes the nature of its operation, and these terms are familiar to many readers outside psychology and related fields. Of these, *sublimation* is a less obvious term and refers to the transformation of unacceptable impulses into socially desirable inclinations and activities. *Projection* is one of the more complex defenses in that it attributes to others various thoughts, feelings, motives, and intentions that we find unacceptable in ourselves. We may then find ourselves reacting to those attributed personality characteristics as if they originated in the other person, who, in turn may begin to counterreact in specific ways to us. Thus, a complex exchange of problematic projections, reactions, and counterreactions is created and often encountered in the therapeutic relationship.

Contemporary psychoanalytic writers have added to the list and typically differentiate defense mechanisms thought to be more primitive, including those that blatantly distort reality (such as denial), from those considered more sophisticated (such as identification, in which we model ourselves after admired or desired others). There is no "complete" list of defense mechanisms, as psychoanalytic theorists and writers continually elaborate and develop more complex models of this psychological operation. Otto Kernberg is often mentioned as one of the more influential modern psychoanalytic thinkers who contributed significantly to our understanding of personality disorders and the role played by psychological defense mechanisms in maintaining the psychopathology of those conditions.

### **Psychological Defense and the Therapeutic Process**

Although the ongoing development of the psychological defense construct has added both sophistication

and explanatory power to theoretical models, it is in the realm of the therapeutic relationship where this idea has proven to be of the greatest utility and value. Early analytic writers, following the tradition of Sigmund Freud and his immediate circle, understood the appearance of psychological defense in the course of treatment to be a manifestation of *resistance*, which is defined as the patient's reluctance to allow unconscious psychological material to enter into awareness. It was further understood that part of this resistance was also manifested in the avoidance of a deeper and more intimate relationship with the therapist through which interpretations of unconscious material might provide insight into and understanding of the patient's symptoms and behavior. It should be pointed out that even Sigmund Freud, and certainly Anna Freud, recognized that the use of psychological defenses, while by definition neurotic, was not necessarily pathological. Rather, defenses are used by relatively healthy adults as coping mechanisms for dealing with the challenges, setbacks, and disappointments that life typically provides.

It is perhaps not surprising that the ethos of Freud's time, global war, may have contributed to his conceptualization of psychological treatment as a conflict between the will of the therapist to help the patient recover and the pathological condition of the patient's will to resist that goal. In that parlance, conflict was inevitable within the therapeutic dyad and only by overcoming it could the patient find a cure for his or her psychological ills. As the utility of psychological defense as a coping mechanism became better understood and more accepted, its role in the therapeutic process also evolved.

The emergency of self-psychology, attributed primarily to the writing of Heinz Kohut, suggested the need to move away from the drive-defense model of classical psychoanalysis and to conceptualize the human psyche in more holistic and less conflict-oriented terms. Although Kohut's work is not as thoroughly covered in academic training settings as that of Sigmund Freud, he has nevertheless had a profound influence in the understanding of what occurs between client and therapist.

### **Working With the Defenses**

Recent and contemporary models of counseling and psychotherapy, even those that include a psychodynamic perspective, now tend to see the operation of psychological defense as a potential expression of the



client's need for independence, autonomy, and maintaining healthy psychological boundaries. This is not to argue that all defensive operations are healthy and appropriate, but that the therapist needs to distinguish those that require restructuring and those that are a relatively healthy expression of the client's sense of self.

Interpersonal and process-oriented psychotherapy practitioners tend to take the perspective that clients' psychological defenses are attempts to cope with the demands life is placing upon them, in the best way possible given the psychological and material resources available at that point in time. This approach provides clients with a normalizing experience of their current functioning; depathologizes, where appropriate, the choices being made; and allows for a positive self-experience through the use of healthy defenses against despair, hopelessness, shame, and guilt. As therapists work with the clients' defenses, they seek to make it safe for clients to explore alternate choices, perspectives, and perceptions in a climate of acceptance and support.

### Future Directions

Contemporary practitioners of counseling and psychotherapy have a broader range of theoretical and applied models available to them than ever before. The search for "evidence-based" or "empirically supported" treatments has encouraged practicing professionals to seek out approaches that are grounded in research and that reflect solid scientific thinking. There is a relative paucity of findings that unequivocally support the classical psychoanalytic theory of psychological defense, but the same may be said of many other current theoretical models as well. The longevity of any psychological construct is intimately connected to its utility in the practice arena. The construct known as psychological defense has demonstrated its utility across both time and theoretical formulation in explaining the vicissitudes encountered when therapist and client enter upon the healing way. From that perspective, it is likely to be with us, in some form, into the foreseeable future.

*James W. Bartee*

**See also** Coping (v2); Counseling Theories and Therapies (v2); Ego Strength (v2); Evidence-Based Treatments (v2); Freud, Sigmund (v2); Jung, Carl (v2); Personality Disorders (v2); Personality Theories, Psychodynamic (v2); Projective Techniques (v2); Psychoanalysis and Psychodynamic Approaches to Therapy (v2)

### Further Readings

- Freud, A. (1937). *The ego and the mechanisms of defence*. London: Hogarth Press and Institute of Psycho-Analysis.
- Freud, S. (1976). An outline of psycho-analysis. In J. Strachey (Ed. & Trans.), *The standard edition of the complete psychological works of Sigmund Freud* (Vol. 23, pp. 141–207). New York: Norton. (Original work published 1938)
- Freud, S. (1976). The psychopathology of everyday life. In J. Strachey (Ed. & Trans.), *The standard edition of the complete psychological works of Sigmund Freud* (Vol. 6, pp. 1–279). New York: Norton. (Original work published 1904)
- Hartmann, H. (1958). *Ego psychology and the problem of adaptation*. New York: International Universities Press. (Original work published 1939)
- Hartmann, H. (1964). *Essays on ego psychology*. New York: International Universities Press.
- Kernberg, O. (1967). Borderline personality organization. *Journal of the American Psychoanalytic Association*, 15, 641–685.
- Kohut, H. (1977). *The restoration of the self*. New York: International Universities Press.
- Teyber, E. (2006). *Interpersonal process in therapy: An integrative model* (5th ed.). Belmont, CA: Thompson/Wadsworth.

---

## DEMENTIA

---

*Dementia* is an inclusive term describing a group of brain disorders that cause memory loss and a decline in mental function. Researchers distinguish two types of dementia, reversible and irreversible dementia. *Reversible dementia* means the loss of memory can be cured partially or completely with treatment. *Irreversible dementia* is incurable; patients eventually become unable to take care of themselves and require 24-hour care.

Within the United States, approximately 2 million people have severe dementia, and an additional 1 to 5 million exhibit mild to moderate symptoms. Five to eight percent of people over the age of 65 have some form of dementia and the number doubles every 5 years over age 65. Up to half of those aged 85 and up are expected to contract the disease. These numbers are expected to grow as the baby boomers (individuals born between 1946 and 1964) retire and the "graying" of America accelerates.



*Alzheimer's disease* (AD; also known as *senile dementia*) is the most common form of dementia. Some of its primary hallmarks include memory loss, repeating the same thing repeatedly, having increasing difficulty naming items, and losing things or getting lost more frequently. Other signs are a change in eating habits, an abandonment of hobbies, and the loss of ability to engage in common, everyday activities. The exact causes of Alzheimer's disease are unknown, though neurofibrillary tangles and beta-amyloid plaque are hypothesized as being crucial. Other risk factors include advanced age, head injury, cardiovascular disease, renal failure, and vitamin deficiencies. Alzheimer's disease is incurable and neurodegenerative (it gets worse over time). Thus, while palliative treatments do exist, no treatment stops or reverses the progression of the disease.

The American Psychiatric Association has established two generally accepted criteria for the diagnosis of dementia, the erosion of recent and remote memory and the impairment of one or more of the following functions: language, motor activity, recognition, and executive function. The diagnosis of dementia also requires that a physician rule out the existence of delirium, a transient, acute mental disturbance that manifests as disorganized thinking and a decreased ability to pay attention to the external world.

There are three stages to Alzheimer's disease, with the first being the beginning or mild stage. In this stage, AD victims seem healthy, but they are having increasing problems dealing with life (e.g., they cannot find the right word or they engage in uncharacteristic behavior). It often takes time for an observer to realize that something is wrong because the initial Alzheimer's symptoms are often confused with changes that take place in normal aging. In the second stage, called the moderate stage, the brain becomes more damaged and problems in areas that control language, reasoning, sensory processing, and thought become more prominent. The symptoms and signs of Alzheimer's disease become more pronounced and behavioral problems can occur in this stage. In the third stage, called the final or severe stage, Alzheimer's disease sufferers may lose the ability to walk, speak, feed themselves, and recognize others.

*Cary Stacy Smith and Li-Ching Hung*

**See also** Cognition/Intelligence, Assessment of (v2); Coping (v2); *Diagnostic and Statistical Manual of Mental Disorders (DSM)* (v2); Memory, Assessment of (v2); Mental Status Examination (v2); Neuropsychological Functioning (v2)

## Further Readings

- Dash, P., & Villemarette, N. D. (2005). *Alzheimer's disease*. New York: Demos Medical Publishing.
- Gordeau, B., & Hillier, J. G. (2005). *Alzheimer's essentials*. New York: Carma Publishing.

---

## DEPRESSION

---

Depression is a normal human emotion that is experienced periodically in the form of "sadness," "disappointment," "grief," or being "down in the dumps." It is not uncommon to experience these feelings, particularly if environmental experiences are unrewarding, stressful, negative, or aversive. However, factors such as the frequency and duration of stressful life experiences, attribution style (or way of interpreting events), absence of environmental rewards, and a lack of coping resources influence whether these normal human experiences become symptomatic and evolve into a depressive disorder.

According to the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR)*, the two primary diagnostic criteria for major depressive disorder (MDD) are depressed mood and loss of interest or pleasure in most activities. At least one of these symptoms must occur for a duration of at least 2 weeks. Secondary symptoms include significant appetite change or weight loss or gain, sleep disturbance, psychomotor agitation or retardation, fatigue or energy loss, feelings of worthlessness or guilt, attention or concentration difficulties, and recurrent thoughts of death and/or suicide. Some depressed persons also may have psychotic symptoms (i.e., hallucinations or delusions). Typically, these symptoms are associated with increased depression severity, longer depressive episodes, and greater incapacity, and they are more resistance to treatment. The purpose of this entry is to provide information about the prevalence of depression and its effects on life functioning, risk factors associated with depression, and assessment strategies and treatment methods.

## Prevalence and Impact of Depressive Disorders

The lifetime risk of MDD is between 10% and 25% for women and 5% and 12 % for men. There is some



evidence that the incidence of depression and suicidal behavior is increasing across generations. For example, depression is now believed to be more frequent in adolescence than in adulthood. Within primary care medical settings, depression is possibly the most commonly experienced psychiatric problem. From 10% to 29% of patients in these settings have a depressive disorder and psychologists believe that clinical depression is largely unrecognized in this context.

Episodes of major depression are associated with extensive disruptions of normal functioning. These disruptions include exacerbation of medical illness and impaired physical health; diminished ability to concentrate, reason, and problem solve; decreased participation in pleasurable and rewarding activities; and problems with interpersonal relationships. The experience of a major depressive episode greatly increases the likelihood that future depressive episodes will occur. Major depression also increases vulnerability to other psychiatric problems such as anxiety disorders and alcohol abuse. The direct cost (e.g., health care and medication) of treating clinical depression is about \$400 million to \$500 million annually.

### **Risk Factors**

A variety of factors account for the greater incidence of depression observed among women relative to men. Women face different stressors (e.g., physical and sexual abuse) than men and have greater stress reactivity. They also differ in their cognitive coping styles and self-report strategies. Biological factors including increased responsiveness to hormonal changes such as those associated with the menstrual cycle and postpartum period also play a role.

Other risk factors include Caucasian ethnicity, marital separation or divorce, prior depressive episodes, poor physical health or medical illnesses, low socioeconomic status, unemployment, loss of a loved one, and family history of depression. Although major depression may develop at any age, the average age of onset is 15 to 19 years in females and 25 to 29 years for males. The average age of onset has been decreasing steadily over the past 3 decades. The elderly do not appear more susceptible to depression.

### **Assessment Strategies**

Numerous strategies have been developed to assess depression and related constructs such as attribution

style, hopelessness, and depressive vulnerability. Approaches for assessing depression include unstructured or structured interviews, self-report measures, behavioral observation, and functional analysis. The level of skill and training necessary to use these strategies is quite variable, ranging from the minimal skill required to administer and interpret a self-report measure, to the moderate skill needed to conduct and evaluate a structured interview, to the extensive skill required to perform a comprehensive functional analysis of depressive symptoms.

### ***Unstructured and Structured Interviews***

Clinical interviews include unstructured and completely flexible approaches, semistructured approaches that provide some direction while maintaining a degree of flexibility (e.g., intake form), and structured methods that are more restrictive and goal directed. Most contemporary practitioners use a combination of assessment procedures that include some type of intake form or checklist and some unstructured procedures to allow a degree of flexibility. In recent years concerns about the reliability and validity of unstructured interviews has led psychologists to place greater emphasis on more structured procedures. Among the more common structured interviews are the Structured Clinical Interview for DSM-IV—Patient Version, Anxiety Disorders Interview Schedule, Schedule for Affective Disorders and Schizophrenia, and the Hamilton Rating Scale for Depression.

### ***Self-Report Measures***

Self-report measures of depression are useful as screening instruments, as one component of a comprehensive diagnostic process, as tools for monitoring progress across treatment sessions, and as outcome measures for assessing the effectiveness of various psychosocial and pharmacological interventions. Scales are available to assess a tremendous range of content areas, including affective, verbal-cognitive, somatic, behavioral, and social symptoms of depression. At present, there are at least 80 measures designed to assess depression and related constructs, and the majority of these instruments have adequate to excellent psychometric properties. The most commonly used measures include the Beck Depression Inventories, Hamilton Depression Inventory, Center for Epidemiological Studies' Depression Scale, Harvard Department of



Psychiatry/National Depression Screening Day Scale, Reynolds Depression Screening Inventory, Minnesota Multiphasic Personality Inventory-2 Depression Scale (MMPI-2), and the Personality Assessment Inventory. All of these assessment instruments are acceptable for use in clinical practice, but the latter two are more comprehensive and more costly personality inventories.

### **Observational Methods**

Observational methods are used to measure the frequency and duration of observable behaviors that are symptomatic of depression. Some symptoms reflect behaviors that occur in *excess* of normal behavior (e.g., crying, irritation, and agitation). Others include *deficits* in normal behavior (e.g., minimal eye contact, psychomotor retardation, decreased participation in recreational and occupational activities, and disruption of sleeping, eating, and sexual behaviors).

Depressed individuals generally exhibit a slower and more monotonous rate of speech, take longer to respond to the verbal behavior of others, exhibit an increased frequency of self-focused negative remarks, and use fewer “achievement” and “power” words in their speech. Compared to nondepressed individuals, depressed individuals smile less frequently, make less eye contact, hold their head in a downward position more frequently, and are rated as less competent in social situations. Couples research suggests that when one partner is clinically depressed, interactions are more apt to involve conflict. Depressed mothers tend to be less active and playful and exhibit shorter eye-gaze durations with their children.

Several useful coding methods have been designed to assess both verbal and nonverbal behaviors. These methods will often involve video- and audiotape review, but more practically can involve direct observations in home, school, or employment contexts. Some behavioral coding systems require substantial training to achieve reliable and valid results.

### **Functional Analysis**

Functional analysis is the process of identifying important, controllable, and causal environmental factors that may be related to the etiology and maintenance of depressive symptoms. Performing a functional analysis is an essential step prior to initiating an appropriate behavioral intervention. Functional analysis involves the operational definition of undesirable

(nonhealthy) depressive behavior(s) such as lethargy, social withdrawal, crying, alcohol abuse, and suicide potential. Strategies for conducting functional analyses include interviews with the patient and significant others, naturalistic observation, and the manipulation of specific situations that result in an increase or decrease of target behaviors. Often functional analysis involves some form of daily monitoring (e.g., frequency of occurrence, the context and consequences of depressive behaviors).

When performing a functional analysis the therapist is concerned with identifying the function the depressed behavior serves for an individual (i.e., why the depressed behavior occurs). According to behavioral theory, depressive behavior occurs because reinforcement for healthy behavior is minimal or because reinforcement for depressive behavior is excessive. In other words, depressed behavior may be maintained because it leads to pleasant consequences (e.g., other people give the depressed person attention and sympathy and assume his or her responsibilities) or because it results in the removal of aversive experiences (e.g., they allow the depressed person to avoid unpleasant or stressful activities).

A functional analysis also may be performed by cognitively-oriented therapists to gain an understanding of the maladaptive thought processes they believe to be critical in eliciting depressive affect. Strategies such as thought-monitoring logs or thought-sampling methods can be used to identify the specific thought patterns elicited by certain environmental events and to determine how these cognitions correspond to depressive mood states. Behavioral interventions for depression also incorporate some form of functional analysis to help in generating specific treatment goals.

### **Treatment Strategies**

Treatment options for major depression generally include pharmacological, alternative, or psychotherapeutic approaches. Tricyclic antidepressants, monoamine oxidase inhibitors, selective serotonin reuptake inhibitors (SSRIs), and atypical antidepressants such as bupropion and venlafaxine have been shown to be effective in lessening clients' feelings of depression. In general, tricyclic antidepressants, SSRIs, and the newer atypical agents are the pharmacological treatments of choice. SSRIs and atypical antidepressants are generally preferred when they are effective because they have fewer and less aversive side effects.



For more severe depressions where other interventions have not been useful, electroconvulsive shock therapy may provide some relief. Although the evidence is unclear at this stage, alternative treatments such as St. John's Wort and omega-III fatty acids may have promise as effective treatments for clinical depression.

Psychotherapy for major depression generally includes cognitive-behavioral, problem-solving, interpersonal, supportive, psychodynamic, psychoanalytic, and couple and family approaches. Of these interventions, cognitive-behavioral, problem-solving, and interpersonal approaches have received the most support.

Research has demonstrated that both antidepressant medication and short-term psychotherapy can be effective in treating clinical depression. Some research suggests that in the short-term, antidepressant medications may be more effective than interpersonal psychotherapy or cognitive-behavioral therapy for individuals with less severe depression. Other studies suggest cognitive therapy is more effective than tricyclic medication in reducing depressive symptoms and in altering people's views of themselves, the world, and the future. Although a combined treatment might logically seem to be more effective than psychotherapy or medications alone, research has not yet demonstrated that multimodal therapy has an added benefit in treating clinical depression. However, several studies suggest this strategy may be promising among patients with more severe (chronic) depression. There are some data to suggest that depressed patients who respond to psychotherapy may be less likely to relapse following treatment termination than patients treated using only antidepressant medication.

Randomized clinical trials have been conducted to evaluate the efficacy of psychosocial interventions for depression. Using standard criteria, cognitive, behavioral, and cognitive-behavioral interventions are *efficacious* (i.e., empirically validated) and problem-solving therapy is *possibly efficacious*. It is difficult to draw conclusions about the relative therapeutic utility of these interventions, the generalizability of the findings, and the mechanisms responsible for the beneficial change. That is because researchers have used inconsistent operational definitions and measurement criteria, have provided inadequate sample descriptions, have used inappropriate statistical strategies, and have other methodological limitations.

Many factors are associated with a negative (or limited) treatment response, however, including

increased severity and chronicity of depression, family history of depression, presence of a personality disorder, coexistent Axis I conditions (e.g., anxiety disorders), perceived social stigma, increased cognitive and/or social dysfunction, marital problems, decreased treatment expectations, and double depression (or a major depressive episode superimposed on a preexisting dysthymia).

Most individuals with clinical depression receive their treatment in primary care medical settings from their primary care physicians. Many depressed individuals are undiagnosed or misdiagnosed in this setting. Furthermore, the quality of care for depression for those who are correctly diagnosed is *moderate to low* compared with that provided in more traditional mental health settings. There is minimal evidence that the specific medication prescribed is related to the treatment outcome. A more serious problem is that only 11% of primary care medical patients receive an adequate dosage and duration of antidepressant medication. Even when primary care physicians are provided with psychiatric consultations, antidepressant pharmacotherapy still is not adequately provided to a majority of patients.

In primary care medical settings, psychotherapy and pharmacotherapy have much to offer patients who are diagnosed with depression. However, these treatments either are not readily integrated into today's managed health care system, which does not support lengthier psychotherapy, or are often used inappropriately (e.g., prescription of inadequate doses of antidepressant medications). One potential solution seems to be increased use of collaborative care management programs. These programs involve an intensive primary care team (e.g., depression care manager, primary care physician, psychiatrist, and primary care expert) that provides a more integrated and effective treatment protocol to depressed patients. Given the training required to become proficient in interpersonal and cognitive psychotherapy and difficulties in administering these treatments in a time-efficient manner, the most feasible and effective psychosocial treatments for depression in primary care may be problem-solving therapy or behavioral activation. Indeed, there is no convincing research to suggest these abbreviated and more practical interventions can't address depressive symptom patterns to the same extent as more comprehensive cognitive-behavioral or interpersonal approaches.

In conclusion, depression is a prevalent and debilitating psychiatric disorder. Psychologists have a solid understanding of many of the risk factors associated



with depression and a number of effective, empirically-validated treatment strategies are available. These include cognitive-behavioral therapy, interpersonal psychotherapy, problem-solving therapy, and antidepressant medications that include tricyclic medications, SSRIs, and newer atypical antidepressants such as venlafaxine and cymbalta.

Nevertheless, many patients do not receive adequate treatment for depression in primary care settings and many patients are dissatisfied with the treatment they do receive for depression. Effective management of depressive symptoms via antidepressant medications is questionable, and antidepressants demonstrated as efficacious in clinical trials are not administered effectively under conditions of routine care. For this reason, psychotherapy for depression is preferred over pharmacotherapy in many cases. Psychotherapy appears to be equally or in some cases more effective than pharmacotherapy, and less patient relapse may occur following psychotherapy.

*Derek R. Hopko and Sarah M. C. Robertson*

**See also** Beck, Aaron T. (v2); Behavioral Observation Methods, Assessment (v1); Behavior Therapy (v2); Clinical Interview as an Assessment Technique (v2); Cognitive-Behavioral Therapy and Techniques (v2); *Diagnostic and Statistical Manual of Mental Disorders (DSM)* (v2); Evidence-Based Treatments (v2); Panic Disorders (v2); Psychological Well-Being, Dimensions of (v2); Psychopathology, Assessment of (v2)

### Further Readings

- American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed., Text rev.). Washington, DC: Author.
- Beck, A. T., Shaw, B. J., Rush, A. J., & Emery, G. (1979). *Cognitive therapy of depression*. New York: Guilford Press.
- DeRubeis, R. J., & Crits-Christoph, P. (1998). Empirically supported individual and group psychological treatments for adult mental disorders. *Journal of Consulting and Clinical Psychology*, 66, 37–52.
- Hopko, D. R., Lejuez, C. W., Armento, M. E. A., & Bare, R. L. (2004). Depressive disorders. In M. Hersen (Ed.), *Psychological assessment in clinical practice: A pragmatic guide* (pp. 85–116). New York: Taylor & Francis.
- Mazure, C. M., & Keita, G. P. (2006). *Understanding depression in women: Applying empirical research to practice and policy*. Washington, DC: American Psychological Association.

- Mynors-Wallis, L. M., Gath, D. H., Day, A., & Baker, F. (2000). Randomised controlled trial of problem solving treatment, antidepressant medication, and combined treatment for major depression in primary care. *British Medical Journal*, 320, 26–30.
- Nezu, A. M., Ronan, G. F., Meadows, E. A., & McClure, K. S. (2000). *Practitioner's guide to empirically based measures of depression*. New York: Kluwer Academic/Plenum.
- Pettit, J. W., & Joiner, T. E. (2006). *Chronic depression*. Washington, DC: American Psychological Association.
- Weissman, M. M., Markowitz, J. C., & Klerman, G. L. (2000). *Comprehensive guide to interpersonal psychotherapy*. New York: Basic Books.
- Young, A. S., Klap, R., Sherbourne, C. D., & Wells, K. B. (2001). The quality of care for depressive and anxiety disorders in the United States. *Archives of General Psychiatry*, 58, 55–61.

---

## DEVELOPMENTAL COUNSELING AND THERAPY

---

Developmental counseling and therapy (DCT) is a counseling approach developed by Allen Ivey for understanding and helping people. It is based in theories of individual uniqueness, human growth and development, family and environmental systems, wellness, multicultural awareness, counseling and therapy, and change. DCT may be described as an integrative metatheory that incorporates other theories and counseling approaches in a systematic manner. As a consequence, it provides a means for counselors to assess their clients accurately and choose interventions most likely to assure successful counseling outcomes.

### Human Developmental Nature

Individuals change and grow over their life span. Their unique life experiences combine to create an exclusive life story for them. That story tells how they make sense of their life experiences and transitions. How they deal with the changes and challenges of each life period becomes part of their life story. Each individual has strengths built through his or her experiences. Individuals also have some blind spots, or lack of awareness of the thoughts and feelings that keep them from living life to the fullest.



## ***Normal Development***

Basic to the DCT model is a wellness approach and a search for what is right in client development. Counselors seek to help people grow in a positive manner over the life span. Changes and transitions are normal, yet even normal changes can create difficulties. People are often confused when a transition creates conflicting emotions such as joy and sadness. This is typical because with every transition, some new and desired things are gained, and some things are lost as well. For example, the birth of a new child is a joy to parents and a cause for celebration. The birth also brings a major change in the activities of each day. "Free" time may be lost as the needs of the child require the attention of parents.

Counselors help people sort through the conflicting emotions of normal transitions and work through them successfully. Success both requires and results from one's strengths. These strengths are defined in terms of *wellness*, a holistic perspective that includes aspects of physical, emotional, social, intellectual, occupational, and spiritual health. Achieving wellness in all of these areas requires that people make intentional choices on a daily basis. Healthy choices build additional strengths for responding to life challenges.

## ***Developmental Challenges***

The challenges of life create stresses. Sometimes stresses are severe, and environmental trauma or abuse is extreme. Traditional counseling approaches view these extremes as the basis of personality disorders. From a developmental perspective, responses to trauma are normal processes of trying to make sense of one's life experiences. Trauma threatens one's sense of safety and requires defenses that match the severity of the situation. Emotional and personality disorders are thus logical responses to extreme life circumstances. For the traumatized individual, these responses are "normal."

Counselors need to understand how people make meaning of their world in order to help them grow and change. By viewing trauma responses as developmentally normal, counselors are able to focus on understanding the client rather than diagnosing a problem. This understanding is helpful for promoting a positive, proactive view of clients. It also frees clients to develop an awareness of their strengths, not just their limitations.

## **The Developmental Counseling and Therapy Model**

### ***Philosophical Foundations***

DCT is grounded in multiple theories and in the philosophical writings of Plato and the research and applications of Jean Piaget. Both proposed four levels or styles of thinking that are linear and qualitatively different.

#### ***Plato***

In the allegory of the cave, Plato explained the transition to enlightenment. A slave, chained in the dark with only candles for light, sees shadows on the walls. The slave creates stories to explain the shadows. After the slave emerges from the cave the true meaning of the shadows becomes clear. Upon returning to the cave, the shadows no longer have the same meaning. This constitutes a permanent change in perspectives and in ways of thinking. It is impossible to return to earlier stages of thinking. A "blind spot" has been removed.

#### ***Piaget***

Piaget studied the cognitive development of children and proposed four sequential stages in the development of thought processes. These stages are linear and hierarchical. They are also qualitatively different. The sensory motor stage is seen in the infant who experiences the world through the five senses: taste, touch, hearing, smell, and vision. The preoperational child begins to develop mental images to represent things that are not physically present. Lacking life experiences, these images are often incomplete or flawed. Young children, ages 7 to 11, begin to develop a concrete understanding of the world. This allows children to think logically rather than magically to explain events. Adolescents enter the final stage of development and are able to understand abstract concepts. They can imagine future events and think about and hypothesize consequences without needing to take action.

### **Four Cognitive-Emotional-Developmental Styles**

The DCT model is based in a metaphorical interpretation of the theories of Plato and Piaget. These theories propose different ways of thinking and the development of thought processes. In DCT, four



cognitive-emotional-developmental styles (CED) are defined, the sensorimotor, concrete, formal, and dialectic systemic CED styles. These are similar to Piaget's four styles but differ in that they are not linear, not hierarchical, and not sequential. They cycle over the life span in response to new developmental transitions and life experiences. The CED styles are similar to Plato's concepts in that they represent both observable external behaviors and the internal world of ideas.

Each of the four styles is a different way of processing information. An individual can function in one style most of the time or in multiple styles. The styles are not mutually exclusive and an individual can function in more than one style at the same time. Each person has a preference for a particular style in response to a given issue or set of issues. Problems arise when a person overuses one style or when he or she gets stuck in one style and is unable to see other perspectives in a situation.

The four DCT styles blend in a cyclical model and flow from one to another. An early and late component of each style contributes to the transition and flow. It is also possible to move between the styles in a nonlinear manner.

The four styles each help individuals understand their world and their experience in different and important ways. All four are important and necessary ways of understanding their experiences. The inability to function in a style is referred to as a developmental block. This is what was referred to earlier as a "blind spot." Developmental blocks can be overcome through counseling.

### ***Sensorimotor Cognitive- Emotional-Developmental Style***

Sensorimotor functioning is based in sensory experience. What one sees, hears, and feels is important. When an individual has an experience, he or she also has a feeling and feelings are based in senses. Therefore, all of one's experiences in life have a physical component. Another way to say this is that feelings are physically embedded in one's body. When an individual has an experience, he or she has a related body memory of that experience. That memory may be experienced as an image or thought.

Feelings are expressed in images that reflect conscious or unconscious thoughts. Physical sensations and feelings are the foundation of people's affective responses and often the foundation of their behaviors.

People feel and then they act. Often they are not conscious of the feelings and question why they behave as they do.

Early sensorimotor functioning is defined as the experience of feelings. Being able to locate the feelings in one's body is evidence of late sensorimotor functioning. A developmental block in this style may be either an inability to experience one's feelings or an inability to locate feelings in one's body. When individuals act in response to feelings without awareness of their feelings, they may have a developmental block in this style.

### ***Concrete Cognitive- Emotional-Developmental Style***

The concrete CED style is based in logic and details. Thinking concretely means thinking in terms of linear sequences of events. Often an individual can provide extensive detail about these events. In the early concrete stage, specific, linear details of events and circumstances are provided. The late concrete stage is characterized by if-then thinking. When an individual is able to give detailed sequences of events and reflect on those sequences, the next step is to logically see the relationship between antecedents and consequences.

Just because a person gives lots of details does not mean those details are correct or realistic. A person who leaves out important details in telling a story may have an early concrete block. Someone who is overly concrete may be able to provide many examples of overwhelming life circumstances yet be unable to understand why these events occur. This is also a block, but in the late concrete style. A late concrete block occurs when a person cannot understand relationships among events. The person cannot anticipate that *if* he or she does one thing, *then* he or she will experience a certain consequence. If the person cannot anticipate outcomes, then he or she is apt to keep repeating the same mistakes.

### ***Formal Cognitive- Emotional-Developmental Style***

The ability to think abstractly signifies formal operational thinking. In the DCT model, formal thinking means having the ability to be self-reflective and analytical. This allows an individual to see his or her patterns of thoughts, feelings, and behaviors. The individual may recognize the cause-and-effect nature



of repeating patterns as well. Repeating patterns can be positive and healthy or negative and dysfunctional.

In the early formal CED style, people become aware of their repeating patterns but may not understand how those patterns result in the problems they experience. In the late formal style, people begin to understand the patterns and the meaning those patterns have in their lives. Developmental blocks occur when a person distorts or overgeneralizes his or her patterns, or attributes causes to external events and circumstances. Distortions may occur in the area of thoughts, feelings, or behaviors, or any combination of the three. A person may have a block in the ability to see his or her patterns (an early formal block), or to understand his or her patterns (a late formal block), or both.

### ***Dialectic Systemic Cognitive- Emotional-Developmental Style***

The first three orientations in the DCT model comprise internal aspects of functioning. The fourth style, dialectic, requires that people move beyond an egocentric view to see themselves as part of multiple interacting systems. In the dialectic mode, people “think about thinking.” Their cognitive complexity allows them to view themselves and their patterns as developmentally based in family, gender, and cultural influences. They also can recognize the views of others as separate and distinct from their own.

In the early dialectic style, people are able to understand how and when their patterns developed. Typically these patterns developed in their family of origin. This understanding helps people begin to reconsider whether they want those patterns to continue. In the late dialectic style, people are able to challenge their patterns or deconstruct the meaning of the patterns. Given a choice to continue or change, a person may experience the freedom to change. Part of this awareness is the ability to understand how others think, and to recognize that not everyone thinks the same way that he or she does.

An awareness of the influence of systems and multiple interacting systems also becomes apparent in the dialectic style. An understanding of the influence of family, gender, culture, spirituality, and other multicultural factors emerges in late dialectic thinking. This understanding allows individuals to recognize how multiple systems, individually and collectively, have affected their development and continue to affect their relationships, growth, daily functioning, and holistic wellness.

A block in the early dialectic style is reflected in an inability to understand how patterns developed. Individuals may be unable to conceptualize the factors affecting their developmental processes and how those continue to influence present functioning. They also may be unable to understand or appreciate the views of others and consider that only their own perspectives are accurate. People who overuse the dialectic orientation may have a tendency to get caught up in an intellectual cloud. They may spend so much time thinking about alternatives, or who might be affected by what they do, that taking concrete action becomes difficult. They may be unable to understand the influence of one or more systems in their lives and may reject those systems as a consequence.

### **Assessing Cognitive Styles**

Ivey developed the Standard Cognitive Developmental Interview (SCDI) to facilitate exploration and movement through the four cognitive styles. This is a structured, 1 hour or more, clinical assessment during which a particular issue or presenting problem is explored in considerable depth. The assessment is unique in that it is at once an assessment, an intervention, and the foundation for treatment planning.

The purpose of the developmental assessment interview is to determine how well clients function in each of the four cognitive-emotional-developmental styles and whether developmental blocks exist in relation to specific presenting issues. The interview is always situation specific and focused on one particular issue. When multiple issues arise, successful completion of the interview depends on the ability of the counselor and client to maintain a focus rather than pursue multiple possible concerns.

The assessment process begins with the creation of an image related to the presenting issue. For example, a counselor would ask the client to think of one specific time when his or her presenting issue or problem happened. The client would then be asked to describe that time as if it were happening right now. For example, if the presenting issue was arguments with the client's spouse, the client would be asked to think of one particular argument and describe that one argument in detail. The goal in exploring the image is to help the client connect with sensorimotor experiencing in the present.

Once an affective response has occurred, movement to the concrete style is facilitated by asking the



client to provide an example of another time he or she felt the same way. After exploration of a second and sometimes third example, formal operational thinking is explored by asking for reflections on similarities or patterns between the original image and the subsequent example or examples. Movement to the dialectic style is fostered by asking the client to reflect on the origins of the pattern and on how others might view and explain the client's experiences. An important part of this process is helping clients uncover the "rule" that is guiding their behavior in the circumstances described, and that is keeping them stuck relative to their presenting issue.

Throughout the interview, it is important that counselors "stay out of the client's way" by focusing on the client's constructions of meaning. This requires the use of basic microcounseling skills such as attending, listening, paraphrasing, summarizing, questioning, and encouraging. These skills are applied within four sequences of questions corresponding to the four DCT cognitive-emotional-developmental styles. The questioning sequences, given below, are applied after the client generates an image related to a presenting issue. The image is encouraged by an open-ended question that begins with "Tell me what happens for you when you focus on [whatever issue the client has presented]."

### ***Assessing the Sensorimotor Cognitive-Emotional-Developmental Style***

Once the client has generated an image, the goal of the first questioning sequence is to help the client process the issue in the sensorimotor style and experience the issue in both the early and late sensorimotor modalities. The questions are designed to make the image present and experienced or felt in the here-and-now of the session. The following four questions are asked and considerable reflection and exploration of the client's responses is desired before moving to each new question:

What are you seeing?

What are you hearing?

What are you feeling?

Can you locate that feeling in your body?

If the client can respond positively to each of these questions, and is able to experience and explain a bodily sensation directly related to his or her feelings, an

assessment of full functioning in the sensorimotor style may be made.

If the client is unable to tell what he or she is feeling in response to the image, a sensorimotor block may be present. The presence of such a block may inhibit successful completion of the remaining portions of the interview as the embedding of the feeling is of singular importance. Should this occur, further exploration of the image with a focus on developing the image in considerable depth typically results in some type of sensorimotor experience.

The emotions expressed at this point in the interview are not necessarily highly visible and negative. Images may evoke positive feelings, and feelings may run the gamut from mild to extreme. What is important is that the client be able to describe a physical sensation in relation to the image presented, not that the counselor judge the relative importance of the feeling. When the client has reported the experience of a feeling associated with an image, and has been able to locate that feeling physically, then the counselor can summarize the first part of the interview and turn attention to the next style.

### ***Assessing the Concrete Cognitive-Emotional-Developmental Style***

The goal of the concrete questioning sequence is to determine how well the client is able to process an issue in a linear and detailed manner. The transition to this questioning sequence occurs immediately after the embedding of a feeling. It begins with a summary of the sensorimotor image, a reflection of the embedded feeling, and the question "Was there another time you felt the same way?" This question stimulates the client to determine a second example of a time when the first feeling occurred. To explore this second example, the following questions are posed:

Can you tell me specifically what happened?

What happened just before that?

What did you (or others) say (or do) when that happened?

So if you do \_\_\_\_\_, then what happens?

The counselor listens for details and for evidence of logical and if-then thinking. This questioning sequence moves the client away from present sensory experience in preparation for a more reflective style.



If a client is highly concrete and able to offer many details, multiple stories often emerge. It can be a challenge to keep this type of client focused on one story and one sequence of events. Reflecting back to the embedded feeling may be helpful. Once the concrete processing has been completed, two examples have been provided in which the same embedded feeling was predominant.

### ***Assessing the Formal Cognitive-Emotional-Developmental Style***

The transition to the formal questioning sequence begins with the summary of the first two examples. The goal is to assist the client in identifying patterns and repeating patterns by asking questions such as the following:

What similarities do you see in these two (or more) experiences?

Does this kind of thing (feeling, behavior, thought) happen a lot for you when (the situation happens)?

What are you saying to yourself when this happens?

How is your way of reacting to each situation similar?

Clients who enjoy being reflective are often easily able to see their patterns and talk about them. Clients who are not used to being self-reflective may struggle with this style. The goal is to help the client begin to relate the meaning behind his or her affective and behavioral responses to the presenting issue.

### ***Assessing the Dialectic Systemic Cognitive-Emotional-Developmental Style***

Once patterns have been identified and the meaning of the patterns has been explored, the dialectic questioning sequence may be initiated. The sequence begins with a summary of the first (sensorimotor image), second (concrete situation), and third (reflection on patterns) sections of the interview. The transition is somewhat more awkward than in the earlier parts of the interview. The first three sections are internally focused. The dialectic perspective requires that clients reflect on their situation from the perspective of others and from the lens of multiple interacting systems. For example, how are the client's reactions to his or her situation different, or not different, when interacting with family members, with coworkers in a work setting, with friends

and neighbors, or during interactions with members of a social club or religious institution. During this sequence, the counselor elicits the client's perspectives on how others might view the situation and what others might say in response to the client's concerns.

The questions are more difficult and the flow less fluid, as the client is challenged to think in new ways. Questions that may be asked in this part of the interview include:

How do you think this pattern developed (in your family or current living arrangements)?

Does this pattern happen in your family at all?

How did you learn this way of thinking and acting in your (family)?

What rule are you using when you think/act/feel this way?

The identification of a rule is perhaps the second most difficult part of the interview, after the process of embedding a feeling. Many people do not like to use the word *rule*, yet it succinctly encapsulates the issue.

The process of deconstructing or challenging the rule may be facilitated with this type of question:

I wonder if it is possible to identify any flaws in this rule, any way that following this rule keeps you from getting what you need or want?

Deconstruction is followed by directing attention to co-construction of a new rule, which leads into a commitment to continued exploration and counseling. The following two questions are asked:

As you think about it, is there a way to change this rule so you do get what you need or want?

Is this something you would like to work on in counseling?

This final question signifies both the end of the interview and the transition to a new working alliance between counselor and client. It commits the client to return for more sessions, and it sets the stage for the counselor to begin thinking about interventions.

## **Treatment Planning Using the DCT Model**

The DCT assessment interview is often a therapeutic experience that begins the change process. Identification



of the rule is tantamount to an “a-ha!” experience in which the client learns the reasons underlying automatic behaviors, or *blind spots*. Empowerment to change occurs in concert with the commitment to continue exploration in counseling. Consistent with a philosophy of wellness, clients are encouraged to make positive lifestyle choices to improve their quality of life. Such choices may occur in the physical arena, in terms of nutrition, exercise, or basic self-care activities such as tooth flossing, or in spiritual, vocational, emotional, cognitive, or intellectual areas. Personal traits such as sense of humor, sense of control, self-esteem, and rational beliefs may become the focus of wellness efforts, which are holistic and affect the total person, much as integrative counseling models address the needs of the whole person at a particular point in time.

An advantage of integrative counseling models is that they bring together assessments, interventions, and multiple theoretical approaches. What is unique about DCT is the structured manner in which the model is presented. This structure allows for virtually all counseling theories and methods to be integrated in a purposeful manner so that clinicians may use assessment results to select interventions most likely to be successful with a particular client in response to a given presenting issue. Examples of the preferred interventions based on the four styles are as follows:

*Sensorimotor*: bodywork (acupuncture, massage, yoga); catharsis; exercise (walking, jogging); focusing on emotions in the here-and-now; Gestalt interventions; guided imagery; medication; meditation; psychodynamic free association; relaxation training

*Concrete*: assertiveness training; behavioral counts and charts; brief therapy; cognitive automatic thoughts charts; crisis intervention; decision and problem solving; desensitization and establishment of anxiety hierarchies; narratives and story telling; psychoeducational skills training; reality therapy; Rational Emotive Behavior Therapy; thought stopping

*Formal*: Adlerian therapy; bibliotherapy; cognitive therapy; dream analysis; logotherapy; narratives and reflecting on stories; person-centered therapy; psychodynamic therapies; Rational Emotive Behavior Therapy

*Dialectic Systemic*: advocacy for social justice; community genograms; community or neighborhood action; consciousness raising groups; family dream analysis; family genograms; feminist therapy; multicultural counseling and therapy; self-help groups

Experienced counselors may complete the assessment within the first 100 or so words of the session as a client tells about a presenting problem. A counselor trained in DCT is usually able to determine preferred cognitive-emotional-developmental style from a short interview segment. At that point a choice may be made whether to use the assessment questions as an intervention or whether to use the information available to begin an intervention plan. As the client begins to change, intervention styles will change. An assessment of preferred style on each new issue is necessary so that optimum matching of styles and interventions may continue. Alternately, a counselor may intentionally mismatch a client's preferred style to help a client overcome a developmental block and to promote optimum development and wellness.

## Applications and Research

DCT has been used successfully with children, adolescents, and adults of all ages. It is effective and appropriate for a wide range of client populations and issues, and is useful for teaching counseling skills and for supervision in the acquisition of those skills.

*Jane E. Myers and Allen E. Ivey*

*See also* Adult Development (v1); Clinical Interview as an Assessment Technique (v2); Constructivist Theory (v2); Counseling Skills Training (v2); Counseling Theories and Therapists (v2); Identity Development (v3); Integrative/Eclectic Therapy (v2); Ivey, Allen E. (v1); Ivey, Allen E.: Counseling Theory and Skills Training (v3); Life Transitions (v2); Multicultural Counseling (v3); Therapist Techniques/Behaviors (v2)

## Further Readings

- Cashwell, C. S., Myers, J. E., & Shurts, W. M. (2004). Using the Developmental Counseling and Therapy model to work with a client in spiritual bypass: Some preliminary conclusions. *Journal of Counseling & Development*, 82, 403–409.
- Ivey, A. E. (2000). *Developmental therapy: Theory into practice*. North Amherst, MA: Microtraining Associates. (Original work published 1986)
- Ivey, A. E., & Goncalves, O. F. (1988). Developmental therapy: Integrating developmental processes into the clinical practice. *Journal of Counseling & Development*, 66, 406–413.
- Ivey, A., & Ivey, M. B. (1990). Assessing and facilitating children's cognitive development: Developmental



- counseling and therapy in a case of child abuse. *Journal of Counseling & Development*, 68, 299–305.
- Ivey, A. E., & Ivey, M. B. (1998). Reframing DSM-IV: Positive strategies from developmental counseling and therapy. *Journal of Counseling & Development*, 76, 334–350.
- Ivey, A. E., & Ivey, M. B. (1999). Toward a developmental diagnostic and statistical manual: The vitality of a contextual framework. *Journal of Counseling & Development*, 77, 484–490.
- Ivey, A. E., & Ivey, M. B. (2007). *Intentional interviewing in counseling* (6th ed.). Belmont, CA: Thomson/Brooks/Cole.
- Ivey, A. E., Ivey, M. B., Myers, J. E., & Sweeney, T. J. (2005). *Developmental counseling and therapy: Promoting wellness over the lifespan*. Boston: Lahaska Press.
- Kenney, D., & Law, J. (1991). Developmental counseling and therapy with involuntary mid-life career changers. *Journal of Young Adulthood and Middle Age*, 3, 25–39.
- Kunkler-Peck, K. P. (1999). The development and initial validation of the supervisee cognitive-developmental profile questionnaire (Doctoral dissertation, University of Connecticut, 1999). *Dissertation Abstracts International*, 60(11A), 4196.
- Marszalek J., & Cashwell, C. (1998). The gay and lesbian affirmative development (GLAD) model: Applying Ivey's developmental counseling therapy model to Cass' gay and lesbian identity development model. *Journal of Adult Development and Aging: Theory and Research*, 1(1), 13–31.
- Myers, J. E. (1998). Bibliotherapy and DCT: Co-constructing the therapeutic metaphor. *Journal of Counseling & Development*, 76, 243–250.
- Myers, J. E., Shoffner, M. F., & Briggs, M. K. (2002). Developmental counseling and therapy: An effective approach to understanding and counseling children. *Professional School Counseling*, 5, 194–202.
- Myers, J. E., & Sweeney, T. J. (2005). *Counseling for wellness: Theory, research, and practice*. Alexandria, VA: American Counseling Association.
- Rigazio-DiGilio, S. A. (1989). Developmental theory and therapy: A preliminary investigation of reliability and predictive validity using an inpatient depressive population sample (Doctoral dissertation, University of Massachusetts, 1989). *Dissertation Abstracts International*, 50(5B), 2163.
- Rigazio-DiGilio, S. A. (1994). A co-constructive-developmental approach to ecosystem treatment. *Journal of Mental Health Counseling*, 16, 43–74.
- Rigazio-DiGilio, S. A., Daniels, T. G., & Ivey, A. E. (1997). Systemic cognitive-developmental supervision: A developmental-integrative approach to psychotherapy supervision. In C. E. Watkins (Ed.), *Handbook of psychotherapy supervision* (pp. 223–245). New York: Wiley.
- Rigazio-DiGilio, S. A., & Ivey, A. (1990). Developmental therapy and depressive disorders: Measuring cognitive levels through patient natural language. *Professional Psychology: Research and Practice*, 21, 470–475.
- Strehorn, K. C. (1999). Examining services to postsecondary students with learning disabilities through the use of Ivey's Developmental Counseling and Therapy (DCT) model (Doctoral dissertation, University of Massachusetts, 1998). *Dissertation Abstracts International*, 59(7-A), 2367.
- Weinstein, T. M. (1994). The application of developmental counseling and therapy (DCT) to group treatment of binge eating and weight management. *Dissertation Abstracts International*, 55(8-B), 3604.

---

## DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS (DSM)

---

The *Diagnostic and Statistical Manual of Mental Disorders*, or *DSM*, is an official classification system of mental disorders used in the United States and by many health professionals around the world. Published by the American Psychiatric Association, the *DSM* is an evolving text that is periodically revised to reflect the most contemporary knowledge regarding psychological disorders. Since its inception in 1952, this handbook has undergone a series of revisions (*DSM-II*, *DSM-III*, *DSM-III-Revised*, *DSM-IV*, and *DSM-IV-TR*).

Reflecting the human penchant for organizing and categorizing, the *DSM* contains comprehensive descriptions of several hundred psychiatric disorders, ranging from relatively minor adjustment-related issues to severe, persistent, and disabling conditions. In recent editions of the *DSM*, researchers have rigorously attempted to establish a valid and reliable diagnostic system. To this end, numerous task forces were appointed to ensure that the diagnoses reflect distinct clinical phenomena that can be applied to individuals showing a particular constellation of symptoms.

Early versions of the *DSM* were criticized for their identification with a psychodynamic theoretical orientation. The authors of recent versions purposely adopted an atheoretical approach to diagnosis, whereby descriptions of psychological disorders represent observable phenomena rather than formulations of



possible etiologies. In this respect, the *DSM* provides practitioners and researchers with a common language for delineating disorders, and it ensures that the diagnostic labels represent agreed-upon clinical phenomena.

### Epistemological Assumptions and Definition of *Mental Disorder*

The *DSM* makes the assumption that mental disorders reflect an external reality. While its creators and contributors acknowledge that mental disorders are imperfect constructions, they also posit that such constructions yield considerable practical and heuristic value (e.g., guiding clinical practice and treatment planning). To reap such benefits, the term *mental disorder* requires a meaningful operational definition. However, like many constructs in science and medicine, a consistent and all-encompassing definition remains elusive. While no definition will adequately address all elements that may distinguish abnormal from normal, the *DSM* makes a comprehensive attempt. According to the *DSM*, a mental disorder must reflect distress or disability that is present over a designated period of time and that affects the individual's life enough to create clinically significant suffering, cause a significant decrease in normal functioning, or involve serious risk to the individual. Furthermore, these experiences must not simply reflect an expectable or culturally sanctioned response to an event, such as sadness related to the death of a loved one. Finally, irrespective of their etiology, the current difficulties must be conceptualized as manifestations of personal behavioral, psychological, or biological dysfunctions.

### The Medical Model and Categorical Approach

Early in the evolution of the *DSM*, its creators attempted to establish a diagnostic system that was compatible with a broader worldwide medical taxonomy—that is, the *International Classification of Diseases, Injuries, and Causes of Death (ICD)* developed by the World Health Organization (WHO). Hence, the *DSM* adopts a medical model of diagnosis for which mental disorders, regardless of whether their etiology is biological or psychological, are viewed as “mental illnesses” requiring treatment. Furthermore, implicit in this model is the assumption that mental disorders comprise behavioral and psychological

symptoms that form a distinct and definable pattern or “syndrome.” Thus, the creators of the *DSM* made a conscious choice to adopt a categorical taxonomy of mental illnesses. It is important to note, however, that the *DSM* makes no assumption that all mental disorders are discreet entities with absolute boundaries. Rather, it adopts a prototype model with several accommodations for the “fuzzier” diagnostic situations and for within-disorder heterogeneity. These accommodations include the use of severity specifiers and subtypes, general categories for clinically significant conditions that do not meet the specifications for more specific categories (but nonetheless require clinical attention), and polythetic criteria sets whereby diagnoses are made based on a proportion of endorsed criteria out of a larger criteria set. The *DSM* has also made special efforts to increase cultural awareness and sensitivity in diagnosis by including descriptions of cultural variations in manifestations of *DSM* disorders, an appendix of known culture-bound systems that are not included in the *DSM* nomenclature, and a guide for cultural formulation.

### The Multiaxial System of Diagnosis

Over time, professionals have increasingly acknowledged that psychological disorders involve complex interactions of biological, social, and psychological factors. With this shift to a more holistic view of mental illness, or the *biopsychosocial* approach, clinicians and researchers have called for a more comprehensive approach to diagnosis. Consequently, authors of *DSM-III* accounted for this paradigm shift with the introduction of a multiaxial system of diagnosis. This system comprises five axes along which each individual is diagnostically evaluated. Each mental disorder in the *DSM* is diagnosed on either Axis I or II. The remaining three axes are used to characterize an individual's physical health (Axis III), environmental and psychosocial stressors (Axis IV), and overall level of functioning (Axis V).

#### Axis I: Clinical Disorders and “V” Codes

The major clinical disorders, or syndromes, such as depression, schizophrenia, and bipolar disorder, are diagnosed on Axis I. Axis I also includes adjustment disorders, or extreme reactions to life events that would not normally be expected (e.g., prolonged depression following the loss of a job). Also located on



Axis I are *V codes* that are used to acknowledge conditions that are not attributable to a mental disorder (e.g., academic problems, acculturation problems), but are the primary reason for seeking treatment. When these problems are evident, but not the primary focus of concern, they are noted on Axis IV.

### **Axis II: Personality Disorders and Mental Retardation**

Personality disorders and mental retardation are diagnosed on Axis II. Personality disorders reflect the presence of pervasive, inflexible, and maladaptive behaviors, thoughts, and responses that interfere with normal interpersonal relationships and cause an individual considerable distress or impairment. An example is paranoid personality disorder where an individual is significantly suspicious and distrustful of other people and interprets their intentions as threatening and malevolent. This orientation to others is often so extreme that the individual has few close relationships.

Also located on Axis II is the diagnosis of mental retardation. Although not a personality disorder, mental retardation is considered a pervasive condition that has a significant influence on a person's behavior, personality, and cognitive functioning. Of note, it is possible to have multiple diagnoses on Axis I and/or II to account for co-occurring conditions.

### **Axis III: General Medical Conditions**

Practitioners use Axis III to document any physical complaints or medical conditions that may play a role in the individual's psychological discomfort. For example, an individual suffering from panic disorder may also experience occasional asthmatic attacks in which he or she experiences respiratory distress. Given the dynamic interaction between these two experiences, it would be useful to be aware of both conditions when conceptualizing the case, developing a treatment plan, and communicating the case to other professionals.

### **Axis IV: Psychosocial and Environmental Problems**

Practitioners use Axis IV to document stressors in the environment that may aggravate, exacerbate, or in some way relate to the individual's current psychological functioning. Some examples include job loss, death of a family member, or a recent divorce.

### **Axis V: The Global Assessment of Functioning Scale**

Axis V is used to document the practitioner's overall judgment (on a scale of 1–100) of an individual's level of psychological, social, and occupational functioning.

## **DSM Assessment**

In addition to traditional diagnostic methods (e.g., clinical interviewing, objective and projective testing), several specific systems have been developed to facilitate *DSM*-based diagnosis. The most notable are the Structured Clinical Interview for DSM-IV Axis I Disorders (SCID-I) and the Structured Clinical Interview for DSM-IV Axis II Disorders (SCID-II).

## **Benefits**

Although the creators of and contributors to the *DSM* acknowledge that its constructivist and categorical foundation has limitations, they also argue that it provides major benefits to the mental health field. Such benefits include (a) the promotion of effective communication among practitioners and researchers; (b) the facilitation of problem-identification, treatment, and prevention; (c) the facilitation of research into the etiology and treatment of specific mental conditions; and (d) the provision of a heuristic for teaching psychopathology and training practitioners on psychodiagnosis.

*Michael J. Constantino  
and Christopher M. Spofford*

**See also** Attention Deficit/Hyperactivity Disorder (v1); Bipolar Disorder (v2); Dementia (v2); Depression (v2); Developmental Disorders (v1); Eating Disorders (v2); Mental Status Examination (v2); Panic Disorders (v2); Personality Disorders (v2); Psychopathology, Assessment of (v2); Schizophrenia, Adult (v2); Underdiagnosis/Overdiagnosis (v2)

## **Further Readings**

- American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed., Text rev.). Washington, DC: Author.
- Fauman, M. A. (2002). *Study guide to DSM-IV-TR*. Washington, DC: American Psychiatric Press.
- First, M. B., Spitzer, R. L., Gibbon, M., & Williams, J. B. W. (1996). *Structured Clinical Interview for DSM-IV Axis I*



- Disorders, Clinician Version (SCID-CV)*. Washington, DC: American Psychiatric Press.
- First, M. B., Spitzer, R. L., Gibbon, M., & Williams, J. B. W. (1996). *Structured Clinical Interview for DSM-IV Personality Disorders (SCID-II)*. Washington, DC: American Psychiatric Press.
- Frances, A., First, M. B., & Pincus, H. A. (1995). *DSM-IV guidebook*. Washington, DC: American Psychiatric Press.
- Frances, A., & Ross, R. (2001). *DSM-IV-TR case studies: A clinical guide to differential diagnosis*. Washington, DC: American Psychiatric Press.

---

## DIALECTICAL BEHAVIOR THERAPY

---

Dialectical behavior therapy (DBT) is a cognitive-behavioral treatment program originally developed by Marsha Linehan as a treatment for highly suicidal women with borderline personality disorder (BPD) and other difficult-to-treat mental disorders. DBT draws its principles from behavioral science (e.g., reinforcement, classical conditioning), Zen mindfulness practices (e.g., quieting the mind and focusing attention), and dialectical philosophy (e.g., finding the synthesis between two differing or opposing positions). The essence of DBT as a treatment is helping the client find the synthesis of and middle path between acceptance and change. This emphasis came out of the finding that focusing solely on behavioral change or on acceptance and validation of the client's pain led to poor outcomes. Clients in DBT require a balance of acceptance and validation of their painful experiences while also working to change the behaviors and environmental factors contributing to the pain.

### Functions and Modes of DBT

DBT is a comprehensive treatment approach designed to serve five functions. First, DBT therapists help clients correct behavioral skills deficits by enhancing their capabilities. Second, motivational enhancement is generally accomplished by removing factors that detract from therapy success and increasing reinforcement of effective behaviors. A third function of DBT is to assure generalization of skillful behaviors to client's lives outside of therapy. Fourth, therapists and clients work to structure the client's environment and intervene in the world outside of therapy in ways that maximize therapy gains. Finally, to avoid therapist burnout and increase the chances of therapy being

successful, DBT serves the function of enhancing therapist capabilities and motivation.

DBT uses individual therapy, telephone consultation, therapist consultation teams, and group skills training to serve these functions. The individual DBT therapist takes primary responsibility for a client's treatment plan, progress toward therapy goals, integration of therapy modes, and management of life-threatening behaviors and crises. Individual therapy dyads engage in brief phone consultations to help the client engage in effective behavior outside of therapy sessions. DBT therapists meet as a consultation team to help one another engage in more effective treatment and to reduce burnout.

The fourth mode of DBT is skills training, which teaches clients four sets of skills. The core set of skills includes the mindfulness skills of observing, describing, fully participating, being nonjudgmental, focusing on one thing in the moment, and focusing on being effective. Interpersonal effectiveness skills include obtaining objectives, maintaining or improving relationships, and increasing self-respect in interactions. Emotion regulation skills include methods to increase positive emotions and to decrease ineffective emotional responses. Finally, distress tolerance skills include methods to help clients accept life's unchangeable and unwanted characteristics and survive crises.

### DBT Targets

DBT provides a hierarchy of treatment targets to help organize therapists' work with clients who have chaotic lives and multiple problems. Life-threatening behaviors including suicide attempts and intentional self-injury, and urges to engage in these behaviors are the highest targets. Once these objectives are obtained, the focus turns to the elimination of client and therapist behaviors that interfere with the effectiveness of therapy. The next target is behaviors that interfere with quality of life (e.g., criminal behaviors, interpersonal dysfunction, high-risk sexual behavior, or homelessness). Finally, DBT individual therapists help clients acquire skills.

Overall, the goals of DBT are to help clients replace suicidal behaviors with more effective behaviors and to help clients build lives they regard as worth living.

*Nicholas Salsman*

*See also* Behavior Therapy (v2); Cognitive-Behavioral Therapy and Techniques (v2); Coping (v2); Crisis Counseling (v2); Evidence-Based Treatments (v); Group



Therapy (v2); Individual Therapy (v2); Positive Psychology (v2); Positivist Paradigm (v2); Rational Emotive Behavior Therapy (v2); Stress Management (v2); Suicide Potential (v2)

### Further Readings

- Linehan, M. M. (1993). *Cognitive-behavioral treatment of borderline personality disorder*. New York: Guilford Press.
- Linehan, M. M. (1993). *Skills training manual for treating borderline personality disorder*. New York: Guilford Press.
- Salsman, N. L., & Linehan, M. M. (2006). Dialectical-behavior therapy for borderline personality disorder. *Primary Psychiatry*, 13, 51–58.

---

## DISCRIMINATION AND OPPRESSION

---

Discrimination and oppression are grounded in the belief of the superiority of one group over another, with corresponding rights to greater power and opportunity in society. Prejudicial feelings and beliefs are not necessarily oppressive, but frequently result in oppression when acted upon. Oppression refers to the economic, political, and cultural actions and behaviors that overpower, stifle, and exploit individuals. At the core of oppression is the unequal and often punitive use of power in society to target individuals. Justification for the abuse of power and mistreatment of individuals is found in the disparagement, vilification, and dehumanization of individuals and selected groups.

### Discrimination

Individuals and institutions discriminate when they make distinctions between people based on differences without regard to individual attributes. Discrimination is grounded in prejudice that incorporates negative attitudes or stereotypes attributed to specific groups or categories, strong emotive and affective responses to the groups, and a capacity for behavioral responses consistent with the cognitive and affective reactions towards these groups. The basis for prejudice is the belief that all individuals within a particular grouping possess equal and identical beliefs, attitudes, and abilities, and subsequently, can be expected to act and behave in predictable patterns.

*Direct discrimination* refers to the immediate experience at the point of the prejudicial act, whereas *indirect discrimination* describes the long-term effects and consequences that occur because of the direct discrimination. Discrimination promotes inequities in economic resources, educational opportunities, employment status, political power, medical access, social promotion, and cultural development.

*Reverse discrimination* is the process by which deliberate and direct policies or acts are used to benefit groups that have historically been targeted for discrimination. Also referred to as *affirmative action* and *positive discrimination*, reverse discrimination attempts to rebalance the social structure, governmental directives, and institutional policies that have promoted discrimination. However, it simply provides a possibility for greater opportunity for some traditionally disadvantaged groups and fails to address the deeply ingrained cultural and psychological factors that promote the development of prejudices and acts of discrimination within society.

### Forms of Discrimination

To fully understand the complexity of discrimination, it is essential to explore its manifestations within a multicultural society. The concept of *multiculturalism* refers to a philosophical stance that there are multiple groups in society distinguishable by many factors, including but not limited to ethnicity, class, race, gender, cultural and economic background, religion, sexual orientation, disability, and age. In a multicultural perspective, none of these factors is considered superior or inferior. However, it is common that individuals harbor preconceived notions or assumptions about divergent groups of people. These prejudices are learned through subtle and overt socialized behaviors and stereotyping. Beliefs that members of one group of people should be treated differently from members of another group lead to various forms of discrimination, often referred to as the *isms*. The more common forms of discrimination experienced in society are described in the following sections.

### Racism

Racism is the discrimination of individuals based on the belief that race is a biological factor that determines intellectual, physical, emotional, moral, traditional, and historical differences. It is a complex system



of oppression that encompasses attitudes, emotions, practices, and institutions. Intentional racism appears to date back to the beginning of the 20th century when focused attention turned to measured evaluation of superiority and inferiority among the various racial groups. An increasingly prevalent type of discrimination is *unintentional racism*, also referred to as *aversive racism*, where individuals perceive themselves as moral and good, are unaware of their biases, experience uncomfortable feelings when confronted with individuals of another race, and tend to engage in discrimination when they can rationalize their behavior as positive or “in the best interest” of the individual.

There are three distinct manifestations of racism: individual, institutional, and cultural. *Individual racism* is discrimination based on personal prejudice against specific racial groups, and ranges from deadly hate crimes and genocide at one extreme to minor acts of segregation and separation. *Institutional racism* is discrimination against individuals of color perpetuated by an organization in its policy, practice, or structure. *Cultural racism* is discrimination based on the belief that one race is superior to another, and it results in discrimination, segregation, and prejudice.

### **Anti-Semitism**

Anti-Semitism is discrimination against people of the Jewish religion, race, or ethnic background. Historically, this prejudice has ranged from individual hatred to the more organized persecution and genocide perpetrated by the Nazis. Inherent in anti-Semitism is the belief that Jewish individuals can be harmful to society and are often responsible for evils that occur in society. Anti-Semitism can be manifested in various ways, including (1) acts of hatred directed toward Jewish individuals, property, or religious institutions; (2) allegations about Jewish people that may be dehumanizing, demonizing, or stereotypical in nature; (3) hostility directed toward the state of Israel, which is seen as representative of the Jewish community; and (4) denial of the Holocaust.

### **Sexism**

Sexism refers to the discrimination of individuals based on gender. Sexism is founded in the belief that one gender is superior to the other, that there are inherent differences between the sexes that should determine gender role and opportunities in society, and feelings of

general hostility or anger toward women or men, known as *misogyny* and *misandry*, respectively. Traditional sexism focused on the inferiority of women and demonstrated overt hostility and aggression toward women. Throughout history, society has perpetuated sexist attitudes through the unequal treatment of men and women in laws, traditions, and values.

Contemporary sexism is exhibited through indifference to the inequities between men and women, and attribution of the differences based on biological and physical factors rather than social influences. Sexism is often seen on a continuum. Although there is a general understanding that women should have equal opportunity, many people still maintain the belief that gender differences are pervasive. Often they denigrate characteristics that are associated with women (e.g., emotionality, sensitivity) and attribute greater superiority to men.

### **Heterosexism**

Heterosexism refers to the discrimination of homosexuals by heterosexual individuals. There is a prominent belief in our society that the only respectable and healthy relationship is founded in heterosexuality. The heterosexual relationship, with a clear direction toward marriage, is the one that most often promotes social status and success.

Religious institutions, education, government, and society have all played a major role in forming a strong base for heterosexism. Abrahamic religions have emphasized the notion that homosexuality is contrary to natural law and is, consequently, sinful. Consequently, this view promotes the married, heterosexual relationship as the only acceptable type of relationship. Education promotes heterosexism by maintaining the heterosexual relationship as the ideal throughout the curricula and by providing little opportunity for discussion or exploration of alternative relationships. Government has also contributed to heterosexism by maintaining antisodomy laws and banning same-sex marriages in many states. These institutions work collectively to promote heterosexual relationships and provide an oppressive force against groups or practice that deviate from the norm.

### **Classism**

Classism is the discrimination against people who are perceived to be in a lower social class, frequently



indicated by a lower socioeconomic status. Classism can exist at an individual or institutional level. *Individual classism* occurs when individuals discriminate against others whom they consider to be in a lower social class, and therefore unworthy of equal respect or consideration. *Institutional classism* occurs when organizations are structured in a way that excludes or limits people from lower social classes.

Classism is based on the premise that all individuals have equal opportunity for class mobility, social progress, educational development, and economic wealth. Failing to achieve high social class status is perceived as a personal failure rather than a structured society process. Most of the focus in the literature has revolved around the issues of poverty and deficits among poor people rather than the economic, political, and psychological factors that maintain classism.

### **Colorism**

Colorism refers to the discrimination of people based on physical traits, specifically skin color, eye and hair color, hair texture, and facial features that may be reflective of a specific race or ethnic group. Slavery in the United States provided the foundations for the development of colorism. During this time, the White majority created an ideology that suggested that individuals with white skin color were the only civilized and worthy human beings and that individuals with black skin color were underdeveloped, lowly, and incapable of moral development.

Colorism has since developed to include other racial groups, such as Hispanics and American Indians, and is especially important in its impact on identity, attitudes about self, and social status. Skin tone, as related to lightness or darkness, has a profound influence on evaluations of self-worth, self-esteem, self-efficacy, and self-competence, especially among women. There appears to exist a hierarchical system where the lighter skin tone is associated with higher class status, greater physical beauty, and more privileges and opportunities.

### **Lookism**

Related to colorism, lookism is the discrimination of individuals based on a person's physical appearance, including facial expressions, clothing style, body shape or size, or perceived attractiveness. It is not related to racial or ethnic identity, but rather to physical looks, and is often perceived as one of the "more

acceptable" and "deserving" types of discrimination. In particular, weight and body size are tremendous sources of discrimination and prejudice in society, and obesity is associated with a wide variety of negative characteristics, including inability to work effectively, alienation from romantic partners and sexuality, being weak willed, and generally discontent with themselves and life.

### **Ageism**

Ageism refers to the discrimination against individuals based on their age. It is usually noted in two types: discrimination against youth and discrimination against the elderly. Ageism against the young is based in the belief that young people are irresponsible, lack maturity, exhibit poor judgment, demonstrate low impulse control, and in general, are not meriting respect equal to that of their older counterparts. On the opposite side, ageism against the elderly ranges from a general sense that older individuals are not as energetic, attractive, or competent in the workplace to more practical concerns that they merit greater benefits and compensation for their experiences. Governmental agencies have made efforts to address concerns of ageism through legislation focused on equal employment opportunities for all individuals.

### **Ableism**

Ableism is the discrimination of individuals with disabilities based on what they are able or unable to do physically and/or mentally. It originates in the belief that humans should exist without differences or disabilities and often blames the individual for his or her impairment. As such, individuals with disabilities are expected to find their own solutions to their "limitations" and society can ignore issues of accessibility and personhood. Individuals may lose status and be denied full social and economic opportunity because they are negatively evaluated.

Most countries have instituted laws that forbid discrimination based on physical or mental disabilities. These laws, more commonly referred to as *disability acts*, attempt to protect individuals' basic rights and promote equality for disabled people.

## **Forms of Oppression**

*Individual oppression* is perpetuated by one person with strong prejudicial feelings who discriminates by



utilizing personal power and status in society to oppress another. *Institutional oppression* refers to the acts of discrimination that are carried out within organizational settings with the intent and purpose of oppressing individuals and groups of people.

*Internalized oppression* is the system by which individuals maintain and identify with the oppressive conditions imposed by society. People often experience oppression at an individual and group level. These individuals frequently exhibit a sense of powerlessness, helplessness, inferiority, and degradation that hampers their efforts to liberate themselves from the internal and external oppressive forces. This is of particular concern because it results in cultural depreciation, separation from cultural identities, low self-esteem, poor identity development, and internalization of negative group identity. At the extreme, internalized oppression may lead to the disintegration of cultural development and intercultural contrast. Change to internalized oppressive forces would require challenges to the internal psychological patterns as well as the social conditions that promote oppression.

Caridad Sanchez-Leguelinel

**See also** Antisemitism (v3); Bias (v3); Classism (v3); Discrimination (v3); Diversity (v3); Multiculturalism (v3); Oppression (v3); Prejudice (v3); Racism (v3); Reversed Racism (v3); Sexism (v3); Stereotype (v3); Tokenism (v3); Visible Racial/Ethnic Groups (v3); Xenophobia (v3)

### Further Readings

- Beck, J. (1999). Should homosexuality be taught as an acceptable alternative lifestyle? A Muslim perspective: A response to Halstead and Lewicka. *Cambridge Journal of Education*, 29(1), 121–123.
- Casas, J. M. (2005). Race and racism: The efforts of counseling psychology to understand and address the issues associated with these terms. *The Counseling Psychologist*, 33, 501–512.
- Coates, R. D. (2003). Law and the cultural production of race and racialized systems of oppression. *American Behavioral Scientist*, 47, 329–351.
- Elia, J. P. (2003). Queering relationships: Toward a paradigmatic shift. *Journal of Homosexuality*, 45(2/3/4), 61–86.
- Gold, N. (2004). Sexism and anti-Semitism as experienced by Canadian Jewish women: Results of a national study. *Women's Studies International Forum*, 27, 55–74.
- Green, S., Davis, C., Karshmer, E., Marsh, P., & Straight, B. (2005). Living stigma: The impact of labeling, stereotyping, separation, status loss, and discrimination in the lives of individuals with disabilities and their families. *Sociological Inquiry*, 75, 197–215.
- Hunter, M. L. (2002). If you're light you're alright: Light skin color as social capital for women of color. *Gender & Society*, 16, 175–193.
- Ostrove, J. M., & Cole, E. R. (2003). Privileging class: Toward a critical psychology of social class in the context of education. *Journal of Social Issues*, 59, 677–692.
- Sue, D. W. (2005). Racism and the conspiracy of silence: Presidential address. *The Counseling Psychologist*, 33, 100–114.
- Thompson, M. S., & Keith, V. M. (2001). The blacker the berry: Gender, skin tone, self-esteem, and self-efficacy. *Gender & Society*, 15, 336–357.
- Wilkinson, D. (2002). The clinical irrelevance and scientific invalidity of the "minority" notion: Deleting it from the social science vocabulary. *Journal of Sociology and Social Welfare*, 29, 21–34.
- Yancy, G. (2000). Feminism and the subtext of whiteness: Black women's experiences as a site of identity formation and contestation of whiteness. *The Western Journal of Black Studies*, 24, 156–166.

## DUTY TO WARN AND PROTECT

The *duty to warn* refers to a counselor's obligation to warn identifiable victims. The *duty to protect* is a counselor's duty to reveal confidential client information in the event that the counselor has reason to believe that a third party may be harmed. The understanding of a counselor's duty to warn begins with acknowledgment of the difference between the ethical responsibility of confidentiality and the legal term of *privileged communication*. *Confidentiality* is a demonstration of respect bestowed on the client by the counselor wherein information between the two will not be divulged by the counselor. *Privileged communication* is a legal doctrine (also known as therapist–patient privilege) that declares client–counselor therapeutic communications are to be kept private by the counselor. The client, rather than the counselor, owns this legal privilege and generally, only the client has the right to release information from the relationship. *Privileged communication* is not available in all states and it is not absolute. An exception exists, for example, when a client threatens to harm him- or herself or others. The American Psychological Association's and the American Counseling Association's Code of Ethics recognize exceptions and note that counselors are not



required to maintain confidentiality when clients pose a threat or risk to identifiable others.

The legal precedent for establishing a duty to warn and a duty to protect was set in the wrongful death case of *Tarasoff v. Regents of the University of California*. Tatiana Tarasoff was murdered by Prosenjit Poddar, a student from India enrolled at the University of California. Upon the rejection of Ms. Tarasoff's affection, Mr. Poddar became distraught and sought counseling at the university student counseling center. During therapy, the psychologist working with Mr. Poddar became concerned that Mr. Poddar intended to harm Ms. Tarasoff. The psychologist, along with a psychiatrist, unsuccessfully attempted to have Mr. Poddar committed. The psychologist also advised the campus police of his concerns. The campus police questioned Mr. Poddar, but he assured them he would not harm Ms. Tarasoff and he was subsequently released. Mr. Poddar terminated therapy and eventually went to Ms. Tarasoff's home, shot her with a pellet gun as she ran from the house, and ultimately killed her with a kitchen knife.

Ms. Tarasoff's parents filed wrongful death suits against the university as well as the psychologist and the psychiatrist because of their negligence to warn Ms. Tarasoff of the imminent danger posed by Mr. Poddar. The defendants won in the lower court, but the case was appealed and the original ruling was overturned. In overruling the lower court in 1974, the California Supreme Court issued a ruling that established a duty for therapists to warn potential third-party victims. Moreover, the California Supreme Court extended therapists' responsibility to take reasonable steps necessary to protect intended victims, thereby establishing duty to protect in the 1976 rehearing of the *Tarasoff* case. The court held that danger to the public supercedes the protective privilege of a therapeutic relationship.

The duty to warn and protect has been upheld in other states and has become the standard of practice for mental health professionals. The duty to protect continues, however, to be open for interpretation throughout the United States. In deciding whether duty to protect is present under the law, judges generally consider whether (a) there was a special relationship and the client communicated an intended threat directly to the therapist, (b) harmful action (such as severe injury, death, or psychological harm) was foreseeable and imminent, and (c) the victim

was identifiable. Different interpretations in various jurisdictions can result in apparent inconsistencies. Although many cases have issued rulings consistent with *Tarasoff*, others have resulted in rulings that allow a cause of action to a "foreseeable" victim who may or may not have been identifiable by a therapist.

### Application in the Context of Other Therapeutic Issues

The duty to warn and protect may arise in contexts other than threat of injury or homicide of identifiable victims. Counselors should be mindful of obligations to warn and protect against clients' threats of danger to identifiable or foreseeable victims of (a) HIV/AIDS, (b) child abuse or neglect, (c) incest, and (d) battery. There are also reporting considerations regarding self-injury and abortion.

Mental health professionals performing an evaluation and developing a treatment plan may be at risk for malpractice litigation when reasonable care is not exercised to prevent harm to a third party. If, in the course of developing a diagnosis or treatment plan, a counselor becomes aware of a client's physical threats to a third party, the counselor might have a duty to protect others from potential harm. An incorrect diagnosis would fall under this same guideline. For instance, if a client did not receive appropriate treatment because of an incorrect diagnosis, the client might follow through with hostile and harmful behavior. The condition of the special relationship associated with duty to protect seems to apply in both instances.

### Guidelines

There is not a simple formula to determine when the duty to warn and the duty to protect will arise, as each case is different and statutes vary among states. Generally, counselors should (a) approach potentially dangerous clients with sensitivity, (b) attend to detail and standard of care in therapeutic interventions, and (c) apply a procedure for assessing dangerousness and record-keeping. In addition, past records should be reviewed to evaluate a client's history and propensity for violence and for any other information that would give rise to a reasonable belief that the client will injure a third party. Pragmatically, counselors should obtain professional liability insurance.



### Therapeutic Considerations

Additionally, there are considerable therapeutic considerations associated with duty to warn and protect. A primary concern is client well-being. If the client turns out not to be dangerous and the counselor was insensitive in forming an assessment, the client may lose the opportunity for therapeutic intervention for long-term progress. A second therapeutic consideration is client autonomy. For example, encouraging clients to develop coping skills such as anger management could potentially serve to facilitate client self-growth and ultimately decrease the client's risk to society. A counselor has the therapeutic opportunity as well as the obligation to model socially-responsible behavior for a client who might threaten harm to others, even in a joking manner. Counselors should inform the client of the consequences of the client's intent and the necessity of the counselor to protect others.

### Steps to Follow

The following guidelines are intended to help counselors treat "potentially-dangerous" clients ethically while observing their legal obligations:

- Inform clients at the outset of and during the relationship of confidentiality limitations, and include these limitations in an informed consent document that is signed by both the counselor and the client.
- Formulate and enact steps to assess dangerousness, such as determining if the potential danger is imminent and whether a threat is to an identifiable or foreseeable victim. At a minimum, dangerousness assessment should include a history of violence (the most predictive factor), evaluation of current thoughts, and aggressive behaviors. Other risk factors include a lack of social support, mental incapacity, an organized or feasible plan for violence, and a history of substance abuse. Recognize that it is very difficult to assess homicidal intent.
- If the counselor determines imminent dangerousness, the next step is to notify the intended victim and required professionals (such as police or other authorities, Department of Health and Human Services, and 911 or any other emergency services), the necessity for whom is indicated by the case and/or the counselor's professional judgment. If possible, the counselor should decide in consultation with another qualified mental health professional precisely who should be consulted to help prevent victimization.
- Therapeutically related identified steps for counselors to protect the public include (a) increasing both the number of therapy sessions and amount of telephone contact with the client, (b) referring the client for a medical evaluation, (c) teaching anger management skills or arranging for those to be taught in individual or group settings, (d) arranging for commitment to a hospital, and (e) developing a "no-harm" contract for the client and having the client sign the contract. These steps may vary in sequence and content, depending on the circumstance of the case.
- Document (a) the justification of the decision to disclose confidential client information; (b) consultations with any necessary professionals such as psychiatrists, attorneys, law enforcement officials; and (c) any actions taken.
- Track recommendations to be certain they were followed.

Client confidentiality is generally tempered by the counselor's obligation to warn potential third-party victims. With case law varying among states, counselors must study and follow the evolving law in the state or states where they practice.

Vaughn S. Millner

**See also** Code of Ethics and Standards of Practice (v2); Confidentiality and Legal Privilege (v2); Ethical Codes (v1); Ethical Dilemmas (v1); Informed Consent (v2); Relationships With Clients (v2)

### Further Readings

- American Counseling Association. (2005). *ACA code of ethics* [Online]. Available from [www.counseling.org](http://www.counseling.org)
- American Psychological Association. (2002). Ethical Principles of Psychologists and Code of Conduct. *American Psychologist*, 57, 1060–1073.
- DiMarco, M., & Zoline, S. S. (2004). Duty to warn in the context of HIV/AIDS-related psychotherapy: Decision making among psychologists. *Counseling and Counseling Psychology Journal*, 1(2), 68–85.
- Fischer, L., & Sorenson, G. P. (1985). *School law for counselors, psychologists, and social workers*. New York: Longman.
- Herlihy, B., & Sheeley, V. L. (1988). Counselor liability and the duty to warn: Selected cases, statutory trends, and



implications for practice. *Counselor Education and Supervision*, 27(3), 203–215.

Simon, R. (2001). *Psychiatry and the law*. Washington, DC: American Psychiatric Press.

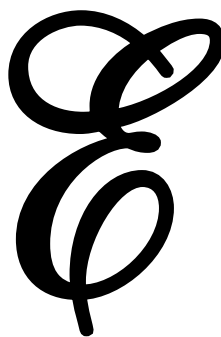
Stanard, R., & Hazier, R. (1995). Legal and ethical implications of HIV and duty to warn for counselors:

Does *Tarasoff* apply? *Journal of Counseling & Development*, 73(4), 397–400.

*Tarasoff v. Regents of the University of California*, 118 Cal. Rptr. 129, 529 P.2d 533 (1974).

*Tarasoff v. Regents of the University of California*, 17 Cal. 3d 425, 551 P.2d 334 (1976).





---

## EATING DISORDERS

---

Eating disorders (EDs) are characterized by chronicity and relapse and are some of the most common psychiatric disorders faced by girls and women. The two most common eating disorders are anorexia nervosa and bulimia nervosa. According to the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR)*, the criteria for *anorexia nervosa* include emaciation (i.e., a body mass index  $\leq 17.5$ ), an intense fear of becoming fat, disturbed perception of body shape, denial of the seriousness of low body weight, and for postmenarcheal women, the absence of at least three consecutive menstrual cycles. Criteria for *bulimia nervosa* include uncontrollable binge eating followed by compensatory behavior to prevent weight gain (e.g., vomiting, excessive exercise, misuse of laxatives, fasting), occurring at least twice a week for a minimum duration of 3 months. People with anorexia or bulimia evaluate themselves primarily by their body shape and weight.

Individuals who have some, but not all, of the specific characteristics of anorexia or bulimia may meet the *DSM-IV-TR* criteria for *eating disorder not otherwise specified* (EDNOS). One example of EDNOS is binge eating disorder, which is marked by uncontrollable binge eating in the absence of compensatory behaviors. It is important to note that obesity is not recognized as an ED by the *DSM-IV-TR*, because it has not been associated with a psychological or behavioral syndrome.

## Health Risks

Disordered eating behaviors include starvation, inadequate nutrient intake, bingeing, frequent vomiting, and abusing laxatives and diuretics. These behaviors can result in numerous negative health consequences. Cardiovascular complications such as a loss of heart muscle mass, abnormal heart beat and rhythm, and cardiac failure can result from the common ED symptoms of emaciation, electrolyte disturbances, dehydration, and weight cycling. These complications can range from being relatively benign to life threatening.

Lowered bone mineral density or osteoporosis affects a large number of individuals with anorexia due to their chronic inadequate intake of nutrients such as calcium and vitamin D. Gastrointestinal difficulties such as constipation, ulcers, tears in the esophagus, and gastrointestinal bleeding can result from purging via laxatives and vomiting. Hormone functioning can be altered as a result of malnutrition and purging, which could lead to reduced fertility, increased miscarriage, and premature/underweight births. Other biochemical abnormalities from inadequate nutrient intake and purging can affect energy levels and overall physical functioning (e.g., headaches, general muscle weakness) and psychological functioning (e.g., lower well-being, elevated depression).

Individuals who chronically engage in ED behaviors are at a higher risk for these deleterious health conditions. Yet, many others participate in ED behaviors less frequently, but may still be at a significant



risk for these conditions. Periodic malnutrition (i.e., from fasting, skipping meals), electrolyte disturbances, and weight cycling are common among those who meet some, but not all, of the criteria for clinical eating disorders. This finding highlights the importance of attending to all individuals who display ED symptoms and not solely focusing on those who meet the threshold for a clinical ED diagnosis.

## The Spectrum of Eating Behavior

Eating behavior may be conceptualized along a continuum, with one pole representing clinical EDs and the opposite pole reflecting adaptive eating. The intermediate range is characterized by the use of harmful weight control strategies and food preoccupation, but at a less severe level than that of a diagnosable ED. However, because individuals in the intermediate range may jeopardize their physical and psychological health via maladaptive weight control techniques, it is crucial for counselors to focus on preventing and treating all degrees of ED symptomatology.

### *Eating Disorders and Less Severe Eating Disturbances*

Clinical criteria for EDs are quite strict. Despite a popular belief that a high percentage of adolescent girls and young adult women have bona fide EDs, only a small number are diagnosed with anorexia (0.5%), bulimia (1%–3%), or EDNOS (2%–5%). Yet, an overwhelming number of young adult women report engaging in the unhealthy weight regulation practices that fall in the intermediate category on the eating behavior continuum. In their research, Tracy Tylka and Linda Subich uncovered large percentages of high school and college women who skipped meals (59%), ate fewer than 1,200 calories a day (36.7%), eliminated fats (30.1%) and carbohydrates (26.5%) from their diet, and fasted for more than 24 hours (25.9%).

### *Adaptive Eating*

Individuals may not display ED symptomatology *per se*, but may eat maladaptively by habitually eating in the absence of hunger or eating everything on their plate with no regard to satiety level. Therefore, it is important to articulate, define, and promote adaptive eating. Studying adaptive eating is important for counselors, as it could (a) reveal how to best foster and

maintain this eating style, (b) highlight behaviors to help people strive toward in order to enhance their well-being rather than solely pinpointing maladaptive behaviors to avoid, and (c) facilitate understanding of how to prevent and treat disordered eating, as these efforts should result in an increase in adaptive eating behaviors alongside a reduction in maladaptive symptoms. Recently, Tylka supported the adaptive properties of *intuitive eating*, defined as eating in response to internal physiological hunger and satiety cues in lieu of situational and emotional cues. Although the study of adaptive eating has gained momentum, most theory and research on eating behavior has focused on ED symptomatology.

## Assessment of Eating Behavior

Eating behavior often is assessed via interviews or several psychometrically sound instruments. The Eating Disorder Examination by Christopher Fairburn and Zafra Cooper is a popular standardized interview schedule that measures dietary restraint and concern with eating, shape, and weight. Some self-report assessment instruments that measure ED symptomatology are scored according to decision rules that determine whether a person meets ED diagnostic criteria and, if so, provides the diagnosis. The Questionnaire for Eating Disorder Diagnoses (Q-EDD) by Laurie Mintz, Sean O'Halloran, Amy Mulholland, and Paxton Schneider differentiates between ED, symptomatic, and asymptomatic individuals and between those with anorexia, bulimia, and EDNOS diagnoses. The Eating Disorder Diagnostic Scale (EDDS) by Eric Stice, Christy Telch, and Shireen Rizvi diagnoses anorexia, bulimia, and binge eating disorder. A continuous ED composite score also can be calculated from the EDDS.

Other self-report instruments are scored along a gradient to reveal the degree of eating disturbance. The Eating Attitudes Test-26 (EAT-26) by David Garner, Marion Olmsted, Yvonne Bohr, and Paul Garfinkel measures dieting, bulimia, food preoccupation, and oral control and is often used as a general measure of ED symptomatology. The Eating Disorder Inventory-3 (EDI-3) by Garner measures many behavioral characteristics of EDs, such as drive for thinness and bulimia, as well as many psychological correlates of EDs (e.g., low self-esteem, perfectionism); an overall ED risk composite score can be computed. The Bulimia Test-Revised (BULIT-R) by Mark Thelen, Janet Farmer, Stephen Wonderlich, and Marcia Smith assesses levels of bulimic symptomatology. In terms of adaptive



eating behavior, the Intuitive Eating Scale (IES) by Tylka measures unconditional permission to eat, eating for physical rather than emotional reasons, and reliance on internal hunger/satiety cues to determine when and how much to eat. An overall score also can be computed.

### **Risk Factors**

There is no single cause of EDs. Rather, researchers suggest that sociocultural variables (e.g., cultural pressures for thinness), personal variables (e.g., personality, physical, behavioral, cognitive, and affective variables), and relational variables (e.g., lack of social support) are associated with the development and maintenance of eating disorders.

#### ***Sociocultural Variables***

Cultural and environmental factors that encourage individuals to focus on the appearance of their bodies in lieu of internal characteristics such as personality and intellect can lead to increased body dissatisfaction. Consequently, individuals attempt to employ maladaptive weight control strategies to conform to the cultural thin-ideal prototype. Women constitute roughly 90% of individuals with diagnosable EDs. Thus, ED symptomatology could be related to the cultural sexual objectification of women's bodies. One form of sexual objectification is the pressure to be thin that women face from family, friends, partners, and the media. Sociocultural variables are thought to play a more important role in fostering eating pathology than in maintaining it, as they are the backdrop against which individual development occurs.

In 2002, Stice conducted a meta-analysis of longitudinal studies of eating pathology. He noted that pressure for thinness leads to ED symptomatology as well as internalization of the thin-ideal societal standard, body dissatisfaction, dieting, and negative affect (i.e., a combination of anxiety, depression, and low self-esteem). He concluded that the adverse effects of pressure to be thin are more pronounced for individuals with specific maladaptive personal and relational characteristics, such as those presented next.

#### ***Personal Variables***

Stice highlighted how several personal variables may combine with other variables to increase women's

risk of disordered eating. First, elevated body mass leads to pressure for thinness and body dissatisfaction, but does not directly lead to or maintain ED symptomatology. Second, internalization of the thin-ideal societal standard leads to body dissatisfaction and negative affect, both of which lead to and maintain ED symptomatology. Third, body dissatisfaction and negative affect appear to influence each other. Fourth, maladaptive perfectionism, a personality trait characterized by unrealistically high expectations coupled with severe criticism for falling short of these expectations, leads to and maintains ED symptomatology. Although not investigated in Stice's meta-analysis, poor awareness of internal states (i.e., hunger, satiety, emotions) also has been found to contribute to ED symptomatology within several models of disordered eating.

#### ***Relational Variables***

High levels of social support from family and friends may buffer the effects of stress on ED symptomatology, as feeling accepted and appreciated by others is believed to help people feel more positively about themselves and their bodies. Therefore, low levels of social support could contribute to negative affect as well as intensify the negative effects of stress on ED symptomatology.

### **Prediction of Eating Disorder Symptomatology**

#### ***Objectification Theory***

According to Barbara Fredrickson and Tomi-Ann Roberts, sexually objectifying encounters socialize girls and women to self-objectify, or treat themselves as objects to be looked at and evaluated (e.g., by habitually monitoring their bodies and internalizing the societal thinness standard as the only attractive body type). Self-objectification, then, directly leads to consequences such as body shame and decreased awareness of internal bodily states (e.g., hunger, satiety, emotions). These consequent variables are believed to directly contribute to women's eating pathology. Many researchers have demonstrated support for the pathways of objectification theory and found that sexual objectification only influences women's ED symptomatology indirectly through its associations with personal variables (i.e., self-objectification, body shame, decreased internal awareness).



### **Dual Pathway Model**

In 1996, Stice, Carol Nemeroff, and Heather Shaw proposed the dual pathway model to explain the development of bulimic symptomatology. This model asserted that sociocultural pressures to be thin foster body dissatisfaction, as repeated messages that one is not thin enough likely encourages dissatisfaction with one's body. Internalization of the thin-ideal societal standard additionally contributes to body dissatisfaction because this ideal is difficult to attain. Body dissatisfaction in turn promotes dieting (in an attempt to achieve the thin-ideal) and negative affect (as low body esteem is equated with low self-esteem). Dieting and negative affect are the two pathways that connect body dissatisfaction to bulimic symptomatology. Dieting encourages bulimic symptomatology because the violation of strict dietary rules results in disinhibited eating, and negative affect promotes bulimic symptomatology as binge eating temporarily provides comfort and distraction from negative emotions. This model has been supported in several longitudinal studies with adolescent girls.

### **Interaction Models**

The confluence of several risk factors places individuals even more at risk for ED symptomatology. For instance, many women may experience body dissatisfaction, but of these women, only those with high levels of other variables (e.g., maladaptive perfectionism, low self-esteem, body surveillance, negative affect, or having a family member or friend with an ED) have an increased likelihood of displaying ED symptoms. These findings underscore the importance of examining how variables interact in their prediction of ED symptomatology.

## **Prevention and Treatment**

Less than 25% of individuals with EDs receive treatment; of these individuals, only 30% of clients show symptom remission that persists for at least 4 weeks. In light of the limited success in the treatment of diagnosed eating disorders, extensive efforts have been directed toward developing prevention and treatment programs designed to curb maladaptive eating practices before they develop into eating disorders. However, when evaluated (e.g., typically with female high school or college students in a school or university setting), only a few of the many extant programs

have produced lasting symptom reduction at follow-up, ranging from 1 month to 2 years.

### **Prevention of Disordered Eating**

Based on research documenting the multidimensional nature of ED risk factors, prevention programs focus on one or more of the identified risk factors. Programs that have produced lasting effects such as improvements in body dissatisfaction and amelioration of ED symptomatology typically were several hours in length (ranging from 4 to 10 hours); promoted healthy weight control behaviors, body acceptance, resistance of cultural pressures for thinness, self-esteem enhancement, and stress management; and presented information on EDs and the effects of cognitions (i.e., thoughts) on emotions. Several programs that demonstrated significant improvements had women actively challenge their beliefs about their bodies or the thin-ideal body type promoted by society. In one 4-hour program, girls who were at high-risk for ED symptomatology actively replaced their negative appearance self-statements with positive statements. Systematic desensitization (i.e., an intervention that pairs muscle relaxation with anxiety-producing objects arranged along a gradient from low to high anxiety) also was used to reduce body anxiety.

Counterattitudinal exercises in which participants actively critiqued the cultural thin-ideal body were used to reduce participants' endorsement of the thin-ideal. Women receiving this intervention showed greater reduction in ED risk factors and bulimic symptoms at the end of the program and lower binge eating through a 12-month follow-up than women who did not receive this intervention. Moreover, women in another intervention group (i.e., where a healthy-ideal weight was defined, the thin-ideal societal standard was refuted, and public commitments to follow an individualized plan that included a balanced diet and increased exercise were encouraged) achieved similar benefits.

### **Treatment of Disordered Eating**

Treatment of EDs is challenging. Clients who were once reinforced for losing weight may be reluctant to relinquish their fantasy of attaining the thin-ideal body shape. As such, many clients only enter treatment because of significant others' pleas. Clients may not yet be contemplating change.

Treatment of individuals with EDs is multidisciplinary and may involve counselors (e.g., psychologists,



social workers), physicians, and dieticians. Treatment setting is determined by the severity of ED symptomatology; medical danger from extreme emaciation or severe bingeing and purging may warrant inpatient hospitalization. Settings include outpatient treatment (e.g., weekly therapy sessions), partial hospitalization (i.e., consisting of 4–8 hours per day of treatment for 8–14 weeks), or inpatient treatment at a hospital or ED treatment facility. Regardless of the setting, intense psychotherapy and strict attention to the medical needs of the clients are imperative, and therapy may include a combination of psychoeducation (e.g., media literacy, information on healthy eating) and individual, family, and group psychotherapy. Certain antidepressant medications (i.e., Prozac) may also be used to treat bulimia and binge eating disorder, but they appear to be less effective for treating anorexia.

There are various types of psychotherapy for treating ED symptomatology. Many counselors choose to integrate aspects of these approaches and tailor the treatment to the client's individual needs. Cognitive-behavioral therapy (CBT), interpersonal therapy (IPT), feminist therapy, and family therapy are common treatment frameworks. Much empirical research has supported CBT and IPT in the treatment of ED symptomatology; more research needs to be conducted on the other approaches to determine their effectiveness.

One of the most popular approaches for treating ED symptomatology is CBT. First, in a psychoeducational component, clients are given information regarding EDs, the role of thinking in maintaining EDs, and nutrition information. They monitor their eating behaviors during this phase. For instance, individuals with bulimia may note that they binge after fasting for 8 hours. They are encouraged to begin a pattern of regular eating (e.g., three planned meals plus two or three planned snacks each day), to identify triggers for their ED symptomatology, and to generate a list of adaptive coping strategies and use these strategies (in lieu of binge or restricted eating) to deal with stress. Second, in a cognitive-restructuring phase, clients are taught to identify, question, and restructure their maladaptive general thought patterns (e.g., dichotomous, black-or-white thinking) and irrational thoughts specific to food and weight that maintain their ED and negative affect. Last, in a relapse prevention phase, clients learn how to anticipate events that may impede their continued progress and make plans to deal effectively with these events.

The focus of IPT is on addressing clients' current interpersonal relationships and how to make them

more satisfactory. The first phase is geared toward establishing rapport, explaining the treatment approach, and assessing client problem areas with careful attention to interpersonal difficulties (e.g., interpersonal deficits, grief, disputes). The second phase addresses interpersonal difficulties identified in the first phase and may include a psychoeducational component about negative affect, EDs, and how to effectively solve problems. In the last phase, clients are prepared to deal with future problems and therapeutic progress is reviewed.

Feminist therapy highlights how environmental factors such as objectification and cultural pressures to be thin contribute to ED symptomatology. After establishing an egalitarian relationship, counselors often help clients pinpoint the connection between their eating problems and the deleterious environment that maintains these problems. For instance, clients' body dissatisfaction emanating from their belief that the thin-ideal is the only attractive body shape is connected to cultural messages that espouse this unrealistic body shape. This strategy is referred to as "making the personal political." Clients are encouraged to disentangle themselves from self-objectification, and interventions are designed to foster body acceptance and appreciation by focusing on how the body functions rather than its appearance. Strategies to critically evaluate media portrayals of women and men are discussed (i.e., media literacy efforts). Assertiveness skills help clients find their voice within interpersonal encounters. Sex-role analysis helps clients identify messages they have been taught with regard to their gender that serve to maintain their ED behaviors (e.g., women should be passive and thin, men should be muscular). Clients are prompted to express their emotions within the safe therapy environment.

Because a family member's ED may be a manifestation of a problem within the entire family system, family therapy often is used to treat ED symptomatology. In structural family therapy, counselors focus on identifying roles, alliances, conflicts, and interaction patterns within the family that are related to the ED. Once these patterns are acknowledged, counselors tailor their interventions to facilitate appropriate and healthy expression from each family member and enhance the well-being of the entire family system.

## Future Directions

Most theory and research on ED symptomatology has focused on women who are young, Caucasian, and



heterosexual. As a result, ED symptomatology may be different for other individuals and therefore not reflected in *DSM-IV-TR* criteria for EDs. For instance, anorexia is much less prevalent among men than women, and only about 10% of the individuals with bulimia are men. Yet, one third of all men desire a leaner body and approximately one quarter of all men want a more muscular body. Some of these men may internalize environmental pressures to become more muscular, become dissatisfied with their bodies, and go to extreme efforts to gain muscle mass by using anabolic steroids and eating maladaptively (e.g., eating excessive amounts of protein, becoming preoccupied with eating 20 grams of protein in 2-hour intervals). Indeed, contemporary American men display substantial body dissatisfaction, which is often expressed as muscle belittlement (i.e., believing they are less muscular than they are). This dissatisfaction is closely associated with depression, ED symptomatology, use of performance-enhancing substances, and low self-esteem.

Although body dysmorphic disorder may reflect men's muscle dysmorphia, the associated maladaptive eating behaviors are not recognized in the *DSM-IV-TR*. This neglect has clinical implications, as it may lead to counselors overlooking these deleterious behaviors in their clients. Furthermore, because many ED instruments were designed to assess only diagnostic criteria for EDs and not other maladaptive eating behaviors, counselors may miss maladaptive eating behaviors when they exist, leading to some clients not being appropriately identified or treated for an eating disturbance.

Future efforts also need to be directed toward exploring extant models of ED symptomatology with diverse samples and developing models that more appropriately reflect the experiences of other groups of individuals. Ethnic identity (e.g., expressing positive ethnic attitudes; identification with, affirmation of, and belonging to an ethnic group) has been asserted to protect individuals of color from internalizing Western cultural standards of attractiveness and developing body dissatisfaction and ED symptomatology. However, preliminary findings suggest that a strong ethnic identity may not directly protect women of color from internalizing the Western thin-ideal body type, having a negative body image, or displaying ED symptomatology. Instead, ethnic identity appears to positively influence the self-esteem of women of color, and self-esteem then protects these women from

internalizing the thin-ideal body type, body dissatisfaction, and ED symptomatology.

Tracy L. Tylka

**See also** Cognitive-Behavioral Therapy and Techniques (v2); *Diagnostic and Statistical Manual of Mental Disorders (DSM)* (v2); Ethnic Identity (v3); Family Counseling (v2); Feminist Therapy (v1); Physical Health (v2); Psychoeducation (v2); University Counseling Centers (v1)

## Further Readings

- American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed., Text rev.). Washington, DC: Author.
- Fredrickson, B. L., & Roberts, T. A. (1997). Objectification theory: Toward understanding women's lived experiences and mental health risks. *Psychology of Women Quarterly*, 21, 173–206.
- Garner, D. M. (2003). *The Eating Disorder Inventory-3 manual*. Odessa, FL: Psychological Assessment Resources.
- Garner, D. M., Olmsted, M. P., Bohr, Y., & Garfinkel, P. (1982). The Eating Attitudes Test: Psychometric features and clinical correlates. *Psychological Medicine*, 12, 871–878.
- Kashubeck-West, S., & Mintz, L. B. (2001). Eating disorders in women: Etiology, assessment, and treatment. *The Counseling Psychologist*, 29, 627–634.
- Mintz, L. B., O'Halloran, M. S., Mulholland, A. M., & Schneider, P. A. (1997). Questionnaire for Eating Disorder Diagnoses: Reliability and validity of operationalizing DSM-IV criteria into a self-report format. *Journal of Counseling Psychology*, 44, 63–79.
- Moradi, B., Dirks, D., & Matteson, A. V. (2005). Roles of sexual objectification experiences and internalization of standards of beauty in eating disorder symptomatology: A test and extension of objectification theory. *Journal of Counseling Psychology*, 52, 420–428.
- Olivardia, R., Pope, H. G., Borowiecki, J. J., & Cohane, G. H. (2004). Biceps and body image: The relationship between muscularity and self-esteem, depression, and eating disorder symptoms. *Psychology of Men and Masculinity*, 5, 112–120.
- Stice, E. (2002). Risk and maintenance factors for eating pathology: A meta-analytic review. *Psychological Bulletin*, 128, 825–848.
- Stice, E., Nemeroff, C., & Shaw, H. (1996). Test of the dual pathway model of bulimia nervosa: Evidence for dietary restraint and affect regulation mechanisms. *Journal of Social & Clinical Psychology*, 15, 340–363.
- Stice, E., Shaw, H., Burton, E., & Wade, E. (2006). Dissonance and healthy weight eating disorder prevention



- programs: A randomized efficacy trial. *Journal of Consulting and Clinical Psychology*, 74, 263–275.
- Stice, E., Telch, C. F., & Rizvi, S. L. (2000). Development and validation of the Eating Disorder Diagnostic Scale: A brief self-report measure of anorexia, bulimia, and binge-eating disorder. *Psychological Assessment*, 12, 123–131.
- Thelen, M., Farmer, J., Wonderlich, S., & Smith, M. (1991). A revision of the Bulimia Test: The BULIT-R. *Psychological Assessment*, 3, 119–124.
- Thompson, J. K. (Ed.). (2004). *Handbook of eating disorders and obesity*. Hoboken, NJ: Wiley.
- Treasure, J., Schmidt, U., & van Furth, E. (Eds.). (2003). *The handbook of eating disorders* (2nd ed.). West Sussex, UK: Wiley.
- Tylka, T. L. (2004). The relation between body dissatisfaction and eating disorder symptomatology: An analysis of moderating variables. *Journal of Counseling Psychology*, 51, 178–191.
- Tylka, T. L. (2006). Development and psychometric evaluation of a measure of intuitive eating. *Journal of Counseling Psychology*, 53, 226–240.
- Tylka, T. L., & Subich, L. M. (2002). Exploring young women's perceptions of the effectiveness and safety of maladaptive weight control techniques. *Journal of Counseling & Development*, 80, 101–110.

---

## EGO STRENGTH

---

The concept of ego strength derives from psychoanalytic theory and refers to the healthy, adaptive functioning of the *ego* (i.e., the capacity for effective personal functioning). Sigmund Freud conceptualized the ego as an intrapsychic substructure that serves the essential organizing and synthesizing functions that are necessary for an individual to adapt to the external world. When the ego performs these functions adequately (Table 1), individuals experience themselves as coherent, functional human beings with an enduring sense of personal identity. They are said to possess *ego strength*.

### Intrapsychic and Interpersonal Dimensions

Ego strength has both intrapsychic and interpersonal dimensions. It implies a composite of internal psychological capacities—both cognitive and affective—that individuals bring to their interactions with others and with the social environment. Ego strength reflects a person's capacities for adaptability, cohesive identity,

personal resourcefulness, self-efficacy, and self-esteem. Ego strength also connotes mental health as encapsulated in Freud's well-known phrase “to love and to work.” Indicators of ego strength include interpersonal competence, a sense of purpose, life satisfaction, and the capacity for meaningful activity. Like the solid foundation of a well-built house, ego strength supports the individual across developmental stages in the pursuit of life goals, dreams, and ambitions, especially under stressful conditions or during turbulent times. Ego strength provides an individual with a cohesive sense of self, ensures coping abilities, increases as individuals grow in maturity, and is recognizable during initial clinical assessment and throughout psychotherapy.

### Utility and Relevance

The importance of ego strength as an area for clinical assessment derives from the notion that the significant problems in living for which people seek therapeutic assistance often express themselves as *ego deficits* (i.e., a lack of ego strength). Deficits in ego strength can manifest as poor judgment, difficulties with reality testing, and problems with interpersonal relationships or intimacy. A lack of ego strength can also show in extreme defensiveness, lack of self-control, and the inability to regulate emotions or self-soothe when distressed. Ego deficits are also apparent in the individual with poor self-esteem, no cohesive identity, unrealistic or inconsistent life goals, and issues with mastery and competence.

Psychotherapists pay special attention to ego strength when assessing a client's current capacities and potential to benefit from therapy. Their ability to support a client's current and developing ego strength depends on their ability to identify and assess ego functions in the clinical situation. In psychoanalytic theory, a client can grow in ego strength over time by identifying with and incorporating the therapist's own ego strength. Across mental health practice disciplines, clinicians assess ego strength to locate a client on a developmental continuum. That allows them to identify a suitable place to begin therapeutic work, provides data to develop therapeutic goals, and constitutes a baseline against which to measure psychotherapeutic progress.

### Historical Perspective

#### *Structural Theory*

Freud's conceptualization of the ego took shape around the turn of the 19th century. Freud was deeply



**Table 1** Ego functions

<i>Ego Function</i>	<i>Client Description</i>	<i>Sample Assessment Item</i>
Reality testing	Distinguishes between inner and outer stimuli	Explains problems by means of false beliefs or control by a supernatural power
Judgment	Aware of appropriateness and likely consequences of intended behavior	Makes foolish, poorly considered, or bad decisions
Sense of reality of the world and self	Experiences external events as real; differentiates self from others	Able to look realistically at his/her good and bad qualities
Affect and impulse control	Maintains self-control; can tolerate intense affect and delay gratification	Gets upset or loses control when dealing with strong feelings
Interpersonal functioning	Sustains relationships over time despite separations or hostility	Seems to just use people to get the things he/she needs
Thought processes	Attention, concentration, memory, language, and other cognitive processes are intact; thinking is realistic and logical	Seems weird, bizarre, or out of touch with reality
Adaptive regression	Relaxes ego controls, allowing creative integrations to increase adaptive potential	Recovers from emotional upset quickly, with previous capacities intact or improved
Defensive functioning	Defenses satisfactorily prevent anxiety, depression, and other unpleasant affects	Explains his/her problems as caused entirely by others
Stimulus barrier	Aware of sensory stimuli without stimulus overload.	Easily overwhelmed by too much activity or interaction with others
Autonomous functioning	Cognitive and motor functions (primary autonomy) and routine behavior (secondary autonomy) are free from disturbance	Structures his/her own time and enjoys it
Synthetic-integrative functioning	Able to integrate contradictory attitudes, values, affects, behavior, and self-representations	Believes he/she is a good person, worth caring about, but with some problems
Mastery-competence	Performance is consistent with existing capacity	Lives up to his or her potential and feels good about his/her work

Source: Adapted from Bellak (1989).

pessimistic about human nature and impressed with the archaic drives and primitive passions that seemed to shape human behavior. He came to understand civilized, adult behavior as the end result of the ego's

struggle to mediate between the powerful, infantile, even bestial forces of the *id* and the punitive requirements of the *superego* for social conformity. The ego of Freud's structural theory lacked strength relative to



the id. His metaphor for the ego was a person on horseback who can barely hold in check the superior strength of the horse. Freud did not recognize the fullness of an ego that, in addition to its job of holding id impulses in check, performs other vital functions, including perception, cognition, judgment, reality testing, and affect regulation.

## **Ego Psychology**

Colleagues who carried Freud's structural theory forward in the first decades of the 20th century did so in the context of a devastating First World War, the deadly flu pandemic of 1918, and the destruction of the Austro-Hungarian empire. That historical era was followed by the Great Depression, the rise of Nazism, the earliest days of the Holocaust, and the burgeoning militarism that culminated in World War II. In contrast, ego psychology was elaborated during the more optimistic post-World War II era by European expatriates who emigrated to the United States to escape Nazi persecution. They shared Freudian beliefs about the power of the id and its biological drives but, buoyed by the political freedom and optimism of American society, they were far more interested in the ego and its functions. In particular they focused on how ego functions contributed to the unfolding of human capacities in response to the interaction between environmental factors and innate potentials. The psychoanalyst Heinz Hartmann was the first to suggest that some ego functions are independent of, and autonomous from, the drives (id). Since this seminal contribution, many others have elaborated ego psychology, most notably Erik Erikson, who proposed an enduring stage theory of ego development over the life span.

## **Assessing Ego Strength**

### **Ego Function Assessment**

The most comprehensive and systematic effort to describe and study ego functions, whose healthy adaptations essentially constitute ego strength, has been undertaken by Leopold Bellak and colleagues. Beginning in 1958, Bellak began to study the nature of the psychoanalytic process in a controlled, experimental way. His National Institute of Mental Health (NIMH) research study resulted in a list of 12 ego functions considered necessary and sufficient to describe the personality of the individual. The list is a

useful outline for assessing a person's strengths or evaluating therapeutic gains.

### **Other Approaches to Ego Strength Assessment**

An alternative approach to assessing ego strength involves ego-oriented assessment as a process of data collection over several interviews on a client's current and past functioning and on his or her inner capacities and external circumstances. Questions that guide the overall assessment of ego strength include:

1. To what extent is the client's problem a function of
  - stressors imposed by his or her current life roles or developmental tasks?
  - situational stress or a traumatic event?
  - impairments in his or her ego capacities?
  - developmental difficulties or dynamics?
  - the lack of environmental resources or supports?
  - a lack of fit between his or her inner capacities and external circumstances?
2. What inner capacities and environmental resources does the client have that can be mobilized to improve his or her functioning?

Ego strength assessment is not essential to all forms of help giving, but it can help determine where to direct interventions. For example, in some cases it is important to maintain, enhance, or modify inner capacities. At other times intervention is designed to mobilize, improve, or change environmental conditions. Sometimes intervention is necessary to improve the fit between inner capacities and external circumstances. When a client is overwhelmed by current stressors but evidences some ego strength and has at least some environmental supports, the practitioner will use a supportive approach aimed at stress reduction and more effective problem solving. In contrast, clients who have limited ego strength and developmental deficits that interfere with their ability to cope with current life roles need interventions targeted at building ego strength.

*Pamela Bjorklund*

*See also* Clinical Interview as an Assessment Technique (v2); Coping (v2); Defenses, Psychological (v2); Freud, Sigmund (v2); Personality Theories, Psychodynamic (v2); Psychoanalysis and Psychodynamic Approaches to Therapy (v2); Self-Efficacy/Perceived Competence (v2); Self-Esteem (v2); Self-Esteem, Assessment of (v2)



### Further Readings

- Bellak, L. (1989). The broad role of ego function assessment. In S. Wetzler & M. Katz (Eds.), *Contemporary approaches to psychological assessment* (pp. 270–295). New York: Brunner/Mazel.
- Bellak, L., Hurvich, M., & Gediman, H. (1973). *Ego functions in schizophrenics, neurotics, and normals*. New York: Wiley.
- Bjorklund, P. (2000). Assessing ego strength: Spinning straw into gold. *Perspectives in Psychiatric Care*, 36(1), 14–23.
- Erikson, E. (1959). Identity and the life cycle. *Psychological Issues*, 1(1), 50–100.
- Freud, A. (1936). *The ego and the mechanisms of defense*. New York: International Universities Press.
- Freud, S. (1961). The ego and the id. In J. Strachey (Ed. & Trans.), *The standard edition of the complete psychological works of Sigmund Freud* (Vol. 19, pp. 3–66). New York: Norton. (Original work published 1923)
- Goldstein, E. (1984). *Ego psychology and social work practice*. New York: Free Press.
- Hartmann, H. (1939). *Ego psychology and the problem of adaptation*. New York: International Universities Press.
- Schamess, G. (2004). Ego psychology. In J. Berzoff, L. M. Flanagan, & P. Hertz (Eds.), *Inside out and outside in: Psychodynamic clinical theory and practice in contemporary multicultural contexts* (pp. 67–101). Lanham: Rowman & Littlefield.
- Vaillant, G. E. (1993). *The wisdom of the ego*. Cambridge, MA: Harvard University Press.

---

## ELLIS, ALBERT (1913–2007)

---

Albert Ellis, the developer of *rational emotive behavior therapy* (REBT), contributed greatly to the practice of psychotherapy through his clinical practice, involvement with numerous professional organizations, publications of books and articles, and teaching. Ellis was born in Pittsburgh and was raised in New York City. He had a difficult childhood and, due to the family discord, focused his attention toward books and understanding others. In junior high school, Ellis planned to study accounting. Experiencing the Great Depression, however, altered this goal and he graduated from college in 1934 with a degree in business administration from the City University of New York. In 1942, he returned to school, entering the clinical psychology program at Columbia. He started a part-time private practice in

family and sex counseling soon after he received his master's degree in 1943. Ellis earned his Ph.D. in clinical psychology from Columbia in 1947. He had been trained in psychoanalysis as the primary form of treatment and he entered into a training analysis program with the Karen Horney group. Ellis completed the full analysis and began practicing classical psychoanalysis. During this time, Ellis taught at Rutgers and New York University and was the senior clinical psychologist at the Northern New Jersey Mental Hygiene Clinic. He also became the chief psychologist at the New Jersey Diagnostic Center and then at the New Jersey Department of Institutions and Agencies.

Although trained in psychoanalysis, Ellis experienced frustration when his patients showed only moderate improvement when he worked with them from a psychoanalytic orientation. He observed that when he saw clients once a week or even every other week, they progressed as well as when he saw them daily. Ellis found that patients seemed to improve more rapidly when he was active and direct in his methods. The perceived lack of efficacy of psychoanalytic treatment caused Ellis to turn back to his philosophical roots of Greek, Roman, and ancient Asian philosophers and seek a more effective form of therapy. Ellis worked through many of his own problems by revisiting and studying the philosophies of Epictetus, Marcus Aurelius, Baruch (or Benedictus) Spinoza, and Bertrand Russell, and he began to teach his clients these principles.

By the mid-1950s Ellis had completely abandoned psychoanalysis and begun focusing on altering behavior by confronting clients on what he termed their *irrational beliefs*, and then teaching and strengthening their rational beliefs. In 1957, Ellis published his first book on *rational-emotive therapy* (RET), *How to Live With a Neurotic*. Two years after this publication, Ellis founded the Institute for Rational-Emotive Therapy and conducted workshops on RET principles for other therapists. Ellis continued to revise and expand on his style of cognitive-behavioral therapy. In the early 1990s the institute, which is now called the Albert Ellis Institute, sponsored a conference titled “A Meeting of the Minds. Psychoanalysis and cognitive-behavior therapy: Is integration possible?” that resulted in changing the name of the therapy from rational-emotive therapy (RET) to rational emotive behavior therapy (REBT). Albert Ellis published more than 50 books and over 600 articles on REBT, sex,



and marriage. REBT has become a staple in cognitive therapy.

*David T. Dahlbeck and Suzanne H. Lease*

*See also* Cognitive-Behavioral Therapy and Techniques (v2); Psychoeducation (v2); Rational Emotive Behavior Therapy (v2)

### Further Readings

- Albert Ellis Institute. (n.d.). *A sketch of Albert Ellis*. Retrieved September 22, 2006, from <http://www.rebt.org/bio.htm>
- Ellis, A. (1962). *Reason and emotion in psychotherapy*. New York: Lyle Stuart.
- Ellis, A. (1973). *Humanistic psychotherapy: The rational-emotive approach*. New York: McGraw-Hill.
- Ellis, A. (1977). A basic clinical theory of rational-emotive therapy. In A. Ellis & R. Grieger (Eds.), *Handbook of rational-emotive therapy*. New York: Springer.
- Ellis, A., & Harper, R. A. (1975). *A new guide to rational living*. Englewood Cliffs, NJ: Prentice Hall.
- Prochaska, J. O., & Norcross, J. C. (1999). *Systems of psychotherapy: A transtheoretical analysis* (4th ed.). Pacific Grove, CA: Brooks/Cole.
- Sharf, R. S. (2004). *Theories of psychotherapy and counseling: Concepts and cases* (3rd ed.). Pacific Grove, CA: Brooks/Cole.

---

## EVIDENCE-BASED TREATMENTS

---

Within the past 15 years, the field of psychotherapy has wrestled with how to identify the type and nature of evidence that will allow one to validly determine if and when a treatment is likely to be helpful or harmful. Numerous factors, including concerns expressed both by individual citizens and their political representatives, the diverse and contradictory nature of many claims about psychotherapy efficacy and effectiveness, and the alarming number of instances of damage produced by psychotherapy as reported in the news media, fueled these discussions. The debate over how to define an “effective treatment” in the fields of counseling and mental health has revealed some significant schisms among those who adhere to different methods of researching and practicing psychotherapy and counseling.

While counseling and clinical psychology have always been concerned with identifying the effectiveness of psychotherapy, the topic rose to a visible level

when the Society of Clinical Psychology (Division 12 of the American Psychological Association, or APA) initiated a task force to identify treatments for which research evidence on treatment efficacy was available. This task force was initiated in 1993 and issued its first report of *empirically validated treatments* (EVTs) in 1995, with subsequent reports being presented in 1996 and 1998. Each report contained a list of brand-name treatments that were judged to meet certain criteria of effectiveness for a particular diagnostic group. However, as the list of effective treatments grew with each report, so did the concern both with what treatments were still missing from the list and with how “effectiveness” was judged for those treatments that were listed.

Eventually, more than 150 different models and manuals of treatment were identified by different working groups and professional associations, as being “empirically supported.” Armed with the list of endorsed procedures, clinicians faced a daunting task in their search to provide help to the struggling consumer or to achieve demonstrable levels of competence in order to service those who sought their help.

To address criticisms that the original task force report was too restrictive and exclusionary, the initial term of *empirically validated treatments* was changed in 1998 to *empirically supported treatments* (ESTs). This term was thought to be less strident and narrow. Likewise, the criterion of empirical support was expanded from two independent controlled trial comparisons to a requirement that a treatment’s value also should be supported by a preponderance of available scientific evidence. Unfortunately, these modifications did not address the types of concerns that were emerging with the Division 12 effort.

Increasingly, individuals raised concerns that the list of brand-named therapies favored narrow theories over important factors within the relationship and the participants (therapist and client). They argued that these extratherapy factors contributed to change at least as much as did the treatment model itself. Many scholars pointed out that head-to-head comparisons usually found that there were negligible differences among various treatments in the actual amount of change accounted for and that treatments, at best, accounted for only about 10% of the change that was observed in patients over the course of treatment. The scholars and practitioners who raised these concerns asserted the importance of a new way of assessing the nature of effective treatments, one based on an analysis of



research on participant and interpersonal contributors to the therapeutic relationship itself.

### Empirically Supported Relationships

Concerned with the way ESTs were being identified, Division 29 (Psychotherapy) of APA initiated a task force to look for a complementing alternative that would be more compatible with views regarding the importance of the therapeutic relationship. This task force focused on defining what came to be called *empirically supported relationships*, or ESRs. The identified empirically supported relationship factors included participant qualities and treatment processes that were conducive to change, but that were not part of most formal models of psychotherapy. The task force members reviewed available literature and constructed a list of variables and qualities that were either “probably” or “possibly” associated with beneficial outcomes. The most promising of these qualities included the therapeutic alliance, empathy, patient resistance, level of functional impairment, goal consensus and collaboration, group cohesion, positive regard, genuineness, and management of countertransference. Efforts to parse these various factors on the basis of their importance concluded that patient variables (i.e., severity of distress, functional impairment, etc.) account for approximately 25% to 30% of the total outcome variance, the therapy relationship or alliance accounts for a further 10%, the person of the therapist accounts for 8% of total change, and the specific treatment methods employed may add as much as another 8% to the successful prediction of outcomes. While slightly different percentages than these have been suggested by other scholars, using different statistical procedures, the therapeutic alliance is generally accepted as being quite salient as a predictor of change.

These findings did not end the disagreements among proponents of EST and ESR perspectives. Each perspective has been criticized for being too narrowly focused and failing to integrate all or most of the important constructs that have been indicative of benefit. They each have also been criticized for being too wedded to certain research methodologies at the exclusion of other, equally respected ones. Efforts to fashion common ground among these various perspectives have taken one of two directions. They have sought either to expand the nature of the evidence on which “validity” is to be judged, in order to be more

inclusive of different methodologies and preferred variables (e.g., the APA 2005 Presidential Task Force on Evidence-Based Practice), or to establish a set of guiding principles that can incorporate and integrate concepts from both EST and ESR perspectives (e.g., The Division 12/North American Society for Psychotherapy Research Task Force on Principles of Effective Change).

### ***The APA 2005 Presidential Task Force on Evidence-Based Practice***

The president of APA in 2005 initiated a task force on evidence-based practice as part of his presidential initiative. The task force was charged with addressing three specific issues:

1. How to incorporate the wide range of empirical evidence into the application of psychology
2. How to incorporate the roles of scientific findings and clinical expertise in decision making, including the process by which practitioners must choose among and incorporate available research
3. How to highlight the relative importance of different patient variables in treatment of decision making

After much deliberation and input from multiple groups, the task force concluded with a call to extend the definition of what constitutes “empirical support” to include therapist experience and judgment as well as patient preferences and values. The final report of the task force defines *evidence-based practice of psychology* (EBPP) as a practice that seeks to incorporate current, empirical, research with clinical expertise in regards to a patient’s individual characteristics, cultural background, and personal preferences for psychotherapy. The new EBPP was distinguished from the old, empirically supported treatments by its encouragement of clinicians to use subjective judgment and personal opinions, along with patients’ expressed preferences and values, whenever available research findings seem to be inadequate to the task of psychotherapy. By this means, the EBPP task force attempted to integrate the treatment method and procedures with a more global process of assessment, case formulation, and the power of the therapeutic relationship.

To accomplish the broad purposes of their mission, the APA’s presidential task force gave special consideration to the roles of three broad classes of



variables—research, clinical expertise, and patient variables. Integrating these concepts, they concluded that

1. It is not sufficient to know that a given treatment works. Clinicians must use their own experience and judgment to determine the applicability, feasibility, and usefulness of the intervention in the local or specific setting where it is to be offered.
2. Practitioners should consider nontreatment factors that affect treatment outcome, such as the individual therapist, the relationship, and the patient. Good therapists should be able competently to incorporate these different sources of evidence into treatment of decision making.
3. Clinical expertise is necessary in order to incorporate available research with the characteristics of a particular patient. They defined *clinical expertise* as the experience and knowledge attained by psychologists through education and training that ultimately results in effective therapeutic practices.
4. The influence of patient qualities and characteristics should be incorporated into the treatment program and integrated with treatment through the medium of therapist experience and judgment.

### ***The Joint Task Force on Empirically Supported Principles of Therapeutic Change***

Two fundamental concerns with the conclusions by the APA's 2005 presidential task force bolstered the development and foundation of a second task force. The former conclusions were seen as (a) placing unfounded faith in unproven and demonstrably fallible clinical judgment and (b) urging the integration of patient, therapist, relationship, and treatment factors without providing any useful guidance for how this might be accomplished. A task force representing, jointly, the Society for Clinical Psychology (Division 12 of APA) and the North American Society for Psychotherapy Research (NASPR) was convened when members and officers within these groups came to believe that neither EST nor ESR, nor APA's 2005 presidential task force, offered a clear rationale for how patient, therapist, treatment, and relationship variables were to be balanced and integrated.

The joint task force argued that the emerging EST, ESR, and EBPP perspectives failed to capture the

importance of integrating multiple dimensions and processes. Because each of these task forces and working groups emphasized only one set of variables (treatment models, relationship factors, or participant factors) at the relative expense of the others, it was thought that they were poorly positioned for integrating these various domains of influence. Moreover, it was feared that APA's presidential task force, by making clinician judgment the final arbiter of "effectiveness," ignored the fallibility of human judgment, the role of emotion in distorting perspectives, and the self-serving nature of professional judgment for which science had been developed. A more objective and integrative method offering delineated directions for applying concepts from the patient, the therapist, the relationship, and the treatment was needed.

The Joint Task Force on Empirically Supported Principles of Therapeutic Change sought the answers to two cardinal questions:

1. What is known about the nature of the therapy participants, relationships, and procedures within treatment that induces positive effects across theoretical models?
2. How do factors related to these domains work together to enhance change?

The specific mission of the joint task force included an attempt to distill the influences of participant, relationship, and treatment factors into a set of cross-cutting, empirically supported, and informed principles that were not tied to any one theory or perspective of psychotherapy. Unlike APA's 2005 presidential task force, the evidentiary bases for the principles were to be founded directly on scientific evidence. To resolve some of the differences between the EST and ESR models, moreover, this task force accepted a broad view of acceptable research methodologies, as long as the methods research was published in credible scientific journals, based on peer review.

Ultimately, 24 senior scholars and 21 associated scholars were chosen to work on the principles task force. These authors were divided into groups, each addressing one domain of the variables (participant factors, relationship factors, treatment methods) and one type of problem for which counseling and psychotherapy may be useful (depression, anxiety, personality disorder, or chemical use disorders). These groups were asked to extract from the previous task



force reports, and other major research volumes, all of those treatment outcome studies that represented the particular mix of variable domain and problem area to which they were assigned. They were then to dissect the relevant studies, summarize and tabulate the results, and articulate a set of guiding principles that were supported by a preponderance of the available research and that could inform the therapist in treating patients with a particular problem.

The joint task force compiled a set of 61 principles that served to identify aspects of patients, therapists, relationships, and treatments that contributed in predictable and empirically reliable ways to outcome. Twenty-six of these principles were similar in two or more of the four diagnostic problem areas reviewed. The similarity of these principles across problem areas resulted in their being designated “common” principles. In contrast, 35 of the principles were only identified as being adequately supported in one of the four problem areas and thereby, earned the designation as being “unique” principles.

Twenty-eight of the principles (5 common and 23 unique) described ways that extratherapy qualities of the therapist and patient facilitated change in the successful treatment of various problems. The principles emphasized the value of flexibility, the ability to tolerate ambiguity, and tolerance for one’s own negative responses to others. They also identified prognostic indicators among patients, such as the negative affect observed in those with personality disorder, those who lack adequate social support, those with severe problems, and those with a chaotic history and background.

Eleven of the derived principles addressed the use and value of the therapeutic relationship in facilitating change. Most of these (9 of 11) were common to two or more of the problem areas. These latter principles generally pertained to the use of a collaborative framework and to the therapeutic skill required to develop and maintain the therapeutic alliance.

Twenty-two research-informed principles reflected the effective use of different classes of interventions, each being grouped by the impact it had on psychotherapy process (e.g., directive vs. nondirective, insight vs. symptom change). These principles were almost equally divided among those that were common across different problems (12 of 22) and those that were unique to the type of problem being addressed. These principles were clearly integrative, and many of them described ways to tailor interventions

to fit different qualities of the patient and the context in which he or she lives.

## Future Directions

The balancing and integration of science and practice in counseling psychology continues to be a work in progress. The hopeful observation is that there is a continuing dialogue among the various stakeholders in this debate and the discourse is likely to be productive.

*Larry E. Beutler, David Clinton,  
Elaine Gierlach, and David Scott Klajic*

*See also* Counseling Process/Outcome (v2); Empirically Based Professional Practice (v1); Outcomes of Counseling and Psychotherapy (v2); Positivist Paradigm (v2); Quantitative Methodologies (v1); Taxonomy of Helpful Impacts (v2)

## Further Readings

- Castonguay, L. G., & Beutler, L. E. (Eds.). (2006). *Principles of therapeutic change that work* [Report of the Joint Task Force]. New York: Oxford University Press.
- Chambless, D. L., & Hollon, S. D. (1998). Defining empirically supported therapies [Part of a special section on defining empirically supported therapies]. *Journal of Consulting and Clinical Psychology*, 66, 7–18.
- Chambless, D. L., & Ollendick, T. H. (2001). Empirically supported psychological interventions: Controversies and evidence. *Annual Review of Psychology*, 52(1), 685–716.
- Levant, R. F. (2005). *Report of the 2005 Presidential Task Force on Evidence-Based Practice*. Washington, DC: American Psychological Association.
- Nathan, P. E., & Gorman, J. M. (Eds.). (2002). *A guide to treatments that work* (2nd ed.) [Supplement to the Division 12 Task Force Report]. New York: Oxford University Press.
- Norcross, J. C. (Ed.). (2002). *Psychotherapy relationships that work: Therapist contributions and responsiveness to patient needs* [Division 29 Task Force Report]. New York: Oxford University Press.
- Norcross, J., Beutler, L. E., & Levant, R. (Eds.). (2006). *Evidence-based practices in mental health: Debate and dialogue on the fundamental questions*. Washington, DC: American Psychological Association.
- Task Force on Promotion and Dissemination of Psychological Procedures. (1995). Training in and dissemination of empirically validated psychological treatments: Report and recommendations [First Division 12 Task Force Report]. *The Clinical Psychologist*, 48(1), 3–23.



---

## EXPECTATIONS ABOUT THERAPY

---

Client expectations about counseling and psychotherapy are widely believed to influence the therapy process and outcome. Theorists from disparate theoretical persuasions have included expectations as a central construct in their theories. Research on the common factors that account for much of the success of psychotherapy confirms the influence of client expectations.

### The Construct of Expectations

#### *Development of Construct of Expectations*

Oswald Kulpe and Edward B. Titchener formulated the concept of an expectation as a cognitively mediated preparatory set or disposition to behave in a particular manner in a given situation. Narziss Ach named this disposition a “determining tendency,” thereby emphasizing the effects of expectations on perception and behavior. By definition, therefore, expectations influence perceptual and judgmental processes, learning, and behavior.

Jerome Bruner, Leo J. Postman, and Harry Helson elaborated the role of expectations in influencing behavior. Bruner and Postman theorized that the process of perception begins with an expectation or hypothesis. Helson viewed expectations as critical determinants of people’s “adaptation level” (i.e., the cognitive norms people use in interpreting sensory information). Learning theorists such as Edward C. Tolman (cognitive theory), Clark L. Hull and Kenneth Spence (drive reduction theory), and Julian B. Rotter (social learning theory) viewed learning as a function of the reinforcement of one’s expectancies regarding the outcome of behavior in a given situation.

Social psychologists incorporated expectancies as a central construct in explaining social cognition. Cognitive *expectancies* (i.e., preparatory sets) are viewed as primary determinants of behavior in George A. Kelly’s personal construct theory, Kurt Lewin’s aspiration theory, Leon Festinger’s cognitive dissonance theory, and Theodore Newcomb’s attraction theory.

#### *Expectations in Counseling and Psychotherapy*

Theorists also viewed expectations as central to the success of psychotherapy. Clients’ expectations

influence their decision to enter into and remain in therapy and they moderate the effectiveness of therapy. Clients approach therapy with expectancies regarding the nature of therapy and the roles they and their counselors will assume. Counselors’ and clients’ expectations are important determinants of their behavior in counseling.

Arnold P. Goldstein distinguished between prognostic expectations (e.g., beliefs concerning the probability of success in counseling) and participant role expectations (i.e., beliefs regarding the behaviors that will be displayed by the client and counselor). Bernard Apfelbaum suggested that clients expect one of three basic types of counselors. The *critic* is a cold, rigid, judgmental therapist who gives advice, but is not concerned with whether the client uses it. The *model* is a tolerant, accepting, permissive therapist. The *nurturant therapist* is giving, guiding, and protective. Expectations such as these influence people’s choice of a help giver, their perceptions of their therapists, the quality of the communication process, their persistence in counseling, and the effectiveness of counseling. Most of these theoretical assertions have been supported by empirical research.

### Early Research on Expectations About Therapy

Most research on expectations about counseling prior to the early 1970s focused on the placebo effect of expectancies and expectations regarding the therapists’ behavior.

#### *Placebo Effect of Expectancies*

The *placebo effect* was named after the practice in medical research of prescribing a benign treatment (e.g., a “sugar pill”) to a control group of patients. This allows researchers to determine whether spontaneous, non-treatment-related improvements occurred during the study. It is possible that the mere act of entering therapeutic treatment could stimulate improvement. Some psychologists theorized that all of the gain from therapy was the result of a placebo effect.

Research through the early 1970s investigated whether the gains observed in therapy were attributable to the mere expectation that therapy would be effective. Several early studies supported that theory. Wallace Wilkin’s critical analysis in 1973, however, demonstrated that those studies supporting the placebo



effect theory had not used suitable experimental controls. Studies in which effective experimental controls were used did not support the placebo effect.

Psychologists now understand that the creation of an expectation to benefit from therapy is one of the common factors associated with a positive therapeutic outcome. All approaches to psychotherapy strive to create hope and a more positive outlook on life by stimulating an expectancy to benefit from therapy. While advocates of the placebo hypothesis thought that expectancy effects accounted for all of the gain from therapy, psychologists now estimate that 15% of the gain from therapy is due to expectancy effects.

### **Therapist Behavior**

Another line of research investigated the types of behaviors students expected from counselors. In general, students expected their counselors to maintain confidentiality and to be thoroughly prepared for the interview, at ease with them, and skilled at dealing with their problems. Consistent gender differences in expectancies were observed. Males expected a more directive, critical, and analytical counselor; females expected a more nonjudgmental, permissive listener. However, both men and women preferred that the therapist offer advice.

### **Measuring Expectations**

Prior to the 1980s, investigators constructed their own questionnaires to measure expectations about counseling. This resulted in numerous problems. Each study focused on a single or very limited range of expectancies and often a single item was used to measure expectancies. The single-item and multiple-item scales that were used lacked reliability and validity. Many of the instruments did not distinguish clearly and accurately between expectations, preferences, and perceptions, and many instruments defined expectations inaccurately. Systematic programs of research were lacking. These practices yielded idiosyncratic findings and interfered with the development of a coherent understanding of expectancy effects.

### **Expectations, Preferences, and Perceptions**

Distinguishing among expectations, preferences, and perceptions is critically important because research reveals differences among them. Expectations are subjectively held probability statements that

represent the person's estimate of the likelihood that an event will occur (e.g., the counselor will understand my problem) or a condition will exist (e.g., the therapist will seem trustworthy). Expectations refer to the future, and they can exist in the absence of direct experience with the event or condition. Some investigators have used *anticipations* as a synonym for *expectations*, but that term is most commonly used in studies of serial anticipation learning. *Expectations* is the term that is more commonly used throughout psychology, and particularly in studies examining issues pertaining to counseling and psychotherapy.

*Preferences* refer to the strength of the person's desire that an event will occur or a condition will exist. Preferences can be stated in the absence of direct experience with the event or condition. Some investigators have used *hope* as a synonym for *preference*, but hope (i.e., to look forward with desire and reasonable confidence) involves both expectations and preferences. Knowledgeable psychologists avoid the use of *hope* in studies of expectations and preferences.

*Perceptions* refer to the person's comprehension, understanding, or knowledge of an event or the existence of a condition gained by means of direct observation. A perception is a subjective statement of fact. Perceptions refer to events or conditions that occurred in the past or that are ongoing at the present. Perceptions require direct experience with the event or condition.

### **Expectations About Counseling—Brief Form**

The development of the Expectations About Counseling—Brief Form (EAC-B) was an important landmark in psychologists' efforts to investigate the influence of expectations on the counseling process and outcome. The development of a reliable and valid measure of expectations and the clarification of the constructs of expectations, preferences, and perceptions helped to advance the methodological rigor of research on expectations about counseling.

The EAC-B is a 66-item instrument that measures 17 specific expectations and 3 broader expectations factors. The 17 expectations are grouped into five clusters, expectations about: client attitudes and behaviors (Responsibility, Openness, and Motivation), counselor attitudes and behaviors (Acceptance, Confrontation, Genuineness, Directiveness, Empathy, Self-Disclosure, and Nurturance), counselor characteristics (Attractiveness, Expertise, Trustworthiness, and Tolerance), characteristics of the therapy process (Immediacy and



Concreteness), and quality of outcome (Outcome). The three factors measured by the EAC-B are the expectation to make a Personal Commitment, the expectation that the Facilitative Conditions will be present during therapy, and the expectation of Counselor Expertise. Analysis of counseling research in the 1990s revealed that the EAC-B was the sixth most commonly used instrument in published counseling psychology research. The instrument has been translated into Chinese, Dutch, French, Icelandic, Polish, and Spanish and used around the world.

### ***Reliability and Validity of EAC-B***

Numerous studies have documented the internal consistency, test-retest, and parallel forms reliability of the EAC-B and its validity using varied criteria. The factorial validity of the EAC-B has been demonstrated across variations in culture, language, and client or nonclient status. The three-factor structure has emerged from analyses using all of the major variations of the components analysis and factor analysis procedures. The evidence demonstrates unequivocally that the factor structure of the EAC-B is not an artifact of the item format, and that the EAC-B measures constructs that are distinctly independent of related constructs such as career concerns, counseling readiness, ego strength, level of psychosocial development, perceived psychological difficulty, perceptions of counseling, perceptions of counselors, and personality.

Much of the research on expectations has been performed on college and university campuses using typical students. Psychologists have questioned the generalizability of research on students to clients seeking services in university or nonuniversity settings. There is encouraging evidence that the results obtained with nonclient students are generalizable to student and adult clients. Studies comparing students (not in counseling) to student and nonstudent clients indicated that the expectations of the students did not differ from those of either of the client groups, and that the internal structure of the EAC-B was the same for students and adults who were seeking counseling.

### **Importance of Expectations**

The likelihood of mental illness is higher in the 15- to 24-year-old age range than in other age ranges, and suicide is the third leading cause of death in that age range. Nevertheless, a national study by Darrel A. Regier and his associates of more than 20,000

individuals revealed that only 28.5% of those who met the criteria for a mental or addictive disorder received any treatment during that year. Many psychologists believe that negative opinions about mental illness and expectations about psychotherapy are responsible for the underuse of mental health services.

### ***Prevalence of Unrealistic Expectations***

A national survey of practicing therapists conducted in 1993 by Howard E. A. Tinsley revealed that a significant proportion of their clients have unrealistic expectations about counseling. The percentage of therapists reporting that “some, many, or most” of their clients have unrealistically low expectations ranged from 7% for the expectation of counselor expertise to a high of 81% for the expectation to assume responsibility for the success of therapy. The percentage of therapists reporting that “some, many, or most” of their clients have unrealistically high expectations ranged from 19% for the expectation of client openness to a high of 88% for the expectation of counselor directiveness. Adding the percentage of clients that have unrealistically low and high expectations (e.g., 67% + 19% = 86% for client openness) reveals that a sizable majority of clients have unrealistic expectations of counseling. In general, clients tend to underestimate the work they will have to do in counseling and to overestimate the skill of the counselor, a phenomenon that has been described as “magical thinking.”

### ***Consequences of Unrealistic Expectations***

The national survey conducted by Howard E. A. Tinsley and associates revealed that from 36% to 100% of therapists view unrealistically low expectations as detrimental to the counseling process, depending on the specific expectation. Unrealistically high expectations about counseling are viewed as detrimental by 38% to 93% of therapists. Thus, experienced therapists report that a majority of their clients have unrealistic expectations about counseling and that those expectations are detrimental to the therapeutic process.

### **Expectancy Manipulation**

One of the early goals in therapy is to help the client form more realistic expectations about the therapy process, but therapists describe that as difficult to accomplish. The percentage of therapists who view the modification of unrealistic expectations as



moderately difficult ranges from a low of 59% for Facilitative Conditions to a high of 66% for Personal Commitment and Counselor Expertise. Therapists most frequently report that three aspects of Personal Commitment (Attractiveness, Outcome, and Responsibility) and two of the Facilitative Conditions (Nurturance and Trustworthiness) are very difficult to modify.

### **Overview of Expectancy Manipulation Research**

Close to 50 studies have investigated the effectiveness of alternative approaches to modifying expectancies. The individuals studied in this research have included children, counseling center clients, college students, church group members, community mental health center clients, psychiatric outpatients, schizophrenic patients, rehabilitation center clients, and veterans receiving vocational counseling. Investigators have attempted to modify expectancies for the facilitative conditions (e.g., counselor expertness, attractiveness, and trustworthiness), prognosis for therapy, therapist techniques, therapist theoretical orientation, client behaviors and role expectations, and general counseling process and procedures.

In aggregate, these studies investigated six types of interventions. Audiotaped expectancy manipulations generally present research participants with an introduction to therapy in the form of direct instruction or examples of effective and ineffective interviews. Videotaped or motion picture interventions typically provide didactic information for role induction purposes. Verbal instructions usually involve telling participants face-to-face about the nature of therapy, appropriate in-session behavior, and prognostic expectancies. Printed materials typically provide information about the expectancies the investigator is attempting to change. Use of the counseling interview to modify expectancies typically involves administration of an expectancy measure, conducting an intake or initial interview, and then readministering the same expectancy measure. The single study in which a complex intervention was used involved a preparatory psychotherapy class in which written and verbal materials, a film, a group discussion and role-playing exercises were used.

Methodological weaknesses are widespread in this research because investigators violated basic principles of experimental design. They failed to randomly assign participants to the experimental conditions, so

any differences observed after the experimental intervention may be due to initial differences among the groups. Many used a pretest–posttest design in which participants' expectations were measured prior to the manipulation. This alerts participants to the issues under investigation. For example, asking participants whether they expect a therapist to use confrontation sensitizes them to this issue. Furthermore, most of the investigations focused on a single or narrow range of expectancies. Typically, the measures used in this research consisted of single items, lacked demonstrated reliability and validity, used invalid definition of expectations, and confused expectations, preferences, and perceptions. The investigators often failed to evaluate the long-term effects of the expectancy manipulations, to relate expectancy manipulation to any important aspect of the therapeutic process or outcome, or to perform a manipulation check (i.e., to determine whether the manipulation had the desired effect). Finally, when multiple manipulations were performed, they failed to examine the possibility of interactions among the manipulation procedures.

### **Effectiveness of Modification Strategies**

Despite these flaws, three conclusions can be drawn from the literature. First, the use of complicated experimental interventions is unnecessary and unsuccessful. Audiotaped and videotaped interventions are most likely to be successful. Printed materials typically have been ineffective and the effectiveness of verbal interventions is doubtful. Second, there is no evidence that actual experience in counseling is an effective method of changing expectations; the studies that examined this approach were of quite poor quality. This procedure is more costly than a direct experimental intervention and it is unlikely to be more effective. Third, the conditions under which the expectancy manipulation strategies are effective are unclear because each type of intervention frequently failed to produce significant results.

There are theoretical and empirical reasons for viewing expectancies as important to the success of counseling, there is unambiguous evidence that unrealistic expectancies are common and detrimental to the counseling process and outcome, and therapists report that changing expectations is difficult. These suggest that a concerted focus on the efficacy of expectancy manipulation strategies deserves a high priority from psychologists.



## Correlates of Expectations

### *Culture*

Expectations are learned and modified through interactions with the environment. This suggests that the social and cultural milieu in which people develop influences their expectations about counseling. However, three caveats suggest caution when interpreting the research on cross-cultural differences in expectations. First, most theories of counseling and psychotherapy reflect the North American and Western European (i.e., Euro-American) cultural perspectives. These theories define the desirable roles and behaviors of the therapist and client, and consequently the interpretation of research comparing the expectations of persons from different cultural heritages. Second, the rate of cross-cultural interaction is increasing exponentially. The cultural heritage of each generation is different from that of the preceding generation, so research findings obtained only a couple of decades ago may already be dated. Finally, while this issue has enjoyed some research attention, the body of evidence is so sparse that only a very tentative summary can be offered.

In general, Euro-Americans are more skeptical than others about the expertise of the counselor and the likelihood that facilitative conditions will be salient during therapy. They are more pessimistic that the counselor will be able to help them determine what is the matter with them, help them identify particular aspects of their behavior that are relevant to their problems, or help them solve their problems. They have lower expectations that the counselor will explain what is wrong and offer useful suggestions and advice. They think it is less likely that the counselor will understand and help them to better understand and explain their feelings. They also regarded it as less likely that the counselor will give them support, encouragement and reassurance, or praise them when they show improvement.

Individuals raised in Middle Eastern, Islamic, and African cultures are somewhat similar to each other in their expectations of counseling, and more similar to Euro-Americans and individuals raised in a Spanish culture than to Asians. When compared to persons raised in a Euro-American culture, they generally have stronger expectations regarding the likelihood of counselor expertise and facilitative counselor attitudes, behaviors, and techniques such as immediacy and concreteness. In other respects, their expectations differ little from those of Euro-Americans. Too high

an expectation of counselor expertise may represent a form of magical thinking, but the skepticism underlying low expectations for counselor expertise is not a healthy prognostic sign either. Counselors working with clients exhibiting either type of unrealistic expectation typically report that they need to help the client gain a more realistic expectation before progress in counseling is likely.

Asian individuals expect the counselor to remain more disengaged than persons from other cultures. They report stronger expectations that the counselor will be courteous, respect their privacy, and keep their relationship distant and smooth. In general, they expect to be more guarded in revealing important information to the counselor. They expect the counseling process to be less focused on their feelings and problematic behaviors, and they expect to be less personally revealing about those issues. Perhaps as a reflection of this expectation regarding personal revelation, they also have lower expectations that the counselor will genuinely reveal him- or herself.

Asian individuals expect to take less personal responsibility for making decisions, for talking about their concerns during counseling, and for working on their problems outside of counseling. They also have lower expectations to work during the counseling sessions on new behaviors and ways of solving problems. Relatively speaking, they expect the counselor to be less likely to focus on inconsistencies between their feelings and behaviors and between their goals and present behavior, and they are more pessimistic about gaining a better understanding of themselves and improving their relationships with others. Counselors who are not aware of multicultural differences may view the behavior of their Asian clients as indicating an unwillingness to work hard and make a serious commitment to therapy.

Persons from Hispanic cultures have a stronger expectation to take personal responsibility for the success of therapy than Asians (and in some respects stronger than all other groups). They have a stronger expectation to persist in counseling despite the occurrence of painful and unpleasant times. They expect to work on their concerns outside of counseling and to practice new behaviors and new ways of solving their problems during the counseling interviews. They have stronger expectations to take personal responsibility for making decisions during therapy, for gaining a better understanding of themselves and others, and for improving their relationships with others. They report



stronger expectancies to openly discuss their emotions and problems during counseling and to work with the counselor to better understand their feelings and discover aspects of their behavior that contribute to their problems. They expect to face up to inconsistencies in their thoughts and actions and inconsistencies between their goals and behaviors.

### **Developmental Level**

Erik Erikson theorized that life-span development progresses through a series of psychosocial stages characterized by developmental tasks. Completion of these tasks provides the individual with new methods of coping with the environment, new ways of viewing the world, and advancement to the next stage.

Expectations about counseling vary as a function of the development of mature educational plans, career plans, and lifestyle plans. The development of mature educational plans is associated with uniformly more positive expectations about counseling. The development of mature career and lifestyle plans is associated with a more varied pattern of change in expectations. Psychologists modify their counseling styles to communicate effectively with persons at different levels of psychosocial development.

Individuals' expectations about their own attitudes and behaviors during counseling are unrelated to their level of psychosocial development. However, their expectations of the counselor, the counseling process, and the outcome of therapy become more positive as they gain in psychosocial maturity. For example, expectations about the facilitative conditions become more favorable as psychosocial maturity increases. Developmentally less mature students are more skeptical that these conditions will exist, and they may be less likely to perceive the level of facilitative conditions that exist within the actual counseling relationship. Developmentally less mature students are also less likely to understand the necessity of working hard in counseling and of taking responsibility for the success of counseling. One early goal of therapists working with less developmentally mature students is to help them develop a sense of personal responsibility for the success of counseling.

### **Research Directions**

This entry highlighted numerous weaknesses in the research on expectations about counseling, including

the frequent use of instruments having no demonstrated reliability or validity and the lack of programmatic research. This entry also identified areas needing research attention. Perhaps the most significant oversight, however, is the lack of research on the effects of expectations about counseling on the counseling process, counseling outcome, and premature termination.

It is reasonable to think that clients' expectations will have an important effect on their behavior during therapy, at least during the first few sessions. The quality of the counseling relationship is critical to the success of counseling, regardless of the theoretical orientation and specific approach of the psychologist. Despite this, investigations of the counseling process have largely ignored client expectations.

One investigation of the relation of client's expectations to their level of involvement during career counseling hints of the importance of this issue. Clients having relatively high expectations of personal commitment and facilitative conditions were paired with clients having relatively low expectations on those factors. Both clients in a pair received services from the same therapist, and audiotapes of the first interview were rated to obtain measures of the client's level of involvement in therapy.

The clients with more positive expectations participated at a higher level of involvement during the initial interview. They were more willing to talk about themselves rather than people in general, more likely to become emotionally involved, and more likely to report personal reactions and to describe their feelings. In contrast, the clients who had relatively negative expectations of counseling talked about external events and limited themselves to descriptions of behaviors and intellectualized self-descriptions. They never departed from this guardedness during the initial interview.

These findings only hint at the importance of this line of research. Numerous studies have found that a high level of involvement is positively related to counseling outcome. Research that examines the relation of expectations to aspects of the counseling process and outcome has great potential to significantly advance knowledge of the therapy process.

*Howard E. A. Tinsley*

*See also* Client Attitudes and Behaviors (v2); Common Factors Model (v2); Counseling Process/Outcome (v2); Cultural Values (v3); Culture (v3); Facilitative Conditions



(v2); Gelso, Charles J. (v2); Outcomes of Counseling and Psychotherapy (v2); Tinsley, Howard E. A. (v4); Wampold, Bruce E. (v2); Working Alliance (v2)

### Further Readings

- Gonzalez, J. M., Tinsley, H. E. A., & Krueger, K. R. (2002). Effects of psychosocial interventions on opinions of mental illness, attitudes toward help seeking, and expectations about psychotherapy in college students. *Journal of College Student Development, 43*, 51–63.
- Hayes, T. J., & Tinsley, H. E. A. (1989). Identification of the latent dimensions underlying instruments measuring perceptions of and expectations about counseling. *Journal of Counseling Psychology, 36*, 492–500.
- Kunkel, M. A., Hector, M. A., Coronado, E. G., & Vales, V. C. (1989). Expectations about counseling in Yucatan, Mexico: Toward a “Mexican psychology.” *Journal of Counseling Psychology, 36*, 322–330.
- Reiger, D. A., Narrow, W. E., Rae, D. S., Manderscheid, R. W., Locke, B. Z., & Goodwin, F. K. (1993). The de facto U.S. mental and addictive disorders service system: Epidemiologic catchment area prospective one-year prevalence rates of disorders and services. *Archives of General Psychiatry, 50*(2), 85–94.
- Tinsley, D. J., Hinson, J. A., Holt, M. S., & Tinsley, H. E. A. (1990). Level of psychosocial development, perceived level of psychological difficulty, counseling readiness, and expectations about counseling: Examination of group differences. *Journal of Counseling Psychology, 37*, 143–148.
- Tinsley, H. E. A. (1980). *Expectations About Counseling—Brief form*. Mukilteo, WA: Author.
- Tinsley, H. E. A. (1980). *Manual for the Expectations About Counseling*. Mukilteo, WA: Author.
- Tinsley, H. E. A., Barich, A. W., & Bowman, S. L. (1994). Unrealistic expectations about counseling and psychotherapy: Counseling psychologists’ perceptions of their effects and modification. *Guidance and Counselling, 9*, 20–24.
- Tinsley, H. E. A., Bowman, S. L., & Barich, A. W. (1993). Counseling psychologists’ perceptions of the occurrence and effects of unrealistic expectations about counseling and psychotherapy among their clients. *Journal of Counseling Psychology, 40*, 46–52.
- Tinsley, H. E. A., Bowman, S. L., & Ray, S. B. (1988). Manipulation of expectancies about counseling and psychotherapy: A review and analysis of expectancy manipulation strategies and results. *Journal of Counseling Psychology, 35*, 99–108.
- Tinsley, H. E. A., Tokar, D. M., & Helwig, S. E. (1994). Client expectations about counseling and involvement during career counseling. *Career Development Quarterly, 42*, 326–336.
- Tinsley, H. E. A., & Westcot, A. M. (1990). Analysis of the cognitions stimulated by the items on the Expectations About Counseling—Brief Form: An analysis of construct validity. *Journal of Counseling Psychology, 37*, 223–226.
- Wampold, B. E. (2001). *The great psychotherapy debate: Models, methods, and findings*. Hillsdale, NJ: Lawrence Erlbaum.









---

## FACILITATIVE CONDITIONS

---

Facilitative conditions are those conditions or counselor attitudes that enhance the therapeutic relationship and are conducive to successful outcomes in counseling and psychotherapy. The three primary facilitative conditions were first suggested by Carl R. Rogers in his 1951 publication on the *person-centered* counseling approach. These conditions are *unconditional positive regard*, *genuineness*, and *empathy*. According to Rogers, if counselors express these core conditions, those being helped will become less defensive and more open to themselves and their world, and will tend to behave in more prosocial and constructive ways. Rogers believed that these three conditions were both necessary and sufficient for positive outcomes in the counseling process. Other theorists have argued that although these conditions may be necessary, they are not sufficient for positive therapeutic outcomes. Current discussions of common factors related to positive therapeutic outcome identify the *therapeutic relationship* as essential to client progress. The facilitative conditions are key to the establishment of a positive therapeutic relationship.

### Unconditional Positive Regard

Unconditional positive regard is the therapist's unqualified attitude of acceptance and a nonpossessive caring toward the client and toward the client's feelings and experiences. This involves a valuing of the client as a worthy human being regardless of his or her past choices, problems, or issues and a warm acceptance of

each aspect of the client's present experience as it unfolds in the here-and-now of the counseling context. The client's thoughts, feelings, and behaviors are not evaluated by the counselor as good or bad. This facilitative condition, in which clients are unconditionally accepted, provides clients with a therapeutic context in which they are given the freedom to be themselves and experience their own being, thoughts, and feelings without any outside conditions or demands. This freedom gives the clients a safe, accepting context in which to express and explore the many deeper hidden dimensions of themselves and the freedom to self-reflect and consider new choices and options.

Having unconditional positive regard for the client does not mean condoning all the client's actions. For example, a counselor working with a mass murderer would have unconditional positive regard for the client. The counselor would have an acceptance of the anger the client is expressing at being charged with murder. The counselor does not necessarily agree with the client's choice to have committed murder, but does have unconditional positive regard for the client as a person and the client's experience of the emotion of anger. The counselor accepts the client as a fellow human and values the client as such, regardless of the client's choices. A second example is a counselor working with a person who has issues surrounding addiction. The counselor would have unconditional positive regard for the client and his or her experience of addiction. The counselor's liking the client would not be conditionally based on the client's stopping use of drugs or alcohol. The counselor would value the client as another person. However, Rogers understood that not all counselors could have unconditional



positive regard for all clients. In these instances, referral to another counselor is the best option.

### Genuineness

Genuineness, which has also been called *congruence*, *realness*, and *transparency*, is the state or condition in which the counselors are themselves in the context of the counseling relationship. Rather than adopting the role of expert or a facade of detached objectivity, the counselors openly and honestly express themselves as “real” and “transparent” people to the client. In this congruent state, the counselors are aware of their own feelings and reactions to what is happening in the present (here-and-now), aware of their attitudes toward the client, and able to honestly express their awareness to the client, as appropriate.

There is a close match or congruence between the internal experience of the counselor and what is outwardly expressed to the client. The facilitative condition of genuineness enhances the sense of realness, immediacy, and openness in the therapeutic relationship and creates a context of safety and sharing. It diminishes the sense of professional distance between the counselor and client. The counselor’s self-awareness, honesty, and openness about moment-to-moment feelings and attitudes provide a model for the client’s own therapeutic work and life. In the case of a client discussing the death of a parent with little or no emotion, an example of counselor genuineness would be the counselors saying to the client, “I’m feeling a great sense of sadness about the death of your father.” At this point, most clients would then respond in some way regarding the father’s death and their previously unexpressed sadness. In the case of a client who expresses a desire to attend college yet continually takes actions that sabotage this goal—even after promising the counselor to change some of the sabotaging behaviors—the counselor might say, “I am feeling frustrated with how you say you want to go to college on the one hand, and on the other you make some choices that damage your chances of going to college. I wonder if on some level you’re not sure you want to go to college.”

### Empathy

Empathy or empathic understanding involves a deep, accurate awareness of the client’s emotional and cognitive world. It is the ability of the counselor to see

deeply into the subjective experience of the client and to sense the client’s private world. Empathy is an active and ongoing understanding and reflection of feeling and meaning that occurs in the here and now of the therapeutic session. This includes the ability of the counselor to sense the clients’ moment-to-moment feelings and understand the clients’ worldviews, structures of meaning, and interpretations of events. Furthermore, the counselor is able to effectively and accurately communicate this understanding to the clients in a way that clarifies the clients’ comprehension of their own experiences. The facilitative condition of empathy allows clients to feel understood, acknowledged, and accepted in a way that can greatly enhance the therapeutic relationship and allow for a deepening of therapeutic insight. Advanced empathy is a state where the counselor is so deeply aware of the client’s world and emotions that the counselor is aware of things that the client has yet to become aware of in that world. For example, in the case of a person going through divorce, the client may be angry with his spouse. The empathic counselor acknowledges the client’s obvious anger at his wife, but with advanced empathy senses the client’s underlying anger at himself for how he contributed to the breakup of the marriage.

*Jeanmarie Keim and Matthew Dahlsten*

**See also** Common Factors Model (v2); Counseling Process/Outcome (v2); Humanistic Approaches (v2); Outcomes of Counseling and Psychotherapy (v2); Relationships With Clients (v2); Rogers, Carl R. (v2); Therapist Techniques/Behaviors (v2); Therapy Process, Individual (v2); Working Alliance (v2)

### Further Readings

- Bozarth, J. D., Zimring, F. M., & Tausch, R. (2002). Research in client-centered therapy: The evolution of a revolution. In D. J. Cain & J. Seeman (Eds.), *Humanistic psychotherapies: Handbook of research and practice* (pp. 147–188). Washington, DC: American Psychological Association.
- Greenberg, L. S., Rice, L. N., & Elliott, R. (1996). *Facilitating emotional change: The moment-by-moment process*. New York: Guilford Press.
- Rogers, C. (1951). *Client-centered therapy*. Boston: Houghton Mifflin.
- Rogers, C. (1957). The necessary and sufficient conditions of therapeutic personality change. *Journal of Consulting Psychology*, 21, 95–103.



- Rogers, C. (1977). *Carl Rogers on personal power: Inner strength and its revolutionary impact*. New York: Delacorte Press.
- Watson, J. C., Goldman, R. N., & Warner, M. S. (2002). *Client-centered and experiential psychotherapy in the 21st century: Advances in theory, research and practice*. Herefordshire, UK: PCCS Books.

---

## FALSE MEMORIES

---

False memory refers to the phenomenon of “remembering” something that never actually occurred. False memories can be small, such as mistaken details of an event, or they can consist of whole events that never actually happened. People experiencing a false memory generally believe the memory to be true, and often experience sensory detail and emotions, just like with real memories.

### How Memory Works

#### *Not All Memories Are Created Equal*

Memory is not perfect. It does not record like a tape recorder or video camera. Instead, people tend to store bits of information from their experiences. These portions of memory are susceptible to distortion because memory is a reconstructive process. People tend to create memories from the various bits of stored information in their brain each time they remember something. In the process, details are sometimes changed or chunks of new material added.

Another reason for imperfect memory is that people tend to store the gist of events in their memories instead of the details. Not all events that people experience end up being stored as long-term memories. Many aspects of daily life go unnoticed or are quickly forgotten. For example, people fail miserably when asked to describe a U.S. penny because details, such as the way Abraham Lincoln is facing and the location of the date on the penny, simply aren't important enough to be remembered.

Time is also important to people's ability to recall information. Memories fade as time passes and become more prone to distortion. Also, the phenomenon of *infantile amnesia* makes it difficult for people to remember events from when they were very young.

Adults generally cannot remember events that occurred before age 2, even if the events were very important or traumatic.

### *Distortion in Memory*

How does memory distortion occur? One important influence on memory is called a *schema*. Schemas are ways of organizing knowledge into predictable patterns or expectations. For example, people have schemas about how certain types of people are expected to behave (stereotypes) and about how events are supposed to happen (such as how to behave in a restaurant). By providing a “script” for how events are supposed to unfold, schemas act as energy savers that allow the mind to take shortcuts when processing information.

Usually these shortcuts work well, but sometimes they mislead memory. For example, when people are presented with a list of words that include *bed*, *rest*, and *dream*, but not the word *sleep*, and they are asked to recall all the presented words, people often falsely report the word *sleep* as being part of the list. This occurs because the list of words forms a script that is highly consistent with sleep. Because people's memories are influenced by schemas, they sometimes “remember” things that are consistent with the script for an event, even though those events did not occur.

False memories also occur when people make mistakes about the source of certain information. For instance, someone could mistakenly recall an event happening to him or her when in reality the person merely dreamed or imagined it. *Source monitoring errors* occur when information is recalled correctly, but the source is not.

Psychologists previously believed that certain highly emotional memories of great personal importance—*flashbulb memories*—were impervious to distortion or forgetting. However, even these memories are prone to distortion. In one psychological investigation, people were asked the day after the *Challenger* explosion in 1986 to write an account of how they had first learned about the event. Three years later, these same people were asked to describe again how they had learned about the tragedy. A surprising amount of memory distortion was present in these recollections, even for those people who reported intense emotional reactions to the event. In fact, 25% of the participants had completely false memories of learning about the explosion. No one



recalled the incident without some distortion of facts, and only 7% recalled the episode with close to perfect accuracy. When shown their earlier written accounts, those individuals with false memories expressed surprise at the discrepancies and remained unable to remember the true details of the event.

### **How to Create False Memories**

False memories for events can occur naturally, as in the *Challenger* study, or they can be created through the actions of another person. One way that false memories can be created is through a phenomenon called the *misinformation effect*. This occurs when a person is given misleading information about an event which they subsequently incorporate into memory. In one experiment, participants watched a slide show of a car accident involving either a stop sign or a yield sign. They were then asked questions containing information about the sign that was either consistent or inconsistent with what they had actually seen (for example, “Did another car pass the red Datsun when it was parked at the stop sign?”). When shown two slides of the accident and asked to choose which they had seen, 75% of those who had been asked questions containing consistent information about the sign chose the correct slide. After misleading questions, they were correct only 41% of the time. Since they could have guessed correctly 50% of the time, this indicates the strong influence misinformation can have on memory.

Suggestive and leading questions can also distort memory reports. A question like “How fast were the cars going when they smashed into each other?” can lead accident witnesses to recall a higher speed than the same question asked with *hit* substituted for *smashed into*. Multiple leading questions can be particularly dangerous.

Although these methods are used by researchers to deliberately create memory distortion in participants, similar influences exist in the real world. For example, one witness may inadvertently give another witness incorrect information about a crime. The second witness may then come to mistakenly remember this information as being true. Also, research and recent cases of wrongful conviction have shown that suspects can be led to falsely confess to crimes they did not commit when subjected to certain interrogation practices. Police routinely provide misinformation to suspects during interrogation, which in some rare

cases may cause the suspect to create false memories of committing a crime.

## **False Memories in Clinical Settings**

### **Therapeutic Techniques**

Some practices in clinical settings may enhance the likelihood of developing false memories. Attempts to recall “repressed” memories can be particularly dangerous. *Repressed memories* refer to memories that a person has suppressed out of conscious awareness, but that are thought to exist still whole and unchanged deep in the mind. There is little empirical support for the notion of repressed memories. Instead, research demonstrates that techniques used to aid recall of memory can create false memories. Techniques that encourage the client to imagine how events might have occurred, or rely on dream interpretation, are particularly prone to source-monitoring errors. Hypnosis and the use of “truth serum” drugs, such as sodium amytal, also place clients in suggestive states in which they are susceptible to memory distortion.

### **Legal Implications**

False memories can have harmful consequences for patients, family members, and clinicians. Delayed discovery laws in some states allow a person with “recovered” memories of abuse to bring charges against his or her alleged abuser years after the normal statute of limitations has ended. If these memories are false, these legal proceedings can result in lawsuits or criminal convictions against an innocent person. Clients who recover memories in therapy and later reject those memories as false sometimes sue the therapist for malpractice. In the case of *Burgis v. Braun* (1997), a woman and her two children developed memories of belonging to a satanic cult, where among other things they were forced to eat thousands of babies. No evidence ever arose to support these outlandish claims. Eventually, the family sued, and was awarded a \$10 million settlement.

### **Avoiding False Memories**

Serious false memories of the kind described above are rare, and reputable clinicians take steps to reduce their occurrence. They avoid suggestive questions and therapeutic techniques, in favor of open-ended and



balanced discussions and activities. Warning people of the possibility of false memories and asking them to focus on the source of information has been shown to reduce the rate of memory distortion. One way to minimize the likelihood of false memories is to be aware that they exist, and to understand what factors aid memory accuracy and what may make memory susceptible to distortion.

*Suzanne O. Kaasa and Elizabeth F. Loftus*

*See also* Code of Ethics and Standards of Practice (v2); Constructivist Theory (v2); Memory, Assessment of (v2)

### Further Readings

- Brainerd, C. J., & Reyna, V. F. (2005). *The science of false memory*. New York: Oxford University Press.
- Loftus, E. F. (2003). Make-believe memories. *American Psychologist*, 58, 864–873.
- Loftus, E. F. (2005). A 30-year investigation of the malleability of memory. *Learning and Memory*, 12, 361–366.
- Loftus, E., & Ketcham, K. (1994). *The myth of repressed memory*. New York: St. Martin's Press.
- Loftus, E. F., Miller, D. G., & Burns, H. J. (1978). Semantic integration of verbal information into a visual memory. *Journal of Experimental Psychology: Human Learning and Memory*, 4, 19–31.
- Loftus, E. F., & Palmer, J. C. (1974). Reconstruction of automobile destruction: An example of the interaction between language and memory. *Journal of Verbal Learning and Verbal Behavior*, 13, 585–589.
- Neisser, U., & Harsch, N. (1992). Phantom flashbulbs: False recollections of hearing the news about *Challenger*. In E. Winograd & U. Neisser (Eds.), *Affect and accuracy in recall: Studies of "flashbulb" memories* (Emory Symposia in Cognition, pp. 9–31). New York: Cambridge University Press.
- Nickerson, R. S., & Adams, M. J. (1979). Long-term memory for a common object. *Cognitive Psychology*, 11, 287–307.
- Roediger, H. L., & McDermott, K. B. (1995). Creating false memories: Remembering words not presented in lists. *Journal of Experimental Psychology: Learning, Memory, and Cognition*, 21, 803–814.

---

## FORGIVENESS

---

Forgiveness occurs in an interpersonal context, as a response to the intentional harm caused by another.

When one individual insults another, reveals confidential or embarrassing knowledge, harms another or another's valued property, or is unfaithful to a committed partner, then the victim rightly feels that a moral transgression has occurred. One may seek justice to repair the harm or not, but the immediate cognitive, emotional, and behavioral responses are likely to be condemnatory, angry, and retaliatory. The long-term effects of the harm may involve angry rumination, chronic negative feelings, and obsessive thoughts of revenge. These long-term effects may lead individuals to seek alternative coping responses, either on their own or with therapeutic intervention. Forgiveness represents an alternative response that leads to more positive thoughts, feelings, and actions, while reducing anger, anxiety, and depression.

### The Definition of Forgiveness

Forgiveness is often defined by exclusion. Forgiveness does not involve condoning an offender's behavior, nor does it imply that the offense is forgotten. One may seek to understand the offender and the reasons behind his or her behavior in order to achieve some cognitive resolution. To the extent that the behavior can be excused, due to inexperience or extenuating circumstances, then forgiveness is not relevant. Finally, forgiveness does not necessarily imply reconciliation.

There is no consensually agreed-upon definition of forgiveness, but there is some common ground for forming an understanding of the concept. Forgiveness is an intrapersonal phenomenon, occurring within the individual, but taking place within an interpersonal context. It involves letting go of negative thoughts, feelings, and behaviors, and their gradual replacement by more charitable ones. Forgiveness of another involves the transformation of oneself, challenging one's assumptions about the world and others, and coming to terms with reality.

### Types of Forgiveness

There are two primary ways of thinking about forgiveness: as a state and as a trait. State forgiveness is defined as the degree of positive thoughts, feelings, and intentions toward an offender, in regard to a specific instance of interpersonal conflict. Several self-report questionnaires have been developed to measure state forgiveness; individuals describe a time when they were betrayed or hurt and answer questions about



their current feelings, thoughts, and intentions toward the offender. These instruments show that the context surrounding the event plays a role in the likelihood of forgiveness. If the offender shows remorse, apologizes, and/or tries to make amends, then forgiveness is more likely. Similarly, forgiveness decreases with the severity of the event and increases with the closeness of relationship between the offender and the individual. Using these instruments, one can assess the current experience of forgiveness in relation to a specific context and measure changes over time.

The second way of conceptualizing forgiveness is as a relatively stable characteristic, that is, an individual or personality trait. Warren H. Jones and his colleagues have developed the Forgiving Personality Inventory that assesses forgiveness as a personality trait, operative across a variety of contexts. Forgiving individuals value forgiveness, have a higher threshold for perceiving offenses, and are less willing to endure the separation from relationship partners that follows from a lack of forgiveness. Ryan P. Brown has developed a measure to assess the Tendency to Forgive. He found that highly forgiving individuals recall fewer offenses and get over their conflict experiences more quickly. Kathleen A. Lawler-Row has studied the forgiving personality in adults across the age range. Highly forgiving adults have better conflict management skills; they express less anger outwardly, but are more likely to calmly confront an offender, discuss the conflict, and come to an acceptable resolution. These measures of trait forgiveness are used to determine individual differences in forgiveness and their relationship to other variables, such as age, gender, or religious commitment.

### **The Case for Forgiveness: Psychological Well-Being**

The rationale for the development of forgiveness, either as a personality characteristic or as a response to a specific event, rests on its relationship to psychological well-being and beneficial character traits. Trait forgiveness has been positively related to empathy, relationship satisfaction, and self-esteem. In addition, the tendency to forgive has been related to lower levels of anxiety, depression, hostility, rumination, narcissism, passive-aggressive behavior, and neuroticism. Thus, forgiveness has clear psychological benefits for the forgiver, even when the offender is not in a position to alter his or her behavior or to make amends.

Forgiveness has been shown to increase with age and vary with gender. Women have higher scores on trait forgiveness, while men have higher scores on state forgiveness. Among older adults, trait forgiveness is associated with several dimensions of successful aging: positive relations with others, self-acceptance, environmental mastery, purpose in life, personal growth, and autonomy. In addition, forgiveness is positively correlated with healthy behaviors, social support, and religious, existential, and subjective well-being.

### **The Case for Forgiveness: Physical Well-Being**

Forgiveness has also been shown to have physical health benefits. Highly forgiving adults have lower resting blood pressure, while state forgiveness has been associated with decreased magnitude and duration of physiological stress responses. In addition, both state and trait forgiveness have been correlated with fewer physical symptoms of illness, lower rates of smoking, and fewer medications. Statistical models indicated that these associations between forgiveness and health are mediated by existential well-being, conflict management, stress, and negative affect. Highly forgiving individuals have higher levels of existential well-being, or purpose in life, and better conflict resolution skills. People who forgive also experience less stress and less negative affect, particularly less anger, depression, and tension. When these factors are taken into account, the relationship between forgiveness and health is reduced.

### **Interventions to Help Clients Forgive**

Given the positive associations between forgiveness and psychological well-being, several interventions for helping clients forgive have been developed. Robert D. Enright was the first to study forgiveness from a therapeutic perspective; he developed a process model for increasing forgiveness and decreasing negative affect, particularly excessive anger. This model employs four phases: uncovering, decision, work, and deepening. In the *uncovering* phase, clients explore their anger and the effects it has on their lives. During the *decision* phase, clients explore their current coping strategies and consider forgiveness as an option. In the *work* phase, reframing, developing empathy, bearing the pain, and giving a moral gift are considered. Within the *deepening*



phase, clients focus on finding meaning, examining their worldview, and finding a new purpose. This model has been successfully employed with a range of client populations, and guidelines have been prescribed for applying the model to clients with depression, anxiety, substance abuse, and eating and personality disorders.

### Forgiveness in Families

Numerous events within families necessitate forgiveness. Families that report forgiveness report better individual mental health and better family functioning. Parental socialization is a significant factor in teaching forgiveness, and individuals with secure attachment styles show greater levels of forgiveness. Thus, forgiveness can be thought of as both a moral value and a coping skill that is learned through example and specific training within the family. As the family is the source of many of the offenses that one experiences growing up, this method of conflict resolution can have an impact on both the quality of family life and individual, subjective well-being.

Various interventions have explored the role of forgiveness in marriage, showing that forgiveness is related to relationship satisfaction, intimacy, and lower levels of conflict. Kristina Coop Gordon and colleagues have developed a trauma-based, cognitive-behavioral therapy for couples that have experienced a significant betrayal. The *impact* stage focuses on emotional regulation, the *meaning* stage adds insight therapy to promote greater understanding of the partner, and the *moving on* stage assesses the viability of the relationship and the couple's commitment to work toward change. Assessment of these couples shows both improved forgiveness and dyadic functioning.

### The Future of Forgiveness

Research has focused on forgiveness of others and its effects on the forgiver. Future work will seek to examine the effects of forgiveness on the forgiven and the effects of self-forgiveness. The natural history of forgiveness within the context of real-life events will be important to address the issue of whether forgiveness is always beneficial. False forgiveness, or forgiveness offered without having traversed the difficult path of arriving at genuine forgiveness, is critical to understand in developing effective forgiveness

interventions and in determining the long-term effects of forgiveness.

Kathleen A. Lawler-Row

*See also* Couple and Marital Counseling (v1); Family Counseling (v1); Happiness/Hardiness (v2); Hope (v2); Physical Health (v2); Positive Psychology (v2); Psychological Well-Being, Dimensions of (v2); Spirituality/Religion (v2)

### Further Readings

- Baskin, T. W., & Enright, R. D. (2004). Intervention studies of forgiveness: A meta-analysis. *Journal of Counseling and Development*, 82, 79–90.
- Enright, R. D., & Fitzgibbons, R. P. (2000). *Helping clients forgive*. Washington, DC: American Psychiatric Association.
- Enright, R. D., & North, J. (1998). *Exploring forgiveness*. Madison: University of Wisconsin Press.
- Lawler, K. A., Younger, J. W., Piferi, R. L., Jobe, R. L., Edmondson, K. A., & Jones, W. H. (2005). The unique effects of forgiveness on health: An exploration of pathways. *Journal of Behavioral Medicine*, 28, 157–167.
- McCullough, M. E. (2001). Forgiveness: Who does it and how do they do it? *Current Directions*, 10, 194–197.
- McCullough, M. E., Pargament, K. I., & Thoresen, C. E. (Eds.). (2000). *Forgiveness: Theory, research and practice*. New York: Guilford Press.
- Worthington, E. L., Jr. (2005). *Handbook of forgiveness*. New York: Routledge.

---

## FREE ASSOCIATION

---

*Free association* is an inadequate translation into English of the German term *freier Einfall* (meaning “free irruption”), which Sigmund Freud used to characterize ideas that irrupt into consciousness. Freud first described this irruption when he was investigating the causes of symptoms, parapraxes (slips of the tongue), and dreams. As a precondition of analyzing these phenomena, Freud required his patients to attend to what was being analyzed while at the same time suspending their judgment and reporting everything that came to mind. Seemingly irrelevant ideas then often forced themselves into consciousness. The candor required of the patient constituted the fundamental rule of psychoanalysis, and the patient's



reporting what came to mind was the method of free association.

The thoughts and associations reported by the patient were not complete, continuous, or orderly, and Freud assumed that the gaps pointed to unconscious psychological processes that, when discovered, could be interpolated into and complete the trains of thought that would lead to the source of the patient's conflict. Freud claimed natural science status for psychoanalysis because the interpolated unconscious processes were logically identical to the unobservable physical processes postulated in chemistry and physics.

Freud assumed that the determinants of trains of association were internal and relatively unaffected by influences external to the thinker, including unconscious suggestion from the particular analyst. Free association should, therefore, contribute to the clinical goal of building a picture of the patient's past that was essentially complete and corresponded to the patient's real history. Freud made explicit claims for the reliability and validity of the method; differences in orientation among analysts contributed only in a minor way to what patients reported and would not distort the overall picture. Suggestion from therapist to patient could be disregarded altogether.

Whether they related to a single element of a dream or symptom, a whole train of thought, or some complex aspect of a patient's history, associations had to be interpreted by the analyst. Freud set out no rules by which interpretation could be guided or judged. Nevertheless, it is clear that he valued the internal consistency of his interpretations. It was important to Freud that the elements of his interpretations were related to the phenomenon being analyzed in a coherent manner. He placed a higher value on this consistency than on the correspondence of the interpretation with the patient's past experiences.

The absence of specific guidelines for the interpretation of free associations suggests interpretations could easily be influenced by the analyst's theoretical perspectives. It is known that in clinical situations resembling psychoanalysis, patients produce material consistent with the theoretical beliefs and expectations of their therapists. Beginning in the mid-1920s with the separation of Freud and Otto Rank, and continuing through the 1960s, numerous "schools" of psychoanalysis developed, each strongly influenced by its founder's perspectives and supported by different kinds of free associations and largely incompatible interpretations.

These differences point to two fundamental problems: the low reliability and validity of free association, and the basic indeterminacy of interpretation. It is clear that associations are not as free of external influence as Freud believed. Nevertheless, very few analysts have questioned the reliability or validity of free association or raised the problem of the indeterminacy of interpretation. It is also clear that the clinical situation is a very difficult arena from which to gather data that leads to good theories about patients and clients.

*Malcolm Macmillan*

*See also* Freud, Sigmund (v2); Narrative Therapy (v2); Personality Theories, Psychodynamic (v2); Projective Techniques (v2); Psychoanalysis and Psychodynamic Approaches to Therapy (v2); Therapist Interpretation (v2)

### Further Readings

- Macmillan, M. (1997). *Freud evaluated: The completed arc*. Cambridge: MIT Press.
- Macmillan, M. (2003). Challenges to psychoanalytic methodology. In M. C. Chung & C. Feltham (Eds.), *Psychoanalytic knowledge and the nature of mind* (pp. 219–238). London: Palgrave.
- Macmillan, M., & Swales, P. J. (2003). Observations from the refuse-heap: Freud, Michelangelo's *Moses*, and psychoanalysis. *American Imago*, 60, 41–104.

---

## FREUD, SIGMUND (1856–1939)

---

Sigmund Freud wanted to show the importance of a force outside of everyday experiencing that we cannot know directly which governs our actions—the unconscious part of the mind. According to Freud, the *unconscious* is the source of wishes arising in childhood that are socially reprehensible and blocked from consciousness. We can only be certain of the unconscious because wishes regarding intimacy with caregivers that emerge in the preschool years attempt partial satisfaction, disguised as slips of the tongue or dreams. Freud relied both on the force of his argument as a distinguished scientist and on his autobiography in demonstrating that there is an unconscious. If he had used reports by his clients, his theory might have been dismissed as the accounts of troubled persons. Further, considerations of confidentiality limited the



detail he could provide from his clients' accounts. For this reason, to understand his theory it is particularly relevant to know about Freud's history.

Sigismund Freud, as he was called in his youth, was born in the Austrian Empire, in what is now the Czech Republic. He was the firstborn son of Amalia Nathansohn, a woman 20 years younger than her husband, and Jacob Freud, an impoverished wool merchant who had two grown sons, Emmanuel and Philipp.

### Early Developmental Influences

Emmanuel had two children, John and Pauline, who were close to Freud's age. In a 1899 paper on *screen memories* (i.e., memories of early life experiences that presumably are a cover for even earlier psychologically significant memories that are censored from awareness because they are more painful), Freud described an incident in which he and John, rivals for Pauline's attentions, snatched away the bunch of yellow flowers Pauline was picking in a mountain meadow. He connected this incident with the early awakening of his sexuality. (Freud reports that a yellow flower was the only one that he had difficulty identifying on his medical school examination, an instance of a "neurotic inefficiency.")

Freud's parents had eight children. Freud's next youngest brother, Julius, and his mother's brother Julius both died as young Freud approached his second birthday. His mother was emotionally preoccupied with mourning her losses and transferred Freud's care to a succession of governesses. When Freud was 2½ years old and still acutely suffering the loss of his mother's emotional support, he lost this favorite governess, who was arrested for petty theft. When Freud was 4, his father decided to move the family to Vienna. Biographer Peter Gay recounted that years later, while in the midst of his self-analysis following his father's death, Freud recalled that he had shared a bedroom on the train with his mother and saw her naked while preparing for bed. The wish stimulated by this encounter, together with the social prohibitions against awareness of this wish, led Freud to experience anxiety which was displaced onto train travel, and this accounts for Freud's lifelong phobia of train travel.

It is striking how much these early childhood experiences shaped Freud's writing and clinical technique. Mothers are almost always missing from Freud's most well-known case studies. Further, Freud insisted that personality development does not begin until sometime

between ages 3 and 5. At this age the little boy experiences rivalry with his father for the attention of his mother, and the little girl experiences rivalry with her mother for her father's attention. Freud devoted little study to the quality of the very young child's tie to his or her mother.

After World War II psychoanalysis followed developmental psychology into the detailed study of the child's attachment and the course of the mother-child relationship. At this point Freud's daughter Anna, the "gatekeeper" of psychoanalysis following her father's death, observed that her father's theory emphasized problems arising from conflicting wishes and desires arising during the preschool years rather than the experiences of earliest childhood. It would appear that Freud never completely resolved his grief following his emotional loss of his mother. Further, Freud's case studies are replete with incidents in which governesses contributed to the client's later distress.

### Freud's Education

Freud excelled in his studies in Vienna and entered the Gymnasium, or academic high school, which emphasized instruction in the classical languages. He learned to read, write, and speak many European languages, as well as English, and would have liked to become a classical scholar. His father explained he couldn't afford to support Freud's graduate studies, and that "denominational" concerns (the family was Jewish) would prevent Freud from obtaining a university professorship. At that time all such appointments were approved by the government education ministry, which opposed the appointment of Jewish scholars. The collapse of the Hapsburg monarchy in 1867 marked the end of a socially and politically liberal period in Vienna and the emergence of the anti-Semitism that overspread Europe in the 20th century.

Inspired by an essay on natural philosophy, Freud entered medical school at the University of Vienna. It was there that Freud met physician Josef Breuer, the "doctor's doctor" to the medical school faculty, who had returned to medical school to learn the new physiological psychology. Breuer became Freud's mentor in medical school, and helped to pay for his medical studies. Despite the pragmatic decision to pursue a career in which he could expect to find employment, Freud's scholarly interests are reflected in the fact that he took 8 years rather than the usual 5 to complete his degree. He filled his extra time by reading Aristotle's



metaphysics with the renowned philosopher-psychologist Franz Brentano and conducting research on issues that today would fall into the discipline of developmental neurobiology in Ernst Brücke's laboratory. Breuer became Freud's mentor in medical school, and in the late 1880s, when Freud was becoming the preeminent neurologist in Central Europe, they collaborated on the psychotherapy of hysteria.

Freud married Martha Bernays and settled into a comfortable apartment at 19 Bergasse (Mountain) Street in Vienna, on the road leading to the university and the medical school. The Freuds had six children, the youngest of whom, Anna, became an internationally renowned child psychoanalyst. She continued as the most important figure in psychoanalysis from her father's death in 1939 until her own death in 1983.

### Oedipus Complex

Freud's collaboration with his mentor, Josef Breuer, from 1886 to 1893, on the innovative psychotherapy of hysteria focused on the psychological meaning of symptoms rather than posthypnotic suggestion. Their 1895 book, *Studies in Hysteria*, reported on their clinical studies, but by that time, Freud had ended his friendship with Breuer. While Breuer maintained that the origin of hysteria was based on a set of associations split off from consciousness, Freud posited that hysterical symptoms were used as a defense to prevent the individual from becoming aware of desire that conflicted with prevailing social standards.

A striking feature of Freud's psychotherapy of hysteria was his observation of a nearly universal recollection of a father's seduction of his daughter during early childhood. In an 1897 letter to his confidante, Wilhelm Fliess, Freud suggested that this seduction may not be a reality, but rather a universal fantasy of early childhood arising from the daughter's wish for intimacy with her father. Freud's father had died in October of the preceding year, at age 81, and Freud was propelled into an introspective self-analysis, discovering that the father whom he loved was also a rival for his mother's love. Freud believed that this family dilemma was analogous to that in Sophocles' trilogy of plays about Oedipus. His self-analysis enabled him to discover the significance of dreams as disguised or socially acceptable expressions of the *nuclear wish* (later called the *Oedipus complex*) that arises during the preschool years. This wish arises in the aftermath of the triangular conflict of love of the

opposite-gender parent, and rivalry for this parent for the love with the parent of the same gender. The nuclear wish is always pressing for satisfaction, but it is socially unacceptable and therefore is repressed to keep it out of consciousness.

*The Interpretation of Dreams*, published in 1900, is the masterpiece of the 23 published volumes of Freud's work. In this book, he depicted the nuclear wish (the Oedipus complex) as the determinant of all mental life. Over the succeeding decade, Freud argued that many aspects of the personality were *compromise formations* whose function was to provide at least partial satisfaction of the nuclear wish while shielding the individual from awareness through repression. In addition to dreams, compromise functions included fears, phobias, hysterical and obsessive afflictions, works of art, so-called unintentional actions such as slips of the tongue, and all human relationships, including the relationship with the analyst.

### Freud's Topographic Model

Freud's first *topographic* model of the mind depicted variations in the individual's level of awareness from unconscious to consciousness. Freud maintained that this model explained attention; what we notice at any moment is determined by the effort to satisfy wishes originating in childhood desires. These desires always remain out of awareness but always seek satisfaction. Freud believed that all thought is ultimately determined by aspects of the personality that lie outside the range of consciousness.

From 1905 to World War I, Freud developed his model depicting the mind as motivated by the need to defend the individual against the awareness of socially unacceptable wishes and intents. Freud was invited in 1909 to Clark University in Worcester, Massachusetts, where he delivered five lectures that systematically portrayed the model of the mind he first portrayed in *The Interpretation of Dreams*. The case reports and essays he published in the years before World War I elaborated his model to show that, in addition to dreams, so-called unintended actions (or the psychopathology of everyday life) and psychological or psychoneurotic symptoms also represented disguised satisfaction of the nuclear wish. Freud's topographic model was most fully portrayed in the lectures he delivered to a mixed medical school and lay audience (with then-educator-daughter Anna in attendance) in the winter terms of 1915–1916 and



1916–1917. The lectures were later published as the *Introductory Lectures on Psycho-Analysis*.

### Illustrations From Case Reports

The concept of *repression* as the determinant of consciousness was demonstrated in Freud's case reports, such as his 1909 *Analysis of a Phobia in a Five-Year-Old Boy*, in which Freud described "Little Hans," the son of one of his early collaborators, who had developed a phobia about going out in the street. The power of the nuclear wish as a cause of hysteria was shown in his 1905 *An Analysis of a Case of Hysteria*, a failed analysis of Dora, a so-called hysterical young woman. Only in retrospect did Freud realize his own contribution to his conflicted relationship with his patient. Freud's report of his work with Dr. Ernst Lanzer (the "Rat Man"), in his 1909 *Notes Upon a Case of Obsessional Neurosis*, described a brief analysis of a man with obsessive symptoms who died tragically in the first days of the war. Freud's notes on his sessions with Lanzer are the only published record of how Freud worked during that time. In his 1918 *From the History of an Infantile Neurosis*, Freud reported on his work with Sergei Pankejeff, a Russian nobleman Freud described as the "Wolf Man," a name inspired by Pankejeff's childhood dream featuring still white wolves on a tree outside his parents' bedroom. Freud also wrote a psychobiography based on the 1911 book *Memoirs of My Nervous Illness* by Daniel Schreber, a troubled German jurist struggling with his paranoid feelings regarding his punitive father (inventor of the first gym "workout" machines). His detailed 1910 psychobiographical study *Leonardo da Vinci and a Memory of His Childhood* showed how the censored nuclear wish could appear in a culturally valued or sublimated form.

### Psychoanalysis

With the translation of *The Interpretation of Dreams* into English and the critical acclaim for this epochal study and other papers published before World War I, European and American physicians and intellectuals flocked to Vienna to learn from Freud. First meeting as a regular Wednesday evening discussion group, these meetings were the foundation of the Vienna Psychoanalytic Society and, later, the International Psychoanalytic Association. During these interwar years, Freud's work garnered international recognition

and he was awarded numerous prizes for scientific achievement.

In his papers on the theory of psychoanalytic technique or method, written between 1911 and 1915, Freud discussed issues in the relationship of analyst and client. He further developed the concept of the *transference* (or displacement) of affections from earliest childhood to the analyst as a transference neurosis. Freud viewed transference as the experiencing of desires that are stimulated by the process of psychoanalysis. Freud warned of the dangers inherent in the analyst's response to the expression of the patient's loving feelings. He regarded these as the replay of childhood desire now displaced on to the analyst. He highlighted the importance of reliving or working through and putting to rest these unrequited desires and other remembered feelings and experiences. Freud identified forces in the psychoanalytic encounter that assist the process of working through and resolving childhood experiences and memories and those that create resistance to working thorough and resolving neurotic conflict. Falling in love with the analyst and tenaciously refusing to understand the basis of this desire provides at least partial satisfaction of the nuclear wish of childhood in the same manner as slips of the tongue, dreams, psychoneurotic symptoms, and sublimations. Clients inevitably experience resistance both to the awareness and to the resolution of this transference neurosis.

Following World War I, Freud turned his attention to the study of psychoanalysis and the necessity and discomfort inevitable in social life. This concern led Freud to revise his prewar topographic model of the mind. In 1923, Freud revised his theory to feature three interrelated personality structures: self, desire, and external social prohibitions and moral standards, translated from the German as ego, id, and superego. This model portrayed personality as driven by desires emanating from the unresolved nuclear conflict of the preschool years. The *id* demands immediate gratification of every desire, the *superego* demands that moral authority be obeyed, and the *ego* attempts to mediate these expectations to comply with the demands of the real world.

Freud managed his writing and clinical work from 1923, on even as he struggled with cancer. In 1938, following the German annexation of Austria, Freud's friend, Princess Marie Bonaparte, directly interceded with Hitler on behalf of the Freud family, and the Freuds journeyed into exile in England. Freud died in London in September 1939.



## Conclusion

Freud's contributions to the study of mental life have continued to inform psychoanalytic technique and to provide innovative perspectives for study in the human sciences and the humanities. Psychoanalysis is now recognized both as a "one-person" or intrapersonal psychology and as a relationship or "two-person" psychology in which the analyst's personality and experiences become a part of the collaboration to help the client gain greater self-understanding and resolve neurotic suffering. Freud's legacy is that of compassionate concern for human welfare and profound wisdom concerning the human condition.

The founder of psychoanalysis occupies a unique although controversial position in psychology. Psychoanalysis is both an approach to understanding motivation and a systematic approach to psychotherapeutic intervention. Challenged by a variety of alternative psychotherapies from within both psychology and biological psychiatry, contemporary psychoanalysis has redoubled efforts at systematic study of the technique of clinical psychoanalysis. This inquiry includes the relationship between analyst and client, study of the interplay of biological substrate and personal distress, and process and outcome studies focused on the long-term success of psychoanalysis.

Few founders of intellectual perspectives have been as venerated and disparaged as Freud. Freud adopted the term *ambivalence* from Swiss psychiatrist Eugen Bleuler's to refer to the concurrent positive and negative emotional attitudes of children toward their parent of the same sex. This ambivalence characterizes both lay and public attitudes toward the founder of psychoanalysis. Nearly 70 years after Freud's death, many published papers in the psychoanalytic literature begin with a review of his work on their topic before proceeding to more recent commentary and perhaps a case formulation. The popular press continues major stories regarding the significance of Freud's legacy with pronouncements that psychoanalysis is (or is not) dead as an intellectual discipline and method of psychotherapy.

Bertram J. Cohler

*See also* Defenses, Psychological (v2); Ego Strength (v2); False Memories (v2); Jung, Carl (v2); Meaning, Creation of (v2); Personality Theories, Psychodynamic (v2); Projective Techniques (v2); Psychoanalysis and Psychodynamic Approaches to Therapy (v2); Transference and Countertransference (v2); Working Alliance (v2)

## Further Readings

- Chodorow, N. (1999). *The power of feelings*. New Haven, CT: Yale University Press.
- Freud, S. (1953). The interpretation of dreams. In J. Strachey (Ed. & Trans.), *The standard edition of the complete psychological works of Sigmund Freud* (Vols. 4 & 5). London: Hogarth Press. (Original work published 1900)
- Freud, S. (1957). Introductory lectures on psycho-analysis. In J. Strachey (Ed. & Trans.), *The standard edition of the complete psychological works of Sigmund Freud* (Vols. 15 & 16). London: Hogarth Press. (Original work published 1916–1917)
- Freud, S. (1961). Civilization and its discontents. In J. Strachey (Ed. & Trans.), *The standard edition of the complete psychological works of Sigmund Freud* (Vol. 21, pp. 57–220). London: Hogarth Press. (Original work published 1930)
- Freud, S. (1961). The future of an illusion. In J. Strachey (Ed. & Trans.), *The standard edition of the complete psychological works of Sigmund Freud* (Vol. 21, pp. 1–56). London: Hogarth Press. (Original work published 1927)
- Freud, S. (1961). New introductory lectures on psychoanalysis. In J. Strachey (Ed. & Trans.), *The standard edition of the complete psychological works of Sigmund Freud* (Vol. 22, pp. 1–82). London: Hogarth Press. (Original work published 1933)
- Freud, S. (1964). Moses and monotheism. In J. Strachey (Ed. & Trans.), *The standard edition of the complete psychological works of Sigmund Freud* (Vol. 23, pp. 1–38). London: Hogarth Press. (Original work published 1939)
- Gay, P. (1988). *Freud: A life for our time*. New York: Norton.
- Mitchell, S. A., & Black, M. J. (1995). *Freud and beyond: A history of modern psychoanalytic thought*. New York: Basic Books.
- Young-Bruehl, E. (1994). *Anna Freud: A biography*. New York: Norton.





---

## **GAY, LESBIAN, AND BISEXUAL THERAPY**

---

In most cases, gay, lesbian, and bisexual (GLB) clients seek out counseling and therapy for the same reasons that heterosexual clients seek services, including relationship and family issues as well as concerns about work and social stressors. However, several therapeutic concerns specific to GLB sexual orientation include coming out and sexual identity development; anti-GLB and heterosexist attitudes, prejudice, and discrimination; and GLB relationship and family issues. Therapists who are of any sexual orientation can be effective working with sexual minority clients as long as they are knowledgeable about GLB therapeutic concerns and are relatively free of heterosexist assumptions and biases.

### **Coming Out and Sexual Identity Development**

#### ***The Process of Coming Out***

*Coming out* is a term used to describe the disclosure of one's sexual orientation to others (e.g., family, friends, coworkers), either by identifying as GLB or by indicating a same-sex relationship or orientation. Someone who has not disclosed his or her GLB orientation either with significant others or at work is often referred to as being "in the closet." Coming out is not a one-time occurrence, rather it is a process that GLB individuals have to grapple with each time they meet someone new or enter an unfamiliar environment. When thinking about coming

out, GLB individuals often consider issues of safety and acceptance; for some, coming out could mean risking their employment or family relationships. Because it is commonly assumed that people are heterosexual, GLB people consider coming out important for conveying a sense of who they are, and this goes beyond sexual attraction and desire. Individuals range in their comfort with coming out. For some, disclosing sexual orientation is a natural process; however, for others, particularly when they are first gaining awareness of their same-sex attractions, it can be a challenge and may become a central focus of therapy. For example, some university counseling centers provide coming out groups, and many therapists will help clients practice coming out to others or even facilitate coming out to family members as part of the therapeutic process.

Research suggests that it can take as many as 9 years for individuals to come out to themselves and their significant others, and for some who live and work in extremely heterosexist environments, coming out as GLB is not a safe option. Typically, GLB clients come out to friends first, followed by supportive siblings, mothers, and finally, fathers. Although reactions to coming out differ in each situation, self-disclosure often sets off a response similar to other ways a family has responded to crisis or change. Individuals close to a GLB person will have their own coming out process as they integrate new information and wrestle with their own self-disclosure issues.

#### ***Sexual Identity Development***

The process by which individuals become aware of their same-sex attraction and subsequently identify as



GLB is referred to as *sexual identity development*. Many different developmental sexual identity models have been proposed, and while they can serve as useful guidelines for understanding a client's experience, they do not capture the complex and distinct ways individuals come to understand and express their GLB sexual identity. Vivian Cass and Richard Troiden first introduced stage or phase models of sexual identity development in 1979. Numerous models followed, and while each had its own perspective, they shared several common themes. The first phase is characterized by feelings of being socially different from heterosexual peers, which are often accompanied by strong feelings of isolation and fear. Clients at this phase may not be aware of their same-sex attractions, and often will present in therapy with depression, loneliness, and illnesses. The focus of therapy is to treat symptoms rather than emphasize sexual identity concerns.

When same-sex attraction begins to have some personal relevance, a person may be in phase 2, characterized by private labeling of feelings as possibly "not heterosexual." Such awareness can lead to extreme confusion, and some will seek therapy to work through their feelings of grief and loss of heterosexual privilege. Clients at this point are struggling with stereotypes and negative internalized messages about homosexuality as they attempt to integrate an new understanding of themselves. It is vital for therapists to not rush the sexual identity process and to match the clients' pace, particularly with how they choose to describe themselves.

As clients enter the third phase, they find an identity label that more accurately describes their affectional and sexual attractions than the term *heterosexual* does. They have moved into understanding themselves as probably GLB rather than possibly not heterosexual; therefore, appropriate referrals to positive role models and community support are of particular importance. They may begin to see themselves as belonging to a GLB community, even if peripherally, and socializing with other GLB individuals is more common. Many clients find themselves experiencing a new adolescence in which they feel as if they are starting over with dating and having strong emotional attachments perhaps for the first time. It is important for therapists to provide clients with continuity of identity exploration and facilitate healthy self-disclosure.

When contacts with GLB community members are positive, clients may move into phase 4. At this point they accept, rather than simply tolerate, their sexual

identity and begin an active social life. Clients may begin to label themselves as GLB, and the therapist may begin to use the language the clients use to describe themselves. Often, individuals in therapy are beginning relationships during this phase and may seek support for navigating as a new couple. Learning to self-disclose selectively and with appropriate language is also central in this phase. Sometimes clients begin to experience a great deal of distrust and anger over their position as GLB individuals in a heterosexist society. They may sever ties with heterosexual family and friends, and engage in dichotomous "us vs. them" thinking. However, as GLB individuals are met with affirming heterosexual allies and the diversity of the GLB community, they may begin to revise their philosophies by learning to trust and depend on others based on qualities other than sexual orientation. Additionally, they may deepen their understanding of their sexual identity as merely one aspect of their lives and not the central focus. Final stages of sexual identity development are characterized by a synthesizing of GLB identity with other aspects of self, in which sexual orientation is not the only defining quality of personality.

### **Anti-GLB and Heterosexist Attitudes, Prejudice, and Discrimination**

Although GLB individuals have advanced a great deal in terms of equal rights in the past decade, heterosexist attitudes and actions continue to create challenges for GLB individuals. For example, in some states, GLB individuals can be fired simply for disclosing their sexual orientation. In most states, there is still no protection for sexual orientation for equal housing or public services. Similarly, except in Massachusetts, GLB individuals in the United States cannot marry their same-sex partners, which limits their access to over 1,300 federal benefits, including hospitalization rights, tax benefits, and family rights. In addition, through adoption prohibitions and fertility treatments limited to married couples, there is systematic discrimination of GLB individuals who wish to create families. GLB people are more at risk for violent hate crimes, and Gregory Herek's research has shown that on average it takes 5 years to recover from a targeted attack due to one's group membership rather than the 2 years that typically is required for a person to recover from a random act of violence. As GLB individuals encounter discriminatory practices or crimes



targeted against them, they may present in therapy with issues of anxiety, depression, hopelessness, and even posttraumatic stress disorder. It is important that therapists be aware of the legal issues that GLB clients face and have appropriate referrals for legal advice and planning.

## Relationship and Family Issues

### *Social Support*

GLB individuals and couples receive less social support than do heterosexuals from their families of origin; however, they tend to report feeling satisfied with their overall level of social support. While it is true that many GLB individuals experience conflict and disruptions in their families upon coming out, for the most part GLB individuals remain in connection with their families of origin. In order to counterbalance the lack of support from families of origin, GLB people often create families of choice, a close-knit group of friends who serve in every function as family. Such constellations of support are important for therapists to keep in mind as they explore family dynamics and social support. Even if GLB clients do not report that they have close families, it cannot be assumed that there are not close networks just as vital to the client as blood relatives. Therapists should be cautioned against focusing on fragmented family-of-origin relationships at the expense of other more central systems of social support. Nevertheless, it is important to not discount that families of origin may not be providing support to GLB individuals.

### *Relationship and Parenting Issues*

Besides structural and legal obstacles to creating GLB families, many couples struggle with acceptance of their families. While GLB relationships are reported to be just as relationally and sexually satisfying as heterosexual relationships, there are few supports for same-sex relationships. Same-sex couples are often not provided with spiritual or religious recognition, and many have to form their own spiritual communities. Individuals in a same-sex couple can come to the relationship with differing experiences of coming out and sexual identity development, as well as internalized *homophobia* (the degree to which GLB individuals adopt negative attitudes and

beliefs about homosexuality). Such internalized homophobia can negatively impact the couple relationship in numerous ways, including sexual satisfaction and intimacy, as well as communication and trust.

GLB parents, in particular, are vulnerable to heterosexism. Even though the 2000 Census revealed same-sex couples living in 99% of counties in the United States, and 55% of these couples reported raising children, same-sex partners are rarely allowed to both be full legal parents due to the limits of second-parent adoptions (only available in select cities and jurisdictions) and laws denying two parents of the same sex to be listed on birth certificates. When GLB families encounter difficulties such as relationship separation or death of a partner, they are often faced with no legal support for resolving custody issues or no legal rights to children whose parents they are in every way but in the eyes of the law. Therapists can help by acknowledging the negative impact of such extant laws on clients, supporting clients to seek GLB-affirmative legal support, and advocating for equal family rights for GLB individuals.

*Sharon G. Horne and Brandy Smith*

*See also* Career Counseling, Gay and Lesbian (v4); Discrimination (v3); Family Counseling (v1); Identity (v3); Multicultural Counseling (v3); Prejudice (v3); Sexual Orientation (v4); Social Support (v2)

### Further Readings

- D'Augelli, A. R., & Patterson, C. J. (Eds.). (2001). *Lesbian, gay and bisexual identities and youth*. New York: Oxford University Press.
- Garnets, L., & Kimmel, D. (Eds.). (2003). *Psychological perspectives on lesbian, gay, and bisexual experiences*. New York: Columbia University Press.
- Laird, J., & Green, J. (1996). *Lesbians and gays in couples and families*. San Francisco: Jossey-Bass.
- Perez, R. M., Debord, K. A., & Bieschke, K. J. (2000). *Handbook of counseling and psychotherapy with lesbian, gay, and bisexual clients*. Washington, DC: American Psychological Association.
- Ritter, K. Y., & Terndrup, A. I. (2002). *Handbook of affirmative psychotherapy with lesbians and gay men*. New York: Guilford Press.
- Whitman, J. S., & Boyd, C. J. (Eds.). (2003). *The therapist's notebook for lesbian, gay and bisexual clients*. Binghamton, NY: Haworth Press.



---

## GELSO, CHARLES J. (1941– )

---

Charles J. Gelso, who was born on November 27, 1941, in Pittston, Pennsylvania, has been a professor of counseling psychology at the University of Maryland for most of his career. He is the author of more than 110 articles in professional counseling journals, as well as 10 book chapters and 4 books. His scholarship addresses issues such as the research training environment, time-limited counseling, research methodology, and the psychotherapy relationship. His articles on research methodology and the psychotherapy relationship, in particular, are among the most frequently cited writings in the field of counseling psychology. Gelso was the editor of the *Journal of Counseling Psychology* from 1982 to 1987, and in 2005 he began a term as the editor of *Psychotherapy* that will run through 2009. He is a Fellow of the American Psychological Association, the American Association of Applied and Preventive Psychology, and the American Psychological Society. He received the 2003 Distinguished Psychologist Award from the American Psychological Association's Division of Psychotherapy, and the 1996 Leona Tyler Award for career achievement in, and outstanding contributions to, the field of counseling psychology from the American Psychological Association's Society for Counseling Psychology.

### Research Methodology

Gelso developed a taxonomy for classifying and thinking about counseling research. According to this taxonomy, counseling research can be categorized as occurring in the field or in the laboratory, and variables can be experimentally controlled or naturally observed. Research that is conducted in the field has *high external validity* (i.e., its results generalize more readily to actual counseling than research conducted in the laboratory). Studies in which the researcher exerts experimental control by manipulating independent variables allow for causal statements to be made about the effects of the independent variable(s) on the dependent variable(s). Such studies are said to have *high internal validity*.

Gelso noted that each type of research has advantages and disadvantages and that no study is perfect. This last idea he called the *bubble hypothesis*, likening it to the notion of an air bubble that gets caught under a windshield sticker. One can move the bubble

around but not eliminate it entirely. Similarly, researchers can try to correct for the flaws that exist in previous research on a topic, but they can never remove all of the flaws in any one study. In short, a perfect study cannot be conducted.

### The Psychotherapy Relationship

Gelso conceptualized the relationship between the therapist and client as consisting of the *working alliance*, the *real relationship* (i.e., clients' and therapists' realistic perceptions of each other and the extent to which each is authentic with the other), *transference* (i.e., the client's unconscious redirection of feelings and personal issues onto the therapist), and *countertransference* (i.e., the projection of therapists' unresolved personal issues onto the client). Gelso and his colleagues developed a measure of the real relationship that allowed research to be done in this area. His systematic program of research on countertransference identified factors that contribute to countertransference, the effects of countertransference on the therapy process, and strategies therapists can use to manage their countertransference reactions.

Jeffrey A. Hayes

*See also* Facilitative Conditions (v2); Relationships With Clients (v2); Transference and Countertransference (v2); Working Alliance (v2)

### Further Readings

- Gelso, C. J. (1979). Research in counseling: Methodological and professional issues. *The Counseling Psychologist*, 8, 7–36.
- Gelso, C. J., & Carter, J. (1985). The relationship in counseling and psychotherapy: Components, consequences, and theoretical antecedents. *The Counseling Psychologist*, 13, 155–243.
- Gelso, C. J., & Fretz, B. R. (2001). *Counseling psychology* (2nd ed.). Fort Worth, TX: Harcourt.

---

## GOLDBERG, LEWIS R. (1932– )

---

Lewis R. Goldberg is an internationally acclaimed psychologist best known for his programmatic studies testing the lexical hypothesis that any culturally



important personality characteristic will be represented in the language of that culture.

Goldberg was born in Chicago on January 28, 1932. As an undergraduate at Harvard (1949–1953), he decided against following his father into the legal profession and majored in social relations. Although interested in quantitative methods, he pursued graduate study in the University of Michigan's psychoanalytically oriented clinical psychology program (1953–1958). Luckily for him (and the field of personality measurement), E. Lowell Kelley, the one member of that program with a quantitative orientation, became his adviser and dissertation director. Kelley provided Goldberg the opportunity to study the quantitative personality assessment techniques for which he has become so well known.

As an advanced graduate student at Michigan, Goldberg met Warren T. Norman, a new assistant professor, who became a lifelong friend and collaborator. Following a 2-year appointment as an assistant professor at Stanford, Goldberg went to the University of Oregon and the Oregon Research Institute where he continues to produce fundamental research in personality assessment. In his early years at Oregon, he served as a field selection officer for the U.S. Peace Corps beginning during a period when Kelly was serving as its director of selection. He has been president of the Society of Multivariate Experimental Psychology and of the Association for Research in Personality. He is a fellow of the American Psychological Association, the American Psychological Society, and the American Association for the Advancement of Science. In 2006, he won the Jack Block award for Personality Research from the Society of Personality and Social Psychology.

A long history of research in psychology has demonstrated that the thousands of adjectives used in everyday language to describe variations among people actually refer to a relatively small number of dimensions. Norman replicated this research with peer ratings and introduced Goldberg to these issues at Michigan. With students and colleagues, Goldberg tested the lexical hypothesis by examining the robustness within and across cultures of five factors (which he dubbed the "Big Five") composed of adjectives used in rating self and others. Collaborating with researchers around the world, Goldberg and his students and colleagues have examined the similarities and differences in the multidimensional organization of adjectives used to describe stable characteristics of personality. This work has been done using both

Indo-European and non-Indo-European languages. Most recently, Goldberg and Sarah Hampson analyzed data collected by his colleague John Digman to examine the longitudinal consistency of personality ratings over 40 years.

Three hallmarks of Goldberg's research are the depth with which he examines fundamental problems in assessment, the openness with which he shares the results, and his willingness to collaborate with one and all. Perhaps the best example of all three of these tendencies is his remarkable "collaboratory." This International Personality Item Pool (IPIP) makes available to all researchers a pool of more than 2,000 items and 250 carefully constructed scales that measure the plethora of constructs associated with particular proprietary instruments. The item pool uses short phrases instead of adjectives to better capture the nuances of personality. Validity information for the scales are derived from a longitudinal study of a sample of community volunteers in Eugene, Oregon, who completed the IPIP items and commercial inventories measuring traits, interests, values, and activities.

*William Revelle*

*See also* Personality Assessment (v2); Personality Theories (v2); Personality Theories, Five-Factor Model (v2); Quantitative Methodologies (v1)

### Further Readings

- Goldberg, L. R. (1990). An alternative "Description of personality": The Big-Five factor structure. *Journal of Personality and Social Psychology*, 59, 1216–1229.
- Hampson, S. E., & Goldberg, L. R. (2006). A first large cohort study of personality trait stability over the 40 years between elementary school and midlife. *Journal of Personality and Social Psychology*, 91, 763–779.
- Norman, W. T., & Goldberg, L. R. (1966). Raters, ratees, and randomness in personality structure. *Journal of Personality and Social Psychology*, 4, 681–691.

---

## GOLDMAN, LEO (1920–1999)

---

Leo Goldman gave critical attention to the use of psychological tests in counseling. As editor of the *Personnel and Guidance Journal*, he emphasized the importance of educating counselors in the use of psychological tests. He was skeptical of the value of



standardized tests and concerned with the potential misuse of test information in the public school system. Following a critical review of the literature in 1972 titled "Tests and Counseling: The Marriage That Failed," Goldman concluded that a meaningful relationship between testing and counseling practice was in doubt. He questioned whether and how counselors can derive functional utility from testing and measurement, beyond understanding the technical characteristics of the instruments used. Goldman advocated alternative assessment approaches found in qualitative methods, and he also argued for the use of qualitative research methods.

Goldman's proposals for qualitative assessment and qualitative research became in the next decade a more radical call for counseling psychologists to consider alternative research paradigms. In his 1976 article titled "A Revolution in Counseling Research," Goldman became one of the first to advocate for a paradigm change in counseling research. Goldman viewed the limitations of standardized testing as part of the limitations of the quantitative research paradigm that has dominated the field of psychology. Measurement-driven research utilizes psychological tests that have demonstrated reliability and claims of validity. Standardization as a scientific norm upheld in the test and measurement industry has been shared by the experimental tradition in psychology. These paradigmatic values and practices constitute the context of test development and test usage, and for Goldman, the basis of his criticism of them.

Goldman also expressed concern about the needs of minority populations and argued that professional practice including assessment approaches must take into account their needs. He viewed the issue of validity in testing as part of the increasing awareness of cultural factors in assessment and counseling interventions. The issue of cultural validity in standardized test use was more than an epistemic issue for Goldman; it has implications for social justice. In his 1990 presidential address to APA Division 17 (Society of Counseling Psychology), titled *Participants and Gatekeepers*, Goldman called for more inclusiveness in the counseling profession. Consistent with methodological pluralism in research, he argued for practice-oriented methods of assessment and a culture-sensitive professional practice that is inclusive of diverse groups.

The influence of Goldman's work is seen in recent contributions that reflect the counseling professional's role in testing, and counselors as consumers of test

information. The relevance of test information to counseling and inquiry continues to be important to practitioners and researchers. Issues of validity and cultural bias are intertwined with the social and political uses of testing, issues that were anticipated in Goldman's critical perspective and the moral vision that he provided in his autobiographical 1998 essay, "Still the Serendipitous Maverick."

Lisa Tsoi Hoshmand

**See also** Achievement, Aptitude, and Ability Tests (v4); Culture-Free Testing (v3); Meehl, Paul E. (v2); Psychometric Properties (v2); Qualitative Methodologies (v1); Test Interpretation (v2); Translation and Adaptation of Psychological Tests (v1)

### Further Readings

- Goldman, L. (1961). *Using tests in counseling*. New York: Appleton-Century-Crofts.
- Goldman, L. (1972). Tests and counseling: The marriage that failed. *Measurement and Evaluation in Guidance*, 4, 213–220.
- Goldman, L. (1989). Moving counseling research into the 21st century. *The Counseling Psychologist*, 17, 81–85.
- Goldman, L. (1998). Still the serendipitous maverick. In L. Hoshmand (Ed.), *Creativity and moral vision in psychology* (pp. 67–90). Thousand Oaks, CA: Sage.

---

## GROUP THERAPY

---

Group therapy is a form of psychotherapy where one or more therapists treat a small group of clients together. Group therapy, like individual psychotherapy, is intended to help people who would like to improve their ability to cope with difficulties and problems in their lives. The therapist uses the emotional interactions of the group members to help them get relief from distress and modify their behavior. The aim of group psychotherapy is to help with solving the emotional difficulties and to encourage the intra- and interpersonal development of the participants in the group. At least 3, and usually more, group members are necessary to establish the critical mass that allows the types of interactions that give the psychotherapy group its unique character. From 6 to 10 members is considered an ideal number, and 13 or more are too many. With too many members, it is impossible to



create a therapeutic atmosphere and have enough time for each member to work personally. The group meets regularly at stated intervals, usually once a week, for a specific period of time, for the purpose of bringing about psychological change in the group members. The length of each session can be from 1½ hours to 3 hours. The duration of the group—from a few months to a few years—depends on many components, such as the severity of the problems and the outcome goals sought. Having a designated leader is an essential aspect of group therapy.

### **Types of Groups**

Group psychotherapy and group therapy are often used synonymously with group therapy being the colloquial and shortened version. Group therapy is also used on occasion to represent a broader category of group work. In addition, some practitioners use the terms *group counseling* and *group psychotherapy* interchangeably. However, position statements issued by the Association of Specialists in Group Work (ASGW) of the American Counseling Association (ACA) have defined the terms as two different entities with group psychotherapy being one of four distinct group types: task groups, psychoeducational groups, counseling groups, and psychotherapy groups.

### **Task and Counseling Group Focus and Goals**

Task groups are designed to accomplish identified work goals. They include committees, task forces and social action groups, study circles and learning groups, planning and discussion groups, and other group experiences where the participants have a task to accomplish that is external to the individual members. Psychoeducational groups provide participants with information, skills, and increased awareness of some life problem and the knowledge and tools to better cope with it. The goal is to prevent various psychological problems and educational deficits by imparting, discussing, and integrating factual information.

Counseling groups are very similar to therapy groups. However, counseling groups are not concerned with the treatment of more severe behavioral and psychological disorders. The main differences between psychotherapy and counseling groups is that counseling groups are not aimed at major personality changes; they deal primarily with conscious

problems and they focus on resolving specific short-term concerns.

### **Psychotherapy Group Focus and Goals**

The psychotherapy group, more than other types of groups, is designed primarily to help individuals with chronic or acute emotional or mental disorders that produce marked distress and impairment. The group allows individual group members to reconstruct major personality dimensions and remediate in-depth psychological problems. Thus, psychotherapy groups focus upon addressing personal and interpersonal problems of living, modifying perceptual and cognitive distortions, reducing repetitive patterns of dysfunctional behavior, and promoting personal and interpersonal growth and development among participants who are experiencing severe or chronic maladjustment. Psychotherapy groups allow for the development of appropriate group norms and task elements necessary to support the intensity of the social and emotional interaction that promotes change. While conceptualized, composed, and conducted as an intervention to deal with those needing intense interpersonal work to modify major psychological dysfunctions, it can also provide attention to interpersonal problem solving and to psychoeducational information and skill acquisition as a part of the overall therapeutic group experience.

Psychotherapy groups provide a safe environment in which group members can experiment with new ways of looking at life, experiment with new behaviors, and offer a powerful opportunity for positive change. Even though group psychotherapy frequently focuses on participants with severe problems, the scope of group psychotherapy is extremely broad. Psychotherapy groups are used to treat individuals with mild to moderate personality problems, interpersonal conflicts, and neurotic disorders. Psychotherapy groups are especially helpful in improving interpersonal relationships, although evidence suggests they are quite useful for anxiety and depression. Groups are ideally suited to people who are struggling with issues like intimacy, trust, and self-esteem. The group interactions help the participants to identify, get feedback on, and change the patterns that are sabotaging their relationships outside the group. The great advantage of group psychotherapy is working on these patterns in the “here and now”—in a group situation similar to members’ reality and close to their interpersonal



events. Members learn how they can achieve more happiness in general and how to create meaningful, supportive, and loving relationships with others. Groups also create a setting where, through seeing others who are struggling with similar concerns, participants find their issues normalized, and through seeing others succeeding, participants are given hope.

### Varieties of Psychotherapy Groups

Group psychotherapy is based on the fact that mental dysfunction and emotional illness can be relieved through the psychological effects of several people upon one another. Improvement in mental functioning tends to alleviate psychological distress and may eventually alleviate mental illness. This has inspired numerous efforts to utilize the healing force of the group to meet the therapeutic needs of a wide range of clients—individuals at all phases of the life cycle with highly diverse problems needing treatment. Simultaneously, virtually all schools of psychotherapy have embraced group practice and have attempted to incorporate their respective conceptual frameworks into group work. As a result, group psychotherapy is not based on a single theoretical perspective, but takes from many theories what seems to be most helpful. The techniques used in group therapy can be verbal, expressive, psychodramatic, and so forth. The approaches can vary from psychoanalytic to behavioral, from Gestalt to encounter, from existential to rational. Each approach has its advantages and drawbacks.

Groups differ not only in their theoretical approach, but also in their focus and application. Some of these differences may be based on the therapist's general orientation and specific approaches; the goals of the treatment; the subjects of the treatment, including problem areas and client characteristics; setting; and the time and duration components of the group.

Groups can be categorized as either small or large, short term or long term, outpatient or inpatient, ongoing or time limited. Psychotherapy groups can be open groups or closed groups. *Open groups* replace members as they drop out or terminate. *Closed groups*, after a period of forming, do not allow new members to join. Psychotherapy groups can be heterogeneous or homogeneous. *Heterogeneous* groups have members with quite different presenting diagnoses, complaints, or life problems. *Homogeneous* groups are made up of people with the same presenting diagnosis, complaint, or life problems. Usually psychotherapy groups are

composed of individuals who do not have preexisting emotional ties to each other, although couples may become a part of a group of unrelated persons or may join other couples in a couples' group. Families also may be treated using a group modality—referred to by names such as multifamily group psychotherapy, family group consultation, and others. Some psychotherapy groups focus on a specific area of common concern, such as relationships, anger, stress-management, and so forth. These groups often have an educational or teaching component and are frequently more time limited than general process-oriented psychotherapy groups. These homogeneous groups are especially beneficial for providing support, normalizing the concern, and encouraging modeling of participants who are successfully addressing their issues.

Group therapy is also used in psychiatric hospitals, general medical hospitals, and outpatient clinics to help clients deal with the psychological impact of terminal illness, cancer, attempted suicide, and stress. Individuals with profound ego impairment can be treated in psychotherapy groups in hospital groups, post-hospital follow-up groups, and day hospital groups. Group psychotherapy is extremely helpful as a part of an overall institutional treatment program in combination with psychological medication, individual therapy, and milieu therapy. Large psychotherapy groups are usually conducted in community or institutional settings, and such groups are often organized to work on a specific problem—for example alcoholism, obesity, rehabilitation, or another area of concern.

### Outpatient Therapy Group Process

The prototypical psychotherapy group is the open, heterogeneous, outpatient group that meets weekly for 6 months or more, admitting new participants as necessary to maintain a critical mass. The group therapist, leader, or facilitator chooses as candidates for the group those people who can benefit from group interaction and who are likely to have a useful influence on other members in the group. Most screening and selection procedures are subjective and rely on the intuition and judgment of the group leader. Usually, a moderate amount of social ability and psychological-mindedness, along with some commitment to change interpersonal behaviors and some positive expectations about the benefits of group treatment, are considered important for participation in a group. Certain



individuals are less likely to benefit. These include people who are extremely self-centered, acutely psychotic, highly paranoid, or actively suicidal, or extremely aggressive and hostile people, with a tendency to act out.

Group psychotherapy is the deliberate effort to alter the feelings, thinking, and behaviors of group members. In group therapy, past experiences, experiences outside the therapeutic group, and especially the interactions between the members of the group and the therapists become the material for the therapy. Frequently, the people in the group represent others in participants' past or current lives with whom they have difficulty. Essentially, the problems that the clients experience in daily life will also show up in their interactions in the group, allowing the problems to be worked through in a therapeutic setting, generating experiences and behaviors that may be transferred back to life outside the group.

Members of the group share with the others in the group personal issues that they are facing. Participants can talk about events they were involved in during the week, their responses to these events, and the effectiveness of those responses. Participants can share their feelings and thoughts about what happened in previous sessions, and relate to issues raised by other members or to the leader's words. Other participants can react to words and behaviors, give feedback and encouragement, provide support or criticism, or share their thoughts and feelings following interactions. The leader does not determine the subjects for discussion, as subjects rise spontaneously from the group. The members in the group feel that they are not alone with their problems, and they discover that there are others who are experiencing similar issues. The group can become a source of support and strength in times of stress for the participant. The feedback they get from others on behavior in the group can make them aware of maladaptive patterns of behavior. At that point, they can change perceptions and points of view, and they can adopt more constructive and effective reactions. The psychotherapy group can become a laboratory for practicing new behaviors.

Group psychotherapy is suitable for people with a large variety of problems and difficulties, from people who would like to develop their interpersonal skills to those with emotional problems such as anxiety, depression, and so forth. While support groups are developed for people in the same situation or crisis (e.g., groups for bereaved parents,

groups for sexually abused women), the prototypical psychotherapy group is as heterogeneous as possible. The leader will try to include men, women, young and old people, married, and singles when choosing people for the group in order to create a microcosm of the participants' world. As noted earlier, the likelihood that group participants will manifest their particular issues in the group makes group psychotherapy especially effective for people with interpersonal difficulties and problems in social, personal, or work relations.

## Effectiveness

Group psychotherapy is usually more cost effective than individual therapy, and possibly even more clinically effective. Evidence from studies published over the last 20 years supports the overall effectiveness of group psychotherapy, and differential effectiveness is dependent upon complex interactive variables present in group treatment.

There are many benefits of group therapy. Because of the confidential, supportive atmosphere, group members can work through personal issues themselves and help others to work through theirs, with members benefiting both through observation and active participation. The group allows members to explore their issues in a social context that mirrors real life, and it provides members with an opportunity to observe and reflect on social skills and to give and receive immediate feedback about issues, problems, and concerns affecting life.

Many professional helpers conduct psychotherapy groups: psychologists, counselors, social workers, psychiatrists, and psychiatric nurses and technicians. The best group psychotherapists are well-trained, reliable, and ethical professionals. Reputable group psychotherapists usually belong to professional associations. In the United States, for example, membership in American Psychological Association (APA), ASGW, American Group Psychotherapy Association (AGPA), and other counseling organizations suggests a professional commitment. The only two credentials that apply specifically to group therapists and assure some degree of expertise are the Certified Group Psychotherapist, or CGP, granted by the AGPA and the Diplomate in Group Psychology awarded by the American Association for Professional Psychology (ABPP). However, many psychologists, counselors, and so forth are very effective as group leaders



even though they have not attained these professional credentials.

*J. Jeffries McWhirter*

**See also** Counselors and Therapists (v2); Family Counseling (v1); Interpersonal Learning and Interpersonal Feedback (v2); Psychoeducation (v2); Self-Help Groups (v2)

### **Further Readings**

- Burn, S. M. (2004). *Groups: Theory and practice*. Belmont, CA: Wadsworth/Thompson Learning.
- DeLucia-Waack, J. L., Gerrity, D. A., Kalodner, C. R., & Riva, M. T. (Eds.). (2004). *Handbook of group counseling and psychotherapy*. Thousand Oaks, CA: Sage.
- Forsyth, D. R. (2005). *Group dynamics* (4th ed.). Pacific Grove, CA: Brooks/Cole.
- Furman, A., & Burlingame, G. M. (Eds.). (1994). *Handbook of group psychotherapy: An empirical and clinical synthesis*. New York: Wiley.
- Gazda, G. M., Ginter, E. J., & Horne, A. M. (2001). *Group counseling and group psychotherapy: Theory and application*. Boston: Allyn & Bacon.
- McWhirter, J. J. (in press). *Functions, factors, and framework in group counseling*. Boston: Houghton Mifflin.
- Yalom, I. D. (1983). *Inpatient group psychotherapy*. New York: Basic Books.
- Yalom, I. D., & Leszcz, M. (2005). *The theory and practice of group psychotherapy* (5th ed.). New York: Basic Books.





---

## HAPPINESS/HARDINESS

---

Happiness can be defined as subjective well-being or as the actualization of human potential. Hardiness refers to an attitude comprised of control, commitment, and challenge that provides the courage and motivation to help a person assess and effectively deal with stressors. This entry will examine both of these constructs and the relationship between them.

### Happiness

#### **Overview**

Counseling by its very nature attempts to alleviate problems and foster happiness. In order to help clients become happier, however, counselors must first define happiness and well-being. Today, there are two prevailing perspectives on the study of happiness. In the empirically derived *hedonic* view, well-being consists of pleasure or happiness. Research that stems from this perspective typically construes happiness as subjective well-being, people's emotional and cognitive evaluations of their lives as measured by their self-reported degree of global positive affect, negative affect, and overall life satisfaction. In the theoretically derived *eudaemonic* perspective, psychological well-being is construed as the maximization or actualization of human potential. Research that stems from this perspective generally focuses on behavior and cognitions rather than feeling. A wide range of constructs such as meaning and purpose in life, values, self-acceptance, and personal goals are studied in this perspective. In order to be complete, the study of

happiness should focus on both hedonic and eudaemonic well-being. Similarly, counselors ideally should be adept at helping clients to achieve hedonic goals such as alleviating pain and increasing happiness, as well as eudaemonic goals such as increasing meaning, enhancing life skills, and promoting effective decision making and behavior.

#### **Measurement and Constituents of Happiness**

Happiness has been measured across time periods that range from daily or hourly to over the lifetime. Although short-term happiness is related to long-term happiness, there are differences between them. Short-term happiness is more changeable than long-term or *trait* happiness (which appears to be partly genetically determined); therefore, counselors are more likely to focus on clients' short-term happiness and fulfillment. Long-term happiness is relatively stable and appears to be affected by life events only for a period of about 3 months, after which it returns to its usual level for most people. General or long-term happiness appears to be partly determined by satisfaction in particular life areas such as work, yet it is also likely that a person's overall happiness level will affect his or her satisfaction in particular life areas. Since general happiness is less changeable, and since most people report relatively high overall happiness, counselors tend to promote happiness by focusing on things that are known to increase short-term or immediate happiness.

The factors that affect happiness, and the theories of happiness, may be grouped as either *bottom-up* or *top-down*. Bottom-up theories, which focus on external



and situational factors, construe subjective well-being as the product of summed pleasurable and unpleasant moments. That is, a person is thought to be happy because he or she experiences more pleasurable moments than unpleasant moments. In contrast, top-down approaches construe subjective well-being as the product of internal traits and psychological processes such as dispositions, goals, coping styles, and adaptive processes. To more fully account for individual happiness, it is important that researchers and counselors focus on internal as well as external sources of happiness, and on the quality as well as quantity of external factors such as relationships and job.

Top-down research has found that temperament and personality dimensions such as neuroticism and extraversion are important determinants of subjective well-being and psychological well-being. Neuroticism, conceptualized as emotional instability, consists of a broad range of negative emotional traits such as anxiety, irritability, sadness, moodiness, and nervous tension. Extraversion incorporates more specific traits related to activity and energy, expressiveness, dominance, sociability, surgency, and warmth. Subjective well-being has also been associated with the personality trait of conscientiousness, and particular aspects of psychological well-being have been linked to both agreeableness and openness to experience.

Although personality is important to happiness across many cultures, personality has been found to be a stronger predictor of life satisfaction in individualistic cultures (in which the focus is more on oneself than on one's group) than collectivistic cultures (in which the focus is more on the group than on oneself). Similarly, although both self-esteem and relationship harmony are important predictors of happiness across cultures, self-esteem appears to be a stronger predictor in individualistic cultures, whereas relationship harmony appears to be a stronger predictor in collectivistic cultures. Thus, when attempting to increase clients' levels of happiness, counselors should consider their cultural values.

### ***What Leads to Happiness?***

Because personality itself is difficult to change, researchers have focused on more changeable top-down characteristics that affect happiness. In this regard, cognitive factors such as broad positive beliefs, generalized self-efficacy, dispositional optimism, positive thoughts, hardiness, and constructive thinking have been proposed to help explain how personality

and environment lead to stress resistance and happiness. Other factors thought to increase happiness are quality interpersonal relationships; physical exercise; domain-specific control beliefs (e.g., beliefs in self-efficacy and competence); future outcome expectancies; setting and meeting important, intrinsic goals that are consistent with one's value system; and learning goal-relevant skills such as problem-solving techniques and social skills. For people with a tendency to experience depression or negative affect, counseling that focuses on management of negative affect and increase of positive affect also may be helpful. For example, teaching such clients to dispute habitual negative thoughts and build in daily exercise and social activities may help them to ward off depression. Assessing clients' goals and teaching clients skills that lead to setting and achieving valued goals as well as overcoming environmental or personal blocks to goals may be an especially important avenue toward happiness. Finally, teaching effective cognitive and behavioral coping skills may be vital in helping clients to overcome problems, restore equilibrium, and increase happiness. A focus on developmental and preventive counseling interventions, such as teaching clients how to structure their time, build meaningful relationships, set and pursue valued goals, and proactively cope, may be especially helpful both in reducing their stress and increasing their happiness.

## **Hardiness**

### ***Definition***

Thought to stem from rewarding childhood experiences, hardiness is theorized to be a tripartite construct composed of a sense of *control* over experienced events, a feeling of *commitment* to various life areas, and a view of life change as a *challenge*. Persons who view stressful situations as meaningful and interesting (commitment), see stressors as malleable (control), and construe difficulties as challenges defined as hardy. These three attitudes are said to provide the courage and motivation to help persons accurately assess stressors and deal with them via active coping efforts.

### ***Measurement and Limitations***

Hardiness has been measured with a variety of self-report instruments, most commonly the Personal



Views Survey, which has recently been revised and abridged. Such measures attempt to assess control, commitment, and challenge, and then combine these indexes into an overall hardiness index. However, combining indexes into a composite hardiness index has been criticized on several grounds. First, two of the measures incorporated into the original composite measure of hardiness failed to distinguish between hardy and nonhardy groups in an earlier study. Second, of the theorized hardiness subcomponents, commitment and control tend to be correlated, and challenge often has had nonsignificant or negative correlations with commitment or control. Hardiness, then, does not appear to be a unitary construct, and many researchers have recommended that its subcomponents be measured separately.

Although factor analyses of some hardiness scales have found three factors, other analyses of subscales have found only one or two factors. Finally, the common procedure of adding scores on the three dimensions into a composite hardiness score, and then using a median split to divide participants into high-hardiness and low-hardiness groups results in heterogeneous groups that may be high in one hardiness component, but low in another.

### ***Lack of Support for Key Hypotheses***

One key hardiness hypothesis is that hardiness buffers the relationship between stress and both physical and psychological symptoms. Specifically, for persons higher in hardiness, stress is theorized to have a weaker relationship to physical and psychological symptoms. However, although some studies have found theorized buffering effects (interactions between life stress and hardiness), most have not. Hardiness generally appears to directly predict mental and physical health outcomes, but this predictive ability is independent of stress and often can be accounted for by commitment or control subcomponents. Thus, it is not necessary to postulate a composite hardiness construct when results can be accounted for more simply by commitment or control beliefs.

There is also considerable evidence that scales of hardiness may inadvertently measure neuroticism. Some items included on hardiness scales appear quite similar to items of neuroticism scales, and controlling for neuroticism often eliminates the predictive ability of hardiness. Hardiness does not affect illness through physical exercise or fitness, and generally does not

predict additional variance in future well-being above the predictive ability of commitment alone.

A second key hypothesis of hardiness theory is that approach and avoidance coping mediate the relationship between hardiness and illness—that is, that persons with higher hardiness will use more approach coping and less avoidance coping, and that more use of approach coping and less use of avoidance coping will predict less illness. Most studies have failed to support these mediational pathways. Some other key hypotheses (e.g., that hardiness modifies the stress-exhaustion process directly by fostering more positive perceptions of events and by indirectly fostering social support and improving health practices) have not yet been rigorously tested.

### ***Hardiness and Counseling***

The relevance of hardiness to counseling is unknown. Most studies that have attempted to increase hardiness have failed, and one that succeeded bolstered only the control subcomponent of hardiness. In addition, no studies have examined the relevance of hardiness to counseling outcomes. One study found that college students who chose short-term counseling to resolve developmental concerns did not differ in hardiness from college students who did not choose short-term counseling. Questions about the construct validity of hardiness and whether or not hardiness can be reliably changed raise questions about the usefulness of including hardiness measures in counseling research.

## **The Relationship Between Happiness and Hardiness**

Similarly, few studies have examined the relationship between hardiness and happiness or well-being. Several “one-shot” studies and one meta-analysis have found a relationship between hardiness and measures of well-being such as happiness, subjective well-being, and life satisfaction. One study, which examined subcomponents of hardiness that accounted for the relationship between hardiness and depression/happiness, found that individuals’ confidence in their ability to handle change and/or social interactions, belief in their competence in general, and receipt of personal meaning from their social and political activities accounted for the effect. Thus, as in research on the relationship between hardiness and other constructs, it may be the subcomponents of hardiness rather than composite hardiness that is responsible for the relationship between hardiness and happiness.



It should be noted that these subcomponents are not unique to hardiness theory, and their effects may be accounted for more simply by other theories. Furthermore, in light of evidence that neuroticism accounts for many of the relationships between hardiness and outcomes, studies of the relationship between hardiness and happiness should control for neuroticism. Finally, gender differences have often been found in the relationship between hardiness and its constituents and outcomes, raising the possibility that even results that are consistent with hardiness theory do not apply to men and women. In light of these findings, studies of hardiness that include both men and women should test for differences in findings across gender.

Given weak evidence for the construct validity of hardiness and the failure to consistently confirm the central buffering and mediational hypotheses, several researchers have recommended abandonment of hardiness research. Nevertheless, study of hardiness continues. Most studies continue to utilize one-shot data collection and correlational analyses to examine the relationships between hardiness and a variety of outcomes, such as adjustment, quality of life, and grief resolution. In order to make a substantive contribution to our understanding of personality and mental health, more longitudinal studies of hardiness should be conducted. Overall, however, the construct validity of hardiness is still doubtful, and hardiness appears to be of questionable relevance to counselors.

Owen Richard Lightsey, Jr.

*Author's Note:* The above entry for happiness relies on and contains information that was first summarized by Lent (2004). The entry for hardiness contains an update of information that was first summarized by Lightsey (1996).

**See also** Cultural Relativism (v3); Hope (v2); Job Satisfaction and General Well-Being (v4); Optimism and Pessimism (v2); Personality Theories, Five-Factor Model (v2); Psychological Well-Being, Dimensions of (v2); Resilience (v2); Stress (v2)

## Further Readings

- Diener, E. (1984). Subjective well-being. *Psychological Bulletin*, 95, 542–575.
- Diener, E., Lucas, R. E., & Scollon, C. N. (2006). Beyond the hedonic treadmill: Revising the adaptation theory of well-being. *American Psychologist*, 61, 305–314.
- Diener, E., Suh, E. M., Lucas, R. E., & Smith, H. L. (1999). Subjective well-being: Three decades of progress. *Psychological Bulletin*, 125, 276–302.

- Florian, V., Mikulincer, M., & Taubman, O. (1995). Does hardiness contribute to mental health during a stressful real-life situation? The roles of appraisal and coping. *Journal of Personality and Social Psychology*, 68, 687–695.
- Funk, S. C. (1992). Hardiness: A review of theory and research. *Health Psychology*, 11(5), 335–345.
- Hull, J. G., Van Treuren, R. R., & Virnelli, S. (1987). Hardiness and health: A critique and alternative approach. *Journal of Personality and Social Psychology*, 53, 518–530.
- Lent, R. W. (2004). Toward a unifying theoretical and practical perspective on well-being and psychosocial adjustment. *Journal of Counseling Psychology*, 51, 482–509.
- Lightsey, O. R., Jr. (1996). What leads to wellness? The role of psychological resources in well-being. *The Counseling Psychologist*, 24, 589–735.
- Maddi, S. (2006). Hardiness: The courage to grow from stresses. *Journal of Positive Psychology*, 1, 160–168.

## HARMFUL PSYCHOLOGICAL TREATMENTS

A widely accepted credo among medical and mental health professionals, attributed to the Greek physician and “father of medicine” Hippocrates, is *Primum non nocere* (“First, do no harm”). Yet, despite the signal importance of this credo, the field of psychotherapy has displayed relatively little interest in the question of potentially harmful psychological treatments. For example, in 2006, the American Psychological Association (APA) Presidential Task Force on Evidence-Based Practice barely mentioned the problem of harmful treatments.

There is no question that psychotherapy is helpful on balance. Meta-analyses consistently demonstrate that a broad spectrum of psychotherapies, including behavior, cognitive-behavioral, interpersonal, and insight-oriented therapies, exert positive effects on a variety of psychological problems. These problems include mood disorders, anxiety disorders, insomnia, and bulimia nervosa. Nevertheless, this positive assessment of the state of the psychotherapy literature must be balanced against one sobering fact: A nontrivial number of clients become worse following psychotherapy.

## Psychotherapy Deterioration

Estimates of *psychotherapy deterioration*—that is, worsening of symptoms following psychotherapy—vary across controlled studies, but typically range from



3% to 10%. In the substance abuse literature, estimates of deterioration have often been higher, averaging 10% to 15%. These percentages have led some researchers, such as Hans Strupp, Richard Stuart, and Scott Lilienfeld, to suggest that psychotherapy can in some cases be *iatrogenic*, that is, capable of causing harm.

Moreover, comprehensive *meta-analyses* (quantitative reviews) of the psychotherapy outcome literature have been reasonably consistent in revealing that control groups—groups that do not receive treatment—show higher end-state functioning than groups that receive treatment in a nontrivial minority of studies. A classic meta-analysis of psychotherapy outcome studies by Mary Lee Smith and Gene Glass found this to be true in 9% of the scientific investigations of the efficacy of psychotherapy. Later meta-analyses have reported similar or even higher percentages of negative outcomes. Even more troubling, meta-analyses of treatments for adolescent behavioral problems have suggested that as many as 29% of studies yield negative outcomes.

Troubling as they are, reported percentages of psychotherapy deterioration and negative effect sizes from meta-analyses are difficult to interpret. As the logical error of *post hoc, ergo propter hoc* (“after this, therefore because of this”) reminds us, deterioration *following* psychotherapy is not the same as deterioration *resulting from* psychotherapy. At least some of the deterioration reported in previous studies could reflect worsening due to extratherapy variables, such as stressful life events. Moreover, certain individuals who deteriorate following psychotherapy might have been even worse off had they not received psychotherapy. Therefore, estimates of psychotherapy deterioration, although suggestive of therapy-induced harm in some cases, cannot be interpreted directly as evidence for the negative effects of therapy.

The same holds for negative effect sizes from meta-analyses. Such effect sizes, especially if close to zero, could reflect random sampling error around a mean effect of zero. As a consequence, treatments that yield small negative effects could be merely inert rather than harmful per se. It should be noted, however, that inert treatments can cause harm indirectly by leading clients to forgo more efficacious therapies. Economists refer to this side effect as an *opportunity cost*, meaning that ineffective treatments may lead consumers to forfeit opportunities for successful treatment.

Randomized controlled trials are the best means of ascertaining whether deterioration following

psychotherapy is attributable to the effects of psychotherapy. In randomized controlled trials, investigators randomly assign some clients to receive the treatment, and others to either receive no treatment or an alternative treatment. If treated groups show worse functioning than untreated control groups following psychotherapy in replicated randomized controlled trials, one can be reasonably confident that a psychological treatment is harmful.

Yet even here, the absence of mean differences between treatments can mask iatrogenic effects. For example, certain treatments may markedly increase the variance in outcomes but leave the average outcome largely or entirely unchanged. In these instances, psychotherapies have produced improvement in some clients but worsening in others. As a consequence, consumers of psychotherapy outcome research must be certain to attend not merely to differences in mean scores following treatment but to potential differences in variance.

### Harm as a Multifaceted Phenomenon

Making matters more complex, harm following psychotherapy is a multifaceted phenomenon. First, harm can be manifested in myriad forms, including a worsening of the signs and symptoms of a disorder, emergence of new signs and symptoms, excessive dependency on therapists, and reluctance to seek future treatment. Traditionally, psychotherapy outcome researchers would regard only the first two of these forms of harm as “deterioration.” In some cases, as in certain coercive restraint therapies (described below), psychological treatments may even produce serious physical harm.

Second, harm can occur in certain symptom domains (e.g., heightened anxiety) but not in others (e.g., depressed mood). This point underscores the need to assess harmful effects using multiple indicators of psychological functioning.

Third, certain treatments may be harmful primarily for the relatives of clients rather than clients themselves. As this entry will discuss below, facilitated communication for autism and recovered memory techniques appear to have led to numerous uncorroborated allegations of sexual abuse against the family members of clients.

Fourth, certain treatments that are efficacious in the long term may engender symptom worsening in the short term. For example, some effective marital therapies appear to result in time-limited increases in marital distress early in treatment, probably because



they force partners to confront long-avoided emotional conflicts.

### Potentially Harmful Therapies

Attention has only recently been accorded to the development of criteria for ascertaining whether a form of therapy is potentially harmful. In recent work, Scott Lilienfeld and his colleagues have generated a provisional list of potentially harmful therapies. Readers are advised to bear in mind that this list is preliminary. It will almost certainly be revised in coming years as additional data become available.

To qualify as a potentially harmful therapy, a treatment should be demonstrated to (a) be harmful across replicated studies (ideally randomized controlled trials), or (b) result in marked increases in adverse events shortly after the introduction of treatment, events that otherwise rarely occur (e.g., recovered memories of trauma), as reported across multiple case studies. Inclusion of a treatment on the list of potentially harmful therapies does not mean that it is harmful for all or even most clients. Instead, a treatment's being designated as potentially harmful should alert therapists to the distinct possibility that the treatment may pose harm in certain cases.

Scott Lilienfeld perused the scientific literature and compiled a list of potentially harmful therapies in 2007. This literature provides reasonably clear-cut evidence that the following six treatments—taken from Lilienfeld's more comprehensive compilation—qualify as potentially harmful therapies.

#### ***Critical Incident Stress Debriefing***

##### **The Treatment**

Critical Incident Stress Debriefing, commonly called *crisis debriefing*, is a widely used treatment designed to ward off symptoms of posttraumatic stress disorder in individuals exposed to trauma. Several thousand counselors administered crisis debriefing or variants of this treatment to the witnesses of the September 11, 2001, terrorist attacks in New York City. Crisis debriefing is typically conducted in a single group session and lasts several hours, although it is occasionally spread out across several sessions. In traditional crisis debriefing, therapists strongly encourage group members to discuss and “process” their negative emotions associated with the trauma. They outline the

symptoms of posttraumatic stress disorder that group members are likely to experience following trauma, and discourage group members from discontinuing participation once the session is underway. With respect to the lattermost point, some crisis debriefing counselors even ask group members to retrieve members who have left in mid-session.

##### **The Evidence**

A meta-analysis of randomized controlled trials for crisis debriefing yielded a small negative effect size ( $d = -.11$ ) for posttraumatic stress disorder symptoms. That figure indicates that individuals exposed to trauma who receive crisis debriefing actually end up with slightly more symptoms of posttraumatic stress disorder than individuals who receive no treatment. Moreover, the results of three randomized controlled trials indicate that crisis debriefing can be markedly harmful for at least some trauma-exposed individuals, perhaps because this procedure impedes natural recovery processes. Incidentally, at least some evidence from randomized controlled trials suggests that grief therapies, which also encourage the expression of intense negative affect following painful experiences, can be iatrogenic for individuals undergoing relatively normal grief reactions.

#### ***Scared Straight Programs***

##### **The Treatment**

Scared Straight programs became popular in the 1970s and were featured in an influential 1978 documentary on Rahway State Prison in New Jersey. The programs aim to frighten at-risk teenagers away from a life of crime by showing them the terrifying realities of prison life. Many of these programs introduce troubled adolescents to convicts in prison.

##### **The Evidence**

A meta-analysis of seven randomized controlled trials and quasi-experimental studies of Scared Straight programs revealed that they increased the chances of reoffending by 60% to 70%. The mechanisms underlying these negative effects are unknown, although some authors have suggested that Scared Straight programs may contribute to further alienation among a subgroup of already alienated teenagers. The research evidence for other “get tough” interventions



with troubled adolescents has been similarly inconclusive or negative. For example, the research support for popular “boot camp” programs for adolescent criminals is mixed. Some studies show significant positive effects, but others show significant negative effects. The factors that account for these varied outcomes are unknown. As a consequence, there is at present no way for practitioners to know whether boot camp interventions will be beneficial or harmful.

### **Facilitated Communication**

#### **The Treatment**

Facilitated communication is based on a radical theory that infantile autism and related developmental disabilities are primarily movement disorders, not mental disorders. According to facilitated communication proponents, individuals with autism suffer from *developmental apraxia* (i.e., a disorder that interferes with the child’s ability to perform well-coordinated movements, including speaking). This condition supposedly accounts for their poor or even (in severe cases) absent verbal abilities, as well as other movement difficulties. Therefore, advocates of facilitated communication argue that individuals with autism and similar disorders can purportedly generate communications using a computer keyboard or letter pad with the assistance of a trained facilitator who offers a combination of guidance and resistance to the individuals’ hands.

#### **The Evidence**

Controlled studies in which individuals with autism and their facilitator were shown different stimuli and had to type out which stimulus they saw provide overwhelming evidence for an *ideomotor effect*—a phenomenon in which the facilitator unconsciously makes subtle motions that influence the communications of autistic individuals. Specifically, in these studies the word typed was in essentially all cases the word seen by the facilitator, not the word seen by the autistic individual. Indeed, there is no compelling evidence that any facilitated communications are generated by autistic individuals themselves. Moreover, facilitated communication has been associated with at least five dozen allegations of sexual abuse against the parents and relatives of autistic children. Most of these allegations have never been corroborated by objective evidence.

### **Coercive Restraint Therapies**

#### **The Treatment**

Coercive restraint therapies are a subset of attachment therapies, which are based on the unsupported notion that certain psychological difficulties, including aggression and oppositionality, stem from aberrant early attachment experiences. These experiences include a premature or abnormally difficult birth. Coercive restraint therapies, like other attachment therapies, are intended to ameliorate these adverse experiences. They include *holding therapy*, in which therapists physically restrain children or adolescents in an effort to release suppressed rage, and *rebirthing therapy*, in which therapists attempt to engage the client in reenacting the trauma of birth. In some variants of rebirthing therapy, practitioners wrap the child in blankets to create an analogue birth canal, and they simulate the birth process by squeezing on the child repeatedly.

#### **The Evidence**

There are no controlled studies supporting the efficacy of coercive restraint therapies or other attachment therapies. Moreover, several children have been injured or suffocated to death during coercive restraint therapies—including 10-year-old Candace Newmaker, who died in Colorado in 2000 during a rebirthing session.

### **Recovered Memory Techniques**

#### **The Treatment**

Several surveys from the 1990s suggest that a sizable proportion of therapists (perhaps 25%) make regular use of suggestive techniques to unearth purportedly recovered memories of early trauma, particularly child sexual abuse. These techniques include repeated therapist prompting of memories, hypnosis (including hypnotic age regression), guided imagery, and “body work,” which encourages clients to access “bodily memories” of early abuse.

#### **The Evidence**

The question of whether suggestive techniques can ever uncover accurate memories of abuse remains scientifically controversial. Nevertheless, laboratory research leaves little doubt that these techniques can lead to *false memories* in a substantial percentage of



participants. Moreover, findings that recovered memory techniques can engender memories of alien abductions and even past-life child abuse offer *existence proofs* that at least some of the memories produced by these techniques are false.

There is also strong reason to suspect that false memories can lead to significant harmful effects in both clients and their family members. For example, data from recovered memory legal claims in Washington State indicate that suicidal ideation increased nearly sevenfold and that psychiatric hospitalizations increased nearly fivefold over the course of recovered memory treatment. Although these findings do not provide definitive evidence of causality, they raise serious concerns about the potential negative effects of such treatment. Moreover, many families have been torn apart by uncorroborated accusations of sexual abuse by children against parents.

### ***Dissociative Identity Disorder-Oriented Treatment***

#### **The Treatment**

Dissociative identity disorder-oriented (DID-oriented) treatment is designed to elicit *alter personalities* (i.e., alternate personalities or *alters*) in individuals suspected of having DID (formerly known as *multiple personality disorder*). The core premise of this treatment is that patients with DID harbor hidden identities that must be brought forth for improvement to occur. DID-oriented treatment methods include a variety of suggestive treatment techniques, including contacting supposed alters through hypnosis, introducing alters to each other, and mapping out the relations among alters. One prominent DID-oriented therapist advocates the use of a “bulletin board” to allow alters to post messages to each other. Another advocates “inner board meetings” as a method of permitting alters to communicate.

#### **The Evidence**

Multiple lines of evidence suggest that DID-oriented techniques more often create alters than uncover them, probably by treating poorly integrated aspects of patients’ personalities as though they were independent identities. For example, only about 20% of patients with dissociative identity disorder display clear-cut alters prior to treatment. Alters emerge in the

remaining 80% of patients only following DID-oriented therapy. Moreover, the number of alters tends to increase over the course of DID-oriented therapy. This finding is worrisome given that the number of alters in dissociative identity disorder patients is associated with a significantly longer time to “fusion,” that is, the integration of alters into a single personality.

### **Future Directions**

Although research evidence indicates that psychotherapy is generally helpful, a growing body of data suggests that certain psychological treatments can be harmful for certain clients and their families. The fields of counseling and clinical psychology are awakening to the need to devote additional resources to the identification of potentially harmful therapies. Efforts to (a) understand the psychological mechanisms underlying the iatrogenic effects of potentially harmful therapies, (b) find better means of detecting and preventing these effects, and (c) educate psychotherapists and mental health consumers regarding the hazards of harmful psychological treatments should therefore be accorded greater attention.

Scott O. Lilienfeld

**See also** Code of Ethics and Standards of Practice (v2); Common Factors Model (v2); Counseling Process/Outcome (v2); Crisis Counseling (v2); Critical Incident Stress Debriefing (v2); Empirically Based Professional Practice (v1); Evidence-Based Treatments (v2); Ethical Codes (v1); False Memories (v2); Panic Disorders (v2); Posttraumatic Stress Disorder (v2); Taxonomy of Helpful Impacts (v2); Therapist Techniques/Behaviors (v2); Wampold, Bruce E. (v2)

### **Further Readings**

- Boisvert, C. (2003). Negative effects in psychotherapy: Research findings and clinical implications. *Directions in Clinical and Counseling Psychology*, 15(4), 37–48.
- Bootzin, R. R., & Bailey, E. T. (2005). Understanding placebo, nocebo, and iatrogenic treatment effects. *Journal of Clinical Psychology*, 61, 871–880.
- Hunsley, J., & Lee, C. M. (1995). The marital effects of individually oriented psychotherapy: Is there evidence for the deterioration hypothesis? *Clinical Psychology Review*, 15, 1–22.
- Lilienfeld, S. O. (2007). Psychological treatments that cause harm. *Perspectives on Psychological Science*, 2, 53–70.



- Lilienfeld, S. O., Lynn, S. J., & Lohr, J. M. (Eds.). (2003). *Science and pseudoscience in clinical psychology*. New York: Guilford Press.
- Lynn, S. J., Lock, T., Loftus, E. F., Krackow, E., & Lilienfeld, S. O. (2003). The remembrance of things past: Problematic memory recovery techniques in psychotherapy. In S. O. Lilienfeld, S. J. Lynn, & J. M. Lohr (Eds.), *Science and pseudoscience in clinical psychology* (pp. 205–239). New York: Guilford Press.
- Mash, E. J., & Hunsley, J. (1993). Assessment considerations in the identification of failing psychotherapy: Bringing the negatives out of the darkroom. *Psychological Assessment*, 5, 292–301.
- McCord, J. (2003). Cures that harm: Unanticipated outcomes of crime prevention programs. *Annals, AAPSS*, 587, 16–30.
- Mohr, D. C. (1995). Negative outcome in psychotherapy: A critical review. *Clinical Psychology: Science and Practice*, 2, 1–27.
- Moos, R. (2005). Iatrogenic effects of psychosocial interventions for substance use disorders: Prevalence, predictors, prevention. *Addiction*, 100, 595–604.
- Rhule, D. M. (2005). Take care to do no harm: Harmful interventions for youth problem behavior. *Professional Psychology: Research and Practice*, 36, 618–625.
- Smith, M. L., & Glass, G. V. (1977). Meta-analysis of psychotherapy outcome studies. *American Psychologist*, 32, 752–760.
- Strupp, H. H., Hadley, S. W., & Gomez-Schwartz, B. (1978). *Psychotherapy for better or worse: The problem of negative effects*. New York: Wiley.
- Stuart, R. B. (1970). *Trick or treatment: How and when psychotherapy fails*. Champaign, IL: Research Press.
- Werch, C. E., & Owen, D. (2002). Iatrogenic effects of alcohol and drug prevention programs. *Journal of Studies on Alcohol*, 63, 581–590.

---

## HEPPNER, PUNCKY PAUL (1951– )

---

Puncky Paul Heppner, born on February 24, 1951, in Bismarck, North Dakota, is a counseling psychologist at the University of Missouri. Early in his career Heppner significantly advanced psychologists' understanding of the role of social influence in the counseling process. Despite the importance of this work, he is most widely known for his significant theoretical and empirical contributions to our understanding of problem-solving behavior.

Heppner received his Ph.D. in counseling psychology from the University of Nebraska at Lincoln in 1979

and accepted a position at the University of Missouri–Columbia (MU) where he remains to date. He has served as training director of the counseling psychology doctoral program and as chair of the Department of Educational, School, and Counseling Psychology. He also cofounded and codirects the University of Missouri Center for Multicultural Research, Training, and Consultation.

In the early 1980s, Heppner developed the Problem Solving Inventory, a widely used measure of applied problem solving that has been used in more than 130 empirical studies. His research on the role of problem solving with stressful life events demonstrated that across a wide range of populations, an individual's problem-solving appraisal (i.e., problem-solving self-efficacy) can moderate the harmful effects of stress. This program of research shaped the conceptualization of counseling as a process of helping people resolve their personal problems, thereby decreasing their distress and enhancing their well-being.

In 1987, Heppner advocated a change in counseling psychologists' conceptualization of problem solving. His innovative application of an information processing perspective to understanding problem-solving behavior anticipated a major paradigmatic change in the conceptualizing of problem solving. He also has been known by many graduate students as the first author of a premier research design text in the field of counseling, *Research Design in Counseling*. Heppner further shaped counseling psychology through his active involvement in professional service. He edited the Lifelines series in the *Journal of Counseling Development* from 1984 to 1990, which published biographies of pioneers, leaders, and early training institutions in the fields of counseling. He edited *The Counseling Psychologist* from 1997 to 2002. He has been involved in APA Division 17 (Society of Counseling Psychology) in a variety of roles, most notably serving as president from 2004 to 2005.

Stephen W. Cook

**See also** Cognitive Information Processing Model (v4); Problem-Solving Appraisal (v2); Social Support (v2); Stress (v2); Stress Management (v2)

### Further Readings

- Heppner, P. P., & Claiborn, C. D. (1989). Social influence research in counseling: A review and critique [Monograph.]. *Journal of Counseling Psychology*, 36, 365–387.



- Heppner, P. P., Kivlighan, D., Jr., & Wampold, B. E. (2008). *Research design in counseling* (3rd ed.). Pacific Grove, CA: Brooks/Cole.
- Heppner, P. P., & Krauskopf, C. J. (1987). An information processing approach to personal problem solving. *The Counseling Psychologist*, 15, 371–447.
- Heppner, P. P., Witty, T. E., & Dixon, W. A. (2004). Problem-solving appraisal and human adjustment: A review of 20 years of research utilizing the Problem Solving Inventory. *The Counseling Psychologist*, 32, 344–428.

---

## HILL, CLARA E. (1948– )

---

Clara E. Hill, born on September 13, 1948, in Shivers, Mississippi, has contributed profoundly to counseling psychology through her innovations in counseling process and outcome research, development of models for teaching helping skills and for working with dreams, and creation of a qualitative research methodology. She has also received several of counseling psychology's highest honors.

Hill completed her undergraduate degree in psychology and her master's and doctoral degrees in counseling psychology at Southern Illinois University. She then joined the Department of Psychology at the University of Maryland, where she is now a full professor. Important early career mentors include Bill Anthony, Bruce Fretz, Paul Schauble, and John Snyder; she has mentored numerous talented protégés, including Jean Carter, Rachel Crook-Lyons, Aaron Rochlen, Barbara Thompson, and Libby Williams. Hill also has influenced counseling psychology research as editor of two of its leading journals.

Hill has contributed to counseling process and outcome research by developing innovative procedures for identifying and measuring moment-by-moment interactions between counselor and client. These innovations enable a deeper and more incisive understanding of the counseling process and its immediate effects. Hill herself applied these techniques to the examination of counselor intentions and techniques (e.g., self-disclosure, silence), client reactions and behaviors, secrets and things left unsaid, misunderstandings, client anger, and client insight.

Hill also applied the knowledge gained from process research to the development of a model for training new counselors. *Helping Skills: Facilitating Exploration, Insight, and Action*, now in its second

edition, provides an empirically grounded three-stage model (i.e., exploration, insight, action) for mastering basic counseling skills that is widely used at the undergraduate and graduate levels.

In addition, Hill developed an accessible model for working with clients' dreams. She views dreams as one avenue through which clients may reach greater understanding of their difficulties and develop strategies to address them. She integrated her helping skills model and existing dream interpretation models into a three-stage process counselors use to facilitate clients' understanding of their dreams. The process begins with an exploration of the client's major dream images. Counselor and client then use that foundation to seek insight into the meaning of the dream and to determine how clients can make changes in their waking life. In over 20 studies, Hill has helped establish that dream work is effective in facilitating insight and action ideas, and in fostering the working alliance and client satisfaction.

Finally, Hill has contributed to the development of a qualitative research methodology (i.e., consensual qualitative research, or CQR). CQR enables researchers to examine experiential phenomena: Because participants respond verbally (often via a telephone interview) to a semistructured protocol of open-ended questions, the rich data obtained using CQR enable researchers to examine phenomena in depth. A primary team of researchers works collaboratively to collect and analyze participant data, and outside auditors check the work of the primary team. CQR has been used extensively to study the counseling process.

Sarah Knox

**See also** Client Attitudes and Behaviors (v2); Counseling Process/Outcome (v2); Counseling Skills Training (v2); Facilitative Conditions (v2); Outcomes of Counseling and Psychotherapy (v2); Qualitative Methodologies (v1); Self-Disclosure (v2); Therapist Techniques/Behaviors (v2)

### Further Readings

- Hill, C. E. (Ed.). (2004). *Dream work in therapy: Facilitating exploration, insight, and action*. Washington, DC: American Psychological Association.
- Hill, C. E. (2004). *Helping skills: Facilitating exploration, insight, and action* (2nd ed.). Washington, DC: American Psychological Association.
- Hill, C. E., & Lambert, M. J. (2004). Methodological issues in studying psychotherapy process and outcomes.



In M. J. Lambert (Ed.), *Handbook of psychotherapy and behavior change* (5th ed., pp. 84–136). New York: Wiley.

Hill, C. E., Thompson, B. J., & Williams, E. N. (1997). A guide to conducting consensual qualitative research. *The Counseling Psychologist*, 25, 517–572.

## HOMework ASSIGNMENTS

Homework assignments are tasks that clients in counseling and psychotherapy work on between treatment sessions. Examples include having a depressed client do one rewarding activity a day, having a couple practice active listening skills between sessions, asking a Navajo client exploring career options to talk to an elder on the topic, having an anxious client practice progressive relaxation techniques, and asking clients to write down their dreams for later processing.

### Relevance

Homework is considered an important component in most behavioral, cognitive, systems, and solution-focused therapies. Practitioners of those methods assign homework with the greatest frequency, but most practitioners, regardless of theoretical perspective, employ home assignments at times. A panel of psychotherapy experts recently rated homework assignments as the intervention most likely to be used more frequently in future years. The economic pressures of managed care have helped spur the use of briefer forms of therapies, and homework has become a cost-effective way of increasing the impact of limited treatment time. Between-session activities have now been proposed by some theorists to be a common factor in the success of all brief therapies.

### Purpose and Benefits

By using the intervals between sessions, homework assignments increase the time clients spend engaging in activities designed to speed their recovery. Homework allows the generalization and transfer of in-session treatment gains through the use of in-vivo practice in natural settings. Clients doing home tasks can acquire insight and skills, and are more likely to view themselves as change agents rather than as passive recipients of therapy. Many counselors and therapists assess homework compliance in evaluating

both treatment progress and the strength of the working alliance. Successful homework is theorized to increase a client's sense of mastery, self-efficacy, and optimism about treatment success. The skill-building approach of home activities reflects the goals of positive psychology models.

## History and Research

Recommendations for assigned tasks outside the therapy hour began appearing in the literature in the 1940s and 1950s. Theoretical and empirical attention to homework activities has largely paralleled the growth in popularity of cognitive and behavioral models of counseling and psychotherapy. Reflecting the pragmatic nature of homework itself, earlier writings often focused on practitioner recommendations, and became available in published workbooks and manuals. Empirical research has demonstrated that adherence to homework assignments is one of the predictors of successful treatment outcome, and that clients who do the most homework benefit the most in treatment.

Preliminary studies suggest that homework is more often completed when tasks are specific, rehearsed in session, and matched to client strengths, motivation level, and treatment goals. Clients may comply more when they have choices of tasks, and when therapists write down the assignment and review it in the next session. Issues presently being investigated by psychologists include these and other factors influencing client compliance with assignments, the reliability of measures of homework quality and compliance, and factors in the process of assigning homework that make it most effective.

*Lee Thomas Rode*

*See also* Behavior Therapy (v2); Cognitive-Behavioral Therapy and Techniques (v2); Common Factors Model (v2); Rational Emotive Behavior Therapy (v2); Solution-Focused Brief Therapy (v2); Treatment Compliance (v1)

### Further Readings

- Kazantzis, N., Deane, F. P., & Ronan, K. R. (2004). Assessing compliance with homework assignments: Review and recommendations for clinical practice. *Journal of Clinical Psychology*, 60, 627–641.
- Scheel, M. J., Hanson, W. E., & Razzhavaikina, T. I. (2004). The process of recommending homework in



psychotherapy: A review of therapist delivery methods, client acceptability, and factors that affect compliance. *Psychotherapy: Theory, Research, Practice, Training*, 41, 38–55.

---

## HOPE

---

Human weaknesses such as hopelessness and aggression have often been the focus of psychologists. This attention to weakness has resulted in information on treatments of psychological disorders such as anxiety and depression. However, with the recent emergence of the positive psychology perspective, more focus is being given to studying human strengths. The aim of positive psychology is to help health care, education, and business professionals apply a science that focuses on the understanding of what makes life worth living. *Positive psychology* is an umbrella term for the study of positive character traits, positive emotions, and enabling institutions. One example of such human strength that has been studied widely is the construct of hope.

### Hope Theory

From the late 1950s and into the 1960s, several theorists focused on the concept of hope and centered the explanation of hope around a person's positive expectations for goal attainment. Simply stated, hope was viewed as the perception that one's goals can be attained. Over time and across research examining the construct, the conceptualization of hope evolved into a much more complex and diverse theory. According to Rick Snyder and his colleagues, hope is a cognitive set that is composed of *agency* (goal-directed determination) and *pathways* (planning ways to meet stated goals). These components add up to the capacity for subjective evaluation of goal-related capabilities, or hope.

The agency component of Snyder's hope theory involves the cognitive energy or willpower that allows an individual to get moving toward his or her goal. The agency component also can be defined as an individual's perceived ability to begin movement toward a goal, and to maintain that movement along the envisioned pathway until the desired goal is reached. Self-affirming statements, such as "I know I can do this" and "I will get this done," are frequently associated with the agency component. Individuals who usually

engage in this type of self-affirming self-talk are those with high levels of hope, whereas individuals who do not typically engage in this type of self-talk are those with low levels of hope.

The pathways component of Snyder's hope theory involves an individual's perceived ability to produce effective routes to reach his or her goals. In order to attain imagined goals, people must be able to perceive that they have the ability to develop possible routes to reach their goals. Individuals with high levels of hope tend to have the ability to create many possible routes to reach their goals, whereas individuals with lower levels of hope may have difficulty creating plans to reach their desired goals. Goals can be long term and/or short term, and they should be attainable by the individual. Effective goal-directed thinking requires both agency thoughts, or goal-directed energy, and pathways thoughts, or the perceived capacity to create workable routes toward goals. The Hope Scale developed by Snyder measures both the agency and pathways components of hope.

### Hope and Aspects of Well-Being

Psychological well-being involves an active engagement in the world, a sense of meaning and purpose in life, and a connection to people or objects beyond oneself. Hope theory provides researchers and practitioners with a framework for understanding and enhancing well-being and adaptive ways of functioning. The remainder of this entry discusses research that links hope to specific aspects of well-being, including academic success, physical health, psychological adjustment, and meaning in life.

### Hope and Academic Success

An important aspect of succeeding in today's society is for one to learn and perform well in educational settings. To be academically successful, students need the ability to enhance their perceived capabilities of finding multiple pathways to meet their educational goals and the motivations to pursue these goals by applying hopeful thinking. Students also need to overcome self-deprecatory thoughts and negative emotions, and to be able to stay on task through hopeful thinking.

Research shows that hope and academic achievement have a strong relationship. Hope relates to higher achievement test scores in grade school children and higher semester grade-point averages in



college students. Hope Scale scores taken at the beginning of college students' first semester predicted higher cumulative grade-point averages, higher graduation rates, and lower dropout rates. Aspects of goals, including goal commitment, goal attainability, and goal progress, play an important role in a student's academic success. The working combination of goal commitment and goal attainability accounted for significant portions of variance in self-assessment of progress toward goal achievement. Perceived progress in goal achievement acts as a cause of change in well-being. If one imagines the negative effects (i.e., lost opportunities, sense of failure, unfulfilled talents) that may occur over a lifetime for students who do not succeed in educational settings, then the research showing that hope may reduce or prevent these negative effects is crucial.

### ***Hope and Physical Health***

Hope has been positively linked to the core foci of health psychology, including promoting and maintaining good health, and preventing, detecting, and treating illness. The powers of hope have been described in terms of primary and secondary prevention. Primary prevention involves thoughts and actions that are intended to reduce or eliminate the chances that subsequent health problems, either physical or psychological, will occur in the future. Secondary prevention involves thoughts and actions that are directed at eliminating, reducing, or containing a problem once it has occurred.

Research concerning hope and the primary prevention of physical illness has revealed that people with higher levels of hope use information about physical illness to their advantage to do more of what helps and less of what is harmful. Knowledge is used as a pathway for prevention. Snyder and colleagues discussed that women with higher levels of hope performed better on a cancer facts test than women with lower levels of hope, even after controlling for their past academic performances and their contacts with others who have had cancer. Furthermore, women with higher levels of hope reported higher intentions to engage in cancer prevention activities than women with lower levels of hope, and people with high hope reported engaging in more preventive behaviors, such as physical exercise, as compared to people with low hope.

Hope also plays a very important role even after physical illness develops. Hope should facilitate one's coping with the pain, disability, and other stressors of

physical illness, and research shows that hope has been related to better adjustment in conditions involving handicaps, severe injury, and chronic illness. More specific studies have shown that higher levels of hope have related benefits in dealing with burn injuries, spinal cord injuries, severe arthritis, fibromyalgia, and blindness.

People with lower levels of hope often experience higher anxiety when it comes to physical illness, and this may result in maladaptive avoidance coping. It also has been shown that people who are physically ill and who have low hope can be overtaken by self-focus and self-pity which, in turn, increases anxiety and compromises the healing process. However, once ill, people with high hope appear to remain appropriately energized and focused on what they need to do to recuperate. It is believed that people who are experiencing profound or chronic pain and who have higher levels of hope should be able to lessen their pain by enlisting more strategies, or pathways, and by having a higher likelihood of using those strategies, or agency, than those with lower levels of hope. Research clearly shows that hope theory can be usefully applied when it comes to prevention, detection, and effective coping with physical illness.

### ***Hope and Psychological Adjustment***

Psychological adjustment is another aspect of well-being that is influenced by hope in many ways. Specifically, hope is related positively with positive affect and negatively with negative affect. It also has been shown that manipulations to increase hope levels resulted in increases in positive affect and decreases in negative affect, and people who have higher levels of hope report having more positive and fewer negative thoughts every day. One specific study showed that college students with high hope as compared to students with low hope reported feeling more inspired, energized, confident, and challenged by their goals, as well as having elevated feelings of self-worth and low levels of depression.

As stated previously, hope is critical for physical health. Hope also is critical for psychological health. Hopeful thought involves assets, such as the ability to establish clear goals, imagine workable pathways to those goals, and motivate oneself to work toward those goals, and people with higher hope yield more successful goal pursuits in many different areas. A stressor is something that interferes with one's



normal ongoing goal of being happy. When one is confronted with a stressor, one must find alternative paths to obtain the “normalcy” goal. People with higher hope are able to produce more strategies for dealing with the stressor and express a greater likelihood of using those strategies, as well as find benefits in ongoing dealings with stressors. Dealing with stressors in one’s life, either effectively or ineffectively, is something that influences one’s feelings, emotions, and affect.

It is argued that positive emotions should flow from perceptions of successful goal pursuits and negative emotions are the product of unsuccessful goal pursuits. Research has shown that when people are confronted with insurmountable goal blockages, they experience negative emotions, and when people are able to follow successful, unimpeded goal pursuit after overcoming impediments, they experience positive emotions. It also has been reported that people who encounter severe difficulties in pursuit of important goals report lessened well-being, and the perceived lack of progress toward major goals is the cause of reductions in well-being. The opposite is true, as well. It has been reported that successful pursuit of goals is associated with elevated self-esteem and well-being.

Snyder and colleagues discussed that psychological health is related to people’s routine anticipation of their future well-being. People with higher levels of hope should expect more positive levels of psychological health as compared to people with lower levels of hope. These kinds of positive expectations will produce higher confidence, and those with high hope will perceive that their hopeful thinking will protect them against future stressors.

Psychological health also involves thoughts and actions that eliminate, reduce, or contain a problem that has already presented itself. When people with high hope encounter a goal blockage, they are flexible enough to be able to find alternative goals and alternative ways to meet these goals, whereas people with low hope tend to ruminate unproductively about being stuck. People with high levels of hope tend to have friends with whom they share a strong sense of mutuality. When stressful situations arise, those with high hope can call on these friends for support. However, people with low levels of hope tend to be lonelier, and lack friends with whom they can talk and call upon in stressful times. All of this plays into people’s overall psychological adjustment.

## Hope and Meaning in Life

Life meaning has been one of the most elusive concepts in many fields of research and study. There are many theories discussing what life meaning truly is, but generally, conceptualizations of meaning share at least two notions. First, life meaning is a global way of assessing or understanding one’s life, and second, believing that life is meaningful is associated with lower levels of negative emotions (i.e., depression and anxiety) and lower risk of mental illness.

Snyder and colleagues posited that hope should relate strongly with life meaning, as measured by a number of instruments assessing meaning or purpose in life, because it is through individuals’ self-reflection about the goals they have selected and the progress they perceive in their journey toward these goals that individuals construct meaning in their lives. Hope Scale scores were found to have significant positive correlations with the life meaning measures, suggesting that hope theory offers a new way to look at the nature of meaning.

Life meaning is viewed as a wider concept than hope because no life meaning theory can be reduced simply to goal pursuit. However, hope can be conceptualized as a component of life meaning, central to its ability to predict variables of well-being. Studies have demonstrated that relations between hope and depression are moderated by life meaning. Researchers believe that the perceived ability to achieve goals that is associated with having higher hope works as a buffer against depression and anxiety, and this, in turn, is related to higher well-being and higher life meaning.

*Kristen N. Bast and Shane J. Lopez*

**See also** Academic Achievement (v2); Depression (v2); Happiness/Hardiness (v2); Optimism and Pessimism (v2); Physical Health (v2); Positive Psychology (v2); Psychological Well-Being, Dimensions of (v2); Self-Efficacy/Perceived Competence (v2)

## Further Readings

- Averill, J. R. (2002). Emotional creativity: Toward “spiritualizing the passions.” In C. R. Snyder & S. J. Lopez (Eds.), *Handbook of positive psychology*. New York: Oxford University Press.
- Feldman, D. B., & Snyder, C. R. (2005). Hope and the meaningful life: Theoretical and empirical associations between goal-directed thinking and life meaning. *Journal of Social and Clinical Psychology*, 24(3), 401–421.



- Hamilton, N. A., & Ingram, R. E. (2001). Self-focused attention and coping: Attending to the right things. In C. R. Snyder (Ed.), *Coping with stress: Effective people and processes*. New York: Oxford University Press.
- Lopez, S. J., Ciarlelli, R., Coffman, L., Stone, M., & Wyatt, L. (2000). Diagnosing for strengths: On measuring hope building blocks. In C. R. Snyder (Ed.), *Handbook of hope: Theory, measures, and applications*. New York: Academic Press.
- Michael, S. T. (2000). Hope conquers fear: Overcoming anxiety and panic attacks. In C. R. Snyder (Ed.), *Handbook of hope: Theory, measures, and applications*. San Diego, CA: Academic Press.
- Seligman, M. E. P., & Csikszentmihalyi, M. (2000). Positive psychology: An introduction. *American Psychologist*, 55, 5–14.
- Snyder, C. R. (1995). Conceptualizing, measuring, and nurturing hope. *Journal of Counseling and Development*, 73, 355–360.
- Snyder, C. R., Cheavens, J., & Michael, S. T. (1999). Hoping. In C. R. Snyder (Ed.), *Coping: The psychology of what works*. New York: Oxford University Press.
- Snyder, C. R., Feldman, D. B., Taylor, J. D., Schroeder, L. L., & Adams, V., III (2000). The roles of hopeful thinking in preventing problems and enhancing strengths. *Applied and Preventive Psychology*, 15, 262–295.
- Snyder, C. R., Harris, C., Anderson, J. R., Holleran, S. A., Irving, L. M., Sigman, S. T., et al. (1991). The will and the ways: Development and validation of an individual-differences measure of hope. *Journal of Personality and Social Psychology*, 60, 570–585.
- Snyder, C. R., Ilardi, S., Michael, S. T., & Cheavens, J. (2000). Hope theory: Updating a common process for psychological change. In C. R. Snyder & R. E. Ingram (Eds.), *Handbook of psychological change: Psychotherapy processes and practices for the 21st century*. New York: Wiley.
- Snyder, C. R., Rand, K. L., & Sigmon, D. R. (2002). Hope theory: A member of the positive psychology family. In C. R. Snyder & S. J. Lopez (Eds.), *Handbook of positive psychology*. New York: Oxford University Press.

---

## HUMANISTIC APPROACHES

---

Humanistic approaches to counseling include a number of theoretical viewpoints. The dominant perspectives in this category are person-centered therapy and Gestalt therapy, which emerged in the 1950s and 1960s as alternatives to the prevailing approaches of the time,

psychoanalysis and behaviorism. This entry will review person-centered therapy and Gestalt therapy, along with a more recent approach that combines elements of these two: process-experiential psychotherapy.

### Assumptions of Humanistic Approaches

Humanistic theorists emphasize the freedom and responsibility of the individual. In psychology, these theoretical viewpoints evolved as a reaction to psychoanalytic and behavioral perspectives that characterized human behavior as determined by forces not directly under individual control. The humanists rebelled against the conception of humans as pawns controlled by genetically programmed instinct or environmental forces and accompanying assumptions that seemed to split the individual into pieces. Instead, humanistic theorists emphasize individual agency and holistic functioning.

A related assumption in humanistic approaches is the importance of individual experiencing. Human functioning is viewed as the direct result of the internal world of the individual; thoughts and feelings are given primacy over external forces in the motivation and production of behavior. However, an essential element of human experience is the relationship with the surrounding environment, most notably, other individuals.

Humanistic approaches to counseling tend to emphasize self-awareness, and these therapists prompt clients to explore their inner worlds. In these systems, it is recognized that it is natural for individuals to deny or distort aspects of experience that they find painful or unacceptable to their self-conceptions. These denied or distorted experiences cause problems in living. The tendency to reject aspects of life experience is seen as learned, primarily from the cultural norms and expectations that are incorporated into people's self-concepts as they traverse the developmental path from childhood to adulthood. Freed from societal influences, individuals' natural growth tendencies lead them to become fully functioning, healthy (in both mind and body) human beings who can adequately satisfy their physiological and psychological needs. Healthy individuals freely experience internal and external events and processes, and live authentic lives unfettered by the rules and dictates of society.

Although specifics differ somewhat across theories, one important task of the therapist in humanistic approaches is to provide the correct therapeutic



environment for the client. The client must be freed from blocks in experiencing so that they can become authentic. To do this, the therapist, too, must be authentic. The therapeutic relationship is viewed as an encounter between two individuals; the client's experiencing is blocked in some way, and the therapist is experiencing more freely. Ultimately, the therapist's acceptance of the client leads to the client's acceptance of the self, with all of its experience.

### Person-Centered Therapy

Person-centered (PC) therapy was developed by Carl Ransom Rogers and has been known by three different names. It was called *nondirective* therapy when first introduced in the 1940s, and then Rogers renamed it *client-centered* therapy in the 1950s. In the 1980s, because many PC concepts were being applied beyond counseling and psychotherapy, in areas such as education, industry, and conflict resolution, Rogers began using the name *person-centered* approach to reflect the potential for application of this theory beyond traditional individual psychotherapy.

As noted earlier, PC theory was developed by Rogers in response to the two dominant psychotherapy approaches in the 1940s and 1950s: Freudian psychoanalytic theory and behavior therapy. Rogers was one of the major figures using the humanistic approach in his time. Reflecting his positive viewpoint on human nature and his insistence on equality in the counseling relationship, he was the first person to use the term *clients* (instead of *patients*) to refer to individuals who seek psychotherapy.

Rogers's most prominent philosophical assumption was that human beings are inherently good. Rogers believed that the primary motivation of human behavior is to grow into one's full capacity. Humans have a self-actualizing tendency that will orient people toward growth if unconditional positive regard and emotional support are provided. When individuals are well functioning, this growth is guided by the internal regulation of the organismic valuing process. The *organismic valuing process* evaluates experiences in terms of whether they are good or bad for the organism, without reference to cultural or societal standards. In addition, Rogers thought that all human beings have a need for positive regard and that individuals seek love from significant others to fulfill this need.

The concept of the self occupies a central position in PC theory. As individuals grow and experience the

world, they soon learn to differentiate self from others and develop a sense of who they are. All of the experiences related to the self and perceptions about who the self is, as well as the values (e.g., positive or negative) associated with them, comprise an individual's *self-concept*. On the other hand, the concept of *ideal self* refers to what a person would like to be based on societal messages. In psychologically healthy individuals, the ideal and real selves are nearly identical.

Rogers used the term *conditions of worth* to describe the underlying source of humans' problematic behaviors. When individuals are young, if they consistently perceive that they are more valued or liked by significant others when they perform some behaviors and less valued when they perform others, then they experience conditions of worth. Initially, conditions of worth are external; that is, they are the reactions of others (such as parents) who value behaviors differentially, often based on societal norms (e.g., boys don't cry, girls don't shout). However, because the need for love from significant others is so intense, the conditions of worth will be internalized as parts of the self if they continue to exist for a period of time.

When conditions of worth are internalized, the individual is said to be in a state of incongruence. Self-relevant experiences are evaluated based on whether they are consistent with the internalized conditions of worth, instead of through the organismic valuing process, which determines whether experiences are growth producing or detrimental to the organism. *Incongruence* is a discrepancy between self and experience; that is, people deny or distort some of their experiences that do not fit the conditions of worth. Another way to describe dysfunction is that the person's real and ideal self (which incorporates the conditions of worth) are discrepant.

Rogers saw therapy as an encounter between two individuals and contended that the therapist's attitude or philosophy was critical to the success of therapy. Thus, there are no formally recognized techniques in this approach. PC counselors strive to develop understanding, supportive, and empathic counseling relationships with their clients. Rogers believed that the therapist's *congruence* (or *genuineness*) was critical to the success of therapy, and along with *empathy* and *unconditional positive regard*, necessary and sufficient for client change. When the therapist consistently provides these conditions and trusts the client to lead the way, the client will be able to get beyond the



internalized conditions of worth, progressing from a state of incongruence to one of congruence. The self-actualization tendency (in tandem with the organismic valuing process) is in charge and orients the individual toward positive growth once again.

Rogers's assumption that each person has sufficient internal resources and strengths to grow and become a better person leads to a therapeutic relationship that stresses client autonomy and encourages clients to be self-directing. The main function of the PC counselor is to provide a safe, empathic, and supportive therapeutic environment that allows clients to follow their own directions. This respect for the individual's autonomy leads to PC counselors' attitude of equality within the therapeutic interaction; they eschew an expert role in the counseling process. In addition, the PC approach is phenomenological; an individual's subjective perception is considered the defining force of reality for that person. Therefore, the focus of PC counseling is on the clients and their perceptions of the situations, not what might be viewed as "reality" by others. As PC counselors respond with empathic reflection and genuine reactions to the clients' presenting concerns, they focus the clients' attention to their own internal wisdom and assist their clients' emerging self-awareness. Simultaneously, they also accept their clients as worthy and valuable beings regardless of their actions. This valuing from the therapists sets the stage for the clients' own self-acceptance.

PC theory has been criticized for being too simplistic and oblivious to the true qualities of human nature. Although counseling outcome research appears to support the effectiveness of the PC theory, empirical evidence indicates that the core conditions (i.e., counselor's empathy, congruence, and unconditional positive regard) are likely to be necessary but not sufficient for therapeutic change. However, research clearly demonstrates that the therapeutic relationship is critical to the outcomes of therapy of all kinds.

Because PC therapy focuses on the person and stresses the necessity of self-actualizing tendency for the person's healthy functioning, the individualistic emphasis within PC theory can be detrimental to clients from more collectivistic cultural backgrounds or to those who have experienced oppression. In addition, PC theory has been criticized for its lack of attention to familial and cultural factors, which may be particularly problematic in dealing with clients from other cultures. On the other hand, PC theory's trust in

the individual to know what is needed can be helpful in working with clients from diverse backgrounds.

## Gestalt Therapy

Fritz Perls is considered the founder of Gestalt therapy (GT). However, several individuals, including his wife, Laura Perls, and Paul Goodman, also made significant contributions to the development of the GT in its early stages. After Perls's death in 1970, second- and third-generation GT therapists such as Walter Kempler, Erving Polster, and Gary Yontef continued to practice and promote the approach. Over time, the theory evolved into several different versions. In fact, a somewhat confusing feature about the GT approach is that although some core principles and theoretical concepts are shared by the various versions of GT, there is little orthodox doctrine about how these are put into action.

Perls believed that humans have the potential to act and function in an authentic and holistic way. GT theory posits that all human beings have an innate tendency to grow toward fulfillment and actualization. GT's existentialist flavor is seen in its strong emphasis on an individual's choice and responsibility. Influenced by the concept of wholeness in Gestalt psychology, a branch of perceptual psychology that explores how humans create meaning out of perceptual stimuli, GT theory holds that it is human nature to integrate one's inner experiences (e.g., feelings, needs, and perceptions) with one's outer reality (e.g., environment) into a whole. According to this holistic perspective, individuals cannot be separated from their environments, nor can they be divided into parts (such as body and mind). Physical and psychological functions are inherently related; thoughts, feelings, and physical sensations are all a part of a unified being.

*Need satisfaction, contact, and awareness* are three central constructs of the GT theory. Perls believed that individuals strive to meet needs such as physical and emotional support throughout the life process. Needs are met through contact with the external environment (including other human beings) or aspects of the self. Contact is essentially an unending cycle of need emergence, activity by the individual aimed at satisfying the need, need satisfaction, and disappearance of the need. For example, when people realize they are thirsty, they might get some water and drink until their thirst is quenched. However, if they are unable to find anything to drink, their thirst is not satisfied and may intensify so



that it becomes all consuming. Psychological needs arise and are satisfied in a similar manner. Effective contact, which involves the successful completion of the cycle, leads to awareness and creates growth. Perls postulated that people have problems because they anticipate that some of their needs or parts of their selves are unacceptable to significant others or society, so they avoid contact by using defense mechanisms such as *introjection* (i.e., unquestioning internalization of values, rules, and standards of behavior from significant persons or aspects of the environment), *projection* (i.e., disowning personal qualities by seeing them as existing outside oneself, often in others who are emotionally important to the person), *deflection* (i.e., directing an impulse toward a substitute object or subject in the environment instead of the object or subject that caused the impulse), *retroflexion* (i.e., doing to yourself what you would like to do to a subject in the environment), and *confluence* (i.e., failure to establish personal boundaries, so it is not clear where you leave off and significant others in the environment begin). Since people's needs are met through contact with the environment, their needs go unmet when they use defense mechanisms to avoid contact. This disrupts their awareness of the environment and results in unfinished developmental business. Lack of awareness disrupts the ongoing cycle of contact by which people meet their needs and it contributes to further dysfunction.

The main goals of GT are to facilitate awareness, rather than directly addressing behavioral problems, and to help clients accept the ownership of their experience as well as personal responsibility for their thoughts, feelings, and behaviors. GT counselors support and encourage clients to freely experience and express their inner feelings and their needs. GT therapists often employ experiential techniques or activities in counseling to help facilitate awareness. In fact, the GT approach is often perceived as synonymous with one well-known technique called the *empty chair* dialogue. In this technique, important others are placed metaphorically in a chair and the client engages in discussions with these people. In another variant of this technique, called the *top dog/underdog* dialogue, a critical, parental facet of the self is placed in the empty chair and the therapist encourages the client's weaker, responsibility-evading self to dialogue with the tyrant. By engaging in some sort of experimentation in which clients are directed to focus on how they are feeling and what they are experiencing in the here and now, it is believed that clients will assume effective contact, heighten their awareness, and begin to accept and take responsibility for experience.

The original GT style presented by Perls was rather confrontive and directive. This was due, in part, to Perls's personal style, which some therapists imitated. However, the modern GT approach has turned its emphasis to creating an authentic, here-and-now relationship between the therapist and client. Exploring experience, however, is still the critical focus of therapy. GT therapists usually do not use any formal assessment or diagnosis. A GT counselor is to be authentic in providing feedback to his or her clients and will self-disclose if it is believed helpful.

GT has been criticized for its extreme emphasis on individual responsibility. This orientation may lead to problems in using this approach with individuals who are from cultures that are more relationship or group oriented. In addition, the emphasis in GT on verbal, emotional, and behavioral expressiveness is counter to the values of many cultural groups. However, GT's emphases on awareness, personal power, and responsibility may be encouraging and helpful to female clients in finding their worth from within rather than in others' perceptions of them.

### Process-Experiential Psychotherapy

A recent approach, process-experiential psychotherapy (PE), fuses aspects of the person-centered and Gestalt approaches. Classified by its authors as one type of emotion-focused therapy, PE is based on the assumption that human emotions are adaptive signals that tell people what is important and prepare them for action. Dysfunction results from problems in symbolizing experience, and accompanying distorted emotional processing of the experience. Thus, the goal of therapy in this approach is to help clients learn new ways of processing emotion that lead to different meanings and more adaptive coping strategies. The therapist in PE first strives to create a therapeutic climate similar to that in person-centered theory in order to evoke and understand client emotional experience. Once the relationship is established, the therapist can then use interventions that help reprocess the emotions; among these are chair dialogues similar to those used in Gestalt therapy.

Process-experiential psychotherapy emphasizes the importance of a collaborative therapy relationship and the power of the therapist's empathic prizing of the client in creating a situation in which clients can productively explore their experiences. Techniques in PE include some that are similar in person-centered theory (focusing, systematic evocative unfolding,



narrative retelling, and meaning creation) and dialogues reminiscent of Gestalt therapy's two-chair and empty-chair techniques. Focusing, systematic evocative unfolding, narrative retelling, and meaning creation are all interventions that support clients' exploration of feelings and the transformation of these feelings in ways that promote effective client responses to them. In the two-chair dialogue, clients experience aspects of themselves as they shift between two chairs. Two types of dialogues are identified: those between conflicting aspects of the self and those between the experiencing self and an aspect of the self that is blocking the expression of emotions or needs. Resolution of the conflict generally requires the two aspects to be accepted by the client so that they can work together.

Nancy L. Murdock and Chia-Chih D. C. Wang

**See also** Counseling Theories and Therapies (v2); Defenses, Psychological (v2); Facilitative Conditions (v2); Individual Therapy (v2); Relationships With Clients (v2); Rogers, Carl R. (v2)

### Further Readings

- Elliot, R., Watson, J. C., Goldman, R. N., & Greenberg, L. (2004). *Learning emotion-focused therapy: The process-experiential approach to change*. Washington, DC: American Psychological Association.
- Kirschenbaum, H., & Henderson, V. L. (Eds.). (1989). *The Carl Rogers reader*. Boston: Houghton Mifflin.
- Lietaer, G., Rombauts, J., & Van Balen, R. (Eds.). (1990). *Client-centered and experiential psychotherapy in the nineties*. Leuven, Belgium: Leuven University Press.
- Murdock, N. L. (2004). *Theories of counseling and psychotherapy: A case approach*. Upper Saddle River, NJ: Prentice Hall.
- Parlett, M., & Hemming, J. (1996). Gestalt therapy. In W. Dryden (Ed.), *Handbook of individual therapy* (pp. 194–218). Thousand Oaks, CA: Sage.
- Perls, F. S. (1969). *Gestalt therapy verbatim*. Lafayette, CA: Real People Press.
- Perls, F. S., Hefferline, R. F., & Goodman, P. (1951). *Gestalt therapy: Excitement and growth in the human personality*. New York: Dell.
- Rogers, C. R. (1961). *On becoming a person*. Boston: Houghton Mifflin.









---

## INDIVIDUAL THERAPY

---

The foundation on which individual therapy is based is the natural network of human social relationships. Discussions of personal life and personal concerns occur continually between family and friend dyads. Primary dyads for personal discussions include mother and daughter, sisters, husband and wife, mother and son, and friends. These universal networks of two people form a foundation for the value, structure, and form of individual therapy.

Within the context of individual therapy, the therapist facilitates, with the client, an exploration of what the client brings to the therapeutic setting. Thus the client is able to receive feedback from someone with a professional viewpoint. A trained counselor is unique in contrast to a friend, as he or she is emotionally present for but not engulfed in the person's life or difficulties. As in other forms of therapy, in individual therapy, a therapist's role includes reflection, active listening, giving feedback, listening with the "third ear," and modeling positive behaviors.

Many contemporary therapists identify themselves as adopting an integrated/eclectic theoretical approach rather than practicing within one single theoretical frame. Though approaches to therapy vary greatly among practitioners, therapists are generally accepting, genuine, and trustworthy.

The opportunity for undivided attention—for listening and processing to be focused just on the individual client—is a relatively unique feature of individual therapy. Total attention to the growth and development of one person gives individual therapy

its popularity and contributes to its efficacy. The therapy process, operating like a greenhouse effect, magnifies the individual's concerns and needs, illuminates the individual's self-concept, and allows a person to focus on the modification of aspects of the self that are creating problems and limitations.

### Logistics of Individual Therapy

Individual therapy occurs in many settings, including college counseling centers, community counseling centers, hospitals, prisons, K–12 schools, and private practice. The fee for individual therapy depends on the setting. In schools, colleges, the military, county clinics, and nonprofit centers, clients may receive free service. In private settings and HMO clinics, health insurance is used. Occasionally, people pay "out of pocket."

Professionals who provide individual therapy include psychiatrists, certified counselors, licensed psychologists, licensed family and marriage therapists, and licensed social workers. Some individuals seek individual therapy for clinical conditions such as depression, anxiety, anger, eating disorders, psychotic disorders, and substance-related disorders. Others seek assistance in dealing with life changes or transitions that exceed their coping resources, such as divorce, self-esteem issues, and work issues. In these instances, individual counseling is analogous to having one's own educational consultant or emotional development coach.

Sigmund Freud, the founder of psychoanalytic theory, laid the theoretical foundation for individual therapy. Successors proposed other significant theories (e.g., psychodynamic theory, person-centered theory,



existential theory, cognitive-behavioral theory, and Gestalt theory) that today provide a rich and multifaceted theoretical framework for individual therapy.

### Individual Therapy in Contrast to Other Forms of Therapy

Neither group nor couples counseling permits an in-depth exploration with the focus solely on one person. For example, in couple therapy, the therapist's attention is primarily on the space between the two partners, and in a group setting, the attention is often on the group process and the sharing of time among members. While the individual focus is appealing in a time-starved and attention-starved world, sometimes it is more intense than desired. The focus is on the client's life and is not diluted by the relationship with other clients. The structure of individual therapy makes it difficult for clients to avoid facing difficult problems.

Individual therapy may be a particularly apt choice when the topics discussed are intensely personal or traumatic for the individual. Individual therapy provides maximum privacy, so as therapy progresses and clients come to know the therapist as an accepting, understanding, and trustworthy confidant, they become less likely to manage their image and less likely to conceal critical information.

### Goals of Therapy

Clients are able to assert their own personal hopes and therapy goals during individual therapy. Individual therapy offers the opportunity for the client to work on external relationships from his or her own viewpoint, with input from the therapist. This allows the client to focus on the changes *he* or *she* would like to make that can affect his or her outside relationships.

In many ways, the therapeutic process is collaborative, as two people work together to identify hopes and goals for the therapy process. Individual counseling is a place where clients can practice new skills or behaviors through role-playing, cognitive changes, and emotion management. Evidence gleaned from half a century of research demonstrates convincingly that the outcome of therapy depends less on theory than on other common factors such as the therapeutic relationship, how much clients believe they will benefit from therapy (i.e., expectancy of therapy), and environmental factors.

### Mechanisms That Produce Change

The therapeutic relationship, or *working alliance* is of the utmost importance in most schools of therapeutic thought. The working alliance is an emotional bond between therapist and client that forms as they work collaboratively to achieve an agreement on the goals of therapy, and tasks will be undertaken to achieve those goals. The formation of a strong working alliance greatly increases the likelihood of a successful therapeutic outcome.

### Attitudes Toward Individual Therapy

In highly individualistic cultures, individual therapy is a modality that fits with the culture because the client is responsible for his or her own decisions, achievements, and losses. The losses—achievement failures, personal betrayals, geographic moves, job changes, changes in friendships—are especially difficult because they are often conceptualized in an individual culture as the individual's responsibility. Thus, therapy is a healing process, and is a way to overcome loss. In an individual, achievement-oriented culture, it is important to learn how to manage failure and loss and continue to try and to compete.

Using individual therapy as a way to improve the quality of one's life and to live effectively, as well as to lessen the distress caused by emotions such as anxiety, depression, and anger, is perceived positively by some culture groups. It is still stigmatized by other groups, in which individuals who seek the assistance of a therapist are perceived as "being crazy" or "insane."

Individual therapy can be an excellent means to achieve more personal maturity and to manage the many demands of contemporary human life. Through listening, goal setting, practice, and the like, individual therapy is a medium that can inspire change and growth at the personal level.

*Thomas Skovholt, Michelle J. Trotter,  
and Juihsien Kao*

**See also** Client Attitudes and Behaviors (v2); Common Factors Model (v2); Counseling Process/Outcome (v2); Counseling Theories and Therapies (v2); Counselors and Therapists (v2); Expectations About Therapy (v2); Facilitative Conditions (v2); Humanistic Approaches (v2); Integrative/Eclectic Therapy (v2); Relationships With Clients (v2); Therapy Process, Individual (v2); Tinsley, Howard E. A. (v4); Wampold, Bruce E. (v2); Working Alliance (v2)



## Further Readings

- Asay, T. P., & Lambert, M. J. (2004). The empirical case for the common factors in therapy: Quantitative findings. In M. Hubble, B. Duncan, & S. Miller (Eds.), *The heart and soul of change: What works in therapy* (pp. 23–42). Washington, DC: American Psychological Association.
- Atkinson, D. R., Ponterotto, J. G., & Sanchez, A. R. (1984). Attitudes of Vietnamese and Anglo-American students toward counseling. *Journal of College Students Personnel*, 25(5), 448–452.
- Beutler, L., Consoli, A., & Williams, R. (1995). Integrative and eclectic therapies in practice. In B. Bongar & L. E. Beutler (Eds.), *Comprehensive textbook of psychotherapy: Theory and practice* (pp. 274–292). New York: Oxford University Press.
- Bordin, E. S. (1979). The generalizability of the psychodynamic concept of the working alliance. *Psychotherapy: Theory, research, and practice*, 16, 252–260.
- Corsini, R., & Wedding, D. (2000). *Current psychotherapies* (6th ed.). Itasca, IL: Peacock.
- Dryden, W. (Eds.). (2002). *Handbook of individual therapy*. Thousand Oaks, CA: Sage.
- Goldfried, M., & Norcross, J. (1995). Integrative and eclectic therapies in historical perspective. In B. Bongar & L. E. Beutler (Eds.), *Comprehensive textbook of psychotherapy: Theory and practice* (pp. 254–273). New York: Oxford University Press.
- Root, M. P. P. (1985). Guidelines for facilitating therapy with Asian American clients. *Psychotherapy*, 22, 349–356.

---

## INFORMED CONSENT

---

Informed consent in counseling and psychotherapy refers to the process by which clients or prospective clients receive information about the proposed treatment and subsequently decide whether to provide consent for the counselor or therapist to proceed with the treatment. Historically, informed consent requirements were applied to surgery and other medical procedures; later these requirements were expanded to include counseling and related activities. Currently, informed consent is mandated by the ethical codes that govern most counselors and psychotherapists. There is significant variability, however, in the beliefs and practices of professionals regarding informed consent, including its content, timing, method, and effect.

## Content of Informed Consent Procedures

What information should counselors and psychotherapists include during the informed consent process? Ethical codes and legal regulations typically offer little guidance regarding the specific topics to cover or particular details to address. In the absence of unambiguous guidelines, counselors and psychotherapists have developed and employed a wide variety of approaches to informed consent.

A number of topics have traditionally been included in the informed consent process. Prospective clients are generally informed about the nature of the counseling or therapy being proposed. This includes what the therapeutic approach is called, how it usually works, what activities it may involve, and how long it may last. They are also typically informed about the effectiveness of the proposed treatment, as well as potential risks and alternative treatments. Of course, the pragmatics of the treatment arrangement are also usually covered: how appointments are scheduled, where and how often sessions will take place, payment arrangements and responsibilities, and emergency contact information. Finally, informed consent procedures have customarily included confidentiality policies, including situations in which the counselor or therapist may need to break confidentiality without the permission of the client (e.g., when the therapist becomes aware of a legal duty to warn a third party of potential danger).

In addition to these essentials, a number of additional topics may merit inclusion in the present-day informed consent process. Recently, numerous authors have identified contemporary issues in the counseling or therapy field about which the client may have a right to be informed. For example, the increasing involvement of insurance companies, managed care organizations, and other third-party payers has had a widespread and well-documented influence on the counseling and psychotherapy professions, and some members of these professions believe this topic merits inclusion in their informed consent procedures. Similarly, therapy manuals (or empirically supported therapies, or best practices guidelines) have resulted in many clients in recent years receiving treatment that is to some extent predetermined or preplanned according to a diagnostic category or presenting problem. Informing prospective clients about their use by a counselor or therapist may be another relatively new addition to the informed consent procedure.



## Timing of Informed Consent

When should counselors and therapists obtain informed consent? Ethical codes and legal regulations generally suggest that informed consent be obtained as early as possible in the therapeutic relationship. The rationale behind this suggestion is clear: Clients should have the opportunity to choose whether to proceed with counseling or therapy before finding themselves immersed in it. However, counseling and psychotherapy are fundamentally different from other practices that utilize informed consent procedures. Consider, for example, a physician who obtains informed consent from potential patients facing the same medical procedure. The procedure is assumed to be essentially similar for all patients, and to be a one-time event, so the physician can provide a uniform informed consent document to all potential patients at the outset.

Counseling and psychotherapy are unique in two important ways: They unfold gradually over time in ways that cannot always be accurately predicted at the outset, and they necessarily differ from client to client. For these reasons, a standardized informed consent procedure cannot be offered to all clients at the outset. Of course, some basic information can and should be provided at the very beginning, including confidentiality and payment policies. However, discussion about more substantive issues, such as treatment orientation, duration, goals, and activities may need to be delayed until the therapist has learned enough about the client to provide personalized information. Thus, many authors on informed consent promote a “process” model rather than an “event” model, such that informed consent represents not a distinct occurrence, but an ongoing and recurrent element of counseling and psychotherapy.

Whether informed consent is viewed as a process or an event, at times it may need to be delayed as a result of client variables. If the client is in an acute crisis state or is temporarily unable to adequately comprehend the information to be provided, it may be clinically and professionally wise to delay informed consent until a more appropriate point in time.

## Methods of Obtaining Informed Consent

How should counselors and psychotherapists go about obtaining informed consent? Historically, two methods—written and oral—have been utilized.

Written informed consent procedures feature the advantage of enabling clients to read over information at their own pace, as well as the opportunity for the counselor or therapist to keep a hard copy of a signed form in the file as proof that informed consent was obtained. Oral informed consent procedures allow for more flexibility and customization of information for particular clients. They also facilitate discussion between the client and the counselor or psychotherapist.

In practice, a combination of written and oral informed consent procedures may be ideal. Numerous standardized written informed consent forms have been made available, and they can be adapted by counselors or psychotherapists working in particular contexts or with particular types of clients. However, these forms, or others originally designed by counselors or therapists for their own practices, should not stand alone. Instead, clients should be given the opportunity to ask questions during the informed consent process, and the counselor or psychotherapist should provide answers to the fullest extent possible. Counselors and psychotherapists can combine the written and oral approaches by supplementing a standard information form with a written list of questions that clients may choose to ask. Whether written, oral, or both, the method by which counselors and psychotherapists obtain informed consent should be consistent with professional ethical codes, applicable laws, and the Health Insurance Portability and Accountability Act (HIPAA).

## Effects of Informed Consent

Research by Mitchell Handelsman and others suggests that as a rule, the informed consent process has a positive effect on clients and prospective clients. Rather than perceiving the process as unnecessary or excessive, clients who are provided with readable, personalized information—as well as a chance to discuss this information—generally look favorably upon the informed consent procedure and the counselors and therapists who provide it. At its best, the informed consent procedure can facilitate not only an informed decision by the client, but a strong therapeutic alliance in which the counselor’s or therapist’s acknowledgment of the client’s autonomy is an important component.

It is also important to note that the informed consent procedure offers professional benefits to the counselor or therapist as well as the client. By appropriately obtaining and documenting informed consent,



the counselor or therapist precludes ethical violations or legal liability that may otherwise arise.

Andrew M. Pomerantz

**See also** Code of Ethics and Standards of Practice (v2); Confidentiality and Legal Privilege (v2); Duty to Warn and Protect (v2); Ethical Codes (v1); Ethics in Computer-Aided Counseling (v1); Ethics in Research (v1); Human Subjects Review in an Online World (v1)

### Further Readings

- American Psychological Association. (2002). Ethical principles of psychologists and code of conduct. *American Psychologist*, 57, 1060–1073.
- Beahrs, J. O., & Gutheil, T. G. (2001). Informed consent in psychotherapy. *American Journal of Psychiatry*, 158, 4–10.
- Braaten, E. B., & Handelsman, M. M. (1997). Client preferences for informed consent information. *Ethics & Behavior*, 7, 311–328.
- Handelsman, M. M., & Martin, W. L., Jr. (1992). Effects of readability on the impact and recall of written informed consent material. *Professional Psychology: Research and Practice*, 23, 500–503.
- O'Neill, P. (1998). *Negotiating consent in psychotherapy*. New York: New York University Press.
- Pomerantz, A. M. (2005). Increasingly informed consent: Discussing distinct aspects of psychotherapy at different points in time. *Ethics & Behavior*, 15, 351–360.
- Pomerantz, A. M., & Handelsman, M. M. (2004). Informed consent revisited: An updated written question format. *Professional Psychology: Research and Practice*, 35, 201–205.

---

## INTEGRATIVE/ECLECTIC THERAPY

---

Eclecticism, or integration, is now the most common theoretical orientation among counselors and psychotherapists in the United States. This has not always been the case. In the mid-20th century, three dominant theories of counseling and psychotherapy were often viewed as distinct and incompatible: psychoanalysis, behaviorism, and humanism. Less contradictory forms of therapy evolved during the second half of the century, and counselors began to combine strategies from diverse theories in an eclectic manner. Early eclecticism was often criticized for its lack of an underlying theory and the absence of

formal guidelines to help counselors make decisions. In response, more formal models of integrative psychotherapy were developed, and today four general routes to integration are recognized: (1) common factors, (2) technical eclecticism, (3) theoretical integration, and (4) assimilative integration. In this entry, formal models of integration are described that exemplify each of these general routes.

### Common Factors

The *common factors* route to integration identifies core ingredients that most forms of psychotherapy share. The advantage of common factors is the emphasis on therapeutic actions that have been demonstrated to be effective. The disadvantage is that common factors may overlook specific techniques that have been developed within particular theories.

Jerome Frank and Julia Frank analyzed cross-cultural approaches to healing and identified the following common factors: (1) an emotionally charged, confiding relationship with a helping person; (2) a healing setting; (3) a rational, conceptual scheme, or myth that provides a plausible explanation for the client's symptoms; and (4) a ritual or procedure that requires the active participation of client and therapist and that both believe to be the means of restoring the client's health. The analysis concluded that the active ingredients in psychotherapy are not unique or new but have been used by healers around the world for many centuries. Research has demonstrated the importance of the therapeutic alliance as well as other common factors.

Scott Miller and his colleagues have described a contemporary common factors approach that ensures that clients experience the kind of changes they desire. This approach is based on research demonstrating common factors related to the client's role in extratherapeutic change, the therapeutic relationship, and expectancies for change. Miller emphasized the importance of working within the *client's* frame of reference as the defining "theory" for psychotherapy, in order to support active participation in shared goals. The therapeutic alliance is strengthened when counselor and client come to a consensus on the methods of treatment and share an emotional bond. There is also ongoing attention to the client's experience of the therapeutic relationship and active attempts to address problems in the relationship when they arise.



## Technical Eclecticism

Technical eclecticism is designed to improve the therapist's ability to select the best treatment for the person and the problem. This route to integration is guided by empirical data on the efficacy of different methods. The advantage of technical eclecticism is that it encourages the use of diverse strategies without being hindered by theoretical differences. A disadvantage is the lack of a clear conceptual framework describing how techniques drawn from divergent theories fit together.

The most well-known model of technical eclectic psychotherapy is Arnold Lazarus's *multimodal therapy*. This approach begins with a thorough assessment of seven modalities: behavior, affect, sensation, imagery, cognition, interpersonal relationships, and drugs/biology. Multimodal therapy represents an ongoing attempt to adapt therapy to the individual. The form and style of therapy are adapted to each client's particular needs.

Larry Beutler's model of *systematic treatment selection* represents another model of technical eclecticism. His approach uses research-based conclusions to describe principles of treatment and to identify the best interventions for particular clients. Clients are assessed on variables such as coping style, resistance level, and emotional arousal. Therapists choose a treatment focus and specific strategies that are consistent with these client characteristics. For example, psychotherapy strategies that focus on symptoms or skill building, structured problem solving, correcting dysfunctional thought patterns, homework assignments, and relaxation training may work best with clients with an externalizing coping style. In contrast, clients who use an internalizing coping style benefit most from strategies that emphasize insight and awareness, such as identifying interpersonal themes and following client affect.

## Theoretical Integration

In theoretical integration, two or more therapies are integrated to create an approach that is better than the constituent therapies. Some models of theoretical integration focus on combining and synthesizing a small number of theories at a deep level. Other models combine elements from several systems of psychotherapy at a more superficial level.

Paul Wachtel's *cyclical psychodynamics* integrates psychodynamic, behavioral, and family systems theories. These systems are seen as complementary

because psychodynamic theories focus on internal change and behavioral theories focus on the external environment. The family system is seen as a crucial environment that often reinforces interpersonal patterns. Wachtel's approach to integration depends on dynamic insight and behavioral action to recognize and change vicious cycles that are often shaped by early family experiences but maintained by current behavior.

Anthony Ryle's *cognitive analytic therapy* integrates ideas from psychoanalytic object-relations theory and cognitive psychotherapy. This approach is based on a cognitive description of relational patterns and describes target problems that often include maladaptive patterns. This reformulation is used as an ongoing reference point to help clients recognize and modify problematic patterns. Ryle encourages the use of cognitive-behavioral methods and an examination of the therapy relationship to understand the way clients enact reciprocal role patterns.

James Prochaska and Carlos DiClemente's *trans-theoretical approach* describes the relationship among several theories. This approach assumes that many systems of psychotherapy are complementary and that different theories tend to target different stages and levels of change. Prochaska and DiClemente used five stages of change (precontemplation, contemplation, preparation, action, or maintenance) and five levels of change (symptom/situational problems, maladaptive cognitions, current interpersonal conflicts, family systems conflicts, or intrapersonal conflicts) to create a two-dimensional matrix that is used to organize 15 theories of psychotherapy and to illustrate their relative emphases. For example, at the symptoms/situational level, motivational interviewing is located at the precontemplation stage and behavior therapy and exposure are located at the action stage. At the level of intrapersonal conflicts, psychoanalysis is suggested for the precontemplation stage, existential therapy is appropriate during contemplation, and Gestalt therapy is suggested for the preparation stage.

## Assimilative Integration

Assimilative integration starts with a firm grounding in one system of psychotherapy, but then incorporates or assimilates ideas or methods from other theories. Many psychotherapists feel comfortable selecting a primary theoretical orientation that serves as their foundation but, with experience, incorporate ideas and strategies from other sources into their practice.



Increasingly, integrationists are acknowledging that most counselors prefer the security of using one primary theory as they begin the process of exploration and integration.

George Stricker and Jerold Gold proposed an assimilative model based on relational psychoanalytic therapy but selectively incorporating more active interventions drawn from cognitive, behavioral, experiential, and systemic approaches. This approach is organized around a three-tiered model of psychological functioning that includes (1) behavior and interpersonal relatedness; (2) cognition, perception, and emotion; and (3) psychodynamic conflict, self-representations, and object representation. Psychotherapists are encouraged to look for links between these tiers and to be aware that interventions aimed at one tier may affect other levels of functioning.

Louis Castonguay's assimilative model rests on a cognitive-behavioral foundation that also includes techniques designed to facilitate interpersonal functioning and emotional deepening. This interpersonal focus on the therapeutic relationship allows clients to receive feedback about their actions and to understand the cause-and-effect links between the environment, cognitive and emotional processing, and the consequences of interpersonal behavior. From a behavioral perspective, emotional deepening can be seen as an exposure method that helps clients overcome a cognitive avoidance of affect.

### Emerging Models

In addition to these established approaches to integration, there are newer models that embrace ideas from more than one of the four established routes. The emerging models described next are also aimed at training counselors to begin thinking and acting in an integrative fashion from the very beginning of graduate school.

Clara Hill's three-stage model of helping skills combines theoretical integration and technical eclecticism; it encourages counselors to emphasize skills from different theories during different stages of helping. First, *exploration* is based on Rogers's person-centered theory, and it emphasizes skills like attending, listening, and reflection of feelings. Second, *insight* is based on psychoanalytic theory and uses skills such as challenge, interpretation, and immediacy. Third, *action* is based on cognitive-behavioral theory and emphasizes skills like giving information and direct guidance.

Glenn Good and Bernard Beitman's integration of common factors and technical eclecticism highlights both core components of effective therapy and specific techniques designed to target clients' particular issues or areas of concern. Counselors are encouraged to learn key concepts from a variety of psychotherapy theories. This approach emphasizes the importance of core processes related to therapeutic communication, working alliance, identifying patterns, and encouraging change. Attention is given to the specific skills that are most helpful when dealing with common concerns like depression, anxiety, and substance abuse.

Jeff Brooks-Harris's multitheoretical approach, a combination of technical eclecticism and theoretical integration, allows counselors to make informed choices when combining theories and intervention strategies. First, counselors are encouraged to systematically assess seven dimensions of functioning (thoughts, actions, feelings, biology, interpersonal patterns, social systems, and cultural contexts) and to choose the most salient dimensions on which to focus. Next, conceptualization is formulated using two or more theories corresponding to the selected focal dimensions. Finally, specific interventions are chosen from a catalogue of key strategies that are drawn from the theoretical approaches corresponding to each focal dimension.

### Therapy Relationships and Personal Integration

Most models of integration focus on the choice of intervention strategies, but the therapeutic relationship has even more impact on outcome than the choice of techniques. In response to this discrepancy, John Norcross and his colleagues described ways that the therapeutic relationship can be customized based on client characteristics including resistance, coping style, expectations, and attachment style. This integrative focus on the therapeutic relationship reminds counselors that any form of psychotherapy should be implemented within an interpersonal relationship based on a phenomenological understanding of the client.

Experienced counselors develop their own individualized and integrated conceptual systems and intervention styles over time. This process of *personal integration* involves an integration of the therapist's personal beliefs with formal theory, clinical experience, and therapeutic methods. Integrative psychotherapy can be seen as an art, and experienced therapists develop their own consistent, personal integrative



approach over time. Personal integration often begins as a form of assimilation with a foundation in one theory and takes on a unique appearance as it is adapted to the personal strengths of different counselors and implemented with different clients.

### Future Directions

Although integrative psychotherapy has become more popular, there are still obstacles to its further growth. Some persistent obstacles include continued allegiance to pure systems of psychotherapy and the difficulty of providing integrative training to graduate students. A more recent obstacle comes from those in the field who advocate the use of manualized treatments whose efficacy has been empirically supported using randomized clinical trials. Many of the integrative approaches described here are implemented in a flexible manner, based on the individual needs of clients. These types of treatment are difficult to manualize and are not consistent with the idea of randomized assignment to structured treatment protocols. In response to the need to document the efficacy of integrative treatments, there has been an increase in outcome research on psychotherapy integration. Although many counselors agree that psychotherapy should be evidence based, there is not always agreement about what evidence is most important.

It is likely that integrative/eclectic therapy will continue to be an important movement throughout the 21st century. New perspectives are likely to emerge that capitalize on the strengths of earlier approaches. Integrative psychotherapy will benefit from empirical research testing its usefulness, as well as continued clarity about how to balance research evidence and clinical wisdom. The consistent strength of integrative therapy will continue to be the recognition that complex individuals can be understood from a variety of vantage points, and effective counselors can combine therapeutic tools drawn from diverse theoretical sources.

Jeff E. Brooks-Harris

**See also** Cognitive-Behavioral Therapy and Techniques (v2); Common Factors Model (v2); Counseling Theories and Therapies (v2); Evidence-Based Treatments (v2); Expectations About Therapy (v2); Hill, Clara E. (v2); Individual Therapy (v2); Norcross, John C. (v1); Therapist Techniques/Behaviors (v2)

### Further Readings

- Beutler, L. E., Consoli, A. J., & Lane, G. (2005). Systematic treatment selection and prescriptive psychotherapy: An integrative eclectic approach. In J. C. Norcross & M. R. Goldfried (Eds.), *Handbook of psychotherapy integration* (2nd ed., pp. 121–143). New York: Oxford University Press.
- Brooks-Harris, J. E. (2008). *Integrative multitheoretical psychotherapy*. Boston: Houghton Mifflin.
- Castonguay, L. G., Newman, M. G., Borkovec, T. D., Holtforth, M. G., & Maramba, G. G. (2005). Cognitive-behavioral assimilative integration. In J. C. Norcross & M. R. Goldfried (Eds.), *Handbook of psychotherapy integration* (2nd ed., pp. 241–260). New York: Oxford University Press.
- Frank, J. D., & Frank, J. B. (1991). *Persuasion and healing: A comparative study of psychotherapy* (3rd ed.). Baltimore, MD: Johns Hopkins University.
- Good, G. E., & Beitman, B. D. (2006). *Counseling and psychotherapy essentials: Integrating theories, skills, and practices*. New York: Norton.
- Hill, C. E. (2004). *Helping skills: Facilitating exploration, insight, and action* (2nd ed.). Washington, DC: American Psychological Association.
- Lazarus, A. A. (2005). Multimodal therapy. In J. C. Norcross & M. R. Goldfried (Eds.), *Handbook of psychotherapy integration* (2nd ed., pp. 105–120). New York: Oxford University Press.
- Miller, S. D., Duncan, B. L., & Hubble, M. A. (2005). Outcome-informed clinical work. In J. C. Norcross & M. R. Goldfried (Eds.), *Handbook of psychotherapy integration* (2nd ed., pp. 84–102). New York: Oxford University Press.
- Norcross, J. C. (Ed.). (2002). *Psychotherapy relationships that work: Therapist contributions and responsiveness to patients*. New York: Oxford University Press.
- Norcross, J. C., & Goldfried, M. R. (Eds.). (2005). *Handbook of psychotherapy integration* (2nd ed.). New York: Oxford University Press.
- Prochaska, J. O., & DiClemente, C. C. (2005). The transtheoretical approach. In J. C. Norcross & M. R. Goldfried (Eds.), *Handbook of psychotherapy integration* (2nd ed., pp. 147–171). New York: Oxford University Press.
- Ryle, A. (2005). Cognitive analytic therapy. In J. C. Norcross & M. R. Goldfried (Eds.), *Handbook of psychotherapy integration* (2nd ed., pp. 196–217). New York: Oxford University Press.
- Stricker, G., & Gold, J. (2005). Assimilative psychodynamic psychotherapy. In J. C. Norcross & M. R. Goldfried (Eds.), *Handbook of psychotherapy integration* (2nd ed., pp. 221–240). New York: Oxford University Press.



Wachtel, P. L., Kruk, J. C., & McKinney, M. K. (2005). Cyclical psychodynamics and integrative relational psychotherapy. In J. C. Norcross & M. R. Goldfried (Eds.), *Handbook of psychotherapy integration* (2nd ed., pp. 172–195). New York: Oxford University Press.

## INTELLIGENCE

Historically, counseling psychology has emphasized cognitive constructs and measures in building models of optimal human development. The Internet and the widespread access to information from all over the globe, however, have transformed the world, making the identification and development of cognitive talent more important than ever. This entry focuses on the nature and organization of cognitive abilities; on their importance in educational settings, vocational settings, and other life contexts; and on dynamic aspects of intellectual dimensions.

### The Structure of Cognitive Abilities

Most psychologists agree that cognitive abilities are arranged hierarchically (see Figure 1). Within this hierarchy, general intelligence, or *g*, constitutes the apex and reflects the common factor that underlies all cognitive abilities. Group factors (or more specific, abilities) form the next tier of the hierarchy. These include specific abilities such as verbal, mathematical, and spatial reasoning (e.g., A, B, and C, respectively, in Figure 1). A large number of narrow abilities form the final stratum. These include skills such as verbal comprehension ( $A_1$ ), numerical facility ( $B_1$ ), and imagery ( $C_1$ ).

### General Cognitive Ability

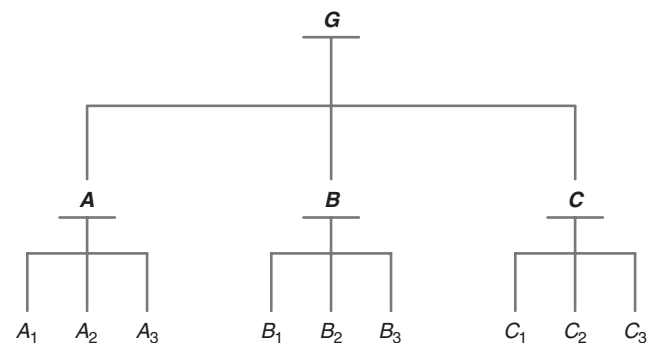
General intelligence, or *g*, accounts for approximately half of the communality among heterogeneous collections of cognitive ability tests. It is assessed through combining many different kinds of cognitive tests to uncover what is common or shared among them. For example, a test that evaluates the ability to read a paragraph and understand its meaning and one that evaluates the ability to solve mathematical problems when presented in story form both require the ability to read and understand verbal material. Thus, while tests may appear to measure different abilities, they all assess to some extent a few basic underlying

abilities. It follows that *g* is the most important and all-encompassing ability underlying performance on tests of cognitive ability.

Thus, *g* represents one of the most scientifically significant dimensions of psychological diversity uncovered by the study of human individuality. It can be used to predict performance in educational and vocational contexts because both the tests that measure *g* and performance in those contexts require the use of *g*. The correlation coefficient is a standardized measure of how strongly variables are related to one another. It can range from +1.00 (a perfect positive relationship) to –1.00 (a perfect negative relationship). Measures of *g* are positively correlated with a wide range of important and fundamental life skills like practical knowledge, response to psychotherapy, social skills, altruism, supermarket shopping ability, preventive healthcare behaviors, and even a sense of humor. Furthermore, *g* is negatively correlated with obesity, racial prejudice, accident-proneness, smoking, delinquency, and impulsiveness.

Close to a century of research on cognitive ability tests has shown that *g* is also a good predictor of occupational outcomes. For example, *g* is a better predictor of job performance and trainability than any of the other numerous variables so far analyzed by researchers. Individuals who have higher levels of *g* perform at a higher level on the job because they more readily assimilate important knowledge that is necessary for performing effectively in the world of work.

The importance of *g* extends beyond educational and vocational contexts. Higher levels of *g* are also related to increased effectiveness in everyday life. Data from the National Adult Literacy Survey shows that higher levels of *g* consistently enhance the probabilities of dealing successfully with everyday life



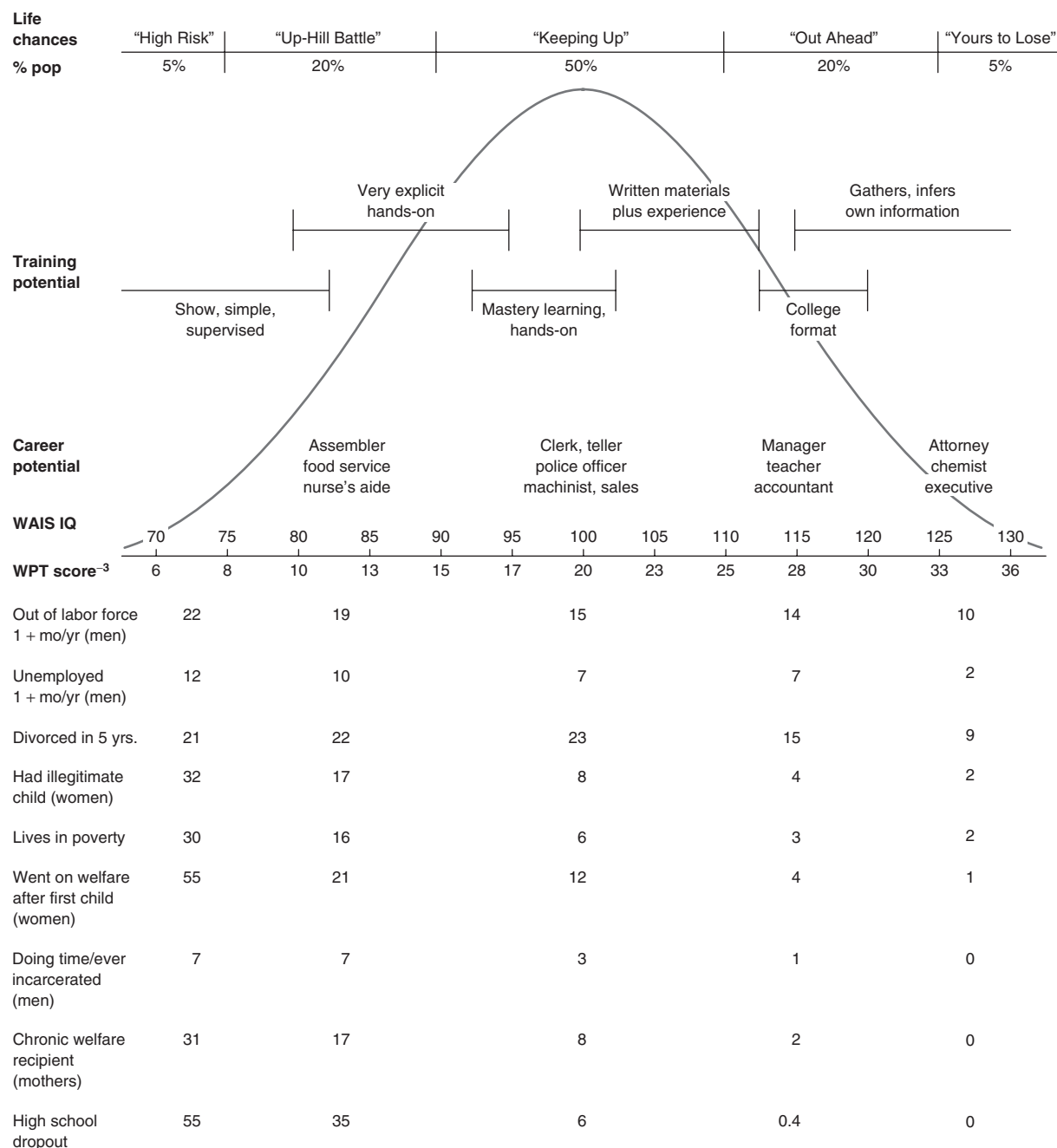
**Figure 1** The hierarchical structure of cognitive abilities



events. In our technologically changing society, *g* matters greatly in many social and practical areas of life because it reflects individual differences in the capacity to process complex information and make effective decisions. Figure 2 summarizes the relation between intelligence and the likelihood of everyday life events. The illustrative occupations depicted at

each level of general cognitive ability are of course based on averages, but the ability ranges of the occupations at each level are similar.

Other models of intelligence have been proposed that are in theory distinct from the hierarchical model. Gardner's theory of *multiple intelligences* argues that there are at least seven independent "intelligences"



**Figure 2** Overall life chances at different ranges of IQ

Source: Adapted from Gottfredson, L. S. (1997). Why *g* matters: The complexity of everyday life. *Intelligence*, 24(1), 79–132.



and that conventional intelligence tests (that measure  $g$  as well as specific abilities) are too narrow. Gardner's seven "frames of mind" are linguistic, logical-mathematical, spatial, musical, bodily kinesthetic, interpersonal and intrapersonal, and naturalist. At least three of these (linguistic, logical-mathematical, and spatial), if measured appropriately, would largely overlap with  $g$  and with the specific abilities in the second tier of the hierarchical structure (i.e., verbal, quantitative, and spatial, respectively). Musical ability is likely related to  $g$  as well. Gardner's bodily kinesthetic, interpersonal and intrapersonal, and naturalist intelligences are not yet measurable in a way that permits a determination of where they might fit in the hierarchical structure of cognitive ability or of the extent to which they are related to  $g$  (see Figure 1). In fact, Gardner's bodily kinesthetic, interpersonal and intrapersonal, and naturalist frames of mind have not yet been adequately measured to date. For this reason, solid quantitative research evaluating Gardner's theory has not been published and evidence to support his theory remains absent.

Sternberg's *triarchic model* posits three independent kinds of intelligence: analytical, practical, and creative. Sternberg has developed measures of each of these forms of intelligence and has conducted studies that he claims support his model. However, independent researchers who have analyzed his data have concluded that Sternberg's three independent intelligences are not genuinely independent. It appears that  $g$  explains the variance in Sternberg's measures of the triarchic model.

### Specific Abilities

Despite the importance of general cognitive ability, there are specific abilities in the hierarchical structure (e.g., spatial visualization, quantitative reasoning, and verbal abilities) that have psychological value beyond  $g$ . One reason for this is that the level and pattern of specific abilities influence how individuals develop, even among individuals in the top 1% of general intellectual ability (i.e., at IQs greater than 137). This is illustrated in Figure 3. The four panels depict three critical developmental time points for intellectually precocious youth who were within the top 1% of general ability by age 13. These youngsters were assessed on spatial, mathematical, and verbal reasoning abilities at age 13 and then tracked longitudinally. At 5, 10, and 20 years later, individual differences in the level and pattern of these three abilities were linked in unique ways to distinct educational and occupational paths.

Panels A and B, respectively, indicate whether participants' favorite and least favorite high school course at age 18 was in the humanities/social sciences or math/physical sciences. Panel C outlines college major at age 23, and panel D shows occupation at age 33. Panel A shows that the favorite high school course of men and women who have above-average mathematical abilities (i.e., SAT-M greater than zero, which represents the standard score average), above-average spatial abilities (i.e., the arrow pointing to the right), and below-average verbal abilities (i.e., SAT-V less than zero) are likely to be in the math and physical sciences area. Those whose verbal abilities are above average and whose mathematical and spatial abilities are below average are more likely to mention courses in the humanities and social sciences as their favorite. To be clear, these standard scores were computed relative to this group of intellectually precocious youth, not the general population.

A repeated pattern across these panels is that participants with high levels of math and spatial abilities relative to verbal abilities ( $M$  and  $S > V$ ) are drawn to engineering and math/computer science fields (courses, majors, and occupations). In contrast, participants with high verbal abilities relative to math and spatial abilities ( $V > M$  and  $S$ ) prefer humanities and social science fields. Across these three points in time, information about the participants' spatial, mathematical, and verbal abilities added predictive power above and beyond the other two specific abilities in predicting these individuals' career preferences.

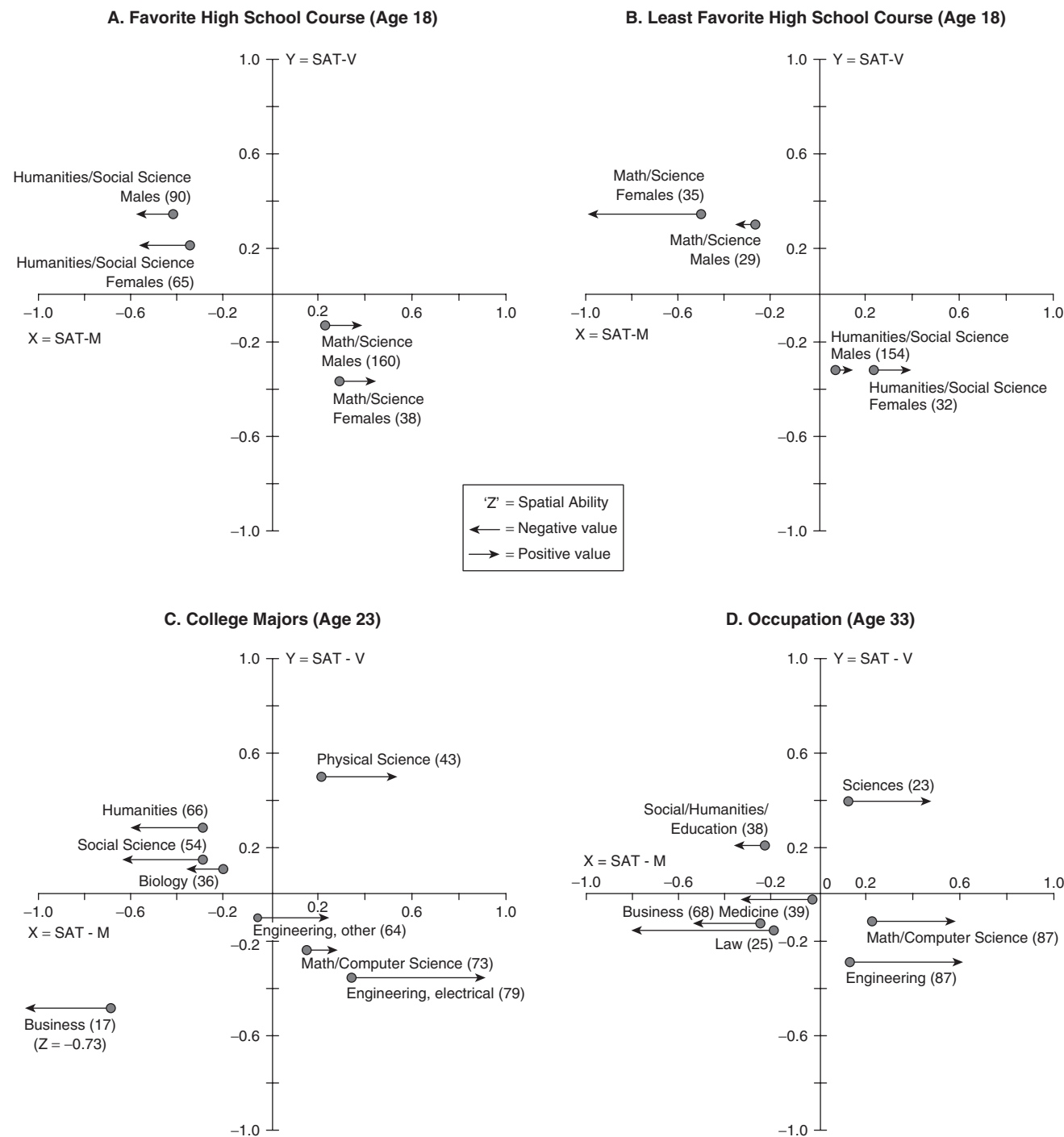
Another reason specific cognitive abilities are important is that their predictive power exists all along the range of general cognitive ability. One third of the ability range lies within the top 1% (e.g., IQs within the top 1% begin at around 137 and extend to over 200). A commonly held belief is that beyond a certain level of ability, more ability no longer matters. For example, a recent letter in *Science*, signed by Carol B. Muller and 78 additional academic administrators and research scientists, illustrates this widespread lack of understanding of how more ability matters in predicting educational, vocational, and thus life outcomes. This letter stated that those scoring in the upper range of standardized tests are unlikely to have more successful scientific careers because too many other factors are involved. Although other factors are involved, it is clear that other things being equal, more ability bestows an advantage.

One study evaluated this belief by examining whether students within the top 1% of cognitive ability before the age of 13 had differing educational and



vocational outcomes as a function of their ability level. This study examined the upper 25% and lower 25% of the top 1% in ability on the SAT-Mathematics. After more than 20 years, the top quartile outperformed the

bottom quartile on such diverse criteria as earning a doctorate, a high income, a patent, and tenure at a top 50 U.S. university (see Figure 4). Other studies examining even higher ability levels have demonstrated the same



**Figure 3** Career interests and career choices of talented groups differing on areas of relative strength

Source: Shea, D. L., Lubinski, D., & Benbow, C. P. (2001). Importance of assessing spatial ability in intellectually talented young adolescents: A 20-year longitudinal study. *Journal of Educational Psychology*, 93, 604–614. Copyright 2001 by APA. Reprinted with permission.



trend: More ability provides an advantage on comparable outcome variables when comparisons are made among highly talented individuals. In summary, technically sound investigations of the ability threshold hypothesis have shown unequivocally that this supposition is untenable. Cognitive abilities have the power to predict important criteria across the entire ability range.

### Dynamics

Heritability is the proportion of phenotypic variation in the population (i.e., variability in physical appearance such as eye color or manifestation of a specific trait such as aggressiveness) that can be attributed to genetic variation among individuals. There is an appreciable heritable component to  $g$ , and the heritability of  $g$  appears to increase over the life span. In

other words, genetic variations among individuals are one important contributor to the differences in  $g$  observed among individuals.

Both genetics and environment play a role in the development of individual differences in cognitive abilities. The part due to the environment is generally regarded as all of the nongenetic influences (i.e., both salient and less evident influences). The more apparent influences include an individual's opportunities for education as well as the educational, financial, and social level of the individual's parents. Less obvious influences include the effects of nutrition before, during, and after birth; hormones; and reduced health.

Although genes and environment are entwined, psychologists use biometric behavior genetic methods to identify the statistical contributions of these two factors to cognitive ability. A population statistic



**Figure 4** Comparison of two mathematically talented groups on four criteria

*Source:* Adapted from Wai, J., Lubinski, D., & Benbow, C. P. (2005). Creativity and occupational accomplishments among intellectually precocious youth: An age 13 to age 33 longitudinal study. *Journal of Educational Psychology*, 97, 484–492. Copyright 2005 by APA. Adapted with permission.

*Note:* These four panels represent the overall (combined across cohort and sex) proportion of participants in the lower 25% (Q1) and upper 25% (Q4) within the top 1% of ability on the SAT-Mathematics earning the respective criteria listed. The upper left panel includes both the percent earning a doctorate (entire bar) and the percent earning an STEM doctorate specifically (bottom segment of each bar). The remaining panels examine one variable each. The mean SAT-M for Q1 and Q4 were 455 and 629, respectively (achieved before age 13).



known as heritability is used to estimate how much of the variance in individual differences in intelligence is due to genetic factors. Psychologists estimate heritability by examining similarities among family members on the trait under analysis (i.e., the similarity to each other in *g* of identical twins, fraternal twins, parents and children, siblings, and adopted children). If individual differences in *g*, for example, are partly influenced by genes, then individuals who are more genetically similar should be correspondingly more alike on *g* (e.g., identical twins who share all their genes should be more alike than fraternal twins who share only half their genes).

Monozygotic (identical) twins who have grown up in separate environments provide a rare opportunity to assess directly the contribution of genes to individual differences in intelligence. Since the twins do not differ in genetic makeup, any difference must be attributable to environmental influences. Heritability can range from 0 (meaning no genetic influence on individual differences) to 1 (meaning individual differences are completely controlled by genetics). Heritability estimates for intelligence vary from approximately 0.4 to 0.8, but these values vary by age, with higher values indicative of later development. Overall, studies based on identical twins raised in separate environments generally indicate a heritability estimate of 0.7. Therefore, it is reasonable to estimate that 70% of the variance in intelligence among individuals is due to genetics.

Studies of adopted children provide another method of assessing the unique contribution of environmental differences to individual differences in intelligence. In the case of adopted children, the biological parents provide the genetic component and the adoptive parents provide the environmental component. Studies using this technique show that 30% or less of the variability in intelligence can be explained by the rearing environment. Thus, these studies provide the same general estimate ( $100\% - 30\% = 70\%$ ) as studies using identical twins reared in separate environments. Furthermore, for adults, this percentage drops to near zero, thus highlighting the dynamic aspect of heritability across the life span.

It is important to emphasize, however, that the large heritable component of intelligence does not preclude the possibility of the environment's influence on an individual's intelligence. Research conducted using animals reveals that severe cognitive deficits can occur when animals are reared in a cognitively sterile environment and that cognitive strengths can be fostered

when animals are reared in a cognitively rich environment. Lack of nutrition or lowered health has also been shown to have a negative impact on an individual's intelligence. Current research is investigating the genes relevant to specific and general cognitive abilities. One objective of the search for relevant genes is to discover what elements of the environment can be altered and which interventions can be implemented to increase intelligence. At present, this information is not known.

### **Phenotypic Growth**

Although cognitive abilities can be improved through learning, the relation between ability level and rate of learning is nonlinear. In other words, students learn at different rates and when students are given opportunities to learn at their optimal rate, those individuals who begin with more ability tend to benefit more from these opportunities. This is observed all along the ability spectrum. Students with developmental delays who are given the finest learning opportunities do not profit as much as typical students. At the upper end of the cognitive ability spectrum, students who scored 700 on the SAT (i.e., the top 0.01% in ability) when tested before age 13, benefited more from educational opportunities than those who scored 500 (i.e., the top 0.5% in ability).

E. L. Thorndike first reported this phenomenon in 1911 and psychologists have documented it repeatedly in the century since that time. Nevertheless, the nonlinear relationship between opportunities for optimal learning and corresponding increases in the level and variability of achievement as a function of ability is still not widely known. Most current articles and discussions do not mention this critically important phenomenon, and advocates of educational and social reform seem to be unaware of it. However, the finding is so robust that it has been christened the *first law of individual differences*.

### **The Flynn Effect**

Oftentimes, a heterogeneous verbal ability measure such as the SAT-Verbal or a nonverbal measure such as the Raven's matrices can provide functionally interchangeable estimates of general intelligence (i.e., both tests can be used to measure *g* to a similar degree). However, a broad ability measure such as the WAIS-R or the Stanford-Binet is necessary for certain avenues of research.



One issue that illustrates the important distinction between narrow and broad measures of intelligence is the meaning of the *Flynn effect*. This phenomenon, named after the scholar who first reported it, refers to the finding that IQ scores appear to have increased across each generation. However, careful analysis reveals that the magnitude of the Flynn effect varies across different assessment tools. Score increases on broad ability measures (e.g., instruments that sample spatial, quantitative, and verbal content) have changed the least. Larger gains have been observed on heterogeneous composites of verbal ability measures (i.e., summing scores on several tests, each of which measures primarily verbal ability). The greatest gains in IQ have occurred on the Raven's matrices. This instrument consists of nonverbal content (e.g., simple geometric shapes and lines that are arranged in a matrix). One cell of the matrix is empty, and respondents must select the element from among the choices offered that will complete the matrix.

This pattern is paralleled by the extent to which each of the aforementioned approaches to assessing IQ measures *g* (and cognitive ability components unique to the test). The Raven's has the least amount of *g* variance (about 50%) and the greatest nonerror uniqueness (40%). The remaining 10% of the variance in scores on the Raven's is attributable to random error. In contrast, broad measures of general intelligence have approximately 85% *g* variance, 5% nonerror uniqueness, and 10% random error. The heterogeneous verbal measures (such as the SAT-V) would be intermediate.

The two variance proportions that differ significantly are those of the *g* and nonerror uniqueness components. The latter component is most prominent in homogeneous tests like the Raven, less salient in heterogeneous composites of verbal measures, and only minimally present in heterogeneous composites that aggregate verbal, quantitative, and spatial abilities. The positive relation between the size of the Flynn effect gains and the variance attributable to the unique features of the test suggests that some of the reported increase in IQ scores is due to the unique components of the test used to measure *g*. In this instance the variance attributable to the unique features of the test is an irrelevant source of variation. Thus it appears that the Flynn effect gains do not reflect actual increases in *g* itself. Yet it is also possible that certain aspects of the Flynn effect are genuine. For example, scores concentrated in the lower end of

the bell curve may have increased due to modern advances in such factors as nutrition, health care, and immunization.

## Benefits

Psychometric assessments of intellectual dimensions, when combined with sound measures of other human attributes, are beneficial in helping people understand and explore the meaning of their individuality. An awareness of this important domain of psychological diversity is essential for all who are concerned with helping their children, students, and clients use psychological information about their strengths and weaknesses to establish and achieve their life goals.

*Jonathan Wai and David Lubinski*

*See also* Academic Achievement (v2); Academic Achievement, Nature and Use of (v4); Achievement, Aptitude, and Ability Tests (v4); Cognition/Intelligence, Assessment of (v2); Intelligence Tests (v3)

## Further Readings

- Bouchard, T. J., Jr., Lykken, D. T., McGue, M., Segal, N. L., & Tellegen, A. (1990). Sources of human psychological differences: The Minnesota study of twins reared apart. *Science*, 250, 223–228.
- Carroll, J. B. (1993). *Human cognitive abilities: A survey of factor-analytic studies*. Cambridge, UK: Cambridge University Press.
- Ceci, S. J., & Papierno, P. B. (2005). The rhetoric and reality of gap closing: When the “have nots” gain but the “haves” gain even more. *American Psychologist*, 60, 149–160.
- Dawis, R. V. (1992). The individual differences tradition in counseling psychology. *Journal of Counseling Psychology*, 39, 7–19.
- Flynn, J. R. (1984). The mean IQ of Americans: Massive gains 1932–1978. *Psychological Bulletin*, 95, 29–51.
- Gottfredson, L. S. (2003). The challenge and promise of cognitive career assessment. *Journal of Career Assessment*, 11, 115–135.
- Jensen, A. R. (1998). *The g factor*. Westport, CT: Praeger.
- Jensen, A. R. (2006). *Clocking the mind: The science of mental chronometry*. New York: Elsevier Science.
- Lubinski, D. (2000). Scientific and social significance of assessing individual differences: “Sinking shafts at a few critical points.” *Annual Review of Psychology*, 51, 405–444.



- Lubinski, D. (Ed.). (2004). 100 years after Spearman's (1904) "General intelligence," objectively determined and measured." [Special section]. *Journal of Personality and Social Psychology*, 86, 96–199.
- Lubinski, D., & Benbow, C. P. (2006). Study of mathematically precocious youth after 35 years: Uncovering antecedents for the development of math-science expertise. *Perspectives on Psychological Science*, 1, 316–345.
- Muller, C. B., Ride, S. M., Fouke, J., Whitney, T., Denton, D. D., Cantor, N., et al. (2005). Gender differences and performance in science. *Science*, 307, 1043.
- Rushton, J. P. (1999). Secular gains in IQ not related to the g factor and inbreeding depression—unlike Black-White differences: A reply to Flynn. *Personality and Individual Differences*, 26, 381–389.
- Schmidt, F. L., & Hunter, J. E. (1998). The validity and utility of selection methods in personnel psychology: Practical and theoretical implications of 85 years of research findings. *Psychological Bulletin*, 124, 262–274.
- Sesardic, N. (2006). *Making sense of heritability*. Cambridge, UK: Cambridge University Press.
- Shea, D. L., Lubinski, D., & Benbow, C. P. (2001). Importance of assessing spatial ability in intellectually talented young adolescents: A 20-year longitudinal study. *Journal of Educational Psychology*, 93, 604–614.
- Thorndike, E. L. (1911). *Individuality*. New York: Houghton Mifflin.
- Wai, J., Lubinski, D., & Benbow, C. P. (2005). Creativity and occupational accomplishments among intellectually precocious youth: An age 13 to age 33 longitudinal study. *Journal of Educational Psychology*, 97, 484–492.

---

## INTERPERSONAL LEARNING AND INTERPERSONAL FEEDBACK

---

Interpersonal learning occurs when individuals, through their interactions with others, acquire self-insight and learn new interpersonal skills. Interpersonal learning is facilitated through processes such as self-observation, self-reflection, feedback from others, and experimenting with new behaviors in an interpersonal context. Related therapeutic processes often occur in individual therapy (e.g., insight work, counselor feedback to the client, working through transference); however, within the counseling field, the term *interpersonal learning* is typically used to denote one of the major therapeutic factors associated with small counseling/therapy groups. A key mechanism through

which interpersonal learning occurs in the group setting is *interpersonal feedback*, in which members share their reactions to, and perceptions of, each other's behaviors.

## Interpersonal Learning in Group Counseling

### *Historical Perspective*

In 1955, Raymond J. Corsini and Bina Rosenberg were the first to present a comprehensive classification of group therapeutic factors. William F. Hill and others presented their own models within the next few years. These classifications included elements of interpersonal learning; however, the term *interpersonal learning* was first proposed by Irvin D. Yalom in his 1970 landmark classification of group curative factors.

Yalom's development of interpersonal learning dimensions had a major influence on later group curative factor classifications. For example, in 1985, Sidney Bloch and Eric C. Crouch presented a model of group therapeutic factors that included "learning from interpersonal action" and "insight (self-understanding)." Together, these two factors closely resemble Yalom's interpersonal learning dimension.

In comparative studies of group therapeutic factors, research findings from the 1970s to the present have consistently ranked interpersonal learning among the most helpful elements in the group process.

### *Therapeutic Factors in Group Counseling*

Therapeutic factors refer to those forces in counseling groups that flow from the interactions among group members (including the group leader or coleaders). These forces promote and support group members' efforts to gain self-insight, pursue goals, and make productive changes in their lives. Some examples of group therapeutic (or curative) factors include cohesiveness, universality (the realization that one's problems are not unique and that others face similar challenges), instillation of hope, and interpersonal learning.

Interpersonal learning is often cited as one of the most important therapeutic factors. Interpersonal learning is particularly important in groups oriented toward member self-insight and the development of social interaction skills (e.g., personal growth groups, encounter groups, and interpersonal groups). Because psychological disturbances are often the result of



underlying problematic interpersonal relationships, interpersonal learning serves as a valuable means of directly addressing such issues.

### ***The Interpersonal Learning Process***

As members of a counseling group interact among themselves and the group leader, they tend to engage in the habitual patterns of behavior that are characteristic of their interactions in social situations outside of the group setting. Both effective and ineffective social behaviors are on display for other members of the group to observe. In effect, a social microcosm is created whereby members get to see each other as they really are. This provides an ideal environment for the interpersonal learning process.

In his formulation of interpersonal learning, Yalom included both input (gaining insight from others' feedback) and output (trying out new behaviors in the group) dimensions. He also emphasized certain elements that mediate the therapeutic effects of interpersonal learning. The social microcosm of the group must provide a safe and supportive environment for members to be themselves and express here-and-now feelings. Also it must at the same time foster honest feedback and the opportunity for reality testing (e.g., for members to compare their perceptions to the perceptions of others). Members must be able to experience intense emotional awareness of the effects of their interpersonal behavior, both in terms of their feelings about themselves and in terms of others' reactions. In essence, a given group member undergoes a corrective emotional experience whereby the individual is re-exposed, within the supportive group environment, to emotional situations that could not be effectively handled in the past. Through such emotional awareness the member can be motivated to develop cognitive understanding by examining and interpreting the experience with the help of other group members.

The interpersonal learning process is likely to follow a cycle that typically begins when a given group member displays a problematic behavior (e.g., constantly criticizing others, dominating the discussion, denying strong feelings, expressing distorted perceptions). The member then observes others' reactions and/or receives feedback from others and engages in reality testing through consensual validation (confirming the validity of the feedback with multiple group members). With the help and support of other group members, the member may then reflect on and accept responsibility for the

consequences of the problem behavior. As a result of such reflection, a decision may be reached by the member to work on changing the ineffective behavior. With the help of others in the group, the member can then work to develop new, more effective behaviors and practice them in the group. This sequence is then recycled as the member receives feedback concerning new behaviors. As more effective interpersonal behaviors are gradually developed, the individual receives increasingly positive feedback which leads to increased confidence and self-esteem as well as an increased willingness to experiment with other new behaviors. Throughout this process, the group leader seeks to facilitate each step and, ultimately, to facilitate the generalization of new, more effective behaviors to functioning outside the group setting.

### **Interpersonal Feedback as an Element of Interpersonal Learning**

Interpersonal feedback represents one of the most direct means by which individuals can learn about themselves from others, and it is widely considered to be a key element in the interpersonal learning process. Interpersonal feedback can be described as sharing one's reactions to another's behavior, and perceptions of that behavior, with that person. This allows the receiver of the feedback to gauge the extent to which others perceived the behavior as it was intended.

The group counseling setting provides a particularly rich environment for the exchange of feedback. Most therapeutic groups are composed of a group leader (or coleaders) plus three to eight group members, providing each member with the opportunity to receive feedback from multiple sources. Strong consensual validation occurs when feedback from multiple sources is in agreement and the recipient cannot dismiss the feedback without careful consideration and self-reflection.

### ***Positive and Corrective Feedback***

Two basic types of helpful feedback exchanged among group members are *positive* and *corrective* (sometimes referred to as *negative*). Positive feedback is often given in the form of praise for behaviors that are considered effective and desirable. Corrective feedback usually takes the form of encouragement to become aware of and reflect on a behavior that seems ineffective or inappropriate from the feedback giver's



perspective. Positive feedback tends to be readily received by most group members. Corrective feedback, though considered essential for the process of modifying ineffective behaviors, may arouse anxiety and be difficult for the receiver to accept and utilize, especially during the early stages of group development.

### **The Effective Exchange of Feedback in Groups**

Group leaders may follow (and encourage group members to follow) certain general guidelines in order to provide a group atmosphere where feedback (especially corrective feedback) can be used productively. For example, research findings have indicated that corrective feedback is usually more effective when delivered after group members have progressed beyond the early stages of group development and group cohesion is relatively high. Corrective feedback is also likely to be more readily accepted when it immediately follows positive feedback, a trusting relationship exists between the giver and receiver, the feedback focuses on specific and observable behaviors rather than being evaluative, and when the receiver has the opportunity to seek clarification and receive help in processing the feedback information.

### **Future Directions**

Interpersonal learning will likely continue to be viewed as one of the most important therapeutic factors operating in counseling groups. Researchers are increasingly focusing on studies to clarify the relative importance of interpersonal learning and other therapeutic factors across the various developmental stages of groups as well as for differing client populations. Additionally, much work is being done to determine which therapeutic factors are most important for particular types of group experiences. Dennis M. Kivlighan, Jr., and Stacey E. Holmes, for example, presented findings of a 2004 meta-analytic study from which they formed a typology of groups based on their therapeutic mechanisms. They concluded that group members ranked interpersonal learning as highly important for groups focused on affective or cognitive insight, but as somewhat less important for groups focused on affective or cognitive support. It seems likely that future research studies will increasingly seek to clarify the unique contributions of interpersonal learning (and component elements such as

interpersonal feedback) as well as the means by which group leaders can most effectively initiate and enhance its facilitative effects.

*D. Keith Morran*

**See also** Family Counseling (v1); Feedback in Counseling, Immediate (v1); Group Therapy (v2); Individual Therapy (v2); Self-Help Groups (v2); Social Support (v2)

### **Further Readings**

- Crouch, E. C., Bloch, S., & Wanlass, J. (1994). Therapeutic factors: Interpersonal and intrapersonal mechanisms. In A. Fuhriman & G. M. Burlingame (Eds.), *Handbook of group psychotherapy* (pp. 269–315). New York: Wiley.
- Kivlighan, D. M., Jr., & Holmes, S. E. (2004). The importance of therapeutic factors: A typology of therapeutic factors studies. In J. L. DeLucia-Waack, D. A. Gerrity, C. R. Kalodner, & M. T. Riva (Eds.), *Handbook of group counseling and psychotherapy* (pp. 23–36). Thousand Oaks, CA: Sage.
- Yalom, I. D., with Leszcz, M. (2005). *The theory and practice of group psychotherapy* (5th ed.). New York: Basic Books.

---

## **INTRINSIC MOTIVATION**

---

Intrinsic motivation occurs when an individual engages in an activity solely because the activity is perceived and experienced as interesting and enjoyable and not because of any external incentive or inducement to do so. Historically, intrinsic motivation has been distinguished from amotivation, which refers to a lack of drive or energy to engage in an activity, and extrinsic motivation, which occurs when someone engages in an activity for some reason other than the sheer interest and enjoyment of the activity. Contemporary models of intrinsic motivation vary in the extent to which they explore the subjective experience of interest and the role it plays in self-regulating behavior. However, all perspectives acknowledge the influence of various situational and individual factors on interest and intrinsic motivation. The integration of these contemporary models with research on emotion, cognitive appraisal, and self-regulation will further advance the applicability of intrinsic motivation research to education, work, and mental, emotional, and physical health.



## The Nature of Intrinsic Motivation

### Definition

In Latin, the root of the word *motivation* means “to move.” The study of motivation involves the attempt to understand why people engage in certain activities (e.g., work, school, social relationships, personal health and fitness) and includes studying the choices people make and whether and how they continue to engage in activities once they begin.

A phenomenological perspective is essential to adequately grasp how social scientists conceptualize intrinsic motivation. In other words, it is necessary to try to understand the subjective experience of the individual, including the personal meaning, importance, and value the individual places on certain activities and the feelings of interest and enjoyment the individual feels. These value- and feeling-related variables are generally positively correlated with one another; however, they may relate somewhat differently to people’s activity choices and their continued involvement in activities over time.

Psychologists conceptualize intrinsic motivation in three ways. Educational and sport psychologists, in particular, conceptualize intrinsic motivation as an individual difference characteristic, traitlike in nature, and they use self-report scales to measure differences in motivation among people. In general, these scales assess differences in people’s preferences for challenging activities, their strivings for competence and mastery, and their perceived interest in certain activities. Other researchers conceptualize intrinsic motivation as a situational characteristic. These scholars examine how altering certain aspects of an activity influence the degree to which the activity is perceived as interesting. For example, researchers have examined the extent to which novelty, sex-typing, performance feedback, and the actual presence of other people affects interest in an activity. A third group of scholars, recognizing that individual and situational factors are likely to influence motivation, examines the ways in which activity characteristics, individual differences, and contextual factors combine to influence interest and motivation.

Although researchers have measured intrinsic motivation in a variety of ways, two measures are most often used. One commonly used method is to ask participants to rate their interest and enjoyment after engaging in an activity (i.e., self-report). The second method involves a behavioral measure of interest during a “free choice” period. In experiments

using this method, participants engage in a specific task under varying conditions (e.g., praise vs. no praise). After finishing the task, the experimenter tells the participant that he or she will not be working with the task any longer. Then, the participant is left alone in the lab with the original task and several distractor tasks for a period of time. During this period, the participant has free choice to engage in any or none of the tasks in the room. The amount of time the participant spends with the experimental task during the free choice period, when no extrinsic reason is in place, is considered the measure of intrinsic motivation.

### A Brief History

People have been pondering the distinction between motivation arising from within the individual and motivation derived from some external source at least as far back as writings attributed to Confucius (551–479 B.C.). As a behavioral phenomenon, intrinsic motivation was initially described in the 1940s and 1950s in experiments with nonhuman animals. In these experiments, animals were observed to engage in exploratory behaviors, appearing curious and playful, even in the absence of any external reinforcer.

The contemporary concept of intrinsic motivation as it relates to human behavior developed as a challenge to learning and behavioral conditioning theories prominent in the field of psychology from the 1940s through 1960s. Operant conditioning theory asserted that people engaged in activities because of the nature of the reinforcements they received as a consequence. In contrast, the concept of intrinsic motivation highlighted that for some activities, the reward came from doing the activity itself, not from what happened after. Even though some learning theories allowed for motivation as a cause of behavior, these theories focused on motivation based on satisfaction of basic physiological needs (e.g., hunger, thirst, sex), or on satisfaction of learned needs that at one point were associated with basic physiological needs (e.g., motivation to obtain money). Initial conceptions of intrinsic motivation, in contrast, highlighted the possibility that some activities were motivated by basic *psychological* needs (e.g., personal causation, competence).

Over the next 40 years, intrinsic motivation research was guided by the proposition that the motivation to satisfy specific psychological needs (e.g., competence, autonomy, relatedness) was the energy source for intrinsically motivated activities. More



recently, the state of intrinsic motivation itself (i.e., the feeling of being interested and immersed in an activity) became a focus of attention due to research suggesting that the satisfaction of these basic needs does not necessarily result in intrinsic motivation. This research highlighted the need to distinguish between the state of intrinsic motivation and the conditions that make it more or less likely to occur. Recent work has also started to focus on the process through which the state of intrinsic motivation may turn into well-developed individual interests that are characterized by extensive knowledge of, valuing of, and long-term commitment to, a particular topic or domain in life.

### Contemporary Models

The following three models were selected to illustrate the different underlying assumptions that have been made regarding the nature of intrinsic motivation. These assumptions have implications not only for how intrinsic and extrinsic motivation are related to one another, but also for how these two forms of motivation relate to other situational and individual characteristics.

#### Flow Theory

The purest and most intense subjective experience of intrinsic motivation has been labeled *flow*. Flow describes the emotional state and change in consciousness that occur when people engage in *autotelic* activities (i.e., activities people do for the activity's own sake rather than for some type of extrinsic reward). *Flow* became the descriptor for this experience after several participants in research studies of certain autotelic activities (e.g., rock climbing, chess, painting) reported that when they were engaged in the activity they felt as if a current were carrying them along effortlessly. This state has also been described as feeling immersed in, or being carried away by the activity, in such a way that one loses one's sense of a separate self.

The defining feature of flow is an intense moment-to-moment involvement in an activity. After the experience, people often report having felt a heightened sense of control, a merging of awareness and action, and an altered sense of time. Although intense flow experiences are relatively uncommon in people's everyday lives, many activities are capable of producing them as long as several conditions are met. First, flow is more likely to occur when a person is engaged in an activity that has a clear set of goals that serve to direct attention to the activity. Second, the person

must feel a balance between the requirements and challenges of the activity and his or her own abilities. When this balance between activity requirements and personal skill exists, the individual's attention is completely absorbed in the activity. When this balance is not present, the person is more likely to experience anxiety if the challenges are perceived as too difficult, or boredom if the activity is perceived as too easy. A final condition that increases the likelihood flow will occur is the presence of clear, immediate performance feedback that enables the person to engage in corrective action. The experience of flow is psychologically rewarding, and participants often comment that they enjoyed an activity so much they would be willing to go to great lengths to experience it again. In order to induce further flow experiences, individuals must seek out increasingly difficult activities as they master skills and challenges. Therefore, the experience of flow itself is assumed to reinforce behaviors underlying human growth and development.

#### Self-Determination Theory

Self-determination theory (SDT) rests on the assumption that people are active organisms, innately motivated toward growth and development. Consequently, people naturally seek to experience optimal levels of stimulation, mastery over challenges, and a sense of volition and choice (i.e., self-determination). The social environment may either aid or thwart people's abilities to meet their basic needs for competence, autonomy, and relatedness.

Within the general SDT framework, *cognitive evaluation theory* focuses on how feedback, praise, and rewards influence a person's intrinsic motivation, based on whether these social factors are perceived by the person as controlling or as information about his or her competence. Events that lower feelings of autonomy will interfere with intrinsic motivation, whereas events that convey positive competence information will enhance intrinsic motivation. From this perspective, an event does not have to be external to have detrimental effects on intrinsic motivation. Internally generated constraints (e.g., internalized pressure to perform well) may also result in lower intrinsic motivation.

This early recognition led to more recent developments within SDT that suggest that motivation can be thought of not just in terms of the distinction between intrinsic and extrinsic motivation but also as existing along a continuum of autonomy or self-determination. The proposed continuum ranges from amotivation on



one end (the least self-determined) to intrinsic motivation on the other (the most self-determined). In between are four types of extrinsic motivation (external, introjected, identified, and integrated) that differ in the degree to which they are experienced as autonomous, freely chosen and arising from important aspects of the self. The two relatively more autonomous forms of extrinsic motivation (i.e., identified and integrated extrinsic motivation) are distinguished conceptually from intrinsic motivation. However, in research and practice, these distinctions are frequently disregarded because these forms of motivation often have similar positive effects on persistence and effort, and on physical and psychological well-being.

The self-determination continuum has been used to help predict effects of different situational variables on behavioral and psychological outcomes, as well as to provide a basis for the development of individual difference measures. These latter measures attempt to identify consistent differences in particular domains (e.g., education, sports) or between individuals in terms of the degree to which they approach situations with self-determined orientations.

### ***Self-Regulation of Motivation Theory***

Although self-determined extrinsic motivation and intrinsic motivation may often have similar effects on outcomes, self-regulation of motivation theory (SRM) suggests that distinguishing between intrinsic and extrinsic motivation may be important in understanding the motivational process. SRM theory is based on the assumption that maintaining motivation to engage in a particular activity over time requires that people have some level of both extrinsic and intrinsic motivation. Feelings of “having to” (i.e., extrinsic motivation) may be essential because the activity may lead to some important outcome; and so it may be critical to persist even when the experience is not interesting. In turn, feelings of “wanting to” (i.e., intrinsic motivation) are essential because it is difficult and stressful to persist indefinitely when one dreads the experience. From this perspective, extrinsic and intrinsic motivation may be bidirectionally integrated into an individual’s self-regulatory process over time. For example, research has shown that an extrinsic reason to value a boring activity (self-determined extrinsic motivation) can lead to intrinsic motivation, by motivating the person to engage in strategies that make doing the activity more interesting. Moreover, engaging in

interest-enhancing strategies can, in turn, lead to seeing the activity as more valuable.

A critical task of self-regulation, therefore, is to regulate both kinds of motivation when and if needed. In other words, intrinsic motivation is embedded in people’s everyday regulation of behavior. Rather than being a rarity, limited to special flow experiences, interest and enjoyment are crucial for the continued performance of activities people deem important to their everyday lives. This perspective suggests that the absence of interest may be an important (and underrecognized) source of motivational and affective problems. For example, the absence of interest during the process of activity engagement may lead individuals to discontinue the activity or to select alternative activities, even when this means foregoing important positive outcomes. Some researchers have suggested that certain problem behaviors among individuals with psychiatric disorders (e.g., failure to sustain treatment) may in fact be reactions to boredom, particularly for individuals beginning to recover from psychotic breaks. Moreover, if individuals attempt to regulate their interest in an activity rather than quitting the activity, the particular strategies they use might be considered off-task or inappropriate, resulting in negative evaluations by others and other negative consequences.

By embedding intrinsic motivation within the everyday self-regulatory process, this perspective illuminates potential implications for the relationships between goals and the experience of interest. For example, rather than identifying certain types of goals as inherently intrinsic or extrinsic, the key is identifying whether working toward a particular goal is associated with the experience of interest for a particular individual. An individual is likely to experience greater interest when the context is congruent with (i.e., matches) his or her goals, and when multiple goals are compatible with each other. Intrinsic motivation does not just depend on particular characteristics of a task or situation, therefore, but rather is a dynamic state that arises through an ongoing transaction among individuals’ goals, activity characteristics, and the surrounding context over time.

### **Related Situational and Individual Factors**

#### ***What Makes Something Interesting?***

Researchers have identified various characteristics of activities and situations that influence the degree to



which an activity is perceived as interesting. For example, the addition of fantasy story lines and the addition of information to make the activity personally relevant can enhance students' interest in educational video games. In general, activities that arouse curiosity, allow people to act effectively, or allow involvement in fantasy tend to be those that individuals find interesting. In contrast, external constraints on behavior interfere with a person's interest in an experience. For example, rewards made contingent on performing an activity that the person would have done anyway because of interest tend to decrease subsequent intrinsic motivation to perform the activity. Rewards made contingent on performing well, in contrast, have a more complex set of effects. Working with other people can lead to greater interest, particularly for some individuals. The next section describes the role of individual differences in understanding what leads to greater or lesser interest.

### *Is It Interesting to Me?*

Researchers have identified a variety of individual differences that serve to moderate the influence of particular activity and situational factors in fostering interest. For example, individuals higher in interpersonal orientation may experience greater interest when working on activities *with* others (assuming that the interpersonal interactions are positive). In contrast, individuals higher in achievement orientation may experience greater interest when working on activities that involve competition *against* others.

Clearly, a wide variety of factors influence activity interest. Yet, how do people decide for themselves whether or not an activity is interesting? The appraisal structure of interest model assumes that interest works similarly to other emotions, resting on an appraisal of the situation and people's capacities to respond. According to the model, people's perceptions of novelty (i.e., the unfamiliarity and complexity of an activity) and their coping potential (the degree to which people believe they can understand a new and complex activity) are two factors influencing the degree to which interest is experienced. People's coping potential encompasses their appraisals of whether they have the resources, skills, power, and personal control to handle the activity effectively. When people approach a novel activity believing they can understand and handle it, they are more likely to experience interest. Over time, the emotional experience of interest may

guide the development of enduring personal interests in certain kinds of activities.

## **Applications of Intrinsic Motivation Theory**

Scientific understanding of the essential role of intrinsic motivation in human motivation and the self-regulation of behavior has been applied to a wide variety of social contexts, including education, health care, parenting, exercise and sports, and work and organizations. Following are several examples of how theory and research on intrinsic motivation have been applied in different domains.

A number of researchers interested in achievement behavior have recognized the important interplay between achievement goals and intrinsic motivation. Traditionally, two types of achievement goals have been distinguished. *Mastery goals* involve attempts to learn and increase one's competence, whereas *performance goals* involve attempts to maximize positive evaluations of competence and minimize negative evaluations. More recently, performance goals have been subdivided into two types: goals to display competence relative to others (*performance-approach goals*) and goals to not appear incompetent relative to others (*performance-avoidance goals*). Research has indicated that mastery goals are positively correlated with interest and enjoyment of learning, hope, and pride as well as with academic performance and prosocial behavior in the classroom. The effect of performance goals is less clear. However, performance-approach goals tend to have more positive consequences for motivation than performance-avoidance goals, and depending on the context (e.g., whether in the classroom or the lab) and individual differences in achievement orientation, their positive effects on interest may be equivalent to the effects of mastery goals.

The SRM model has been applied effectively to understanding individuals' vocational and career choices. Indeed, interest is a main reason people give for their career choices. One question that has been examined concerns why women are less likely than men to choose careers in math, computer technology, and the physical sciences. According to the SRM model, people's career interests are influenced by the degree of match or congruence between their personal work goals and their perceptions of the extent to which different careers offer opportunities to pursue those goals. Women are more likely than men to value



opportunities to work with and help other people, whereas men are more likely than women to value opportunities for high pay and recognition. Both women and men perceive math, computer science, and physical science careers as offering fewer opportunities to work with and help other people and more opportunities for high pay relative to several other career options. One consequence of this gender difference in match between individuals' work goals and their perceptions of different careers is that women and men are likely to find certain career options relatively more or less interesting to pursue.

Sport psychologists have used the concept of intrinsic motivation, both as a situational and individual difference characteristic, to study a number of different phenomena. As a situational characteristic, researchers have examined the effects of performance feedback and coaching climate on people's intrinsic motivation and goal pursuit. As an individual characteristic, intrinsic and extrinsic motivational orientations for athletic involvement have been linked to different levels of alcohol use among college students. Specifically, college athletes and exercisers who were intrinsically motivated toward athletics reported less use of alcohol than did those who were extrinsically motivated. A rather unique element of applied research in this domain is that individuals in a wide age range (i.e., from early childhood to older adulthood) have been included.

Applications of intrinsic motivation theory to general counseling contexts have examined myriad forms of behavior, including the development of parenting skills, offender recidivism, and adherence to therapy regimens.

### The Ongoing Debate

The earliest experiments on intrinsic motivation in the early 1970s found that tangible extrinsic rewards decrease intrinsic motivation. These results were highly controversial because they challenged the predominant behavioral perspective that asserted that carefully constructed reinforcement contingencies were the most effective way to increase motivation. Since that time, nearly 100 published studies have supported the original finding, yet the debate continues. Some behaviorists maintain that rewards do not decrease intrinsic motivation and advocate the use of reward-based incentive systems in schools. Intrinsic motivation researchers respond by emphasizing the need for caution when implementing such systems.

Researchers on both sides of the debate acknowledge the complex effects of rewards on motivation. For example, over the past 20 years the effects of using performance-contingent rewards (i.e., rewards contingent on doing well on a task, not just completing it) have been shown to be distinct from other types of reward. With performance-contingent rewards, individuals who succeed receive something tangible as a symbol of their excellence. Three properties of performance-contingent rewards (i.e., the psychological pressure arising from knowing one is being evaluated, the fact that the reward clearly conveys task competence, and the symbolic cue value of the reward) simultaneously affect motivation in both positive and negative ways. For example, the performance pressure from being evaluated can negatively affect motivation, whereas the positive performance feedback upon the reward's receipt can enhance motivation. By providing a tangible symbol of accomplishment, the reward can also increase interest independently of the positive performance feedback by intensifying the emotional significance and importance of the accomplishment (this may help to explain the popularity of trophies and plaques). This third property of performance-contingent reward can thus enhance interest when rewards are obtained, by making the competence level achieved more tangible and valued. However, the same property may diminish interest when individuals fail to qualify for the reward, because the failure also has greater impact.

These research findings are directly relevant to the current high-stakes testing debate in public education. High-stakes testing is endorsed by some as a way of increasing motivation and performance among students, teachers, and school administrators. Students, teachers, and schools performing at or above state or federal standards are rewarded and those failing to meet standards are punished. The results of extensive research on intrinsic motivation over the past 30 years led to the conclusion that the use of such practices is likely to be harmful to students' and teachers' interest in, and enjoyment of, learning.

### The Future of Intrinsic Motivation

A major concern of psychologists over the next 20 years will be to increase their understanding of the manner in which intrinsic and extrinsic motivation, emotion, cognition, and goal-seeking interact to shape



the self-regulation of motivation and behavior. There will likely be continued movement away from the position that intrinsic and extrinsic motivation are two ends of a continuum and greater recognition of the fluidity and gradations between these forms of motivation and their simultaneous existence. The integration of existing models of intrinsic motivation (e.g., flow theory, SDT, SRM, appraisal structure of interest theory) within the broader field of positive psychology opens up enormous opportunities for social scientists whose goals are to enhance quality of life and well-being.

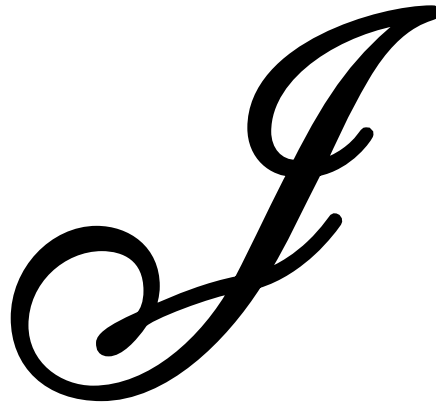
*Carolyn Morgan and Carol Sansone*

**See also** Academic Achievement (v2); Affect (Mood States), Assessment of (v2); Csikszentmihalyi, Mihaly (v2); Deci, Edward L., & Ryan, Richard M. (v2); Leisure (v2); Personality Theories, Phenomenological (v2); Positive Psychology (v2); Self-Efficacy/Perceived Competence (v2)

### Further Readings

- Csikszentmihalyi, M., Abuhamed, S., & Nakamura, J. (2005). Flow. In A. Elliot & C. S. Dweck (Eds.), *Handbook of competence and motivation* (pp. 598–608). New York: Guilford Press.
- Csikszentmihalyi, M., & Csikszentmihalyi, I. S. (Eds.). (2006). *A life worth living: Contributions to positive psychology*. New York: Oxford University Press.
- Deci, E. L., & Ryan, R. M. (Eds.). (2006). *Handbook of self-determination research*. Rochester, NY: University of Rochester Press.
- Eccles, J. S., & Wigfield, A. (2002). Motivational beliefs, values, and goals. In S. T. Fiske, D. L. Schacter, & C. Sahn-Waxler (Eds.), *Annual review of psychology* (pp. 109–132). Palo Alto, CA: Annual Reviews.
- Harackiewicz, J. M., Barron, K. E., Tauer, J. M., Carter, S. M., & Elliot, A. J. (2000). Short-term and long-term consequences of achievement goals: Predicting interest and performance over time. *Journal of Educational Psychology*, 92, 316–330.
- Hidi, S., & Renninger, K. A. (2006). The four-phase model of interest development. *Educational Psychologist*, 41, 111–127.
- Lepper, M. R., Henderlong, J., & Iyengar, S. S. (2005). Intrinsic and extrinsic motivational orientations in the classroom: Age differences and academic correlates. *Journal of Educational Psychology*, 97, 184–196.
- Morgan, C., Isaac, J., & Sansone, C. (2001). The role of interest in understanding the career choices of female and male college students. *SexRoles: A Journal of Research*, 44, 295–320.
- Ryan, R. M., & Deci, E. L. (2000). Intrinsic and extrinsic motivations: Classic definitions and new directions. *Contemporary Educational Psychology*, 25, 54–67.
- Sansone, C., & Harackiewicz, J. (2000). *Intrinsic and extrinsic motivation: The search for optimal motivation and performance*. San Diego, CA: Academic Press.
- Sansone, C., & Thoman, D.B. (2005). Interest as the missing motivator in self-regulation. *European Psychologist*, 10, 175–186.
- Silvia, P. J. (2005). What is interesting? Exploring the appraisal structure of interest. *Emotion*, 5, 89–102.
- Silvia, P. J. (2006). *Exploring the psychology of interest*. New York: Oxford University Press.





---

## JUNG, CARL (1875–1961)

---

Carl Gustav Jung was a Swiss-German psychoanalyst who, with Sigmund Freud, was instrumental in ushering depth psychology (theories of the unconscious) into the 20th century.

Jung was educated at the University of Zurich and as a young man he developed the concept of the autonomous, unconscious complex and the technique of free association, well before joining forces with Freud's Viennese School. Along with Alfred Adler and Sigmund Freud, Jung worked to advance the concept of unconscious motivation. Despite their initial collaboration, however, Jung broke with Freud over the latter's reductionist, psychosexual view of the unconscious and his own espousal of phenomena that Freud regarded as occult.

Just before the outbreak of World War I, Jung experienced a spontaneous series of "visions" that nearly led him to psychosis. These visions awoke in him a revolutionary appreciation of how close his own unconscious life was to the primitive myths and rituals of humankind. The importance of occult experiences was apparent in Jung's first published paper, "On the Psychology and Pathology of So-Called Occult Phenomena." In Jung's writings, the unconscious encompassed not only the biological drives that Freud had emphasized, but also those "spiritual" or occult aspirations that Jung believed were just as integral and innate a part of human individuality. Thus, Jung acknowledged forces within the human psyche for which the Freudian view had little explanation. This fundamental difference in their view of the human personality ultimately led to their break.

In formulating his theories on the collective unconscious and the archetypes, Jung posited an unconscious—and hereditary—source for all of humankind's creative endeavors and spiritual yearnings. Jung divided the unconscious into two levels. The *superficial personal unconscious* houses memories that are too weak to reach consciousness, and memories and traumas that are so threatening they are suppressed by the ego. The *collective unconscious*—sometimes referred to as the *racial memory*—is the repository of the universal religious, spiritual, and mythological symbols and experiences of humankind. The primary structures of the collective unconscious that form the foundation of the human psyche are the archetypes. Jung believed these structures are biologically based and inherited.

Jung defined the *archetype* as a "primordial" psychic image or pattern, representative of our ancestral experiences, that recurs throughout human history in dreams, fantasies, myths, and art. The major archetypal figures of the collective unconscious, Jung proposed, are the shadow, anima, animus, and self. The *shadow* is the amoral, prehuman, animal aspect of personality that is instinctively focused on reproduction and survival. The *anima* is the female aspect of personality present in the collective unconscious of men. The *animus* is the male aspect of personality present in the collective unconscious of women. The *Self* is the unified personality that integrates conflicting aspects of the personality such as the anima and animus. The unconscious is centered around the Self.

Jung also developed a groundbreaking personality theory that introduced the concepts of extraversion and introversion, and that explained human behavior as a combination of four psychic functions—thinking, feeling, intuition, and sensation. (This psychological



typology would provide the theoretical foundation for the well-known Myers-Briggs personality survey.) Other crucial Jungian formulations include compensation, synchronicity, and individuation. *Compensation* refers to the ongoing efforts of the unconscious to correct the ego's one-sided view of reality. *Synchronicity* reflects the importance Jung attributed to occult events. He believed that some meaningful events are not the result of mechanistic causation nor of human intention. Most psychologists and laypersons would call these events coincidences, but Jung believed they are indications that we are connected with other humans and with nature in general through our collective unconscious. *Individuation* refers to the lifelong psychological process of the ego's encounters with, and acceptance of, the archetypes within, especially the unconscious Self.

Jung spent his later years beside Lake Zurich carving in stone the mythological figures to which he had devoted his life. For example, Jung represented the Self as the circle, cross, and mandala. One possibly apocryphal story is that on the night of Jung's death, thousands of his friends and disciples throughout the world dreamed of his passing, and his favorite tree beside the lake was split in two by lightning. Whether true or not, Jung would most certainly have been delighted, for the story honors his lifelong advocacy of occult experience and illustrates his concept of synchronicity, namely, that all humans are connected through the collective unconscious. Perhaps now he was a part of that collective realm that had been the great subject of his life's work.

Thomas C. Gannon

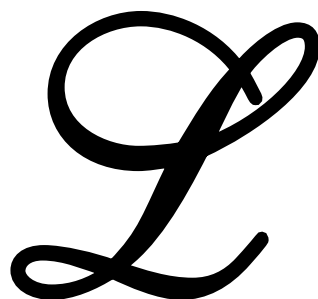
**See also** Defenses, Psychological (v2); Ego Strength (v2); Free Association (v2); Freud, Sigmund (v2); Personality

Theories, Psychodynamic (v2); Psychoanalysis and Psychodynamic Approaches to Therapy (v2); Religion/Religious Belief Systems (v3); Spirituality (v3); Spirituality/Religion (v2); Therapist Techniques/Behaviors (v2); Therapy Process, Individual (v2)

### Further Readings

- Jung, C. G. (1955). *Modern man in search of a soul*. San Diego, CA: Harvest.
- Jung, C. G. (1959). *The undiscovered self*. New York: New American Library.
- Jung, C. G. (1965). *Memories, dreams, reflections* (A. Jaffé, Ed.). New York: Random House.
- Jung, C. G. (1966). Psychological types. In G. Adler & R. F. C. Hull (Eds. & Trans.), *Collected works of C.G. Jung* (2nd ed., Vol. 6). Princeton, NJ: Princeton University Press. (Original work published 1921)
- Jung, C. G. (1966). Symbols of transformation. In G. Adler & R. F. C. Hull (Eds. & Trans.), *Collected works of C.G. Jung* (2nd ed., Vol. 5). Princeton, NJ: Princeton University Press. (Original work published 1911–1912)
- Jung, C. G. (1966). Two essays on analytical psychology. In G. Adler & R. F. C. Hull (Eds. & Trans.), *Collected works of C.G. Jung* (2nd ed., Vol. 7). Princeton, NJ: Princeton University Press. (Original work published 1917)
- Jung, C. G. (1969). Aion: Researches into the phenomenology of the Self. In G. Adler & R. F. C. Hull (Eds. & Trans.), *Collected works of C.G. Jung* (2nd ed., Vol. 9, 2). Princeton, NJ: Princeton University Press. (Original work published 1951)
- Jung, C. G. (1976). *The portable Jung* (J. Campbell, Ed.). New York: Penguin.
- Jung, C. G., & von Franz, M.-L. (Eds.). (1968). *Man and his symbols*. New York: Dell.





---

## LANGUAGE DIFFICULTIES, CLINICAL ASSESSMENT OF

---

The terms *language*, *speech*, and *communication* are used interchangeably by most people. When children or adults are seen by a speech-language pathologist (SLP), however, each of these terms refers to specific behaviors that are assessed and treated differently.

*Language* is a symbolic code organized by rule-governed combinations that are socially shared. Children learn to use this symbolic code by being part of families and communities. This learning process continues when children go to school and learn to read and write and formally study language. Most children have no difficulty learning the code. They quickly and easily recombine words to talk with others (which can be likened to building structures with a Lego set). However, approximately 10% of all children have difficulty learning some aspect of the language code. In addition, some adults have had an experience, for example, a stroke or head trauma, that resulted in specific language impairment.

*Speech* is the spoken production of language. It is an oral neuromuscular process that shapes the sounds particular to each national language and allows verbal transmission of thoughts and ideas between people. The mouth's structures and muscles shape the sounds, but the sounds being shaped are particular to specific symbolic language codes.

*Communication*, the most comprehensive of the three terms, involves the exchange of information between people. This exchange can be *nonverbal*, such as when the body, space, and eye gaze are used to

convey information. It can be *vocal*, such as when those who are hearing impaired or using electronic equipment add their pitched voice, grunts, and so forth to the messages they are sending. It can be *verbal*, such as when information is exchanged by speaking to one another. Language is integral to communication because this symbol system is used to encode information and ideas. Therefore, while language need not be spoken, it is a pivotal aspect of communication.

Language, speech, and communication typically co-occur in everyday life. When considering atypical development or disease, injury, or illness that affects language, each person must be assessed and possibly treated differently. A life-span perspective about language assessment follows.

### ***Birth to Age Three***

Infants who are born with health problems, syndromes, or into living situations that place them socially at risk are eligible to receive early intervention services. The goal of these services is to prevent or reduce the effects of the biological or social conditions on development. Transdisciplinary teams provide services in homes and centers under an Individual Family Service Plan (IFSP). The family rather than the infant alone is considered the client.

Since the development of language is fundamental to communication and later learning, the SLP assesses emerging skills and formulates an intervention program. The focus of the assessment shifts between communication, speech, and language, depending on the developmental status of the infant. Common assessment tools include the Rossetti Infant and Toddler



Language Scale, Receptive-Expressive Emergent Language Test, Sequenced Inventory of Communication Development, and MacArthur Communicative Developmental Inventories. These scales are criterion-referenced instruments that report age equivalencies. The first three provide information about infant understanding of communication and language, and determine how well the infant is communicating by using speech sounds, gestures, and language with others. The last instrument uses parent report to determine the range and depth of the infant's vocabulary development.

### **Early Childhood**

Early childhood extends from approximately 3 to 5 years of age. It encompasses the "magic" years of language development, so called because this is the single most dramatic period of language growth in the life span. Many children who receive speech-language therapy are first identified during this time of life. They are referred for assessment by physicians, who may use instruments such as the Denver Developmental Screening Test to identify concerns; by parents who do not think their child speaks enough or does not speak clearly; and by preschool educators who are concerned about language comprehension, attention, and other skills essential in the learning environment.

For assessment, children may be referred to early childhood programs, free-standing clinics, private practitioners, or university training centers. Regardless of setting, the formal and informal assessment tools used to determine the adequacy of language development will be similar.

Formal assessment usually involves the use of standardized tests, and provides a full range of normative scores. Some common assessment instruments are the Preschool Language Scale, Clinical Evaluation of Language Fundamentals–Preschool, Peabody Picture Vocabulary Test (PPVT), and Expressive Vocabulary Test (EVT). These tests cover a range of language skills. The PPVT and EVT are both vocabulary tests normed on the same cohort, which allow for comparisons between receptive and expressive skills. Vocabulary tests are also embedded in the other instruments as a part of the battery. Other assessment domains include the understanding and production of *grammar* (the way words are combined to make sentences), *morphology* (the way word parts are used, such as prefixes and suffixes), *semantics* (how words and phrases create meaning), and *pragmatics* (awareness of

others as having unique beliefs, desires, and mental states, and the social use of language).

Informal testing consists of observation, recording a sample of the child using language during play with a peer or family member, and charting communication patterns. Informal testing by the SLP provides a cross-check on the standardized test results, since some children may do poorly on the more structured testing yet have adequate developmental language skills. The results of informal testing are reported descriptively and as age or developmental criteria comparisons. While this information may not be as easy to use as standardized test results, it is often better understood by parents and captures the everyday issues that resulted in the referral for evaluation.

### **School Age**

It is assumed that children are developmentally ready to learn when they go to school. Language is a pivotal developmental skill that is used and further developed in classrooms. It also serves as the basis for reading and writing. Some children will continue the treatment begun in early childhood. Others may have been discharged from language therapy but need further assessment because they are having difficulty attending to or understanding language-based classroom activities or learning to read and/or write. Additionally, some children with no history of language problems will exhibit these problems and be referred by teachers. Regardless of a child's history, the child's present status of language-for-learning skills must be assessed.

Assessment of school-aged children is usually based on norm-referenced tests unless a school has a response to intervention (RIP) protocol in place. When an RIP action plan is activated, extra assistance is provided to the child. If the child responds, a full evaluation is not recommended. Those children who continue to have difficulties even with this extra assistance are referred for assessment. In a full diagnostic workup, developmental language skills will be checked, but the emphasis will be on language-for-learning. Some of the most frequently used standardized tests include the CELF, PPVT, and EVT cited earlier, as well as the Illinois Test of Psychological Abilities and Woodcock Language Proficiency Battery. In addition to developmental language skills, phonological awareness, reading, spelling, and writing skills are now assessed. The goal is to determine if there is an unresolved developmental language



difference (for children up through Grade 3) or if the developmental language skills are adequate but the child is having difficulty taking these fundamental skills to a new context and transforming them into different language modalities (i.e., text based). The results of these tests are norm-referenced scores.

Informal assessment is included in a full diagnostic workup. This usually focuses on conversation skills, storytelling, and other pragmatic language skills that are best assessed when an interactive context is established. Results from these procedures are reported descriptively.

## Adulthood

There are many diseases and conditions that can affect language functioning, speech, and communication in adulthood. Most problems are caused by some kind of neurological impairment. For young adults, language difficulties result most commonly from head trauma (e.g., a car accident, motorcycle accident, or bullet wound). As middle age approaches, there is increased risk of stroke or tumor, and these become even more likely as adults move into what are considered the older years. Some problems (such as stroke) are static; once the damage occurs there is no further loss of functioning. Other problems (such as Parkinson's disease or Alzheimer's disease) are progressive; impairment increases over time.

Language assessment in adults is critical for a number of reasons. First, the assessment results will contribute to a better differential diagnosis of the underlying condition or disorder. Second, assessment outcomes will be used to design a treatment program. Finally, test results will provide information that is critical to counseling the client and significant others about the nature of the specific language problems, the probable impact of these problems on daily functioning and quality of life, and the prognosis for change.

Language assessment for adults may be performed in a variety of settings, including acute care hospitals, rehabilitation facilities, freestanding clinics, and the client's home. Virtually all assessments include informal observations of the person's speech, language, and communication skills in everyday tasks and contexts. In some settings, because of time limitations, informal assessment may be the primary process used to identify the problem and develop treatment plans. However, there are a number of language assessment test batteries that can be used to examine all aspects of an adult's

language functioning. For adults with language problems following a stroke, the Western Aphasia Battery and Boston Diagnostic Aphasia Examination are examples of comprehensive batteries. Other tests evaluate language, but also examine other cognitive and perceptual skills impaired by neurological deficits. Examples might include the Ross Information Processing Assessment and the Cognitive Linguistic Quick Test. Still other tests focus on one small aspect of language functioning (e.g., reading, understanding of sentence-length materials, or naming).

## Importance

Speech, language, and communication are complex behaviors. It is important to obtain an accurate assessment of language skills, deficits, and potential to determine the best way to improve language functioning. In addition, since language is such an important tool in counseling, it is critical to understand the person's linguistic abilities and challenges and to make certain that support for communication is provided. Without language, children and adults cannot participate fully in the world around them.

*Barbara B. Shadden and Fran Hagstrom*

*See also* Bilingualism (v3); Communication (v3); High-Context Communication (v3); Low-Context Communication (v3); Psychometric Properties (v2)

## Further Readings

- Brookshire, R. H. (1997). *Introduction to neurogenic communication disorders* (5th ed.). St. Louis, MO: Mosby.
- Chapey, R. (Ed.). (2001). *Language intervention strategies in aphasia and related neurogenic communication disorders* (4th ed.). Philadelphia: Lippincott Williams & Wilkins.
- Haynes, W. O., & Pindzola, R. H. (Eds.). (1998). *Diagnosis and evaluation in speech pathology* (5th ed.). Boston: Allyn & Bacon.
- Owens, R. E., Jr. (2001). *Language development: An introduction* (5th ed.). Boston: Allyn & Bacon.

---

## LEISURE

---

Society perceives activities such as woodworking, writing, and playing a sport differently when performed as a job than when performed as a hobby. This



anomaly led psychologists to question the nature of leisure. What is it that makes an activity “leisure,” and are the consequences of performing these activities as a job different from the consequences of performing these as leisure?

Psychologists began the systematic study of leisure in the early 1970s. Two works influenced psychologists’ study of leisure behavior. In his 1974 book *The Psychology of Leisure*, John Neulinger proposed that activities be distinguished based on the extent to which the activity was freely chosen and was motivated by a desire to receive *intrinsic rewards* (i.e., rewards that are unavoidable consequences of the act of participation). Leisure occurs when individuals freely chose intrinsically satisfying activities. Work occurs when individuals respond to behavioral constraints to achieve extrinsic rewards. Neulinger’s view that leisure is more than the mere absence of work opened the door to psychological investigations of the similarities and differences in leisure and work activities.

Howard E. A. Tinsley and Diane J. Tinsley’s 1986 theory of *transcendent leisure experiences* provided a more multifaceted paradigm for the study of leisure. The theory postulated four conditions that are necessary for an activity to be experienced as leisure: freedom of choice, intrinsic motivation, optimal arousal, and involvement. The theory identified seven attributes of leisure experiences and suggested that leisure experiences are necessary for physical health, mental health, and personal (psychological) growth.

### Attributes of Leisure Experience

Leisure experiences vary from intense, life-transforming experiences to routine experiences that occur on a daily basis. Psychologists have focused on the most intense experiences because the attributes of intense leisure experiences are more readily identifiable than in routine experiences.

Five theorists have shaped psychologists’ conceptions of leisure. Abraham Maslow’s theory of peak experiences is the earliest and most comprehensive theory. Tinsley and Tinsley’s transcendent leisure experiences theory was influenced by Maslow’s work, but it deals more directly with leisure behavior. Maslow and Tinsley and Tinsley believe the attributes of routine leisure experiences are the same as, but less intense than, the attributes of transcendent leisure experiences. Mihaly Csikszentmihalyi proposed a theory of flow experiences that formed the basis for Chester F. McDowell’s

theory of leisure consciousness. Kathleen D. Noble’s theory of transcendent religious and meditation experiences has the narrowest scope.

Several common themes are discernible in these theories. The strongest consensus exists for the following attributes of leisure experiences:

- *Unity.* The individual and the experience become integrated and participants report a sense of unification with the world.
- *Absorption.* Participants focus exclusively on the activity and lose self-awareness.
- *Enriched perception.* Continued participation across time leads to a greater awareness of the nuances and complexities of the experience.
- *Positive outcome.* Leisure experiences provide a desirable way of truth finding that can lead to insights into universal truths.
- *Passive awareness.* Participants relinquish their control and allow the experience to unfold.
- *Loss of inhibition.* Participants feel confident, expressive, and daring; anxiety, defensiveness, restraint, and self-criticism are set aside.
- *Perceptual distortion.* Participants lose track of time and space.
- *Feelings of freedom.* Participants feel free and unconstrained by rules.
- *Intrinsic motivation.* Participants gain enjoyment from the mere act of participating in the activity.

### Causes of Leisure Experience

According to transcendent leisure experiences theory, freedom of choice, intrinsic motivation, optimal arousal, and psychological commitment are necessary prerequisites for an individual to experience leisure.

#### *Freedom of Choice*

Social psychologists refer to freedom of choice as the *illusion of control* because the individual’s subjective interpretation of the situation determines how the experience will be perceived. For example, individuals may perceive themselves as freely choosing to engage in behaviors that appear to others to be the result of external constraints. Leisure, developmental, and motivational psychology all view freedom of choice or the illusion of control as an expression of two of the most powerful motivations underlying human behavior: the desires for personal autonomy and for competence.



The illusion of control is important for maintaining mental health and successful functioning.

Threatening an individual's sense of freedom generates psychological reactance. *Reactance* is an aversive feeling that increases the attractiveness of the threatened freedom, stimulates aggressive feelings, and motivates the person to undertake action to regain the lost freedom. An individual's willingness to substitute one leisure activity for another is inversely related to the amount of external pressure to make the switch.

Research supports the position that freedom of choice is related to the perception of an activity as leisure. In one study, for example, leisure activities were regarded as voluntary approximately 40% of the time, whereas paid employment was seen as voluntary 5% of the time.

### ***Intrinsic Motivation***

Intrinsic motivation refers to the desire for rewards that are unavoidable consequences of the act of participation. For example, an individual who desires social contact would find visiting with close friends to be intrinsically rewarding because the very act itself involves social contacts. Extrinsic motivation refers to the desire for rewards that are not unavoidable consequences of performing the activity. Common extrinsic motivations include external coercion (e.g., work deadlines and imposed goals), the desire to avoid negative outcomes (e.g., criticism), and the desire for rewards such as money, grades, and recognition. From 40% to 65% of study participants described leisure activities as intrinsically motivated, but fewer than 5% described paid employment as intrinsically motivated.

Providing extrinsic rewards for intrinsically rewarding activities can destroy intrinsic motivation if the extrinsic rewards become too salient. Mark R. Lepper, David Greene, and Richard E. Nisbett demonstrated this effect in 1973. Preschool children who originally chose to play with colorful felt-tip markers were much less willing to play with the markers after an intervening time in which they had been promised and subsequently given a reward for playing with the markers. For this reason, parents should not provide extrinsic rewards to encourage their children to participate in activities that are intrinsically enjoyable.

### ***Optimal Arousal***

Walter B. Cannon observed in 1932 that all living organisms have a natural tendency to maintain a state

of internal balance or equilibrium. He called this tendency *homeostasis*. For the most part, homeostasis is maintained automatically. For example, we breathe without having to think about how much oxygen we need. In 1954, Henry W. Nissen extended this concept to include the cognitive functioning of the brain. He reasoned that there is an optimal level of cognitive stimulation (i.e., *optimal arousal*) that is maximally satisfying to the brain. Individual differences in sensation seeking, curiosity, and exploratory behavior are expressions of individual differences in optimal arousal level.

Wilhelm Wundt's general law of hedonic tone provides an explanation of the mechanisms underlying optimal arousal. He theorized that every stimulus has both a pleasant and an unpleasant effect. As the strength of a weak stimulus increases, the strength of its pleasantness component increases more rapidly than the strength of its unpleasantness component. Therefore, the stimulus is perceived as more and more pleasant. However, the pleasantness component reaches its maximum level while the unpleasantness component is still relatively weak. Once the pleasantness component has reached its maximum, further increases in the intensity of the stimulus increase only the strength of the unpleasantness component. That explains why increases in the intensity of a stimulus (e.g., adding salt to a bland dish) results in more pleasant sensations up to a point, after which further increases make the sensation less pleasant.

Daniel Berlyne, Marvin Zuckerman, and Charles Spielberger all proposed dual process explanations of optimal arousal. For example, Spielberger proposed that curiosity and exploratory behavior result from the simultaneous influence of curiosity and anxiety. Initially, increases in the strangeness, novelty, or complexity of an experience are pleasant (i.e., they increase curiosity or exploratory behavior). Pleasure is optimal when strong feelings of curiosity are accompanied by mild feelings of anxiety. As the stimulus becomes stronger, however, the salience of its negative component (i.e., anxiety) increases and the pleasantness of the experience decreases.

The effects of optimal arousal are difficult to investigate because many factors influence the level that an individual will regard as optimal. For example, breadth of interest—the tendency to seek varied, changing, and novel stimuli from a variety of sources—is an enduring personality trait. Some people have broad interests, while others have a limited range of interests. Other personal factors that influence the stimulus intensity an



individual will find optimally arousing include *curiosity* (satisfied by novelty), *sensation seeking* (satisfied by risk or increased stimulus intensity), and *skill* (satisfied by challenge). Csikszentmihalyi's flow model, for example, postulates that optimal arousal (i.e., flow) occurs when there is a balance between the challenge of the activity and the skills of the individual. Individuals who differ in skill level will also differ in the level of challenge that will be optimally arousing.

Despite these difficulties, it is clear that optimal arousal occurs more frequently in leisure than in work activities. Across multiple studies, about 60% describe novelty as an attribute of their memorable leisure experiences, but only 2% mention novelty as an attribute of their memorable work experiences. In general, participants describe their memorable leisure experiences as novel and intrinsically rewarding, their common leisure experiences as relaxing and intrinsically rewarding, and their memorable work experiences as extrinsically rewarding.

### **Involvement**

In 1947, Muzafer Sherif and Hadley Cantril proposed the concept of psychological involvement to explain the process by which individuals relate their personal sense of identity to a social object (e.g., a sports fan's elation when a favorite team wins). Involvement is a psychological state of arousal, interest, or motivation that has personal relevance to the individual. The strength of involvement influences the extent to which a person will seek out and process information about an activity, expend time and energy pursuing the activity, and continue to pursue the activity across time. Involved individuals place a higher value on the long-term benefits of participation in the activity, are more willing to sacrifice in order to continue the activity, and are more willing to derogate alternative activities to make them seem worse than they are.

### **Constraints and Affordances**

Constraints are factors that limit or prevent participation in leisure. There are three general types of constraints. *Intrapersonal constraints* involve individual attributes (e.g., personality characteristics) and psychological states (e.g., a temporary depression or elation). Lack of interest in an activity or prior unpleasant experiences with the activity are examples of intrapersonal constraints. These constraints prevent the individual from forming the desire or intent to

participate in the activity (i.e., they prevent the formation of intrinsic motivation).

*Structural constraints* intervene between the formation of leisure preferences or intentions and actual participation. An individual may find it difficult to participate in a preferred activity because of health problems, the lack of time, or inadequate financial resources. *Interpersonal constraints* involve other people (e.g., family responsibilities or the absence of a leisure partner). Structural and intrapersonal constraints limit the individual's freedom of choice.

Leisure participation is not dependent on the absence of constraints but on the successful negotiation of constraints. Furthermore, *affordances* (i.e., factors that facilitate leisure participation) influence participation. At present, leisure psychologists know little about the strategies used to negotiate constraints or the dynamic interactions between constraints and affordances. Integration of these constructs into a more comprehensive psychosocial model of leisure behavior is needed.

### **Benefits of Leisure Experience**

A benefit is a beneficial change or the maintenance of a desirable situation. Psychologists have examined a wide variety of potential benefits of leisure, including physiological and physical health benefits, mental health benefits, social benefits, economic benefits, environmental benefits, and benefits to the community.

Both individuals and social groups obtain benefits from leisure. Individuals obtain benefits such as increased life satisfaction, but this outcome also may contribute to an improvement in the morale of a family, a classroom, or a community. Social groups may receive direct benefits, such as when vandalism is reduced or community pride increases as a result of a leisure program.

Leisure activities provide 11 psychosocial benefits. In order of importance, they are:

- *Exertion.* Activities high on exertion emphasize vigorous physical activity; those low on this dimension offer relaxation and stress reduction.
- *Affiliation.* Activities high on affiliation provide opportunities to be with other people; activities low on affiliation satisfy the need to be alone and enjoy solitude. The importance of this benefit and nurturance (see below) are consistent with motivation theorists' conclusion that relatedness is one of the primary intrinsic motives.



- *Enhancement.* Activities satisfying the need for enhancement give individuals an opportunity to use their talents and develop their skills; activities low on enhancement provide little opportunity for personal development. This and the next benefit are consistent with motivation theorists' conclusion that competence is an important intrinsic motive.
- *Self-expression.* Activities high on self-expression emphasize variety and the flexibility to try unique approaches and ideas. Activities low on self-expression provide an opportunity to follow a familiar, comfortable routine.
- *Nurturance.* Like affiliation, nurturing activities offer a chance to be with and enjoy the company of others, but they also provide opportunities to support, encourage, and help others. Activities low on nurturance satisfy individuals' needs to pursue their own self-interests.
- *Compensation.* Activities high on compensation provide an opportunity to experience things that are missing from one's job or other routine activities; activities low on compensation provide pleasures similar to those obtained from other aspects of one's daily routine.
- *Sensibility.* Activities high on sensibility provide intellectual and artistic stimulation while those low on sensibility provide opportunities to reduce cognitive demands.
- *Conscientiousness.* Leisure activities high on conscientiousness emphasize responsible behavior and personal restraint; activities low on conscientiousness allow individuals to escape feelings of obligation and to focus on pleasant aspects of the present situation.
- *Status.* Activities high on status provide opportunities to receive attention, influence others, and feel important; those low on status allow individuals to avoid attention and the obligations of leadership.
- *Challenge.* Activities high on challenge emphasize personal skill and high levels of performance; activities low on challenge emphasize process more than outcome.
- *Hedonism.* Activities high on hedonism provide immediate pleasure without the need for long-term planning or commitment. Activities low on hedonism typically involve long-term goals.

### Applications of Leisure Psychology to Counseling

In the 1970s, Robert T. Overs and his associates at the Curative Workshop of Milwaukee developed an innovative leisure counseling program to address the needs of older persons and clients with disabilities. In

addition, several practitioners in the United States began to specialize in leisure counseling. Despite the encouraging results reported by these pioneers, however, mainstream counseling psychology has given scant attention to leisure.

### Future Directions

Almost everyone experiences leisure in some form, and almost everyone enjoys and values leisure, but leisure is presently an understudied aspect of life. Nevertheless, leisure behavior provides an amazingly fertile applied laboratory within which to study phenomena of interest to cognitive, social, motivation, human factors, vocational, and counseling psychologists. The growing interest in developing a positive psychology of the healthy personality may direct increased attention to leisure.

Howard E. A. Tinsley

*See also* Csikszentmihalyi, Mihaly (v2); Deci, Edward L., & Ryan, Richard, M. (v2); Exercise and Sport Psychology (v1); Intrinsic Motivation (v2); Physical Activity Counseling (v2); Play Therapy (v1); Positive Psychology (v2); Psychological Well-Being, Dimensions of (v2); Tinsley, Howard E. A. (v4)

### Further Readings

- Baldwin, K. S., & Tinsley, H. E. A. (1988). An investigation of the validity of Tinsley and Tinsley's (1986) theory of leisure experience. *Journal of Counseling Psychology, 35*, 263–267.
- Crawford, D. W., Jackson, E. L., & Godbey, G. (1991). A hierarchical model of leisure constraints. *Leisure Sciences, 13*, 309–320.
- Driver, B. L., Brown, P. J., & Peterson, G. L. (Eds.). (1991). *Benefits of leisure*. State College, PA: Venture.
- Jackson, E. L., Crawford, D. W., & Godbey, G. (1993). Negotiation of leisure constraints. *Leisure Sciences, 15*, 1–11.
- Neulinger, J. (1974). *The psychology of leisure*. Springfield, IL: Charles C Thomas.
- Peterson, G. L., Driver, B. L., & Gregory, R. (Eds.). (1988). *Amenity resource valuation: Integrating economics with other disciplines*. State College, PA: Venture.
- Tinsley, H. E. A., Hinson, J. A., Tinsley, D. J., & Holt, M. S. (1993). Attributes of leisure and work experiences. *Journal of Counseling Psychology, 40*, 447–455.
- Tinsley, H. E. A., & Tinsley, D. J. (1986). A theory of the attributes, benefits and causes of leisure experience. *Leisure Sciences, 8*, 1–45.



---

## LIFE TRANSITIONS

---

Life transitions may be defined as significant changes within the life course. According to the life course perspective, lives are composed of multiple, interrelated developmental *trajectories*. For example, a life course includes personal relationship trajectories, an educational trajectory, an employment trajectory, and physical health trajectories, among others. These trajectories are marked or accentuated by significant life transitions, with transitions in one trajectory often necessitating or involving transitions in another. The transition to adulthood may involve a residential transition from the family of origin to independent residence, graduation from high school and enrollment in some form of higher education or entry into the workforce, and significant relationship transitions as individuals move away from old friends and form new connections. The implications of life transitions, from a counseling perspective, vary dramatically by historical period, socioeconomic status, gender, race and ethnicity, as well as by individual factors such as personality, coping styles, social support networks, and other resources.

### Life Course Transitions

A traditional developmental perspective describes developmental tasks to be completed at each stage or transition in life. For instance, a Western developmental perspective might define the transition to adulthood as involving further establishment of personal identity, and increasing social and economic independence from parents. A life course perspective acknowledges the developmental uniqueness of transitions, but emphasizes the embedding of transitions within social contexts and historic and temporal processes. Thus, the meaning of a given transition, and individuals' ease in traversing it, depends on the social contexts within which it occurs. Similarly, the effects of social contexts on individuals depend on the stage or transition in the life course during which they occur. For example, research on the psychological and socioeconomic effects of military experiences during World War II found that effects depended on whether entry into the military occurred in early or later adulthood. For those entering the military right out of high school and before they had invested heavily in their careers, military service often resulted in positive socioeconomic outcomes in later adulthood, as it

provided training and work experiences, educational, health, and financial benefits, as well as a much improved economy upon returning home. In contrast, for those entering the military in their early 30s, military experience represented a major interruption of careers and family lives, resulting in significant setbacks upon returning home.

An important distinction is whether transitions occur at normative times and in normative sequences. Life course theory posits that life transitions are age graded, meaning that they typically occur within a given age range, and in a normative sequence. Transitions that occur at unusual ages (i.e., "off time"), or out of sequence, may be particularly difficult. The loss of a parent, for example, although never insignificant, has been found to have very different consequences if it occurs early in life (e.g., during childhood) or at a more normative age in later midlife. In addition to the timing of transitions, their duration is also of consequence. Research on the effects of poverty for children, for example, finds that short spells of poverty are less detrimental than prolonged exposures to economic hardship.

Contrary to developmental perspectives that emphasize continuity and the linear unfolding of human development over time, life course theory emphasizes discontinuity and nonlinearity. For example, research into the effects of job loss and other economic strains during the Great Depression found that economic conditions interacted with personality characteristics. Men with a propensity for aggression became even more aggressive in response to these challenges, and this accentuation of personal characteristics continued across the life course. Perhaps more interesting, however, are how later life transitions may represent turning points within the life course. Research on deviance across the life course has observed an apparent paradox. When viewed retrospectively, nearly all criminals are observed to have had delinquent pasts. When viewed prospectively (i.e., forward in time), in contrast, few juvenile delinquents go on to commit crimes as adults. One reason for the change is that most delinquents are drawn away from deviance through later positive life transitions, such as obtaining stable jobs or entering good marriages. In part, this growing out of delinquency is consistent with a pattern known as *adolescent limited delinquency*. Other research on turning points emphasizes the social psychological and symbolic nature of changes in identities that enable one to take advantage of these potential resources in adulthood.



Life course theory also emphasizes that individuals' transition experiences are inextricably linked to the lives of their significant others (e.g., spouses, partners, children, extended family members, friends, and other social networks). Thus, the effect of a transition is often moderated by the nature and extent of these social connections. For instance, research has found that undesirable economic transitions, such as loss of a job or loss of a family farm, affect parents, but also "spillover" to have detrimental consequences for children. Some research on gender differences in stress has found women to be more exposed to undesirable life events through their more extensive social support networks.

### The Stress Process and Transitions

The stress process model offers additional insights into the potential effects of life transitions. Most broadly, the stress model predicts that undesirable life events (e.g., job loss, death of spouse) produce stress and may result in diminished psychological or physical well-being. Even desirable transitional events, such as the birth of a child or receiving a job promotion, require adaptations that may produce stress. The type or nature of a given life event is critical to understanding its potential consequences. An important distinction within the stress literature is whether a given life event or transition is acute or part of a more chronic pattern of stressors. By definition, *acute stressors* are of short duration. They also tend to be more randomly distributed within the population, and to have more limited and short-term consequences. *Chronic stressors* tend to be associated with socioeconomic and other (race and ethnicity, gender) disadvantages, and represent recurrent problems that may accumulate over the life course and result in serious outcomes (e.g., increased morbidity or mortality). For example, chronic stressors (e.g., unemployment, food insecurity, exposure to environmental hazards) and poor quality social services (e.g., schools, health care) associated with low socioeconomic and minority status are thought to produce a premature weathering of the body and increased risks of morbidity and mortality. Life events that are out of individuals' control, are unexpected, and/or threaten salient personal identities are also found to be more stressful. For example, research has found job or economic-oriented life events to be more detrimental to men's well-being than to women's, as they threaten men's identities as family economic providers. Women, in contrast, may

be more influenced by undesirable life events within the family.

The stress literature also focuses attention on personal and social resources that individuals may draw upon to buffer the effects of transitional life events on well-being. Personal resources often associated with positive outcomes include self-esteem and self-efficacy. An individual's repertoire of coping strategies may also moderate the consequences of life transitions. Persons with more active coping or problem-solving styles are often better able to deal with stressors than those who respond passively or by ignoring the problem. Research also finds that the way individuals appraise the causes of life events (i.e., causal attributions) influences outcomes. For instance, life events that can be attributable to external causes (e.g., job loss during the Great Depression) are less likely to result in negative psychological outcomes than those that are attributed to individual deficiencies. Studies of job losses have found that the more people are able to make lateral social comparisons to others in similar situations, and/or positive social comparisons to those worse off, the better they are able to cope with their own stressors. Research similarly finds that the degree to which the external community attributes life events to the person, versus external causes, influences the amount of social stigma people experience. The material and economic resources at individuals' disposal are of obvious potential benefit for dealing with stressful life transitions. Relating closely to the life course concept of linked lives is the concept of social support. Perceived and actual social support (e.g., from spouses, external family, and social networks) is found to both directly influence well-being and to buffer against the negative effects of undesirable life events.

The life course and social stress literatures offer insights into understanding those who are best able to adapt to life transitions and other undesirable events. A variety of studies identify variables associated with *resilient* individuals (i.e., those able to beat the odds), including individual or social-psychological characteristics such as planfulness, self-efficacy, self-esteem, and intelligence; and social and socioeconomic resources such as community involvement, social support, human and financial capital, and high-quality public institutions and services. These perspectives also highlight the importance of considering how individuals and families actively adapt to their environments and transitional demands. In the study of families living in poor and/or dangerous neighborhoods, researchers have



found that successful parents employ a variety of tactics to minimize youth's exposure to community risks. Examples include "lock-ins," early curfews, family chaperonage, restrictions on places children are allowed to go, and tight control over relationships with peers. Such practices might be characterized as too restrictive or "authoritarian" within lower-risk contexts, but within stressful environments, they appear to be positively adaptive.

### Childhood Transitions

One of the first major transitions in life is the transition from home to formal schooling. Rather than a discrete transition, however, entry into formal schooling may include transitions from home to day care, from day care to prekindergarten (pre-K) programs, and from pre-K programs to kindergarten. Transitions from kindergarten to first grade, and subsequent grade transitions, must also be considered because of their unique developmental and social circumstances. Given associations between later academic difficulties and performance during the first several years of schooling, research and policymakers have focused on factors associated with school readiness, and interventions such as the Head Start program and other pre-K experiences. In addition to cognitive readiness, a student's social and behavioral competencies are also critical. Entry into elementary school involves a considerable change in social context, as kindergartens and first grades are typically larger than preschool or day care arrangements, and involve a more rigid set of behavioral regulations. Most research indicates that positive relationships between children and adults (both teachers and parents) are critical to fostering readiness.

Other research has focused on the yearly transitions from school back to families and neighborhoods during summer breaks. Though children start the school year with varying abilities, research has shown that all children make gains at about the same rate over the school year. However, research has shown that educational inequality increases during the summer. It is believed that the relative lack of resources available within the families and communities of poor and minority children explain these growing disparities over the summer.

A particularly significant maturational transition during adolescence is puberty. Early pubertal development is potentially problematic for both males and females, as it is associated with early sexual activity and increased

delinquency. Among boys, early pubertal development predicts both violent and nonviolent delinquency, likely due to its association with greater access to older peers. Early pubertal development among females is also associated with earlier sexual activity and greater exposure to intimate partner violence. Moreover, greater exposure to intimate partner violence may explain changing gender differences in psychological well-being during this period. Prior to puberty, males tend to have higher depression than females. This gender difference switches during puberty, with females developing higher rates of depression. This disparity is found to persist across much of adulthood. A related important issue for females is perceived body image. Negative perceived body image during adolescence has also been found to account for the higher depression and lower self-esteem of females relative to males.

Transitions from elementary school to middle school and from middle school to high school have also been found to be challenging. Many studies have observed setbacks during these transitions in psychological well-being and academic competence, including diminished perceptions of ability and loss of intrinsic motivations for learning. These transitions are thought to be difficult for several reasons, including ongoing pubertal development, the need to renegotiate peer relations within more diverse (e.g., in terms of ages and social statuses) student bodies, and the increasing competitiveness and stratification of schooling.

Transitions associated with family moves during childhood and adolescence may present challenges due to their disruption of friendship and other social networks. Research has found, however, that supportive parents may buffer youth against the negative effects of family mobility. The effects of family migration also vary as a function of social class and the impetus for moves. Moves associated with upward social mobility are likely to be less detrimental than are those associated with job losses, or that are necessitated by other undesirable life events. Though people's stability in their community is generally found to be associated with positive outcomes, inability to move away from poor and dangerous neighborhoods may be associated with restricted access to resources and ongoing experiences of discrimination.

### The Transition to Adulthood

Perhaps most examined is the transition to adulthood, which typically involves the multiple transitions of



moving away from the family of origin, transitions to higher education and/or employment, and the formation of new family and other significant relationships. Transitions to higher education are now quite widespread, with nearly 70% of high school graduates continuing on to college as of 2005. Not surprisingly, this transition varies significantly across subgroups of the population, with women outpacing men, and Asian and White young adults more likely to be enrolled than African Americans and Latinos/as. Of increasing importance in the transition to higher education are community colleges and other 2-year institutions. Community colleges are particularly appealing to those who have traditionally been unable to pursue higher education, whether due to limited economic resources, poorer academic performance, or other risk factors. Graduate and professional degree programs have also increased in importance, further extending the transition to adulthood and delaying, for many, transitions to marriage and childbearing.

For disadvantaged youth, the transition to adulthood is becoming more perilous. Exposure to violence in poor neighborhoods and schools has been identified as a significant risk factor for poor psychological, social, and behavioral development (e.g., posttraumatic stress disorder, aggression, depression). Exposure to violence undermines youth's sense of control, frustrates learning, and may lead to a foreshortened adolescence. Exposure to street and intimate partner violence has been linked to a variety of "early exits" to adulthood, including dropping out of high school, running away from home, teen pregnancy, and suicidal thoughts. Another significant risk within the lives of disadvantaged young men is incarceration. Increasingly punitive federal and state policies and increased funding for police and penitentiary facilities over the past several decades have resulted in a tremendous growth of the incarcerated population. Most affected by this change are low-education minority men, for whom incarceration is now a nearly expected stage in the life course. For example, nearly 60% of African American males without a high school diploma will have spent some time in prison by their early 30s. For those who have been convicted of criminal offenses, the transition back into the community has also become more difficult due to increased surveillance and monitoring within the parole system, and to limitations placed on their rights to public services, employment and, in some cases, citizenship. The "collateral consequences" of incarceration to relationships between incarcerated

men and their spouses and partners, children, and communities are beginning to receive increased research and policy attention. Though not widespread, comprehensive reunification and fatherhood programs within prisons and the community offer some promise for easing this transition.

Family transitions during early adulthood are becoming both more delayed and diverse. Numerous trends have affected family transitions over the past half century, including delayed age of marriage, increased rates of nonmarital fertility and single parent households, and increased cohabitation. Also contributing to fewer married households were rising divorce rates during the 1960s and '70s, which leveled off and have declined somewhat since the early 1980s. Current projections of the likelihood of experiencing the transition to divorce vary based on assumptions about future demographic conditions. Nonetheless, between 43% and 50% of first marriages are likely to end in divorce within 15 years. These divorce rates vary considerably across subgroups, with women marrying at young ages considerably more likely to divorce than those marrying at later ages. Cohabitation prior to marriage is now the norm, but is also less likely to lead to marriage than in the past, particularly among low-income and minority couples. One very positive trend in recent years is a decline in teenage fertility, particularly among African American youth.

Policymakers have increasingly paid attention to these trends due to the mounting evidence that living in married couple families (i.e., versus single parent families) is associated with a wide range of socioeconomic, psychological, and physical health outcomes. Welfare reform, child support enforcement, and more recent marriage promotion and father involvement initiatives have each sought to change incentives related to marriage and nonmarital fertility. Critics, however, counter that marriage promotion among disadvantaged couples may not make economic sense due to the poor economic prospects of men, and may expose women and children to abuse and other risk factors in the lives of disadvantaged men. Other researchers point out that divorce may result in positive outcomes when it alleviates chronic stress or abuse within the family. As more fathers live apart from their children, researchers have sought to identify factors associated with positive outcomes for children. Fathers able to retain emotional closeness to their children and who actively engage in authoritative parenting have been found to be most successful.



The transition to parenthood is a life-changing process. Previous research finds, particularly in the case of a first birth, that the transition to parenthood frequently produces stress for the individual parents and the couple's relationships. As with other transitions, the nature and degree of consequences depends on personal characteristics, individual and family adaptations, timing, and other contextual resources upon which parents may draw.

### Midlife Transitions and Beyond

Perhaps the best-known concept associated with middle adulthood is the *midlife crisis*. The term usually refers to men's lives and disappointments associated with transitions at work or within the family. Although surveys suggest that many adults expect to go through a midlife crisis at some time, it is perhaps more constructive to discuss the multiple transitions that men and women may face during an increasingly prolonged middle adulthood. Midlife has become both longer and more varied, due to improvements in health care and increased longevity, as well as changes in the nature of careers.

The notion of a single career, pursued within a single company, is a thing of the past, and was a construct that applied mostly to middle- and upper-class White men rather than all workers. It has been replaced for many by careers marked by employment for multiple companies, of mid-career "retooling" (going back to school), and significant career changes. Some have characterized this change as going from linear career trajectories to "negotiated" careers. Longitudinal studies of contemporary careers have identified several common career sequences, including the traditional stable, long-term tenure at a single firm, an upwardly mobile path with multiple transitions between jobs, intermittent careers with multiple entries and exits, and a stable part-time work trajectory. Men are more likely to follow the stable full-time and upwardly mobile paths, whereas women, especially those who are responsible for child or elder care, are more likely to pursue the intermittent and stable part-time routes.

Another common transition, particularly for women who have cut short their educations or careers due to family demands, is to go back to school and/or reenter the labor force. For those going back to school, being a nontraditional student can be both challenging and rewarding. In addition to concerns about fitting in with predominantly younger student

peers, many educational institutions are not organized to accommodate the schedules of older students. Older students are more likely to experience role conflicts or strains associated with juggling both educational and family responsibilities. More positively, however, other research points to the psychological benefits of holding multiple productive roles.

When children are economically independent enough to move out of the parental home, parents may transition into what is commonly called the *empty nest* phase. Far from a crisis, research has actually found that parents are happiest during this empty nest stage. For many, however, this empty nest phase is increasingly delayed or interrupted, as adult children may delay leaving home in order to pursue higher education, save up to buy their own house, or move back home following divorce or other unexpected life events. Within disadvantaged communities, and particularly in the case of single mother families, it is quite common to have multiple-generation households in which grandparents move in to provide social and economic support. The many productive roles that grandparents play within multiple generation households are receiving increased attention within both the research and policymaking communities. An adult's parents may also move into the household due to their own deteriorating health or for economic well-being. If the children are not yet out of the house, this situation is described as a "sandwich," in which adults are doubly burdened by caring for children and their dependent parents. Research into the effects of such multigenerational caregiving on depression suggests that the burden is higher for women, however, other research finds that having multiple productive roles confers positive psychological benefits as well.

Just as careers are becoming more varied, so too is the transition to retirement. Rather than a single transition point, retirement is better conceived of as an ongoing process. Work retirement may be gradual or intermittent, with transitions from full-time to part-time work, from private sector to self-employment, or the starting of second or third careers. For some, the transition begins many years prior to actually leaving the job, with the initiation of financial and lifestyle planning for retirement. The degree of planning for retirement, however, varies considerably by social class and other statuses. Those with unstable work histories, those at risk for job loss, and those with declining health are not able to plan for and retire on their own terms. As is true of work transitions in



general, retirement is a transition that often affects more than one person. An individual's retirement decision making is thus influenced by the career and health transitions of spouses or partners and perhaps other family members.

Due to increases in longevity, researchers are increasingly interested in factors associated with successful aging. Though definitions of *successful aging* (or aging well) vary considerably, most entail the absence of physical disabilities and a sense of life satisfaction. Much like the concept of resilience, being adaptive in the face of change and continued social engagement, including volunteering activities and participation in other productive roles, has been found to be associated with effective maintenance of psychological and physical health.

As life expectancies continue to rise, transitions to caregiving roles increase in both likelihood and duration. Interventions that provide information and respite to caregivers of persons with dementia or other Alzheimer's-related symptoms are receiving increased research attention. The transition to widowhood and its duration is also of increasing importance, particularly for women who have considerably longer life expectancies than do men. Though widowhood often triggers distress and poorer physical health, these associations may be buffered by social support from family, friends, and social networks, positive health habits, and the widows' continued participation in informal community activities.

Finally, researchers have begun to analyze the transition to death, and conceptualize positive transitions in terms of *dying well*. This is usually defined in terms of minimizing unnecessary pain and psychological

distress, facilitating contact between the individual and his or her most significant others, as well as satisfaction of surviving family members with the experience. The quality of physicians' care of patients, and patient and family members' efficacy and control over decision making, are contributing factors to a relatively positive experience. In the case of sudden deaths, however, many of these ideal factors may not be possible, and thus concern focuses on the psychological adjustment of survivors.

*Raymond Swisher*

*See also* Adult Development (v1); Adults in Transition (v4); Aging (v1); Normative Issues (v2); Resilience (v2); School-to-Work Transition (v4); Stress (v2)

### Further Readings

- Aneshensel, C. S., & Phelan, J. C. (Eds.). (2006). *Handbook of the sociology of mental health*. New York: Springer.
- Elder, G. H., Jr. (1974). *Children of the Great Depression: Social change in life experience*. Chicago: University of Chicago Press.
- Goodman, J., Schlossberg, N. K., & Anderson, M. L. (2006). *Counseling adults in transition: Linking practice with theory* (3rd ed.). New York: Springer.
- Moen, P. (Ed.). (2003). *It's about time: Couples and careers*. Ithaca, NY: ILR Press.
- Mortimer, J., & Shanahan, M. (Eds.). (2003). *Handbook of the life course*. New York: Kluwer Academic/Plenum.
- Pillemer, K., Moen, P., Wethington, E., & Glasgow, N. (Eds.). (2000). *Social integration in the second half of life*. Baltimore: Johns Hopkins University Press.









---

**McCRAE, ROBERT R.**

---

*See* COSTA, PAUL T., AND McCRAE, ROBERT R.

---

**MEANING, CREATION OF**

---

The creation of meaning is an essential and unique human function. Because meaning is not inherent in any action or event, it must be constructed in the mind of the participant or observer. The comprehension of past events provides the context for decision making for present and future behavior, as well as individuals' current sense of identity.

In the context of psychotherapy, creation of meaning is a change process in which clients construct the meaning of emotionally charged experiences by putting them into words. Creation of meaning involves perceptual, affective, and cognitive processes. It refers to the creation of language that helps clients know what they feel. It is the cognition of emotion. Because it functions as a critical within-therapy change event, creation of meaning is a key component of psychotherapy process research.

The following is an example of how creation of meaning can have far-reaching consequences for an individual's quality of life and level of success regarding age-appropriate developmental tasks: A 10-year-old boy suffered the loss of his mother when she died in a motor vehicle accident. He then interpreted his mother's death as an act of abandonment; he felt unsafe to form close emotional bonds with others,

particularly women. Twenty-five years later, he sought help from a psychologist for difficulties with committing to an intimate relationship with a partner. These issues created great distress for him and his partner. In the process of psychotherapy, it was discovered that he was still angry about his mother's death and that he held onto the belief that his mother's death was an act of abandonment, which led him not to allow himself to be emotionally attached to anyone. Psychotherapy proceeded to assist this client in achieving an awareness of multiple possible alternative meanings regarding his mother's sudden death (i.e., the motor vehicle accident was an accident, not his mother's deliberate act of leaving her young son), so that his range of choices of behaviors in relationships could become both expanded and conscious. For instance, he could choose women who are capable of forming a long-term intimate relationship, or he could learn to work through conflict instead of ending a relationship at the first sign of a problem.

Creation of meaning occurs in various psychological treatment approaches, such as cognitive-behavioral, experiential, and psychodynamic. It has been identified as a factor in the treatment of many psychological conditions or disorders (e.g., anxiety, depression, or posttraumatic stress disorder). The change processes involved in successful creation of meaning have been demonstrated in research to include both a cognitive and emotional dimension. Successful creation of meaning involves emotional, experiential exploration of the original event. In unsuccessful creation-of-meaning events, clients do not go through a process of exploring the origin of the belief or emotion in a highly experiential way. Therefore, emotion



and cognition need to be linked in designing therapeutic intervention to facilitate successful creation-of-meaning episodes.

Macy M. Lai

**See also** Career Construction Theory (v4); Cognitive-Behavioral Therapy and Techniques (v2); Constructivist Career Counseling (v4); Constructivist Theory (v2); Counseling Process/Outcome (v2); Narrative Therapy (v2); Reframing (v2); Therapy Process, Individual (v2)

### Further Readings

- Clarke, K. M. (1996). Change processes in a creation of meaning event. *Journal of Consulting and Clinical Psychology*, 64, 465–470.
- Sarri, C. (1988). Interpretation: Event or process? *Clinical Social Work Journal*, 16, 378–390.
- Von Glasersfeld, E. (1984). An introduction to radical constructivism. In P. Watzlawick (Ed.), *The invented reality* (pp. 17–40). New York: Norton.

---

## MEEHL, PAUL E. (1920–2003)

---

Paul E. Meehl was an intellect and Renaissance man who made enduring contributions in a diverse array of subject areas in psychology and beyond. In psychology, he was best known for his work in measurement, philosophy of science, biological bases of schizophrenia, statistics, and actuarial approaches to assessment and prediction. He also published in areas as diverse as political science, extrasensory perception, psychology and law, and religion.

Meehl was a relentless analyst, and his formidable critical faculties led him to some radical conclusions. His theory of *schizotaxia* (an inherited predisposition to schizophrenia-spectrum disorders) and his dislike of statistical significance tests as a basis for theoretical inferences have since gained wide acceptance. Other conclusions, such as his inclination to think that “there is something to telepathy” and his “skepticism about the received doctrine of organic evolution,” place him well outside the scientific mainstream and into the area of the “strictly taboo.” Meehl’s open-mindedness and probing intellect led to illuminating commentaries on virtually every subject that captured his interest. As a result, he probably authored or coauthored more “classic” conceptual papers (and

certainly in more diverse areas) than anyone in the history of psychology.

Perhaps his most influential contribution was to measurement theory. In a 1955 article coauthored with Lee J. Cronbach, Meehl revolutionized the process by which psychologists provide evidence for validity of measures used in research and practice. A major contribution of this article was the acknowledgment that, for most psychological measures, validity cannot be established by a straightforward comparison with a criterion, because normally no unambiguously valid criterion measure can be found. For example, one would like to validate a pencil-and-paper measure of depressive tendencies by showing that it differentiates depressed from nondepressed individuals—but there is no perfectly accurate method of differentiating these two groups to serve as a criterion measure. Cronbach and Meehl explored the implications of this revelation for measurement theory and laid the groundwork for a new approach to construct validation that is central to the postpositivist philosophy of science.

Meehl was a unique figure in psychology in another way. He was a first-rate philosophical and mathematical thinker who also identified strongly as a clinician. He practiced from a psychoanalytic orientation during his early professional decades, then incorporated perspectives from rational-emotive and brief psychodynamic therapies in his mature years. Psychologists who take the trouble to read his original papers on applied psychology (rather than relying on textbook or reviewer summaries) are likely to be pleasantly surprised by Meehl’s astute clinical “ear.” His writings reveal a keen appreciation for the virtues of clinical experience as a basis for theory and practice, and offer wise counsel on applied matters including training and certification, assessment and case conceptualization, and the role of science in informing the practice of psychology.

With a foot in each camp, Meehl was fascinated and sometimes surprised by the tensions between those psychologists who identified primarily as scientists and those who identified primarily as practitioners. Members of each faction were granted exalted social status in their respective domains—practitioners in their clinical settings, and scientists in the halls of academia—and each group could be sharply critical of the other, frequently employing unflattering emotion-driven characterizations. Meehl had little patience with such ad hominem attacks, and worked diligently to impress each camp with its limitations as



an exclusive basis for claims about valid theory or optimal practice in psychology.

### Limitations of Clinical Experience

As a clinician, Meehl was acutely aware of the power conferred on psychological practitioners by their social and institutional status. Psychologists are empowered to restrict individual liberty, to challenge and often change clients' construals of their life events, and even to influence law and social policy (via "expert testimony" in courtrooms and beyond). They are also, like all human beings, subject to perceptual and mnemonic biases that can cause them to draw faulty conclusions from their experiences. The dangers of overconfidence in "clinical wisdom" (particularly when the stakes are high) was the theme Meehl chose to return to in his Centennial Award address to the Society of Clinical Psychology (Division 12) of the American Psychological Association in 1997. He stated that clinicians must and should rely on their clinical experience for guidance in many professional contexts, but they should be honest with themselves and others about the limitations of this basis for knowledge claims and for behavior.

A case in point is the diagnostic and predictive decisions made by clinicians in a variety of clinical and legal contexts. Psychologists often rely on vague "clinical impressions" or on idiosyncratic synthesis of impressionistic and objective data in making such predictions. In 1954 Meehl compared such *clinical* (or impressionistic) approaches to prediction with a *statistical* (or *actuarial*) approach in which multiple pieces of information were combined using a (usually quite simple) mathematical formula. His scientific masterpiece, *Clinical Versus Statistical Prediction: A Theoretical Analysis and a Review of the Evidence* (and more recent reviews), demonstrated unequivocally that actuarial methods virtually always yield predictions as accurate as, and quite often more accurate than, less systematic approaches.

Meehl's conclusion—that idiosyncratic methods are more likely to impede than enhance predictive accuracy—has frequently been construed as a broad indictment of clinical judgment per se. This was not Meehl's interpretation of his findings. He set great store by expert clinical observations and noted that the actuarial models in some studies he reviewed incorporated at least some data derived from clinician judgments into the prediction algorithm. In fact, more of *Clinical Versus Statistical Prediction* was devoted to

defending clinicians' unique inferential activities than to criticizing their predictive abilities. Recent reviewers note that many of the studies reviewed by Meehl focused on prediction of broad life outcomes (e.g., Will this person be successful in the army? Will he or she become manic at some point in the future?). Meehl's cautious optimism regarding the validity of clinical judgment receives stronger empirical support when researchers examine moderate levels of inference typical of clinical practice (e.g., judgments that a patient is perfectionistic or sensitive to rejection).

In summary, Meehl believed that when no conclusive scientific data are available expert judgment is a necessary and sound basis for many clinical decisions. However, clinical wisdom, like other conclusions based on anecdotal evidence, is sure to lead to incorrect conclusions at least some of the time, and needs to be distinguished from scientific findings (or "credentialed knowledge"). Meehl believed that practitioners are acting irresponsibly and even unethically when they behave as if their expert opinions constitute credentialed knowledge.

### Limitations of Scientific Research

The scientific method permits a stronger basis for knowledge claims (including claims about effective practices) than expert judgment does. It involves systematic observations and measurements that are replicable in principle, thus reducing the contribution of motivated cognition and other biases to the findings on which conclusions will be based. This does not mean that researchers always follow the scientific conventions that maximize scientific validity (e.g., complete and accurate reporting of a priori hypotheses and research procedures). Nor does this mean that these conventions are rationally derived. Meehl recognized that the scientific method as currently practiced in psychology is imperfect, and with his colleague David Faust, developed a methodology (termed *cliometric metatheory*) for identifying scientific practices that could be demonstrated empirically to enhance the validity of disciplinary findings.

Meehl lamented the tendency of psychological researchers to be preoccupied with methodology but oblivious to the banality of many fashionable theories. In a 1978 article Meehl wrote, "I would take Freud's clinical observations over most people's *t* tests any time" (p. 817). Social sciences (to a much greater extent than physical sciences) are fraught with



conceptual complexities that researchers may be intellectually or methodologically ill equipped to handle, such as the stochastic (probabilistic) nature of causation and the necessity for open (evolving) concepts. Finally, Meehl believed psychologists' use of statistical significance testing as their primary method of theory testing was incompatible with postpositivist philosophy of science, and a chief culprit in the disappointingly "slow progress of soft psychology."

### Science and Practice

The implications of these critiques for the relation between science and practice are complex. Meehl was disheartened by what he saw as some clinicians' unwarranted faith in the authority of conclusions drawn from their own clinical experience, and their seeming disinterest in weighing evidence for alternative interpretations, even when these were grounded in scientific findings. As Meehl wrote in a 1987 essay, the "general scientific commitment not to be fooled and not to fool anybody else" (p. 9) is a desirable characteristic of clinicians as well as researchers.

Meehl acknowledged that few clinicians fulfill the scientist-practitioner aspiration of producing independent research (beyond the dissertation), and was supportive of scholar-practitioner (Psy.D.) training models that (ideally) train students as intelligent and critical consumers of research produced by others. Meehl was pessimistic about the value of most "soft" psychology research for either practice or theory, but identified five "noble intellectual traditions" he considered to have enduring value. Interestingly, three of these (psychometrics, applied learning theory, and behavior genetics) have emerged from scientific findings, whereas the other two (descriptive clinical psychiatry and psychodynamics) constitute practice-based knowledge.

*William T. Hoyt*

**See also** Clinical Interview as an Assessment Technique (v2); Empirically Based Professional Practice (v1); Evidence-Based Treatments (v2); Positivist Paradigm (v2); Psychometric Properties (v2); Quantitative Methodologies (v1); Schizophrenia, Adult (v2); Scientist-Practitioner Model of Training (v1); Test Interpretation (v2)

### Further Readings

Cronbach, L. J., & Meehl, P. E. (1955). Construct validity in psychological tests. *Psychological Bulletin*, 52, 281–302.

- Meehl, P. E. (1954). *Clinical versus statistical prediction: A theoretical analysis and a review of the evidence*. Northvale, NJ: Jason Aronson.
- Meehl, P. E. (1978). Theoretical risks and tabular asterisks: Sir Karl, Sir Ronald, and the slow progress of soft psychology. *Journal of Consulting and Clinical Psychology*, 46(4), 806–834.
- Meehl, P. E. (1987). Theory and practice: Reflections of an academic clinician. In E. F. Bourg, R. J. Bent, J. E. Callan, N. F. Jones, & J. McHolland (Eds.), *Standards and evaluation in the education and training of professional psychologists: Knowledge, attitudes, and skills* (pp. 7–23). Norman, OK: Transcript Press.
- Meehl, P. E. (1989). Paul E. Meehl. In G. Lindzey (Ed.), *A history of psychology in autobiography* (pp. 337–389). Palo Alto, CA: Stanford University Press.
- Meehl, P. E. (1990). Toward an integrated theory of schizotaxia, schizotypy, and schizophrenia. *Journal of Personality Disorders*, 4(1), 1–99.
- Meehl, P. E. (1992). Cliometric metatheory: The actuarial approach to empirical, history-based philosophy of science. *Psychological Reports*, 71(2), 339–467.
- Meehl, P. E. (1997). Credentialed persons, credentialed knowledge. *Clinical Psychology: Science and Practice*, 4(2), 91–98.

---

## MEMORY, ASSESSMENT OF

---

Psychological research has shown that memory is not a unitary construct. Instead, memory consists of a coordinated collection of processes and abilities that work together to enable individuals' day-to-day functioning. Furthermore, one aspect of memory can be impaired while another remains intact. For that reason, psychologists do not rely on a single procedure for assessing memory. Many assessment measures exist, and commonly used assessment procedures contain multiple subcomponents, each aimed at assessing a particular type of memory. This entry reviews several types of memory and explains the different ways that they are assessed. At the end, it describes several full-length memory assessment measures.

### Types of Memory

#### *Immediate Memory*

Often termed *short-term memory*, immediate memory refers to the ability to hold information in



consciousness. This ability is demonstrated when one remembers a phone number long enough to make a call. Immediate memory is distinct from long-term memory, which is the ability to store information for later use, often over extremely long periods such as weeks, months, or years.

The earliest known assessment of immediate memory is the “memory span test” developed in 1887. In this test, a person is given a sequence of items (such as digits) to report in the order in which they were presented. The sequences begin small (e.g., 3–8–4) and are increased in size until they reach a length that consistently exceeds the person’s reporting capacity. The maximum length that a person can consistently report is the person’s memory span. A version of this task, the digit span task, is a component of many present-day memory assessment batteries such as the Wechsler scale (described below).

### **Working Memory**

Working memory refers to the ability to actively manipulate information in immediate memory. It is possible to think of immediate memory as a component of working memory. For example, one might hold a digit sequence in immediate memory while performing computations on it. Some psychologists make the distinction between simple memory span tasks (e.g., the digit span task) and complex memory span tasks. Simple memory span tasks are thought to tap a person’s immediate holding capacity, while complex memory span tasks are thought to tap a person’s higher-order abilities. A complex memory span task involves a simple retention component (e.g., holding a sequence of items in immediate memory) as well as active manipulation (e.g., performing arithmetic on numbers preceding each item in the sequence). Examples of complex span tasks include the reading span, in which people read lists of sentences and are told to remember the last word of each sentence. Later, they are told to repeat all of the “last” words in the right order.

There are verbal and visual forms of simple memory span, each involving different parts of the brain. Verbal memory span involves maintaining verbal information, such as sequences of letters or digits; visual memory span involves maintaining visual information, such as mental pictures. Visual analogs to simple verbal memory span tasks (e.g., the digit span task) include the Corsi Block Test, in which nine small cubes are arranged on a table and an experimenter taps

them at the rate of one a second. This is done several times, with different orders and different lengths of sequences. Participants are asked to point to the same blocks in the same order, and this is a measure of their visual memory span. The procedure can have several variations, in which more or fewer blocks are used, or placed in different positions.

### **Long-Term Episodic Memory**

*The Ability to Form New Memories.* Long-term episodic memory refers to the ability to store particular pieces of information in memory for access at a later time, and to retrieve that information after hours, days, months, or even years have passed. Long-term and immediate memory represent two different types of abilities. Some neuropsychological patients have impaired long-term memory but normal immediate memory span, while others show the opposite pattern.

Disruption to the ability to form lasting memories is associated with damage to the hippocampal, medial temporal, and diencephalic regions of the brain. It can also be associated with frontal lobe damage. Patients with such damage tend to show anterograde amnesia (a marked deficit in the ability to form new long-term memories). Anterograde amnesia can be revealed on memory tests that involve a delay between the encoding and retrieval of information (so that the person cannot rely on simple memory span). An example is a list-learning situation in which there is a delay between the study list and the memory test. Therefore, many memory assessment tests contain delayed list-learning tasks.

*The Ability to Access Established Memories.* Retrograde amnesia, a disruption of the ability to access already-formed long-term memories, can result from head injury. Memories that had been acquired during a short window of time prior to the head injury are commonly affected. However, access to more distant memories can be disrupted when a network of neurons that played a role in a well-established set of memories is damaged. Damage to this neural network can result in disruption of the ability to retrieve portions of one’s past. Tests for assessing retrograde amnesia often assess memory for commonly known information, such as memory for famous faces, famous events, or television shows from a particular era. An alternative assessment procedure involves



obtaining personal information from friends and relatives and then interviewing the amnesic to see what information is still retained.

### **Long-Term Semantic Memory**

Semantic memory refers to one's general knowledge base, such as that an apple is a fruit or a hammer is a tool. Whereas episodic memories are linked to particular events in time, semantic memories appear to have been abstracted away from the particular episodes that led to their formation. For example, many people know state capitals, but few remember the act of learning them. The relation of general knowledge to specific experiences remains a controversial topic, because it is not always easy to make the distinction between semantic and episodic memory.

Disorders of semantic memory, commonly termed *semantic dementia*, are often category specific. For example, there are documented cases of patients having impaired knowledge of plants and animals, but intact knowledge of objects. In other instances individuals' knowledge of objects is impaired, but their knowledge of plants and animals remains intact.

### **Prospective Memory**

Whereas the aforementioned types of memory involve the ability to access information from the past, prospective memory refers to the ability to remember to do things in the future. Time-based prospective memory involves remembering to perform a task at a particular time in the future (e.g., remembering to make a phone call at 3:00 p.m.). In contrast, event-based prospective memory involves remembering to do something in response to a particular event (e.g., remembering to say "happy birthday" to a colleague when encountering her at work). This distinction has been incorporated into some assessment tests. For example, the Cambridge Behaviour Prospective Memory Test (CBPMT) contains four time-based and four event-based tasks.

### **Skill Learning and Implicit Memory**

Implicit memory refers to memory performance on tasks that do not require awareness or conscious remembering. That is to say, people can demonstrate memory for an event without knowing it. An example would be if people received a list of words and later saw the stems of those words (such as *drain* and *dr\_\_\_*), then were

asked to complete the word stems. People often complete the stems to make words they saw earlier, instead of new words (such as *drop* to complete *dr\_\_\_*). This demonstrates memory for the word list, even though participants may not be aware of what guided the word choice. People with anterograde amnesia (the inability to form new memories) can typically still form implicit memories, or learn new skills without being aware of it. There have been examples of anterograde amnesics even learning to play chess after acquiring the disorder.

## **Common Assessment Measures**

The development of memory assessment measures has been driven not only by basic memory research but also by practical considerations. Tests cannot be too long, or patients may become fatigued or impatient. In addition, the abilities that the assessment measures should resemble those memory abilities that are relevant to a person's day-to-day functioning. Memory assessments generally contain normative data in their manuals for use in evaluation. However, scores on memory assessments should be interpreted in light of such considerations as the person's age, intelligence, and level of education. Also, depression can be a significant factor in reported memory problems. An important thing to keep in mind when interpreting scores on a memory assessment is that a wide range of responses can be considered normal, and a large number of variables can affect any one of the different types of memory. This section describes some commonly used memory assessment methods.

### **Questionnaire Methods**

Questionnaires provide a simple means of assessing a person's memory. A number of questionnaires have been developed for this purpose, many of which are aimed at assessing whether a person has memory problems that interfere with day-to-day functioning. Some examples are the Inventory of Memory Experiences, the Everyday Memory Questionnaire, and the Comprehensive Assessment of Prospective Memory (CAPM).

### **Memory Assessment Batteries**

Individuals with memory impairment are not always aware of their impairments and subjective reports by patients and their families are subject to biases. For those reasons, it may be preferable to assess memory by testing memory performance itself.



*The Wechsler Memory Scale—Third Edition (WMS—III).* The WMS—III is one of the most widely used memory assessment procedures. The WMS—III consists of eight primary indexes that describe immediate memory, general memory, and working memory in visual and auditory forms. Each index comprises several subtests. Including the optional subtests, there are 11 subtests in total. They are logical memory, verbal paired associates, letter-number sequencing, faces, family pictures, spatial span, information and orientation, word lists, mental control, digit span, and visual reproducing. It takes around 30 minutes to administer, with an extra 20 minutes for the optional subtests. The WMS—III is the third edition, with the original version first appearing in 1945. It is considered by many to be the best memory assessment available.

*Rivermead Behavioural Memory Test (RBMT).* This test was developed to assess the types of memory that are most relevant to day-to-day functioning. It includes subtests that assess name recall, remembering the locations of hidden objects, prospective memory, picture recognition, recall of a story (immediate and delayed), recognition of unfamiliar faces, recall of a route (immediate and delayed), and remembering a passage. The test requires approximately 25 minutes to administer, and scores on the test correlate well with the number of patient memory lapses observed in clinical settings. The RBMT has four alternative forms for use in longitudinal testing.

*Other Memory Assessment Measures.* Other commonly used memory assessment measures include the Recognition Memory Test (RMT) and the Memory Assessment Scale (MAS). The RMT takes approximately 15 minutes to administer and contains two subtests that assess recognition of words and recognition of faces. Each subtest involves presentation of a study list followed by a recognition test that requires the discrimination of studied and nonstudied items. The MAS contains 12 subtests: list learning, prose memory, list recall, verbal span, visual span, visual recognition, visual reproduction, names-faces, delayed recall, delayed prose memory, delayed visual recognition, and delayed names-faces recall. The MAS requires approximately an hour to administer.

### **Professional Expertise**

The memory assessment procedures described here, like all memory assessment procedures, require graduate-level or professional training to administer

and interpret. Most assessments come with manuals that contain extensive instructions on how to administer the test, as well as normative data for the interpretation of performance. Selecting the appropriate test for a given situation is a matter of the examiner's experience and personal preference.

### **Factors Influencing Assessment**

Memory research has influenced the development of present-day memory assessment techniques, but not all forms of memory are assessed in the commonly used batteries. For example, it is common to assess short-term memory span and delayed episodic memory ability. It is less common to assess implicit memory. Two factors drive such priorities. First, time is of the essence when administering tests. Second, therapists are most concerned with assessing the forms of memory that, when damaged, interfere most with the person's ability to continue in a career or resume daily living. When a person's memory skills have been impaired, psychologists consider how the person might capitalize on spared forms of memory for rehabilitation. For example, psychologists have been successful in training people with anterograde amnesia to use skills that draw upon implicit memory.

*Bogdan Kostic and Anne M. Cleary*

*See also* Dementia (v2); False Memories (v2); Mental Status Examination (v2); Neuropsychological Functioning (v2); Thurstone, Louis L. (v2); Wechsler, David (v2)

### **Further Readings**

- Baddeley, A. D., Kopelman, M., & Wilson, B. (2002). *Handbook of memory disorders* (2nd ed.). Chichester, UK: Wiley.
- Mayes, A. R. (1995). The assessment of memory disorders. In A. D. Baddeley, B. A. Wilson, & F. N. Watts (Eds.), *Handbook of memory disorders* (pp. 367–391). Oxford, UK: Wiley.
- Reeves, D., & Wedding, D. (1994). *The clinical assessment of memory*. New York: Springer.

---

## **MENTAL STATUS EXAMINATION**

---

The Mental Status Examination (MSE) is an evaluation of a client's current overall functioning with emphasis



on his or her cognitive and emotional functioning. The MSE is a structured observational system of the client's behavior, emotions, and thoughts. The MSE is often confused with the Folstein Mini-Mental State Examination, which is a standardized screen for dementia. The MSE has several components, which generally cover the client's appearance, behavior, and attitude toward the examination, speech, affect and mood, thought process and content, sensory perception, and general cognitive functioning. Different clinicians use slightly different categories, but the goal of each approach is the same—to provide a clear and comprehensive description of a client's overall functioning.

Appearance includes a description of the client's body, movements, dress, and overall grooming. Speech includes a description of the client's rate and volume of speech as well as ability to articulate. Affect and mood includes both a statement of the client's self-report of feelings and the clinician's impressions of the stability, appropriateness, and range of the client's affect. A description of the client's thought process and content refers to the coherence of the client's thoughts and the presence of any dangerous or psychotic ideas. A sensory assessment includes vision and hearing problems and the presence of any illusions or hallucinations. Assessment of overall cognitive functioning includes the client's estimated intelligence, alertness, attention and concentration, memory, insight, and judgment.

The psychosocial history and the MSE provide the clinician with information about both the client's past and present functioning and provides the information needed to form a complete picture of the client's current condition. The MSE can be completed in a narrative or a checklist format. MSE checklists for children, adolescents, and adults allow the clinician to gather rich data in a thorough and efficient manner. Two examples of MSE checklists are Schinka's Mental Status Checklist for Adults and Dougherty and Schinka's Mental Status Checklist for Children. Choosing an MSE designed for children is particularly helpful because it adapts the general areas of observation to a child's developmental level.

*Sue Strong*

**See also** Affect (Mood States), Assessment of (v2); Behavioral Observation Methods, Assessment (v1); Client Attitudes and Behaviors (v2); Clinical Interview as an Assessment Technique (v2); Cognition/Intelligence, Assessment of (v2); Dementia (v2); *Diagnostic and*

*Statistical Manual of Mental Disorders (DSM)* (v2); Language Difficulties, Clinical Assessment of (v2); Memory, Assessment of (v2); Neuropsychological Functioning (v2)

### Further Readings

- Carlat, D. (1999). *The psychiatric interview*. Philadelphia: Lippincott Williams & Wilkins.
- Trzepacz, P., & Baker R. (1993). *The psychiatric mental status examination*. New York: Oxford University Press.
- Zuckerman, E. (2000). *The clinician's thesaurus*. New York: Guilford Press.

---

## METAPHORS, USE OF

---

Metaphor is a form of figurative language, often described as facilitating the understanding of one thing in terms of another. In the comparison between two seemingly dissimilar concepts, the meaning of the first is carried over to help illuminate the second. Metaphors are valuable tools in the counseling process because they create structure, explain ideas, evoke emotion, and influence attitudes.

### Metaphor and Counseling

In counseling, metaphors may be generated by the counselor or the client.

Counselors use metaphors to interpret or clarify a client's experience, reflect feelings, organize previous topics, or explain a course of action. Some have argued that metaphor is an effective way to confront clients due to its indirect nature. Social psychologists have demonstrated that metaphor can be an effective tool in persuasion, which is in keeping with a social influence model of the counseling process. Novel metaphors can make an idea or topic more memorable to the client.

Clients may use metaphors to express emotions or experiences that they have no other way of describing. Using metaphors, clients can frame an idea in a way that they believe will be understood, integrating what is complex, and highlighting salient aspects of an experience. Indeed, some would argue that metaphors are the only way to fully express certain abstract and amorphous inner experiences.



## Working With Metaphors

A single metaphor can be as simple as three words, or involve an entire story. It may only arise at one point, or may be extended throughout the course of treatment. The metaphor can also be collaborative, with both counselor and client expanding and refining it over time. In a simple example, a client might describe a relationship this way: "It's like I'm the bank and all I'm doing is cashing checks." Over time, the counselor may ask if there are any deposits being made, and progress may be measured within the framework of the metaphor.

The use of a novel or exaggerated metaphor can often elicit strong visual images that help to make an issue more memorable. The oft used "When are we going to talk about the elephant in the room?" is a good example; the visual image helps convey the idea of importance. Metaphors may also be more effective when the content includes something of personal interest to the listener.

The frequency of metaphor use appears to vary across counselors, clients, and sessions, and there are individual differences in the ability to develop and comprehend metaphors. The aptness and salience of metaphors appears to be more important than how often they are used. It appears that metaphors that are

generated within the context of unique counseling relationships may be most effective.

Some authors have expressed concern about the vagueness of figurative language, and the possibility that it hinders true communication. Research involving the accuracy of client or therapist understanding of metaphors has not yielded any conclusive answers, but it would seem wise for counselors to be aware of these concerns.

Walter A. Kendall

*See also* Barriers to Cross-Cultural Counseling (v3); Communication (v3); Cross-Cultural Training (v3); Facilitative Conditions (v2); Meaning, Creation of (v2); Reframing (v2); Therapist Interpretation (v2); Therapist Techniques/Behaviors (v2)

## Further Readings

- Lakoff, G., & Johnson, M. (1980). *Metaphors we live by*. Chicago: University of Chicago Press.
- Lenrow, P. (1966). Uses of metaphor in facilitating constructive behavior change. *Psychotherapy: Theory, Research, and Practice*, 3, 145–148.
- Siegelman, E. Y. (1990). *Metaphor and meaning in psychotherapy*. New York: Guilford Press.









---

## NARRATIVE THERAPY

---

Narrative therapy (NT) refers to a variety of approaches that focus on the role of language, particularly stories, in counseling. The central thesis of narrative therapy is that clients tell stories in therapy and these stories are useful in assessing and helping clients. Narrative therapy's broad explanatory power and useful therapeutic techniques have generated considerable interest among contemporary counseling psychologists.

### Purposes of Narratives

Narrative therapists maintain that people use stories to make sense of their life experiences. Stories form informal theories or maps of personal experiences and history. Narratives allow storage of large amounts of information, particularly information relevant to personal goals; they facilitate quick decision making; and they organize information about social interactions and experiences.

Narratives provide important information about the speaker's worldview, as illustrated by the following examples. One writer might say "Language is the data of counseling" to explain the importance of narratives in counseling. By that the writer means that much of the important information communicated between counselor and client takes the form of the connotations and denotations of spoken language. But that description also reveals something important about the writer; that is, that the writer tends to view his or her professional world through the role of a *researcher* who seeks to obtain and understand *data* related to counseling.

A more behaviorally oriented writer might say "Language is the behavior of counseling," while a theatrical writer might say "Language is the script of counseling." These descriptions convey different aspects of the potential role of language in counseling, but all are valid and all reveal something of the speaker's roles and worldview.

### Narrative Use in Different Counseling Approaches

All therapies pay attention to language to some degree. For example, rational emotive behavior therapy (REBT) practitioners listen for clients' use of words, such as *must* and *should*, because those words often indicate irrational beliefs (i.e., untrue thoughts) that lead to distress for the individual. For example, a client might say "I must get an A on this test!" An REBT counselor would challenge that statement and explore with the client what would happen if he or she did not receive an A on that particular test. Another example: A father might report "I'm frustrated because my children *always* disobey me," when in fact, most disobedience occurs when the children are physically tired. A solutions-focused counselor might help this client recognize this more complete description so that the client could begin to perceive his children differently.

### Narrative Use to Help Clients Change

Narrative therapists and their clients extract meaning from client stories, with the goals of helping clients understand themselves and change some aspect of their lives. *Deconstruction* is the process in which



therapists help clients become aware of the dominant story that guides their lives and to question its elements so that the story becomes just one possible view of the self. Other life events become more fully incorporated into the story and the client is placed as a more active protagonist in the story. For example, the student who reports that she “must get an A on a particular test” may also tell stories of other tests and courses in which she feels pressure to perform extremely well. However, she is also likely to be able to recall situations in which she did not perform extremely well and no catastrophic consequences occurred. The client may also relate instances when she felt relaxed while performing. Narrative therapists explore events such as these in an attempt to integrate an expanded account into the client’s dominant plot.

Because of the potential importance of emotion-related themes, many narrative therapists also pay particular attention to the affect described in client stories. Emotions are the glue that holds the story together. Some narrative therapists describe this work as similar to a corrective emotional experience in which clients reenact events in their stories. Research with single cases suggests that clients’ disclosures of emotionally charged personal narratives lay the foundation for subsequent change in counseling.

Considerable empirical support exists to support the benefits of finding meaning in narratives. Creating and finding meaning through exploration of personal narratives appears to regulate emotion as well as maintain and repair relationships. For example, in one investigation, college students wrote a description of a vivid memory and completed measures of personality adjustment and coping. The researchers examined the written narratives for the presence of statements that indicated the creation of meaning (e.g., those with beginnings such as “I learned that . . .” or “This experience taught me . . .”). The researchers found that moderate self-restraint, but not low or high self-restraint, was associated with greater numbers of memories related to insight and learning.

### **The Counseling Process in Narrative Therapy**

Exactly how this process of creating meaning and affective expression should proceed in counseling is less clear. The narrative counseling process often appears relatively unique to the particular client and

counselor working together. With each client the counselor finds the best method to overcome obstacles and facilitate client progress. For example, many clients tend to stay in storytelling while therapists attempt to focus them on internal states. With such clients the counseling process often involves weaving between talking about emotional personal narratives and efforts to find meaning in those narratives.

Other narrative therapists describe the counseling process as helping clients stay with and articulate their feelings. This permits key narrative elements to fully emerge and constrains previous habitual interpretations. More emotion is typically present in the beginning of storytelling and clients should not attempt to interpret their stories but just allow them to flow out. Finding meaning in narratives occurs later in the process. Thus, it appears that a successful counseling process involves the client fully exploring and experiencing a personal narrative and later making sense of (or drawing lessons from) the narrative’s events.

A similar pattern occurs when the change process involves *written* narratives. Investigations of the effects of writing about personal traumas typically involve a person writing about his or her deepest thoughts and feelings regarding a trauma for 15 to 30 minutes a day for 3 to 5 days. This procedure requires participants to create a written narrative of some incident, and the evidence suggests that it induces affect and meaning in ways that are very similar to traditional counseling.

Researcher Joshua M. Smyth’s recent meta-analysis (i.e., a statistical analysis of published research data) of 13 studies compared the written narrative procedure with some type of control group (typically another writing task, such as “Write about your plans for the day”). Writers in the narrative procedure typically reported an increase in short-term distress before later improvements became evident. The amount of short-term distress was unrelated to subsequent change. Analyses of word use patterns indicate that persons were more likely to benefit if their writing contained more positive emotion words, a moderate number of negative emotion words, and an increase in the number of causal and insight words from the beginning to the end of the narrative. These findings suggest that coping depends heavily on construction of a meaningful narrative about traumatic events and that successful therapy requires individuals to move from a focus on emotions and self to drawing lessons and meanings from the event(s).



## Future Directions

An approach to counseling that focuses on language appears to arrive, and eventually fade away, every few decades. In the 1970s and 1980s, neurolinguistic programming (NLP) was a popular therapy that heavily utilized storytelling and metaphors. However, many of its tenets did not receive research support or were not evaluated from a research perspective. Given the relatedness of NLP and contemporary approaches to narrative therapy, this is cause for skepticism about the efficacy of narrative therapy. The concern about the efficacy of narrative therapy is heightened by the fact that some contemporary narrative therapists appear disinterested in or openly antagonistic to research evaluations of their work. Nevertheless, process and outcome assessments of client narratives, such as the trauma writing-procedure research described above, appear to be potentially fruitful grounds for further investigation.

*Scott T. Meier*

*See also* Affect (Mood States), Assessment of (v2); Barriers to Cross-Cultural Counseling (v3); Behavior Therapy (v2); Communication (v3); Cross-Cultural Training (v3); Meaning, Creation of (v2); Metaphors, Use of (v2); Rational Emotive Behavior Therapy (v2); Reframing (v2); Therapist Interpretation (v2); Therapist Techniques/Behaviors (v2); Worldview (v3)

## Further Readings

- Angus, L. E., & McLeod, J. (Eds.). (2004). *The handbook of narrative and psychotherapy*. Thousand Oaks, CA: Sage.
- Bandler, R., & Grinder, J. (1975). *The structure of magic*. Palo Alto, CA: Science and Behavior Books.
- Pennebaker, J. W., Mehl, M. R., & Niederhoffer, K. G. (2003). Psychological aspects of natural language use: Our words, our selves. *Annual Review of Psychology*, 54, 547–577.
- Pennebaker, J. W., & Seagal, J. D. (1999). Forming a story: The health benefits of narrative. *Journal of Clinical Psychology*, 55, 1243–1254.
- Polkinghorne, D. E. (2004). Narrative therapy and postmodernism. In L. E. Angus & J. McLeod (Eds.), *The handbook of narrative and psychotherapy* (pp. 53–67). Thousand Oaks, CA: Sage.
- Singer, J. A., & Blagov, P. S. (2004). Self-defining memories, narrative identity, and psychotherapy: A conceptual model, empirical investigation, and case report. In L. E. Angus & J. McLeod (Eds.), *The handbook of narrative and psychotherapy* (pp. 229–246). Thousand Oaks, CA: Sage.

- Smyth, J. M. (1998). Written emotional expression: Effect sizes, outcome types, and moderating variables. *Journal of Consulting and Clinical Psychology*, 66, 174–184.
- White, M., & Epston, D. (1990). *Narrative means to therapeutic ends*. New York: Norton.

---

## NEUROPSYCHOLOGICAL FUNCTIONING

---

Neuropsychology is the study of brain-behavior relationships through objective, scientific methods. The main goal in neuropsychology is to understand how the brain produces and controls behavior and mental processes, including emotions, cognition, and consciousness. This goal is met by studying both healthy and damaged brain systems using objective measures to link biological and behavioral domains.

The goal of *clinical* neuropsychology is to study how cognitive skills such as memory, language, and attention change an individual's life as a result of brain injury, disease, or developmental process. The ultimate objective is the clinical application of that knowledge to human problems. Neuropsychological tests and methods are used to compare an individual's behavior to that of individuals with known brain dysfunction and to a normal control population. Psychologists draw inferences from the test data regarding what type of brain dysfunction may be present. From this point, realistic expectations for adjustment, remediation, and rehabilitation of behavior are made.

Neuropsychology is the fastest-growing subspecialty in psychology. Prior to 1975, neuropsychology was not considered a separate subspecialty, and was often part of clinical psychology, biopsychology, or neuroscience. Between 1975 and 1990, there was an increase in the clinical uses of neuropsychological information beyond the research laboratory, with an emphasis on creating test batteries that could be used to guide diagnosis and intervention with neurology patients. During this era, three professional organizations were founded (the International Neuropsychological Society, the National Academy of Neuropsychology, and Division 40 of the American Psychological Association, or APA), and several academic journals representing the discipline were established. In the years since 1990, neuropsychology has enjoyed increased acceptance in health care and forensic areas, but the economic changes (e.g., decreased reimbursement) that have affected health care in general also have affected clinical neuropsychology.



This entry outlines the main uses of neuropsychological assessment, and discusses the debate regarding the use of fixed versus flexible batteries. A typical neuropsychological evaluation is described. Tests are suggested to measure functioning in a variety of domains. Finally, the future of neuropsychology is addressed.

### **Uses of Neuropsychological Assessment**

Neuropsychological assessment is used for many purposes. Patients may be referred by a neurologists or general practitioner for an assessment as part of a diagnostic workup (e.g., for dementia) or to establish a baseline following an injury or illness. Neuropsychologists may be asked to complete an assessment for the purpose of evaluating competency or independence, or to make a recommendation about a patient returning to work or school.

School personnel may refer students to determine if a learning disorder or other developmental disorder exists, to specify subtype and prognosis of the disorder, and to recommend academic accommodations. Assessment may also be used to provide recommendations for psychosocial or family interventions. Information from the evaluation may help family members accept the patient's limitations and consider changes in the environment to accommodate any deficits.

Finally, neuropsychological assessment may be used to evaluate change over time. This information may be used to determine the course of changes and the prognosis for future functioning in cases involving traumatic brain injury or a progressive disease (e.g., certain dementias). Also, treatment efficacy (e.g., effect of medications or rehabilitation efforts) can be evaluated with repeated assessments.

### **Fixed Versus Flexible Batteries**

One controversial issue in neuropsychology is the use of fixed versus flexible test batteries. The most commonly used fixed battery of tests is the Halstead-Reitan Neuropsychological Battery (HRB). The HRB is a group of psychological tests that, taken together, are used by neuropsychologists to distinguish patients considered to have brain damage from patients with no known history of disease. The HRB uses an index of impairment to predict the presence of brain damage in patients. Test norms exist for a normal control

group and for patients with various types of brain damage. The HRB has stimulated a great deal of research in past years.

There are several advantages to using a fixed battery. Since a standard set of measures is used, the functioning of different patients can be compared. An evaluation is unlikely to overlook an important condition because all subjects are evaluated for all basic neuropsychological abilities. Fixed batteries are easy to teach, because the beginning student does not have to make decisions about test selection, and interpretation is objective and data driven. Finally, fixed batteries are useful for empirical studies and facilitate comparison across different research projects.

There are also disadvantages to fixed batteries. First, the purely empirical approach does not always lead to the most interpretable measures because it can be difficult to describe what the tests are measuring or to tie task performance to real-life situations. Fixed batteries tend to be unnecessarily long and tedious for some patients. This leads to noncompliance and discomfort, especially in older or more impaired patients. These batteries can be difficult to justify economically, which forces the use of technicians. Then the neuropsychologist loses the opportunity to directly observe the patient's behavior during the assessment.

Another approach is the use of a flexible battery (also referred to as the process or hypothesis approach). In this method, the neuropsychologist adapts each exam to the individual patient. Tests are selected based on hypotheses about the patient and available information, such as medical findings and history. Standard tests may be used, or tests may be altered to determine the nature of the deficit. Qualitative interpretations of test results and patient behavior play an important part in forming conclusions.

An advantage of the process approach is that it takes into account the individual nature of the patient's deficits, and adapts the exam to obtain more precise measurements of a cognitive ability. The exam can reduce assessment time by focusing on the most important areas and ignoring those that are not relevant for the patient's prognosis. Finally, the process approach emphasizes the way in which the patient fails or succeeds in a particular cognitive task. For example, if a patient is unable to answer a factual question, the process approach allows further investigation beyond the standardized test. The difficulty could be caused by an impairment of speech comprehension, expressive aphasia, or poor factual knowledge. By allowing the



patient to answer in a different form (e.g., multiple choice), the neuropsychologist obtains information that would have been missed using a purely standardized approach.

One disadvantage of the process approach is that the exam may selectively confirm an opinion because its content emphasizes what the neuropsychologist thinks is important. A deficit may be missed because an area was not considered relevant. This affects prognosis and rehabilitation since they rely on the brain functioning as a whole. Second, using tests that are not standardized for a clinical population can cause problems. Subjective interpretation of what a score might mean may be completely wrong. A test that measures one thing in a normal population may measure something different in a neuropsychological population. Finally, the process approach is more difficult to teach because few rules and procedures exist. Judgments made by the neuropsychologist often depend on extensive clinical experience, so the exam must be conducted by the neuropsychologist rather than a technician. This places limits on the time of the neuropsychologist.

A majority of neuropsychologists combine the fixed and process approaches in the form of a modified battery. They integrate data from a variety of sources (tests, medical findings, and developmental history), while taking into account the injury or disease process, personality, and other moderating variables that may affect test performance.

## Typical Neuropsychology Evaluation

### *History and Behavioral Observation*

A neuropsychological evaluation begins with taking a history of the patient beginning with demographic information, reason for referral, and the patient's chief complaint. Family history should include the state of health or the cause of death of parents, brothers, and sisters; history of familial diseases such as hypertension, stroke, or cancer; and history of cognitive or emotional disorders in the family. Social history should include use of drugs and alcohol, and reactions to life situations of stress and conflict.

A medical history begins with prenatal development and assesses several areas. It is important to assess whether the patient was a premature baby, whether any complications occurred during or after delivery, and history of childhood diseases, developmental problems, major illnesses, accidents, head

injuries, or loss of consciousness. Delays in the acquisition of motor, language, or intellectual skills are examined. When assessing for brain injury, details about the accident are gathered (e.g., when it occurred, loss of consciousness, hospitalization, and occurrence of posttraumatic amnesia).

An educational history is taken, including highest grade level achieved, academic performance, and general attitude toward education. Patients are asked if they ever received any special tutoring, were placed in any special classes, ever failed or had to repeat a grade, or had difficulties with any particular subjects. Vocational history should include the type of jobs held, the frequency of job changes, and any recent occupational problems.

Handedness is determined since it is an indicator of cerebral dominance, which can affect responses to neuropsychological assessments. It is usually sufficient to ask the patient which hand is dominant, but it may be necessary to obtain responses on a lateral dominance exam. Most of the population is right-handed, indicating left hemisphere dominance, but less than half of those who are left-handed are left hemisphere dominant.

Behavioral observations should go beyond physical description and include general appearance, personal hygiene, and noticeable physical defects (e.g., vision, hearing, and gait). In addition, it is important to be sensitive to other aspects of behavior including speech (speech difficulties, flow, appropriateness, and affect), posture, facial expression, eye contact, tics, and any unusual behaviors or involuntary movements.

### *General Intellectual Functioning*

Intellectual functions for adults are most frequently measured with the Wechsler Adult Intelligence Scale—Third Edition (WAIS-III). The WAIS-III consists of 14 subtests that are combined into three IQ scores and four index scores. Although the WAIS-III was not developed to be a neuropsychological instrument, several scores are helpful in forming hypotheses about a patient's presenting problem. The reliability and validity of all of the Wechsler scales have been well documented.

The Verbal Comprehension Index (VCI) is made up of three subtests: Vocabulary (vocabulary knowledge), Similarities (semantic information and abstract thinking), and Information (factual knowledge). Performance on the VCI is influenced by educational



history; it requires understanding words, drawing conceptual similarities, and knowledge of social situations. The Perceptual Organization Index (POI) is a measure of nonverbal abilities and novel problem solving. The POI comprises three subscales: Picture Completion (visual processing and attention to detail), Block Design (visual-motor ability, spatial processing, and problem solving), and Matrix Reasoning (visual processing and abstract reasoning skills in a multiple choice task). The POI assesses ability to examine a problem, use visuomotor and visuospatial skills, create solutions, and then test them.

The Working Memory Index (WMI) consists of the three subtests: Arithmetic (arithmetic abilities and working memory), Digit Span (encoding and verbal short-term memory in Digits Forward and working memory in Digits Backward), and Letter-Number Sequencing (working memory). Working memory is an executive function that is essential for cognitive flexibility and planning ability, as well as learning and self-monitoring. Working memory is an active process and is not the same as short-term memory, which is often viewed as a passive process. Finally, the Processing Speed Index (PSI) includes two subtests, Digit Symbol-Coding (visuomotor coordination and response speed) and Symbol Search (visual processing). The PSI assesses skills in focusing attention and quickly scanning and discriminating between visual information.

Two WAIS-III subtests are not used in computing any index scores, but they are used to calculate IQ scores and they provide information that is useful in neuropsychological assessment. The Picture Arrangement subtest measures visual processing and sequential thinking. The Comprehension subtest measures social knowledge and practical reasoning. Finally, Object Assembly is a completely optional subtest. Matrix Reasoning, which replaced Object Assembly in determining Performance IQ in the WAIS-III provides a purer measurement of perceptual organization because it does not measure speed of performance.

## **Attention**

Attention implies alertness to the world and can be broadly defined as the ability to attend to a stimulus. Four processes must be assessed when diagnosing attention-related disorders.

Encoding is the capacity to briefly hold information in mind while performing some cognitive operation on it. Encoding involves the sequential

registration and recall of information, and is related to listening comprehension. Encoding is typically measured by the WAIS-III Arithmetic and Digit Span (Digits Forward) subtests. Other tests used to measure encoding include the first trial of a list learning test, such as the California Verbal Learning Test, 2nd Edition (CVLT-II), discussed below in Learning and Memory. The interference trials of the CVLT-II can also be used as a measure of encoding. Other narrative tests for encoding include sentence repetition or story recall tests (e.g., the Wechsler Memory Scale—Third Edition [WMS-III] Logical Memory subtest).

Sustained attention is the capacity to stay on task for an appreciable interval, respond quickly to designated targets, and inhibit responses to nontargets. Inhibition is central to the concept of sustaining attention because attending to a stimulus implies inhibiting a response to other stimuli. Sustained attention is typically measured with a continuous performance test presented on a computer or other mechanical device, such as the Gordon Diagnostic System or the Connors' Continuous Performance Test II (CPT II).

Shift is the capacity to shift attentional focus in response to changing information. The Wisconsin Card Sort Technique (WCST), a good measure of abstract reasoning, concept generation, and perseverative responding, is the best measure of the ability to shift attention. The WCST requires patients to sort cards into categories according to color, form (shape), and number, using changing feedback from the examiner. Patients who have difficulty shifting will continue using the same category instead of using feedback to adjust their behavior.

The final component of attention is focus/execute, which is the capacity to concentrate attentional resources on a specific task (focus), screen out distracting stimuli, and respond appropriately and quickly (execute). Focus/execute is typically measured by tests such as the WAIS-III Coding and Symbol Search subtests, the Color-Word and Trail-Making subtests of the Delis-Kaplan Executive Function System (D-KEFS), and the Stroop Color and Word Test. These tests require persons to quickly make perceptual discriminations and a verbal or motor response.

## **Language**

Language functions comprise several cognitive abilities, including comprehension, speech, reading, writing, and spelling. Patients may experience a



variety of language difficulties. Dysarthria is a disorder of articulation that can result in slurring or mumbling. Dysprosody is an interruption of speech melody caused slowing and monotone voice. Apraxia is the inability to carry out movements of the face and speech apparatus. Aphasia is a language disturbance characterized by errors of grammar and word choice. Alexia is a reading inability that occurs either as a loss of reading ability in a previously literate person or as dyslexia, a developmental learning disorder. Finally, agraphia is an acquired disturbance in writing.

The first step in language assessment is to observe the patient's spontaneous speech in response to general questions during the intake interview. Behaviors observed include articulation problems, syntax errors, word-finding pauses, or any other marked change in speech production. Expressive language deficits are usually indicated by word retrieval difficulty or problems with word fluency. These are assessed using a picture naming test (e.g., Boston Naming Test) or a verbal fluency measure such as the D-KEFS Verbal Fluency (described under Executive Functioning Skills below). The Wechsler Individual Achievement Test—Second Edition (WIAT-II) Oral Expression subtest and the D-KEFS Proverbs subtest may also be useful in assessing a patient's expressive language abilities.

A second language area to assess is auditory comprehension or receptive language. Many language disorders cause impairment in this area. To measure auditory comprehension, a patient may be asked to respond to pointing commands (e.g., point to a chair) or yes-no questions, or given the WIAT-II Listening Comprehension subtest. The Token Test provides a more structured measure of receptive language. This test uses a series of tokens in various sizes, shapes, and colors arranged in front of the patient, who is asked to respond to a series of commands of increasing length (e.g., "Put the green circle on the red square").

Both oral word reading and reading comprehension are measured, using tests such as the Word Reading, Pseudoword Decoding, and Reading Comprehension subtests of the WIAT-II, the Reading Decoding subtest of the Wide Range Achievement Test 4 (WRAT4), or the Nelson-Denny Reading Test. These reading skills are supported by different neuropsychological functions and must be assessed separately. Inability to decode words is typically a phonological problem, while reading comprehension is influenced by several factors, such as attention and working memory. Spelling and written expression can be assessed by the

WRAT4 or WIAT-II Spelling subtests and the WIAT-II Written Expression subtest. Usually math skills are assessed with other academic skills, using the WRAT4 Math Computation, or WIAT-II Numerical Operations and Math Reasoning subtests.

### ***Executive Functioning Skills***

Executive functioning involves several complex cognitive skills mediated by the frontal lobes, including planning, sequencing, inhibition, flexibility, organization, reasoning, and problem solving. Working memory allows the individual to maintain internal representations in order to guide behavior, and as such, is an important part of self-control. Difficulties in executive function are associated with several conditions (e.g., attention deficit/hyperactivity disorder, or AD/HD).

Planning involves complex problem solving to achieve a goal. Planning is most often assessed with a tower test, such as the Tower of London or the D-KEFS Tower Test. These tests require the rearrangement of colored balls or disks on pegs to match a model, using rules that define acceptable moves. Maze tracing tasks provide an alternative measure of planning.

Response inhibition is the ability to delay a response or to not respond to nontarget stimuli. Many neuropsychological tests use a measure of rule violations to assess response inhibition. For example, on a tower test, rule violations occur when the patient uses two hands to solve the item, after being told that this is not an acceptable move. Errors on a Stroop color-word interference trial also indicate difficulties with response inhibition, when patients are unable to refrain reading the word when they are only to name the ink color. Finally, most continuous performance tests include a measure of the number of times an individual responds to nontarget stimuli, indicating a problem with response inhibition.

Working memory is viewed as an executive function skill that allows an individual to hold information in mind while performing an operation on it. It is measured using the WAIS-III Digit Span (Digits Backward), Arithmetic, and Letter-Number Sequencing subtests. Another useful test for measuring working memory is Auditory Consonant Trigrams (ACT), which requires the patient to hold three consonants in mind while counting out loud backward from a given number by threes for intervals varying from 0 to 36 seconds.

Concept formation and reasoning tasks can be thought of as measures of abstract thinking, problem



solving, and organization. Several subtests on the WAIS–III measure this component of executive functioning, including Comprehension, Similarities, and Matrix Reasoning. Other measures of concept formation and reasoning include the Wisconsin Card Sorting Test and the D-KEFS Sorting and Twenty Questions subtests.

Finally, verbal fluency can be considered both an executive function skill and a language component. Verbal fluency involves auditory attention, working memory, word production, mental processing speed, and vocabulary storage. It is typically measured with a test such as the Controlled Oral Word Association test (COWA) or the D-KEFS Verbal Fluency test. There are two parts to these tasks. The first measures letter (phonemic) fluency. The patient is instructed to generate words beginning with a given letter (e.g., F, A, S) in a limited time period. Letter fluency relies on working memory to facilitate word retrieval and keep track of recent responses. In category (semantic) fluency, the patient is asked to name as many items in a category (e.g., animals) as possible in a limited time period. Typically category fluency is easier for patients to perform than letter fluency, since information is stored in categories within long-term memory.

### ***Learning and Memory***

A common initial complaint of neuropsychological dysfunction is memory problems. Learning and memory are assessed using a variety of methods, depending on the type of memory being measured. The WAIS–III Digit Span (Digits Forward) subtest is one measure of immediate recall (encoding), while Digits Backward is a measure of working memory. The WAIS–III Information subtest is sometimes considered as an indicator of long-term memory, but is dependent on the individual's academic history.

New learning typically is assessed using a list learning exercise, such as the California Verbal Learning Test, 2nd Edition (CVLT-II) or the Rey Auditory Verbal Learning Test (RAVLT). In the CVLT-II, the examiner reads aloud a list that contains 16 common words, each of which belongs to one of four categories (fruits or spices). The patient is then asked to recall as many of these items as possible. The examiner records how many items the patient is able to recall over several repeated trials, and whether or not category information is being used. Next, an interference list is administered. Immediately after the recall of the interference list, the patient is asked to

recall the trial list again. Finally, after a longer delay of about 20 minutes, the examiner asks the client to recall the trial list a final time. The RAVLT follows a similar pattern, although there are no categories on the lists that are administered, which may make it a slightly more difficult test.

The CVLT-II and the RAVLT are particularly useful because they contain a recognition trial following the final recall trial. It is important to differentiate a patient's ability to voluntarily recall information from his or her ability to recognize it as something he or she previously heard. A difference between recall and recognition of list items allows the examiner to determine if the information was learned and stored, learned and forgotten, or never learned.

Story recall (e.g., WMS–III Logical Memory) is another method of assessing verbal learning and memory that allows the individual to use context clues to aid recall. Visual memory can be assessed using the WMS–III Faces subtest or other tests included in the visual-perceptual exam.

### ***Visual Perception, Constructional Ability, and Sensory-Motor Abilities***

A neuropsychological assessment should include an evaluation of visual perception and constructional abilities, both right hemisphere functions, and sensory and motor abilities. Visual perception consists of two independent process, visuo-perceptual ability and visuo-spatial ability. Visuo-perceptual deficits can take several forms, including visual agnosia (deficits in object and facial recognition) and form or pattern discrimination problems. Object recognition is commonly measured using an object naming test (e.g., the Boston Naming Test). Pattern discrimination is measured using the WAIS–III Matrix Reasoning and Symbol Search subtests. Facial discrimination can be measured by WMS–III Faces test.

Visuospatial deficits include visual neglect, problems with visuospatial judgment (position and orientation of objects), and topographic disorientation (difficulties on navigational tasks). Visual neglect can be measured using cancellation tests (e.g., D-KEFS Visual Scanning) or drawing tests, such as asking the patient to draw a clock, house, or flower. Visuospatial judgment can be assessed with a drawing test, or with the use of a line orientation test (e.g., Benton Judgment of Line Orientation). Finally, the patient's behavior is observed for any difficulties with navigation (e.g., getting lost in familiar surroundings).



Constructional ability is the capacity to draw or assemble an object from memory or by copying a model. Deficits in this domain cause patients to have difficulties integrating parts into a whole. These deficits are typically measured with a copying task (e.g., Rey Complex Figure Test) or a block assembly task (e.g., WAIS–III Block Design subtest).

Sensory and motor abilities are assessed because results can provide information about lateralized cortical problems. Sensory tasks measure the ability to perceive tactile input, and are measured by finger discrimination tasks. Motor speed and control are measured by finger-tapping tasks. Motor programming (e.g., planning, implementing, and automating new motor routines) is measured by imitating hand positions. Fine motor skills include visual motor precision and dexterity, and are measured by finger-tapping or maze-tracing tasks. Finally, motor strength is measured using a hand dynamometer.

### **Mood and Personality**

As a final domain, mood and personality are assessed to determine any evidence of thought, anxiety, or other mood disorder. The presence of psychiatric symptoms can affect scores on neuropsychological measures. Tests used to screen for symptoms include the Beck Depression Inventory, the Minnesota Multiphasic Personality Inventory-2 (MMPI-2), and various behavioral rating scales.

### **Interpretation and Report Writing**

The final step in the evaluation involves the interpretation of the results and preparation of a report. The report is used to inform the referral source and others about the patient, and to provide guidelines that may be used in treatment and remediation. It is good practice to avoid using technical or ambiguous terms, to be objective, to include relevant history but not inappropriate details, and to support all conclusions. All tests and procedures used are described, and performance on all tests is reported, not just scores that suggest some form of impairment. Finally, specific recommendations for the patient that are realistic and based on resources and services that are available are included.

### **Future Directions**

Neuropsychology is likely to continue growing as a psychological subspecialty, particularly as advances in

neuroscience continue to occur. Although most states do not offer specific licensure in neuropsychology, this may change in the future. Currently the only credential available to demonstrate competence is board certification or diplomate status achieved through peer review and examination. Several professional organizations have developed specific guidelines for training in neuropsychology. Minimum criteria for a clinical neuropsychologist now include a doctoral degree in psychology from an accredited university, an internship in a clinically relevant area, state licensure, and two years of specialty training in neuropsychology.

*Ann Westcot Barich*

**See also** Attention Deficit/Hyperactivity Disorder (v1); Behavioral Observation Methods, Assessment (v1); Behavior Rating Scales (v1); Cognition/Intelligence, Assessment of (v2); Continuous Performance Tests (v1); Dementia (v2); Intelligence (v2); Language Difficulties, Clinical Assessment of (v2); Learning Disorders (v1); Memory, Assessment of (v2); Mental Status Examination (v2); Personality Assessment (v2); Test Interpretation (v2)

### **Further Readings**

- Banich, M. T. (2003). *Cognitive neuroscience and neuropsychology*. Boston: Houghton Mifflin.
- Denckla, M. (1996). A theory and model of executive function: A neuropsychological perspective. In G. Lyon & N. Krasnegor (Eds.), *Attention, memory and executive function* (pp. 263–278). Baltimore: Paul H. Brookes.
- Grant, I. G., & Adams, K. M. (1996). *Neuropsychological assessment of neuropsychiatric disorders*. New York: Oxford University Press.
- Hebben, N., & Milberg, W. (2002). *Essentials of neuropsychological assessment*. New York: Wiley.
- Kaplan, E. (1988). A process approach to neuropsychological assessment. In T. Boll & B. K. Bryant (Eds.), *Clinical neuropsychology and brain function: Research, measurement and practice* (pp. 125–167). Washington, DC: American Psychological Association.
- Lezak, M. D., Howieson, D. B., Loring, D. W., Hannay, H. J., & Fischer, J. S. (2004). *Neuropsychological assessment*. New York: Oxford University Press.
- Mirsky, A. F., Anthony, B. J., Duncan, C. C., Ahearn, M. B., & Sheppard, G. K. (1991). Analysis of the elements of attention: A neuropsychological approach. *Neuropsychology Review*, 2(2), 109–145.
- Mitrushina, M., Boone, K. B., Razani, J., & D'Elia, L. F. (2005). *Handbook of normative data for neuropsychological assessment*. New York: Oxford University Press.



- Reitan, R. M., & Wolfson, D. (1993). *The Halstead-Reitan neuropsychological test battery: Theory and clinical interpretation*. Tucson, AZ: Neuropsychology Press.
- Snyder, P. J., & Nussbaum, P. D. (1998). *Clinical neuropsychology: A pocket handbook for assessment*. Washington, DC: American Psychological Association.
- Spreen, O., & Strauss, E. (1998). *A compendium of neuropsychological tests: Administration, norms, and commentary*. New York: Oxford University Press.
- Zillmer, E. A., & Spiers, M. V. (2001). *Principles of neuropsychology*. Belmont, CA: Wadsworth.

---

## NORMATIVE ISSUES

---

Normative issues are those based on intrapersonal and interpersonal concerns that could be expected to occur in the course of a life. When people think about issues that might compel someone to seek professional help, they often envision severe and potentially even life-threatening issues such as major depression, extreme anxiety, addiction, mania, debilitating phobias, and suicidality. These issues obviously deserve the attention of mental health professionals, and it could even be said that “social permission” is implicitly—and sometimes even explicitly—granted to attend counseling based solely on the severity of the difficulties experienced. Clients who are experiencing severe difficulties rarely question their “right” to be in counseling. However, numerous others could benefit from an objective counseling experience as they endeavor to cope with the struggles of everyday living. Some normative issues are developmentally based and could become more problematic for different people at different points in their lives.

This entry provides a brief overview of intrapersonal and interpersonal normative issues that could occur for individuals, couples, and families. While some individuals do seek counseling for severe and diagnosable mental illnesses, many more individuals experience aspects of these normative issues that are emotionally distressing and reduce satisfaction with daily life. These normative issues can also be resolved through counseling.

### Intrapersonal Issues

Many of the normative issues that occur in counseling are intrapersonal issues. *Intrapersonal* may be defined

as occurring or originating within one’s self. The following section outlines some of the more common individual presenting problems in counseling. Although the focus of counseling may be on the identified client, it remains important to consider the systemic and developmental context of the client’s struggles.

### Academic Problems

Beginning school requires transition, and normative academic issues could be expected when children begin preschool or kindergarten. For some parents, the early school years may be the first time they realize that their child is not mastering specific skills at the same pace as other children. Parents may understandably feel reluctant or resistant if a kindergarten or first-grade teacher suggests that their child be tested for a “learning disorder.” There is often misunderstanding about the definitions of learning disabilities, and mental health professionals may be able to assist parents to obtain accurate assessments, diagnoses, and information about potential learning issues.

Academic concerns are not limited to diagnosable learning disorders. School difficulties may involve other systemic and contextual issues, and multiple psychosocial factors may interfere with children’s abilities to perform in a school setting. When a child enters school, the structure of attending school requires adjustment for families and children. Time management issues suddenly become more prominent as parents attempt to accommodate their work and family life to the school schedule. The structure of school also requires that school staff act as surrogate guardians, and parents may feel uneasy with the idea of other adults disciplining their child (or they may realize that their parenting philosophies differ widely from the teacher or school philosophies). At this stage of life, children are also challenged by a fear of separating from parents, and this may cause feelings of stress or “school phobia.” Counselors can assist with school-related issues by acting as advocates for parents and children in the school setting, by providing consultation for school staff, by facilitating parent–teacher communication, and by providing recommendations for interventions based on the needs of the child, family, and school.

Another transitory and potentially stressful turning point in academic life occurs when young adults enter college. Both academic and social issues produce stress for college students. In particular, incoming



freshmen face academic pressures related to grades, test scores and grade point average, difficulties with time management, and the need to use new learning and study strategies to master large amounts of complex material. Undergraduates must also cope with social issues related to adjusting to a new environment, leaving home, and forming new relationships with peers and faculty. Some researchers have suggested that low social support is associated with psychological stress and negative perceptions of the college experience. College counseling centers are ideally situated to assist in the adjustment to college by developing programming to facilitate social interactions among college students and by providing counseling services for those in need.

## Anger

Anger is a fundamental and basic emotion common to the human experience. Feeling angry is a natural and typical reaction to many life events, and it is sometimes healthy to express anger in constructive ways. Unexpressed anger is linked to increased susceptibility to illness, high blood pressure, and low pain tolerance as well as depression. Although it may be important to express anger in some situations, anger can be problematic if it is experienced as a chronic emotional state or if it is expressed in destructive, hurtful, or violent ways. Therefore, anger management is a prevalent reason for people to seek counseling. Anger management refers to a set of strategies or interventions clients can learn in therapy in order to identify, acknowledge, express, and contain their feelings of anger.

Difficulties with anger management may be an issue for multiple age groups. Young children may exhibit behaviors such as scratching, biting, throwing tantrums, or destroying toys. Parents may attend counseling to learn and practice parenting strategies to effectively decrease aggressive behaviors of children. During grade school and high school, bullying occurs. Bullying refers to intentional acts of aggression displayed by one student against another student. Overt acts may include name-calling, pushing, shoving, or hitting, whereas covert acts of bullying may include spreading gossip or ostracizing students from social interactions. Dawn Newman-Carlson and Arthur M. Horne suggested that counselors may be able to intervene with bullying by implementing schoolwide programs to increase teachers' abilities to manage acts of

anger in the classroom. Adults may also seek or be court ordered to counseling due to anger issues expressed in road rage situations, domestic violence, aggression in the workplace, or abuse of children. Adults may benefit from individual, group, or couples counseling to learn about ways to assertively express anger in healthy and constructive ways.

## Stress

Stress is the body's physiologic response to perceived threats. When individuals experience stress, heart and respiratory rates increase, blood pressure rises, and digestive processes are accelerated. This is termed the *fight-or-flight* phenomenon and refers to the way the body prepares to either confront or flee from perceived danger. Stress results from the perception of external threats and pressures, and some amount of stress is necessary for survival. However, stress may become a counseling issue when it occurs frequently or for prolonged amounts of time. Chronic stress may interfere with the ability to cope with daily events, it may cause somatic symptoms, and it results in feelings of irritability, worry, or sadness. Ongoing, repeated exposure to stress increases susceptibility to disease and it may increase risk for depression.

There are typical life events that may cause stress at various points in life. Both positive and negative events may invoke a stress response. Starting a new job, a death in the family, having a baby, moving, and financial difficulties are all examples of common events that may induce the experience of stress. Stress results from both the event and the meaning that individuals assign to the event. Individuals may experience similar life events, but appraise the events differently to result in unique stress experiences.

As individuals struggle to cope with stress, counseling may be a beneficial place to learn skills and strategies to increase relaxation. Multiple interventions may be effective, including breathing strategies, progressive muscle relaxation, cognitive exercises to decrease negative self-talk, and time management.

## Anxiety

In contrast to stress, anxiety is often characterized by a generalized feeling of excessive fear and worry. The anxious feelings are not necessarily associated with any particular life event, although stressors may trigger or exacerbate anxiety. People who experience



anxiety typically realize that their worries are in excess of what might be considered reasonable by others; however, they find it difficult to control their fearful thoughts. Anxiety may be chronic and pervasive in multiple aspects of life, and it can become debilitating because it impairs the ability to function at home, school, work, and/or in social settings. Anxiety may cause symptoms such as irritability, muscle tension, digestive problems, and/or sleep disturbance.

Mental health professionals often think of anxiety disorders as a group of diagnosable conditions with very specific criterion. Counselors use the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR)* to diagnose mental health disorders. In relation to anxiety, the *DSM-IV-TR* outlines conditions such as phobias, obsessive-compulsive disorder, generalized anxiety disorder, and stress disorders related to extreme trauma. Panic attacks are sometimes associated with anxiety and include somatic symptoms related to breathing, cardiovascular functioning, digestive difficulties, and feelings of dizziness. Panic attacks are sometimes mistaken for heart attacks, and this may cause clients to fear that they are dying.

Interventions for clients who experience anxiety disorders may include psychoeducation about the differences between stress and anxiety, work to reduce negative self-talk which may induce anxiety, breathing strategies, progressive muscle relaxation, or guided imagery, among others.

## Sleep

Sleep is a complex process guided by the body's hormonal and neurological responses to light and darkness. On typical nights, humans progress through multiple stages of sleep including a period of rapid eye movement (REM), which is when dreams commonly occur. For health reasons, sleep should progress successively through each of these stages, and a healthy sleeper will usually cycle through all of the stages 4 or 5 times per night. Difficulties arise when sleep is disrupted, shortened, or limited. The impact of sleep deprivation is cumulative across time and the consequences of sleep deficit are staggering. People who are consistently sleep deprived are at high risk for heart disease, cancer, and early death. Sleep deprivation is linked to slowed reaction time, impaired cognitive functioning, and difficulties with emotion regulation. Many work-related accidents and injuries are due to

fatigue, and car accidents are often linked to sleep-related issues. Therefore, sleep deprivation is a normative concern that is often a critical issue for clients.

Sleep dilemmas can occur across the life span for multiple reasons and are presenting issues in counseling sessions. Adolescents are often sleep deprived due to discrepancies between their circadian rhythms and the demands of school schedules. People between the ages of 13 and 25 often experience a delay in their sleep patterns in which they have difficulty falling asleep prior to 11 p.m. However, most high schools require that teenagers arrive at school early in the morning. This disparity often creates issues of sleep deprivation for high school students. In college, time management difficulties are a frequent difficulty for first- and second-year students, and thus "pulling an all-nighter" is a common undergraduate experience. In adulthood, new parents often have difficulties adjusting to newborn sleep schedules because infants typically are unable to sleep through the night until approximately 6 months of age. Working adults may suffer from sleep deprivation due to challenges involved in balancing work and home life, requirements to do shift or night work, or jet lag from business travel. As adults age, their sleep patterns begin to change, and this may cause difficulties or concerns for older adults.

Counselors might provide assistance for sleep-deprived clients by providing psychoeducation about the importance of sleep and information about sleep hygiene. Counseling sessions may be used to develop strategies to combat insomnia, and mental health professionals can assess for more severe sleep disorders such as sleep apnea, narcolepsy, or sleepwalking.

## Interpersonal Issues

All of the above intrapersonal issues could be reason enough to seek out counseling, yet these issues may be exacerbated in the context of a relationship with another person. Furthermore, there are also issues that arise from simply being in a relationship with another person, whether or not there are intrapersonal issues in the mix. The following section will cover some of the more common interpersonal issues that bring individuals, couples, or families to counseling.

## Communication

Understanding, both being understood and understanding the other, is one of the keystones to any good



relationship. Clarity in communication and positive communication brings people closer and provides a space for intimacy, shared goal development, and relationship satisfaction. Thus, difficulties in communication may result in more than misunderstanding; they can cause severe breaches in trust and intimacy within relationships.

One common model for communication is the active listening model, which is based on the active listening that is done by a counselor when he or she is working with clients. This model of communication originated in the therapeutic work of Carl R. Rogers, a proponent of demonstrating unconditional positive regard, acceptance, and empathy for clients. By demonstrating active listening through reflective statements, “I-statements” that indicate a nonblaming stance, paraphrasing both the content and feeling behind what was said, and exhibiting a nondefensive posture both verbally and nonverbally, all individuals can improve their communication skills. Active listening is often taught to individuals in the workplace and to couples as they attempt to work through conflicts. When couples employ nondefensive and nonattacking active listening techniques in their communication, they are more likely to be able to work through their difficulties without anger or causing further damage to their relationship.

The active listening model has been criticized for not translating from the therapeutic relationship to a romantic or work relationship as easily as had been hoped. The difficulty is that the active listening model primarily emerged out of “one-way” therapeutic relationships where the job of the counselor was to be nonjudgmental and nondefensive. The critics of the active listening model reflect that in most two-way relationships it is very difficult to maintain a completely nondefensive stance. Thus, although active listening skills may be present, people may not use them in the midst of conflict. Still, teaching the basics of active listening can help with moderately conflictual communication and communication skills training is often part of non-crisis-oriented counseling.

### ***Relationship Distress/Divorce***

Being in close relation to another person romantically can be one of the most fulfilling and wonderful events in a person’s life. Yet, having a partner also involves negotiating the challenges of sharing one’s life and knowing someone else intimately. Coming from different families with unique ways of approaching

conflict, household chores, money management, parenting, emotionality, and displays of affection can produce different expectations for individual behavior in the couple and a sense of a “right” way of being in a relationship. Furthermore, relationships can also be challenged by developmental transitions and unplanned situations. For example, negotiating dual career issues, the transition to becoming parents or the discovery of infertility, parenting adolescents, coping with the “empty nest” when children leave the home, infidelity, sexual issues, and medical illnesses are all issues that could lead an individual or a couple to counseling. These challenges can cause great distress, as they affect not only the couple but also the family, work, and friendships.

John M. Gottman used outcomes from his extensive research into couple relationships to delineate indicators of problematic relational styles. Specifically, he proposed that it is not the simple occurrence of negative interactions that cause distress, but rather the *type* of interaction. He outlined four problematic ways of interacting that he termed the Four Horsemen of the Apocalypse: criticism, defensiveness, contempt, and stonewalling. Additionally, he discussed the concepts of positive sentiment override and its opposite, negative sentiment override. Positive sentiment override means that if the predominant feeling within a relationship is positive, then small slights or relational errors are overlooked or categorized as unimportant. Conversely, negative sentiment override occurs when the predominant emotion in the relationship is negative, then even an outpouring of positive expression is unlikely to affect the overall well-being of the couple. His studies have revealed that functional relationships exhibit a 5 to 1 ratio of positive to negative interactions within the relationship. When this ratio becomes unbalanced, conflict becomes the main way of communicating and neither partner is satisfied.

The ultimate result of continuing conflict in a relationship is the dissolution of the relationship in either a break-up or divorce. Different people approach grieving the loss of a relationship differently. For some, especially those who did not initiate the separation, the loss of a primary relationship is a devastating event. Others, who are able to make the dissolution of a relationship fit with their views of themselves, do not find the separation as traumatic. One factor that can influence how one reacts to the loss of a relationship is when in the life cycle that the break-up occurs.



For example, a college-age or early marital break-up, while painful, may be considered less devastating than a divorce when there are young children present or after a lengthy partnership.

## Sexuality

Difficulties with sexuality can present themselves at almost any point in the life cycle. When couples are first forming their relationship, negotiating sexual intimacy and the presence or absence of past sexually intimate relationships can be problematic. Once the relationship is formed and the couple decides to have children, research has shown that sexual satisfaction plummets with the birth of children and does not improve for several years. Once the children reach adolescence, the sexual concerns of the family turn from the parent couple to the adolescent children and their developing sexuality. Parents are often concerned with protecting children from falling prey to external influences rather than making good personal choices about sexuality. Once the children leave home, the midlife parent couple faces the challenges of getting to know themselves and their sexuality again. Finally, in later life, issues such as menopause, medical issues, general physicality, and the pervasive influence of negative stereotypes regarding elder sexuality can have an extreme impact on sexuality.

Many couples experience difficulty or discomfort as they attempt to discuss their own sexual concerns or as they attempt to discuss sexuality with their children. Therefore, it is not surprising that it is often difficult for clients to openly discuss their sexual concerns with a counselor. Difficulties with sexuality can happen at any point in the sexual response cycle (i.e., excitement, plateau, climax, and resolution), and these difficulties can change based both on internal factors such as stress, low self-esteem, depression, or anxiety, and on external factors such as relationship difficulties, career issues, or balancing the multitude of daily demands and the tasks of everyday living. Additionally, many couples and individuals feel that only medically diagnosable sexual problems—for example, vaginismus (painful contraction of the vagina), erection difficulties, dyspareunia

(painful intercourse)—deserve the attention of a counselor and do not realize that counseling can help with sexual enrichment. Yet, counseling can be very helpful for teaching couples to talk openly about their wants, desires, and difficulties, and for educating parents and children in the delicate sexual discourse that is necessary as adolescents began to discover their own developing sexuality.

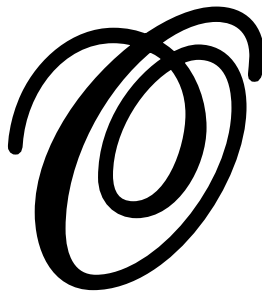
Sara K. Bridges and Michelle S. Goddard

**See also** Affect (Mood States), Assessment of (v2); Bereavement (v1); Bullying (v1); Communication (v3); Couple and Marital Counseling (v1); Family Counseling (v1); Learning Disorders (v1); Panic Disorders (v2); Parenting (v1); Psychological Well-Being, Dimensions of (v2); Quality of Life (v2); School Counseling (v1); Sleep Disorders (v1); Stress (v2); Stress Management (v2)

## Further Readings

- American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed., Text rev.). Washington, DC: Author.
- Carter, B., & McGoldrick, M. (Eds). (1999). *The expanded family life cycle: Individual, family and social perspectives* (3rd ed.). Boston: Allyn & Bacon.
- Clark, L. (1996). *SOS help for parents: A practical guide for handling common everyday behavior problems*. Bowling Green, KY: Parents Press.
- Daniluk, J. C. (2003). *Women's sexuality across the life span: Challenging myths, creating meanings*. New York: Guilford Press.
- Davis, M., McKay, M., & Eshelman, E. R. (2000). *The relaxation and stress reduction workbook* (5th ed.). Oakland, CA: New Harbinger.
- Dement, W. C., & Vaughn, C. (1999). *The promise of sleep*. New York: Dell.
- Gottman, J. M. (1999). *The marriage clinic: A scientifically based marital therapy*. New York: Norton.
- Kleinplatz, P. (Ed.). (2001). *New directions in sex therapy*. Philadelphia: Brunner-Routledge.
- Newman-Carlson, D., & Horne, A. (2004). Bully-Busters: A psychoeducational intervention for reducing bullying behavior in middle school students. *Journal of Counseling & Development*, 82, 259–267.





---

## OPTIMISM AND PESSIMISM

---

Optimism refers to a hopeful disposition or a general belief that good things will happen, whereas pessimism describes a general expectation that bad things will happen. These constructs have been conceptualized as dispositional traits, as well as cognitive styles, and have been examined in relation to various outcomes. Generally, research indicates that optimism tends to be associated with a host of positive outcomes (e.g., higher levels of achievement and both mental and physical well-being), whereas pessimism tends to be associated with less favorable outcomes. However, under certain circumstances, optimism may be maladaptive. Counselors draw from various techniques when using these concepts in their clinical work, but cultural factors influence their use of interventions related to optimism and pessimism.

### Optimism and Pessimism as Dispositional Traits

Michael F. Scheier and Charles S. Carver view optimism and pessimism as personality traits and have derived a self-regulatory model based on expectancy-value theory to describe how these traits relate to human experiences. The expectancy-value approach assumes that behavior is goal directed. The term *expectancy* refers to the probability a person attaches to the likelihood of attaining a given goal, and *value* refers to the value the person places on a particular goal.

According to the self-regulatory model, goals give meaning to people's lives, but goals are subject to

change, based on various forms of feedback. Individuals who experience adversity while pursuing a particular goal reassess the situation and the likelihood of success. This reassessment could lead to the identification of additional resources or alternative approaches to attaining the goal, or to abandoning the goal entirely. Optimists, who are more likely than pessimists to expect that they will be successful in achieving their goals, tend to persist in pursuit of their goals, despite adversity. For example, an optimistic college student might deal with a poor grade on the first exam in Introductory Biology by meeting with the instructor and revising his or her study techniques in order to better prepare for subsequent exams. In contrast, a pessimistic individual might deal with the same situation by "giving up," avoiding the situation (e.g., no longer attending class), and/or dropping out of college.

Abandoning a goal that is unattainable can be adaptive when doing so leads to adoption of a more suitable alternative. For instance, a college student who continues to struggle with biology courses in pursuit of the goal of becoming a physician, might, upon assessment of the situation, decide upon a more suitable career path.

Optimists tend to remain more confident in the face of adversity than pessimists, and are more persistent in pursuing their goals. Optimists are more likely than pessimists to take direct action when dealing with problems, tend to be more planful when dealing with adversity, and take a more focused approach in their efforts to cope with problems. Furthermore, optimists tend to accept the reality of adverse situations more readily than pessimists. Optimists appear to have a greater ability to make the best of a bad situation, and



they appear to be better able to grow or otherwise benefit from negative life experiences.

### Optimism and Pessimism as Cognitive Styles

The notion that cognitive styles bear a causal relationship to our affective experiences derives from Aaron Beck's cognitive theory of depression. According to Beck, depression results from cognitive distortions involving a tendency to highlight negative information while ignoring positive information. In contrast, people who are free from depression engage in a form of cognitive distortion in which they emphasize positive information while overlooking negative information.

According to attribution theory, individuals attempt to explain the events that occur in their lives by "attributing" the cause to one of three dimensions: internal-external, stable-temporary, and global-specific. The internal-external dimension refers to whether an event was due to a person's own actions or was the result of some external force. The stable-temporary dimension refers to whether the cause of a particular event is one that will remain stable across time or is more transient in nature. The global-specific dimension refers to whether the cause of an event is one that will affect many areas of a person's life or only one particular area.

A pessimistic explanatory style involves attributing negative events to internal, stable, and global factors (e.g., "I failed my Spanish exam because I'm stupid"). In contrast, an optimistic explanatory style involves external, temporary, and specific causal attributions for negative events (e.g., "I failed my Spanish exam because my teacher did a poor job of explaining the material, I was having a bad day when I took the test, and I'm not particularly good at learning new languages"). Research has demonstrated that a pessimistic explanatory style is related to depressive symptoms and poorer physical health (e.g., suppressed immune function).

Individuals with an optimistic explanatory style often use problem-focused coping strategies that involve active attempts to cope with a problem by engaging in direct problem solving (e.g., dealing with the stress associated with an upcoming exam by studying in advance). In many cases, such an approach is highly adaptive. However, the use of problem-focused coping strategies may result in wasted effort when the problem is not subject to change or the individual does not have adequate

resources to implement such change. An optimistic explanatory style works well during childhood, adolescence, and much of adulthood, but it may be maladaptive in later life when individuals often face circumstances that are less amenable to change (e.g., declining health and the death of loved ones). Emotion-focused coping, in which individuals attempt to regulate their emotions, may be more adaptive than wasting time and energy on problem-solving attempts in such circumstances. It may be most adaptive for individuals to tailor their explanatory style to the particular event with which they are faced.

### Defensive Pessimism and Strategic Optimism

An alternative view is that "strategic" optimism and "defensive" pessimism are strategies that can be used selectively to deal with specific situations rather than stable traits or styles. *Defensive pessimism* refers to a cognitive strategy of setting low expectations for some upcoming event, thereby preparing for and protecting oneself from potential failure. For instance, a job applicant who is anxious about an upcoming job interview might predict that he or she is going to be unable to respond to interview questions appropriately and come across as a "fool" during the interview, despite previous success in similar situations. Then, after considering all the things that could possibly go wrong, he or she plans carefully to prevent each feared event from occurring.

*Strategic optimism* refers to a strategy of setting high expectations that are consistent with self-perceptions and past experiences. This strategy avoids thoughts about possible negative outcomes associated with an upcoming task while preparing for the task. For instance, a person who has to deliver a formal speech would demonstrate strategic optimism by anticipating on the basis of past performance that he or she will do well and beginning to prepare for the speech at an appropriate time.

### Development of Optimism and Pessimism

Although few studies have examined the genetic basis of optimism and pessimism, scholars generally provide heritability estimates of approximately .25 for these traits. Heritability estimates for other personality traits such as extraversion and neuroticism are



typically higher. Some psychologists believe this implies that heredity exerts an indirect influence on optimism and pessimism. For example, optimism may be influenced by the genes for extraversion and pessimism by the genes for neuroticism. An alternative explanation is that genetic factors directly influence the likelihood of success or failure. These experiences, in turn, stimulate the development of an optimistic or pessimistic explanatory style.

Environmental experiences are indeed believed to influence the development of optimism and pessimism in several ways. Based on past experiences (i.e., success versus failure), children learn to expect future success or failure. Early experiences of helplessness, such as repeated exposure to violence or growing up in poverty, may also predispose children to become pessimistic. Parental modeling of expectations of success or failure and parental instruction in problem solving also are believed to influence the development of optimism and pessimism. In addition, children may internalize attributions for success and failure provided by their teachers and other important figures in their lives.

Results from longitudinal research studies demonstrate that even elementary-school-age children may display pessimistic explanatory styles. These children are more likely than their nonpessimistic peers to become depressed over time, particularly if they experience negative life events. Psychologists are working to develop interventions aimed at changing the pessimistic explanatory styles of at-risk children to prevent depression. These programs (which are based on Beck's cognitive therapy approach) begin by introducing children to the link between thoughts and feelings. Children then learn to dispute their negative thoughts about the causes of events, and are encouraged to search for evidence for and against their beliefs and evaluate situations in a more realistic manner. The results of such programs appear to be promising.

### **Integrating Optimism and Pessimism Into Counseling Practice**

Counseling psychologists use several approaches when helping clients modify their optimistic and pessimistic explanatory styles. Some view cognitive therapy as an effective form of treatment for depression precisely because it reduces pessimistic thinking. This approach focuses on decreasing negative thinking. Others use a variant of cognitive therapy in which interventions are aimed directly at decreasing the use

of optimism-suppressing strategies and increasing the use of positive thinking.

Psychologists have a choice of a variety of interventions aimed at decreasing pessimism and/or increasing optimism. For instance, psychologists might choose one or more of the following approaches:

- Help clients identify and modify their belief that optimistic thinking—such as “If I allow myself to feel confident, I will not prepare enough for the exam”—can be dangerous.
- Use *positive visualization*, which involves having clients visualize challenges they are likely to face in pursuit of a particular goal. Clients are instructed to imagine coping successfully with each challenge as it arises, and to imagine eventually achieving a successful outcome.
- Use *invulnerability training* to teach clients to imagine feeling good about how they handled a particular situation even when things did not turn out the way they had hoped.
- Use the *silver lining* technique to encourage clients to identify at least one positive element associated with each negative experience they encounter.
- Use *pump priming* to help clients spontaneously engage in optimistic thinking more frequently. For instance, a client who is instructed to spend 30 minutes each morning reading an article that discusses altruism might be more likely to recognize prosocial behaviors in others throughout the day. This, in turn, can lead to a more optimistic outlook throughout the day.
- Have clients use an *antipessimism sheet* to record their responses to upcoming events (e.g., the “best,” the “worst,” and the “most likely” outcomes they can foresee). Later, the client and therapist discuss these responses, their relation to the actual outcome, and the impact of the optimistic, pessimistic, and realistic predictions on the outcome.
- Have clients commit acts of kindness (e.g., donating blood, visiting an elderly relative) and practice grateful thinking (e.g., making note of friendships for which the client is thankful). When done in an intentional, focused manner, these actions may lead to increases in subjective well-being.

A few cautions should be observed in considering the preceding information. First, much of what is known about optimism and pessimism as they relate to well-being has been derived from work with Caucasian Americans. Research suggests that the



influence of optimism and pessimism on mental health may be different for Asian Americans. There is some evidence that Asian Americans benefit more from interventions aimed at enhancing optimism, whereas Caucasian Americans benefit more from those aimed at reducing pessimism. Additionally, some authors have suggested that, rather than attempting to change either optimistic or pessimistic thinking in isolation, a more balanced approach aimed at helping the client to develop more realistic cognitions may be most beneficial. Finally, there may be times when an optimistic outlook can be disadvantageous, such as when the circumstances with which individuals are faced are due to factors beyond their control. Nonetheless, there appear to be a number of both physical and mental health benefits associated with optimism.

*Kimberly Stark-Wroblewski*

**See also** Beck, Aaron T. (v2); Cognitive-Behavioral Therapy and Techniques (v2); Coping (v2); Depression (v2); Happiness/Hardiness (v2); Personality Theories, Traits (v2); Quality of Life (v2); Resilience (v2); Self-Efficacy/Perceived Competence (v2); Worldview (v3)

### Further Readings

- Abramson, L. Y., Seligman, M. E. P., & Teasdale, J. (1978). Learned helplessness in humans: Critique and reformulations. *Journal of Abnormal Psychology, 87*, 49–74.
- Beck, A. T. (1967). *Depression: Clinical, experimental, and theoretical aspects*. New York: Harper & Row.
- Chang, E. C. (Ed.). (2001). *Optimism and pessimism: Implications for theory, research, and practice*. Washington, DC: American Psychological Association.
- Isaacowitz, D. M., & Seligman, M. E. P. (2003). Cognitive styles and well-being in adulthood and old age. In M. H. Bornstein, L. Davidson, C. L. M. Keyes, & K. A. Moore (Eds.), *Well-being: Positive development across the life course* (pp. 449–475). Mahwah, NJ: Lawrence Erlbaum.
- Lyubomirsky, S., Sheldon, K. M., & Schkade, D. (2005). Pursuing happiness: The architecture of sustainable change. *Review of General Psychology, 9*(2), 111–131.
- Norem, J. K., & Cantor, N. (1986). Defensive pessimism: Harnessing anxiety as motivation. *Journal of Personality and Social Psychology, 51*, 1208–1217.
- Peterson, C., & Seligman, M. E. (1984). Causal explanations as a risk factor for depression: Theory and evidence. *Psychological Review, 91*, 347–374.

- Scheier, M. F., & Carver, C. S. (1985). Optimism, coping, and health: Assessment and implications of generalized outcome expectancies. *Health Psychology, 4*, 219–247.
- Seligman, M. E. P. (1990). *Learned optimism*. New York: Knopf.

---

## OUTCOMES OF COUNSELING AND PSYCHOTHERAPY

---

Counseling and psychotherapy outcomes are the benefits (or harms) that derive for clients (patients or mental healthcare consumers) as a result of their experiences or treatment in therapy or counseling. Although it is generally assumed that therapy is an effective treatment for mental health concerns, this is not always the case. The determination of therapy outcomes involves a variety of issues and considerations.

### How Are Outcomes Evaluated?

Efficacy and effectiveness are two ways in which the outcomes of counseling and psychotherapy are discussed. *Efficacy* refers to the therapeutic benefits found in comparison of the treatment and a no-treatment control group within the context of a controlled clinical study. In contrast, *effectiveness* refers to the benefits of therapy that occur within a mental health practice context. In the former instance, the question is whether a treatment or intervention is found to achieve a greater benefit for clients than no treatment. If so, the treatment is said to be “efficacious.” In the latter instance, the question is one of how effective counseling is for those clients who seek and receive treatment within the community.

It is alleged that clinical studies create an artificial context in which the therapy that takes place is not characteristic of how treatments are provided in an actual community context. Consequently, finding that a treatment is efficacious cannot be assumed to mean that it is effective (i.e., is beneficial to clients in practice settings). Although there is merit in this criticism, effectiveness findings are generally compromised by the absence of a control group within a practice setting against which to compare client therapeutic gains. As a result, it may not be possible to convincingly determine whether the benefits derived by clients receiving counseling in community



settings are due to the treatment or to some other extraneous factors.

## Significance of Therapy Outcomes

In the consideration of counseling and psychotherapy outcomes, it is important to ask, “When is an outcome significant?” The significance of therapy outcomes can be evaluated in several ways. Outcomes can be evaluated in terms of their statistical significance, and they can be evaluated in terms of the clinical significance or clinical relevance.

### *Statistical Significance*

There are two types of statistical significance that may be considered when evaluating therapy outcomes. The first has to do with differences between or among treatment groups. The second has to do with the changes experienced by individuals within those groups.

Between-group differences are examined by comparing the outcomes of two different approaches to therapy (e.g., a new approach to therapy vs. an established approach), or by comparing the outcome of a specific therapeutic approach with a placebo treatment or a nontreatment (wait list) group (i.e., a control group). Whatever the comparison, if the research is designed so as to rule out extraneous factors as competing explanations for the change, statistical procedures may be used to determine whether the observed differences that appear between groups can reasonably be attributed to differences in the administered treatments or whether it is more reasonable to conclude that the differences are due to chance (e.g., sampling differences). If the difference between the outcomes of the treatment group and the comparison group is in the expected direction and unlikely to be due to chance sampling differences, then it can be concluded that the difference is statistically significant. In other words, the treatment group was more efficacious and yielded a statistically better outcome than did the comparison group.

Although the treatment outcome of one group may differ significantly from that of another group, this does not necessarily mean that the change that occurred was itself significant. Indeed, it is conceivable that the treatment group did not change at all, but rather the comparison group became significantly worse, relative to the treatment group. In order to

evaluate the statistical significance of change within the treatment group (i.e., the statistical significance of its outcome), a different approach is needed. In this approach, a group’s pretreatment performance on some relevant outcome variable is evaluated against its posttreatment performance on the same variable. If the difference between the pre- and posttreatment assessments is in the expected direction and not attributable to chance differences in the measurement of the outcome variable (measurement error), then the change (or outcome) is said to be statistically significant.

### *Clinical Significance (Clinical Relevance)*

While the statistical significance of outcome research findings can provide empirical support for different treatment approaches, it is important to note that just because there are statistically significant differences between groups does not mean that the groups differ in clinically significant ways. That is to say, although the treatment outcome for one group may differ from that of another and be in the desired direction, such a finding may not be clinically meaningful. For example, a treatment for depression might produce therapeutic change in a group of clients that is significantly different statistically from that of a placebo treatment, but this does not necessarily mean that those who received the treatment are no longer depressed. It simply means that as a group, they changed more than those who received a placebo treatment did. Furthermore, a statistically significant within-group pre-post difference does not necessarily mean that the individuals who received the treatment are meaningfully improved. It simply means that their posttreatment scores are reliably different from their pretreatment scores.

Several approaches to the evaluation of clinically relevant change have been proposed. Evidence that treated clients are indistinguishable from a nondisturbed reference group is probably the most convincing evidence of clinically meaningful change. Neil S. Jacobson and Paula Truax extended this notion by proposing a standardized statistical method involving two criteria for assessing clinical significance. First, the treated client should be more likely identifiable as belonging within a distribution of healthy persons than a distribution of troubled individuals. Second, the client change must be reliable; that is, it must be large enough that the pre- to posttreatment change cannot be attributable to measurement error—a criterion for



which there is a *reliable change index* that can be statistically computed. Notwithstanding the above discussion, statistical significance, rather than clinical significance, is the manner in which outcome efficacy is generally reported.

### Perspectives on Therapy Outcomes

The determination of the clinical significance of a therapy outcome is invariably related to the perspective of the outcome evaluator. Early efforts at examining therapy outcomes generally relied exclusively on therapists' impressionistic ratings of client improvement. Over time, outcome evaluation moved from the reporting of therapists' clinical impressions to the use of standardized therapist rating scales to measure general improvement.

Although the use of such scales constitutes an important improvement to the evaluation of therapy outcomes, the possibility of therapist bias in the provision of ratings is problematic. As an additional source of information, client self-reports of improvement are frequently included in outcome evaluations. Often these consist of global measures of improvement framed as judgments of the benefit or value to therapy or client satisfaction on posttherapy questionnaires. Other client self-report efforts include structured personality measures or symptom rating scales—generally collected pre- and posttreatment. Client self-report measures provide a unique and important source of information and perspective regarding change resulting from therapy that can be especially useful to therapists in gauging their effectiveness in providing treatment. Concerns about objectivity that may result from the use of therapist- and client-rated measures has led to the use of persons not involved in therapy who, as raters, are blind to the treatment status of research participants or clients. It has also led to the use of physiological measures and unobtrusive measures such as student grades, judicial records, sales records, and the like.

Hans H. Strupp and Suzanne W. Hadley proposed a tripartite model of therapeutic outcomes that captured three important, yet distinct, perspectives from which the relevance of therapy outcomes could be evaluated: (a) the perspective of the client as consumer, (b) the perspective of the therapist or mental health professional, and (c) society. In discussing their model, they provided a variety of different therapy outcome evaluation scenarios. For example, it is possible for the client to report improvement, while

neither the therapist nor others support that conclusion. Alternatively, the therapist may believe the client has improved, but the client does not. Another possibility is that both the client and therapist may report improvement on the part of the client, but others in the community with whom the client interacts do not see the same improvement. In other words, agreement of these perspectives on the outcome of therapy cannot be assumed. These differences in perceptions of the outcome and therapeutic benefit raise important concerns in terms of the evaluation of therapy outcomes. Suffice it to say, when considering therapy outcomes, it is important to consider that there are multiple legitimate perspectives to consider and often the perspectives are not consistent.

Benjamin M. Ogles, Michael J. Lambert, and Kevin S. Masters incorporated the notion of different legitimate perspectives on therapy outcome into a multidimensional model for considering therapy outcomes. Expanding on earlier perspectives, these researchers include the perspectives of relevant others such as the client's spouse, friends, and work colleagues, plus those of trained observers and institutional referents (i.e., school, work or hospital records, public records of arrest, etc.). In addition to this *social* dimension of outcome measurement and evaluation, they also proposed several additional dimensional perspectives: (a) content, (b) social level, (c) technology, and (d) time orientation.

The *content* dimension refers to the psychological area or aspect of the person on which outcome is being measure and against which efficacy is evaluated. It includes client behavior, cognitions/thoughts, and emotions. The *social level* dimension refers to the degree to which the outcome construct being measured is intrapsychic or internal to the person or interpersonal and external to the person. Intrapsychic constructs include moods, self-concept, cognition or beliefs, and behavioral deficits. Interpersonal constructs include such things as social and work adjustment, delinquency, and group interaction.

The *technology* dimension refers to the variability in the types of instruments that are used for the collection of outcome/change data. This dimension captures the fact that different measures and instrumentation may yield differentially favorable or unfavorable outcome findings. These discrepancies in therapy outcome findings may arise depending on whether outcome is assessed globally or specifically, directly or indirectly. Differences in the sensitivity of the



measurement technology to change on the construct being assessed may also result in outcome discrepancies. The final dimension, *time orientation*, reflects the degree to which the outcome assessment attempts to measure stable/enduring, traitlike features of the person rather than features that are unstable and more dependent on the state or contemporary circumstance of the client.

This multidimensional model suggests that therapy outcomes are best understood and most reasonably evaluated over a number of different dimensions and from multiple perspectives. However, in this regard, it is important to note that conclusions about the effects or outcome of counseling and therapy depend on the particular measure that is used in assessing change in therapy and from what perspective(s) that change is evaluated. In outcome assessment, the measurement tools that are used often are connected with particular theoretical orientations or schools of therapy. Notwithstanding the differences among various orientations toward counseling and psychotherapy, clinicians and researchers recognize the need to assess the outcome of therapy on aspects broader than the dimensions or aspects immediately specific to a particular theory or approach to therapy.

### Is Therapy Better Than No Therapy?

The fundamental question in terms of therapy outcome is whether clients receiving therapy are, at the conclusion of their experience, better off than those who need therapy but do not receive it. In other words, “Does counseling/psychotherapy work?” This is a question about the absolute efficacy of therapy. As suggested earlier, it is generally assumed that therapy is an effective treatment for mental health concerns; however, it is an assumption that has been and continues to be open to the scrutiny of researchers.

A notable first attempt to examine the evidence relating to the effects of therapy was conducted in 1952 by Hans J. Eysenck. As previously mentioned, the evaluation of the efficacy of therapy requires that the effects of treatment be compared with a no-treatment control group. To conduct his evaluation, Eysenck compared the outcomes found in 24 studies of psychodynamic and eclectic psychotherapy with spontaneous remission rates (i.e., rate of improvement in client functioning without benefit of therapeutic intervention) using two control groups. The results of Eysenck’s study were disconcerting, finding that

clients who received psychodynamic or eclectic therapy improved less than those in his control/comparison no-treatment condition. Not only did it appear that therapy was ineffective, it might also be harmful.

Eysenck’s study was not without critiques, as there were serious design problems with his research method. Responding to the challenge to therapy implied by Eysenck’s study, numerous reviews of aggregated efficacy studies of counseling and psychotherapy were conducted during the 1960s and 1970s. While having their own methodological problems, these subsequent studies generally yielded findings supportive of therapy’s efficacy.

Over the years, examinations of the efficacy of counseling and psychotherapy have reached different and even contradictory conclusions. It is noteworthy that these earlier reviews of the outcome literature often lacked objectivity and replicability. They generally involved narrative descriptions of each study included in the review, an evaluation of the results in terms of the type of evidence offered with respect to therapy outcome, and then an implicit summary of the findings to render an overall conclusion about therapy’s effectiveness. However, with the hundreds of outcome studies now available for consideration in evaluating therapy’s effectiveness (outcome), turning the thousands of pieces of evidence that derive from all of these studies into an integrated summary of the benefits of counseling and psychotherapy is problematic.

Although a single outcome study will reveal information about the benefits received by the participants of that study, the answer to the broad question of “Is counseling/psychotherapy effective?” requires the examination of the body of research that has addressed this question. More recent inquiries into therapy efficacy have used the statistical method of meta-analysis to examine the aggregated results of hundreds of different studies that have compared a group receiving counseling or psychotherapy with a control group. Briefly, meta-analysis consists of a set of statistical procedures that allow researchers to gain a comprehensive picture of the research on a question and an unbiased answer to the research question. Through meta-analysis, outcome data from many individual counseling and psychotherapy outcome studies are systematically aggregated, allowing the findings to be analyzed to achieve an answer to the larger question of whether therapy is effective. Unlike the research methods used in individual studies for which the client-participants serve as data points for analysis,



meta-analysis uses the summary statistics from individual studies as the data points for analysis. Although not without detractors, meta-analytic procedures provide a methodology to assemble an overall picture of therapy's effectiveness (relative to no therapy or a placebo treatment) and for comparing across studies of different approaches to therapy in order to investigate the relative efficacy of different treatments.

The first meta-analysis of the outcome of psychotherapy was conducted by Mary Lee Smith and Gene V. Glass. They analyzed the results of 375 published and unpublished therapy outcome studies. The results of their study produced an effect size of .68, which suggests that an average client receiving therapy would be better off (i.e., improved) than 75% of untreated (control group) clients. Although their results suggest that a proportion (34%) of untreated clients also improved (i.e., spontaneous remission), the success rate for those receiving treatment was 66%, leading them to conclude that the research showed the beneficial effects of counseling.

As with the challenges to Eysenck's methodology and findings, there have been critics of and challenges to Smith and Glass's meta-analytic findings. Subsequent meta-analyses of the therapy outcome literature have challenged the validity of those criticisms, while at the same time providing rather convincing support for the absolute efficacy of counseling and psychotherapy. Although it cannot be said that therapy is effective for everyone who seeks it, the likelihood of improvement is high for those in therapy, and much higher than for those left untreated.

### **Negative Outcomes in Therapy**

Research does support a conclusion that there are negative outcomes in therapy; that is, some clients do get worse. This research suggests that a relatively consistent 5% to 10% of clients deteriorate while participating in therapy. However, this does not mean that all instances of worsening that occur during counseling/therapy are the result of the treatment. Some clients may be on a progressive decline that a therapist is unable to stop. There are a number of factors related to the client, therapist, and treatment that are associated with negative outcomes during counseling/psychotherapy. Negative outcomes are more likely in clients being treated for borderline personality disorders and obsessive-compulsive disorders, as well as in clients with interpersonal difficulties and more severe problems at the start of therapy. Therapist

characteristics that are associated with negative outcomes include lack of empathy, underestimation of the severity of clients' problems, and negative countertransference. Experiential therapies are more likely to produce negative outcomes, as are minimal interventions for severely distressed clients.

### **Are Some Therapies Better Than Others?**

One of the interesting, but perplexing, aspects of counseling and psychotherapy is the great diversity of different schools and orientations that exist in the field. In the mid-1960s, one list documented over 60 different approaches to therapy. In 1975, a report of the Research Task Force of the National Institute of Mental Health (NIMH) noted over 130 different types of psychotherapy. Five years later, the number had grown to over 200 different forms of therapy, and in 1986, over 400 different therapeutic techniques were listed. Whether the list of therapeutic approaches has grown or shrunk since that time probably depends on who is doing the counting.

In light of the proliferation of approaches to therapy, it is reasonable to ask whether some approaches are better than others. Such a question is one of the relative efficacy of different treatments. Specifically, does Treatment X produce a better outcome than Treatment Y? In contrast to the evaluation of the absolute efficacy of a treatment ("Is Treatment X better than no treatment?"), researchers evaluate the relative efficacy of different approaches to counseling by contrasting one treatment against another.

In 1936, upon considering the claims of success (and eventually of superiority) of the proponents of the various then-current approaches to therapy, Saul Rosenzweig conjectured that despite purported differences in these various approaches to counseling and psychotherapy, they were essentially equivalent in terms of their outcomes. Borrowing a phrase drawn from Lewis Carroll's 1865 book *Alice in Wonderland*, Rosenzweig remarked, "Everybody has won and all must have prizes"—a phrase now referred to as the Dodo Bird conjecture, after the character in the book that proclaimed the winners of the oddly run Caucus Race.

Although a history of comparative outcome reviews will reveal mixed results in regard to the outcome superiority of various counseling and psychotherapy approaches, contemporary meta-analytic reviews of the comparative outcome research reach a



conclusion remarkably similar to that reached in the Dodo Bird conjecture. In general, and in terms of proportions of clients who improve by the end of therapy, differences between various forms of therapy are generally insignificant, but consistent with the absolute efficacy outcome finding noted above—that is, across different approaches to counseling and psychotherapy, there appears to be uniform efficacy.

### **Are Some Therapies Better Than Others for Certain Problems or Disorders?**

While the results of treatment comparison studies suggest little in the way of outcome differences between different approaches to counseling and psychotherapy, it is reasonable to speculate that outcome differences might exist for different therapies, depending on the problems or disorders toward which they were applied. Such a supposition is reflected in the question of what treatment works best for what specific problem. The implication in this question is that the comparison of various treatment outcomes is too gross a comparison to capture meaningful differences among therapy approaches for specific types of presenting concerns. Instead, it may be that one approach is best for treating depression, while another is best for treating anxiety, and so on. In this regard, detractors of the finding of uniform treatment efficacy (the Dodo bird conjecture) contend that the lack of findings of the superiority of certain various treatments is the result of researchers failing to take into consideration the effect of different treatments on different client problems or concerns.

That there is a vast array of different approaches to therapy has already been noted. Similarly, there are many different sorts of concerns, problems, and disorders that clients present to counselors and therapists. A cross-tabulation of treatments by disorders would be enormous. Adding therapist, client, and circumstantial variables to this mix would result in an impossibly large number of combinations for researchers to test and compare and for counselors and therapists to master.

Notwithstanding the enormity of the challenge posed by considering disorder-specific therapy, there is an increasing large body of research that supports the efficacy of particular treatments for particular problems. These studies provided the evidentiary basis for what are referred to as *empirically supported*

*treatments*. The results of meta-analyses comparing different treatments approaches for different problems, however, generally do not support an interpretation that certain treatments are more effective than others for specific client problem areas.

### **What Makes Therapy Effective?**

The question of what makes therapy effective is not an “outcome question.” Rather it a question about what goes on during therapy—the “process of therapy”—that leads to a therapeutic outcome. Considerable research has been and continues to be conducted that addresses this issue. It is beyond the scope of this entry to review that literature. Suffice it to say that different approaches to counseling and psychotherapy postulate factors specific to each approach as the mechanisms of therapeutic change. However, the findings that different approaches to therapy tend to be equally effective, and that there is little evidence to support the contention that different treatments are differentially effective for different client problems, do not support the argument that factors specific to particular counseling approaches account for change. These findings have led to research on aspects of the therapy process that are common to different approaches to counseling and therapy that might account for the consistency in therapy’s beneficial effects across these different approaches. These two perspectives on the therapy process—change as a function of orientation-specific factors and change as a function of common factors—are central to contemporary process research.

*James W. Lichtenberg and Pamela L. Knox*

*See also* Common Factors Model (v2); Counseling Process/Outcome (v2); Counseling Theories and Therapies (v2); Evidence-Based Treatments (v2); Expectations About Therapy (v2); Harmful Psychological Treatments (v2); Process and Outcome Research (v4)

### **Further Readings**

- Chambless, D., & Ollendick, T. H. (2000). Empirically supported psychological interventions: Controversies and evidence. *Annual Review of Psychology*, 52, 685–716.
- Eysenck, H. J. (1952). The effects of psychotherapy: An evaluation. *Journal of Consulting Psychology*, 16, 319–324.
- Frank, J. D. (1982). Therapeutic components shared by all psychotherapies. In J. Harvey & M. Parks (Eds.),



- Psychotherapy research and behavior change* (pp. 9–37). Washington, DC: American Psychological Association.
- Jacobson, N. S., & Truax, P. (1991). Clinical significance: A statistical approach to defining meaningful change in psychotherapy research. *Journal of Consulting and Clinical Psychology, 59*, 12–19.
- Lambert, M. J., & Ogles, B. M. (2004). The efficacy and effectiveness of psychotherapy. In M. Lambert (Ed.), *Handbook of psychotherapy and behavior change* (5th ed., pp. 139–193). New York: Wiley.
- Mohr, D. C. (1995). Negative outcome in psychotherapy: A critical review. *Clinical Psychology: Science and Practice, 2*, 1–27.
- Ogles, B. M., Lambert, M. J., & Masters, K. S. (1996). *Assessing outcome in clinical practice*. Needham Heights, MA: Allyn & Bacon.
- Rosenzweig, S. (1936). Some implicit common factors in diverse methods of psychotherapy: “At last the Dodo said, ‘Everybody has won and all must have prizes.’” *American Journal of Orthopsychiatry, 6*, 412–415.
- Smith, M. L., Glass, G. V., & Miller, T. (1980). *The benefits of psychotherapy*. Baltimore: Johns Hopkins University Press.
- Strupp, H. H., & Hadley, S. W. (1977). A tripartite model of mental health and therapeutic outcome: With special reference to negative effects in psychotherapy. *American Psychologist, 32*, 187–196.
- Wampold, B. E. (2001). *The great psychotherapy debate: Models, methods, and findings*. Mahwah, NJ: Lawrence Erlbaum.

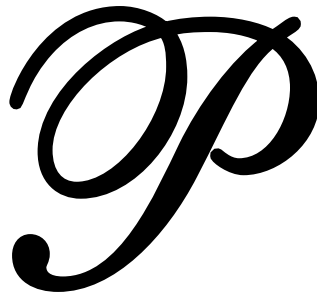
---

## OVERDIAGNOSIS

---

*See* UNDERDIAGNOSIS/OVERDIAGNOSIS





---

## PANIC DISORDERS

---

A panic attack is the sudden onset of intense apprehension, fearfulness, or terror, often associated with feelings of impending doom. In addition, symptoms such as shortness of breath, palpitations, chest pain or discomfort, choking or smothering sensations, and fear of “going crazy” or losing control are present. Panic disorder involves the presence of recurrent and unexpected panic attacks, followed by at least a month of persistent concern about another panic attack, or worry about the possible effects of having another panic attack.

The combination of unexpected attacks and persistent anxiety about recurrent episodes of physiological dysregulation, termed *fear of fear* or *anxiety sensitivity*, distinguishes panic disorder from other anxiety disorders in which panic episodes occasionally occur. Anxiety sensitivity is defined as fear of anxiety symptoms, which arises out of the belief that those symptoms are harmful. For instance, individuals with high anxiety sensitivity may believe chest pains signify an impending heart attack, whereas individuals with low anxiety sensitivity will regard such pains as merely unpleasant. To meet the criteria for panic disorder, the symptoms cannot be due to the direct physiological effects of a substance, a medical condition, or another mental disorder.

There are three types of panic attacks. An *unexpected panic attack* is a sudden, surprising, spontaneous, quick increase of panic symptoms and sensations that seem to arise without an obvious situational trigger or external stimuli. A *situationally bound attack* is one in

which a sudden surge of fear of terror is triggered by exposure to a situational trigger. Situational triggers can either be external, (i.e., a phobic object or situation) or internal (i.e., physiological arousal or sensations). These attacks are characteristics of specific phobias and occur whenever the situational trigger is present.

The third type of panic attack, a *situationally pre-disposed attack*, differs from a situationally bound attack in that exposure to a situational trigger increases the likelihood of panic but does not invariably precipitate it. Concerns about having another attack, or the impact of such, are often linked to the avoidance of specific situations or places. When the avoidance behavior meets the criteria for agoraphobia (i.e., avoidance of open spaces), panic disorder with agoraphobia is diagnosed.

### Panic Versus Anxiety

Although panic disorder is classified in the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR)* as a type of anxiety disorder, the preponderance of research suggests that panic is qualitatively distinct from anxiety; that is, panic is not just a severe form of anxiety. Panic consists solely of fear, while anxiety comprises other dysphoric states in addition to fear. Sudden onset of symptoms also distinguishes panic from anxiety. Episodes of severe anxiety with gradual onset generally do not involve fears of dying or going crazy, and they do not involve as many symptoms as episodes of severe anxiety with a rapid onset. Panic arouses a flight-or-fight response to a perceived immediate



threat, whereas anxiety functions as vigilance for anticipating and coping with future threats. The cognitive content of panic involves imminent danger, whereas the cognitive content of anxiety is composed of worry about a variety of concerns.

### **Anxiety Sensitivity Index**

The Anxiety Sensitivity Index (ASI) has received considerable support as a valid self-report measure of the fear of anxiety symptoms. It consists of 16 5-point Likert scale items that express concerns or worries about the possible consequences of anxiety. It has a high degree of internal consistency and satisfactory test-retest reliability over 3 years. It has a single factor structure, with a low level of shared variance with general trait anxiety. Clients experiencing panic score about two standard deviations above the normative mean on the ASI and significantly higher than clients diagnosed with generalized anxiety disorder (GAD).

### **How Panic Arises**

Research on the causes of panic is still in its early stages, but in general the evidence suggests that panic can occur for a variety of reasons. Cognitive theory hypothesizes that catastrophic misinterpretation of certain bodily sensations (e.g., interpreting palpitations as signs of impending heart attack, dizziness as imminent collapse, or derealization as going crazy) causes panic attacks. Catastrophic misinterpretations escalate anxiety and intensify bodily sensations until they culminate in panic.

Support for this theory is available from retrospective studies in which patients who experienced panic reported that thoughts of imminent threat or danger tended to precede their attacks. Catastrophic thoughts occurred after the detection of a specific bodily sensation but before the emergence of panic. If the cognitive hypothesis of panic is correct, interventions that reduce the likelihood of a catastrophic misinterpretation should reduce the likelihood of panic. This hypothesis has been validated by numerous research studies.

Catastrophic misinterpretation is not the only cause of panic attacks. Some patients recalled having catastrophic thoughts only after they experienced panic symptoms. In another study, 27% of those who experienced panic attacks reported that fearful thoughts did not precede the attacks.

## **Psychological Treatments for Panic Disorder With Agoraphobia**

Psychological treatments that do not include in vivo exposure to feared situations are ineffective in treating phobic fear. Patients told to avoid contact with phobic situations generally experience no improvement or even a worsening of their symptoms. Exposure to feared situations, delivered in a variety of ways, can be effective. For example, between-session exposure to feared situations, assigned by the therapist as self-exposure homework, typically increases treatment effectiveness. Scheduling frequent exposure sessions and spacing exposure sessions do not differentially affect dropout or relapse rates. Furthermore, minimizing or maximizing the patient's level of anxiety during exposure sessions does not seem to affect outcome.

Behavioral psychologists hypothesize that escape from anxiety-provoking situations reduces anxiety and strengthens agoraphobic avoidance behavior. However, the research evidence suggests that it is not "escape" per se that reduces anxiety. It appears that the sense of control experienced by those who believe they have the option of escaping the fear-inducing situation that fosters fear reduction.

The demonstrated effectiveness of exposure therapy has prompted research to investigate adjunctive techniques that might enhance outcome. Overall, relaxation and cognitive procedures add little to exposure in vivo unless they specifically target panic. Cognitive therapy for panic disorder with agoraphobia is helpful only when it incorporates exposure to feared situations in addition to altering persistent tendencies to catastrophically misinterpret bodily sensations. This requires eliciting the client's misinterpretations and assessing the evidence for and against their validity. For example, a cognitive therapist would inquire whether the last episode of chest pains turned out to precede a heart attack. Alternately, the client could engage in shallow breathing for a few minutes to induce bodily sensations similar to the last episode of panic attack, while taking care to ensure that the bodily sensations do not escalate into a panic attack.

Research shows that individuals with panic disorder with agoraphobia experience a significant decrease in panic, anxiety, and agoraphobia avoidance when treated with graduated exposure in vivo, graduated exposure plus relaxation training, and graduated exposure plus cognitive therapy. Both adjunct treatments increase the effectiveness of exposure in vivo;



the cognitive therapy adjunct seems to increase the effectiveness of exposure more than the relaxation training adjunct.

There is a preponderance of evidence supporting the effectiveness of cognitive-behavioral treatment for both agoraphobic avoidance and spontaneous panic. Another non-cognitive-behavioral approach, 3 sessions of psychoeducation and 12 sessions of nondirective psychotherapy, also has demonstrated some effectiveness in reducing panic. These findings should be replicated and the therapeutic factor identified to enhance understanding of what made that particular treatment modality a potential option for treating panic.

Macy M. Lai

*See also* Cognitive-Behavioral Therapy and Techniques (v2); Cognitive Therapy (v2); *Diagnostic and Statistical Manual of Mental Disorders (DSM)* (v2); Homework Assignments (v2)

### Further Readings

- Beck, A. T., Laude, R., & Bohnert, M. (1974). Ideational components of anxiety neurosis. *Archives of General Psychiatry*, 31, 319–325.
- Clark, D. M. (1988). A cognitive model of panic attacks. In S. Rachman & J. D. Master (Eds.), *Panic: Psychological perspectives* (pp. 71–89). Hillsdale, NJ: Lawrence Erlbaum.
- McNally, R. J. (1994). *Panic disorder: A critical analysis*. New York: Guilford Press.
- Peterson, R. A., & Reiss, S. (1992). *Anxiety Sensitivity Index manual* (2nd ed.). Worthington, OH: International Diagnostic Systems.
- Rachman, S., Craske, M., Tallman K., & Solyom, C. (1986). Does escape behavior strengthen agoraphobic avoidance? A replication. *Behavior Therapy*, 17, 366–384.
- Wolpe, J., & Rowan, V. C. (1988). Panic disorder: A product of classical conditioning. *Behavior Research and Therapy*, 26, 441–450.

---

## PARADOXICAL INTERVENTIONS

---

Numerous definitions of *paradox* have been offered that contain several commonalities. First, they involve a statement that is contrary to received, or common, opinion. Second, they involve some sort of logical contradiction. For example, in ancient Crete, Epimenides the

Cretan said, “All Cretans are liars”—which leads to a logical contradiction because he cannot be believed, whether or not he is telling the truth. Third, they often involve an explicit communication that is embedded within an implicit framework that communicates a different message. The famous “I want you to be more spontaneous” injunction is an example, because the explicit message can only be obeyed if it is not obeyed. This is a *double bind*, which some consider the essence of paradoxical statements. The paradoxes inherent in such statements are not easily disentangled and often can be resolved only by leaving the relationship entirely. Fourth, paradox can be seen as an example of dialectical thinking in philosophy, in which any statement may contain its opposite. It can be seen from these definitions that the key word behind paradox is *contradiction*.

Within a help-seeking counseling relationship, paradoxical interventions can be seen as those in which the counselor seems to advocate the continuation or even the worsening of problems rather than their elimination. Some writers see this as *decontextualizing* the problem by altering the context and the supporting environment in which the symptoms appear. In the process, the symptoms are redefined as solutions.

### Paradox in Ordinary Life

Paradoxical ideas and ways of thinking are as old as humanity, especially in Eastern philosophy and major world religions. The *Tao Te Ching* (*Way of Virtue*), written by the founder of Taoism, Lao Tzu, contains much paradoxical advice, such as getting what one wants by being open to receiving its opposite. Buddhism likewise contains many paradoxical ideas. For example, if one seeks enlightenment, one will be unable to attain it because he or she will have attachment to enlightenment itself. Christianity contains many paradoxical statements such as, “Whoever would be great among you must be your servant.”

In lay terms, paradox is similar to reverse psychology, and many examples can be found in literature. *Reverse psychology* is a term that describes a situation in which advocacy of one course of action persuades someone to do the opposite. Examples include Tom Sawyer persuading his friends to paint his fence by describing it as a privilege rather than a task. Likewise, attempts to censor works of art or literature paradoxically result in those works becoming more attractive.



## Paradoxical Interventions in Counseling

Alfred Adler is widely thought to be the first therapist to make explicit use of paradoxical interventions. The use of these techniques stemmed from Adler's belief that a successful power play against the therapist results in increased patient self-esteem and therefore patient improvement. Thus, in a sort of "therapeutic judo," Adler encouraged patients to rebel against him. Adler often used humor in prescribing his injunctions.

From a behavioral point of view, in the 1920s, Knight Dunlap developed an approach that he called *negative practice*. This involved deliberately practicing behaviors that one wanted to eliminate rather than attempting to avoid them. Dunlap saw this as a way of bringing them under control. In doing so, he argued against the law of habit formation, which states that repetition of a response increases the probability of its recurrence.

Perhaps the best known therapist to use paradoxical interventions and the first to use that term explicitly was Viktor Frankl. As part of his logotherapy, he developed what he called *paradoxical intention*, in which he encouraged patients to do or wish for that which they most feared. For example, a patient who was very afraid of contamination was urged to wish to become as dirty as possible. This is very similar to what later was called *symptom prescription*.

### Types of Paradoxical Interventions

There are different ways of classifying paradoxical interventions, but one useful system makes a distinction between compliance-based and defiance-based interventions. All of the specific paradoxical techniques can be placed within one or the other.

#### **Compliance-Based Interventions**

These interventions are used with the expectation the client will comply with the counselor's suggestion or directive and thereby improve. In the original compliance-defiance model, clients who were low on psychological reactance, that is, the tendency to resist interpersonal influence, were expected to do best with these strategies. There are several types of compliance-based interventions.

##### **Reframing**

Also called *positive connotation*, this involves a shift in meaning of the problem behavior from

negative to positive. For example, feeling depressed might be reinterpreted as exquisite sensitivity to one's internal feelings and a willingness to make sacrifices for the good of others. Anxiety might be reframed as a strong sense of caring about the outcome of a task. A related technique is *relabeling*, in which the label of a problem behavior is changed without changing its meaning. Negative connotation can also occur, in which a positive behavior is relabeled as negative, but that rarely occurs because there is little point.

##### **Symptom Prescription**

This strategy involves urging the client to perform or even exaggerate the very behavior that is the problem in the first place. As a compliance-based intervention, it derives its power from the new control the client has over a behavior that was formerly seen as uncontrollable. A variant is *symptom scheduling*, in which the client is directed to (for example) feel deliberately anxious or fight with his or her spouse at a particular time. By implication, if the behavior can be controlled in one direction, it can be controlled in the other. This technique is very similar to Frankl's *paradoxical intention*.

#### **Defiance-Based Interventions**

These interventions are used with the expectation the client will defy the counselor's suggestion or directive and thereby improve. They are similar to Adler's original conceptualization. In the original compliance-defiance model, clients who scored high on psychological reactance were expected to do best with these strategies because they would resist the therapist in order to maintain their freedom.

##### **Symptom Prescription**

Although listed as a compliance-based intervention, this can also be conceptualized as a defiance-based intervention. With reactant clients, it derives its power from the fact that client resistance to the counselor's suggestion or directive to perform the problem behavior deliberately reduces the frequency of that behavior. By implication, the behavior is under more conscious control than the client originally thought. Reactant clients tend to resist *symptom scheduling* as well, often finding it more onerous than simply giving up the problem behavior.



### Restraining Strategies

In using this technique, the counselor either tells the client not to change the problem behavior (*prohibiting change*) or to change very slowly and carefully (*inhibiting change*). With this directive, reactant clients can resist the counselor only by changing, which is the point of therapy in the first place. It also empowers clients by placing the locus of change squarely upon them. The most common use of restraining strategies has been in sex therapy, where impotent couples are told not to attempt to engage in sexual activity for a period of time. With the pressure to perform thus removed, spontaneous sexual activity often occurs, much to their surprise.

### Positioning

Here the counselor deliberately exaggerates clients' negative views of themselves; useful when the counselor suspects these negative statements are designed to elicit positive comments from others in a "fishing for compliments" exercise. Adlerian therapists refer to this as "spitting in the client's soup." This technique should be used judiciously to avoid sounding sarcastic or uncaring. It should not be used with clients who have a truly negative view of themselves.

## Effectiveness of Paradoxical Interventions

The research evidence has shown that paradoxical interventions are effective, although not more so than alternative treatments. It does appear, however, that their effectiveness increases more over time than that of other treatments. Two possible reasons have been suggested for this "sleeper effect." First, paradoxical interventions, by their very nature, may require a period of incubation as clients reorganize their cognitive meaning system. Second, they may result in clients' attributing behavior change to themselves rather than to the counselor, thus leading to a sense of personal empowerment.

Some concerns have been raised about the acceptability of paradoxical interventions, or even if they are ethical. Although the evidence is sparse and somewhat mixed, it does suggest that counselors who use paradoxical interventions may be viewed less positively and seen as more manipulative. In addition, there is evidence that paradoxical interventions are seen as less acceptable. An explanation of the

rationale behind these interventions may help the client be more accepting of these interventions. Of course, that removes some of the mystery that some writers believe is an important part of the counseling and psychotherapy process.

E. Thomas Dowd

*See also* Adlerian Therapy (v2); Code of Ethics and Standards of Practice (v2); Counseling Process/Outcome (v2); Ethical Codes (v1); Harmful Psychological Treatments (v2); Meaning, Creation of (v2); Reframing (v2); Therapist Techniques/Behaviors (v2); Treatment Compliance (v1)

### Further Readings

- Ascher, L. M. (1989). *Therapeutic paradox*. New York: Guilford Press.
- Dowd, E. T., & Trutt, S. D. (1988). Paradoxical interventions in behavior modification. In M. Hersen, R. M. Eisler, & P. M. Miller (Eds.), *Progress in behavior modification* (Vol. 23). Newbury Park, CA: Sage.
- Weeks, G. R. (1991). *Promoting change through paradoxical therapy* (Rev. ed.). New York: Brunner/Mazel.

## PERCEIVED COMPETENCE

*See* SELF-EFFICACY/PERCEIVED COMPETENCE

## PERSONALITY ASSESSMENT

Personality assessment, in its broadest sense, includes any technique that is used to describe or make inferences about the characteristic traits, attitudes, beliefs, values, needs, motives, emotional states, coping styles, or aspirations of an individual. Personality assessment can take many forms, including an Internet dating questionnaire, an epitaph, a letter of recommendation, a psychodiagnosis, an integrity test administered as part of an employment application, and a psychobiography based on a historical record.

For the present purposes, however, three major functions of personality assessment will be considered: assessment in the service of basic research and theory explication; assessment in applied psychology,



including therapeutic, organizational, and forensic settings; and assessment in self-exploration. These different functions of personality assessment determine the personality characteristics to be measured and the instrument or method to be used.

### What to Measure: The Content of Personality

Personality characteristics constitute a fuzzy set, populated by constructs as diverse as extraversion, physical attractiveness, creativity, sexual orientation, gender, and psychopathology. Yet there is some consensus, for at its core, personality is now generally conceptualized at three strata or levels of analysis. In parallel with these three levels of analysis, three goals of personality assessment can be described. The most ambitious of these is *understanding*, followed by *explanation*, then *description and prediction*.

#### **Narrative Accounts**

The deepest of the three strata is the life story, a set of meanings that unfolds over time and which can be linked into a narrative account. The outstanding characteristic of the life story is its individuality. Assessment at this level is aimed at an abstract *understanding* of the person, and typically occurs in specialized contexts such as case studies, biographies, and epitaphs. The narrative account can serve as an implicit criterion against which respondents evaluate the validity of more shallow and more quantitative assessments of personality.

#### **Characteristic Adaptations**

Characteristic adaptations represent a heterogeneous middle level of analysis. These include motives and related mechanisms such as coping and defensive styles, and cognitive factors such as schemas, plans, generalized expectancies, and beliefs. Characteristic adaptations also include developmental constructs such as stage of personality development. A prominent measure at this level is the Washington University Sentence Completion Test, a measure of ego development. Given the heterogeneity of this level, assessment of characteristic adaptations serves many functions. For heuristic purposes, however, the primary reason for assessing characteristic adaptations is to achieve an *explanation* of why behavior does or does not occur.

#### **Traits**

The most accessible and easily quantified level of personality is that of the trait or disposition. The primary objective when assessing personality traits or dispositions is the *description and prediction* of behavior.

#### **The Meaning of Traits**

Traits, the primary unit of personality description, are relatively enduring ways in which individuals differ. Assessment at the level of traits is variable centered and nomothetic, focusing on differences among individuals, as opposed to the person-centered and idiographic approach that focuses on individuals, and that typically characterizes assessment at deeper and more abstract levels of personality.

Because people differ in many ways, psychologists must decide which differences are worthy of study. While evolutionary, psychoanalytic, and behavioral perspectives have been influential in suggesting traits that are worthy of attention when assessing personality, a more pragmatic, data-driven approach has generally held sway. At the most basic level, trait attributions are made based upon simple summaries of past behavior, and because what has happened in the past is likely to recur, traits can serve as valid predictors of future behaviors. Beyond this summary approach, if one takes into account characteristics of the situation as well, traits can help explain behavior and contribute to an understanding of the person. For example, an observation that “Jane has panic attacks in crowds” might lead to an inference of the form that “Jane will not go to the party because she is agoraphobic.” Trait attributions can and frequently do go beyond the trivial and tautological.

#### **The Five-Factor Model**

Factor analytic results indicate that many of the 18,000 words used to describe personality in the English language represent variations of five basic traits. The five-factor model (FFM) and its variants provide the most important contemporary perspective on traits, effectively serving as a paradigm for contemporary research in personality assessment. The five factors, sometimes referred to as the Big Five, are generally conceived of as extraversion, neuroticism, conscientiousness, agreeableness, and openness to experience.



*Extraversion.* The breadth of the five factors can leave them open to multiple interpretations, and this is particularly true for extraversion. For Jung, extraversion and introversion describe an individual's preferred direction of attention or focus: Extraverts focus on the external, shared world, while introverts focus on internal, idiosyncratic experiences. Eysenck offered a physiological explanation of extraversion (which he labels *extroversion*) based on the level of arousal of the reticular activating system. Eysenck viewed extraverts as endogenously understimulated (and so desirous of external stimulation and excitement), and introverts as overstimulated and consequently likely to seek quieter settings. An affective conception is that extraverts are more likely than introverts to experience and report positive affect. From a behavioral perspective, the most visible component of extraversion is social motivation and social skill. The combination of social interest and positive affect has given rise to the interpretation of extraversion as *surgency* or lively sociability.

Given the breadth of the extraversion-introversion dimension of personality, it is difficult to imagine conditions under which the dimension would not be relevant in understanding individual differences in the motivations, behaviors, and satisfactions experienced by individuals. Extraversion is measured in most comprehensive personality inventories used by psychologists.

*Neuroticism.* Neuroticism represents a tendency to experience negative affect, anxiety, and emotional upset; its opposite may be understood as well-being, emotional stability, or adjustment. Neuroticism is associated with sensitivity to punishment rather than reward, and with behavioral inhibition rather than activation. The Americans with Disabilities Act may proscribe the explicit measurement of neuroticism in applied settings (i.e., selection) because psychological health is conceptualized as a component of physical health.

*Conscientiousness.* Conscientiousness is a broad factor that includes discipline, a respectful attitude towards rules, work ethic, behavioral constraint, organization, responsibility, socialization, and impulse control. Conscientiousness is the Big Five trait most closely linked with job performance, and it is associated with scores on the integrity tests that are widely used in personnel selection. The relationship between conscientiousness and social conformity has led to some confusion, for the term *conscientiousness* also

denotes a stage in personality development characterized by the transcendence of mindless conformity and the internalization of a moral code.

*Agreeableness.* Agreeableness includes attributes such as likability, friendly compliance, warmth, and conformity, as well as communion, the positive core of the feminine gender role. Agreeableness is the most evaluative laden of the five factors. Because agreeableness is related to likability, observer ratings of agreeableness are more subjective and may show less interrater consensus than observer ratings of other traits.

*Openness.* The core of Openness to Experience includes breadth of interests, curiosity, and cultural sophistication. For some authors, this factor includes characteristics as diverse as flexibility, intelligence, political liberalism, and hypnotic susceptibility. There is both less cross-cultural generalizability and less agreement on the specific content for this factor. Openness generally appears as the smallest of the factors in statistical analyses. Nonetheless, both the core of openness and its more peripheral, less consensual components are empirically important in many settings.

### Beyond the Five Factors

The five-factor model is one useful starting point for personality assessment, but additional personality characteristics have been identified that may be conceptualized as lying between, beyond, and beneath the five factors. The five factors may be thought of as geometric axes between which other sets of axes may constitute a richer or more theoretically sound framework. For example, Extraversion and Neuroticism may be rotated to the arguably more elemental concepts of Anxiety and Impulsivity. Similarly, beyond the five factors, additional traits appear to be poorly represented in the five factor space, including spirituality, attractiveness, insight, ambition, unpleasantness, manipulativeness, egotism, seductiveness, integrity, thriftiness, risk taking, and humor. Beneath the five factors lie narrower constructs that may have more predictive utility. Punctuality, in some circumstances, may be more informative than the broader trait of Conscientiousness by which it is imperfectly subsumed.

The five-factor model derives ultimately from lay usage; the factor analytic methods that underpin the model provide, in principle, a nonredundant and potentially comprehensive set of tools for describing



the universe of personality trait terms. However, lay usage is not the only useful source from which to derive personality characteristics, and statistical elegance is not the only meaningful criterion governing the selection of a variables. For these reasons, many psychologists continue to prefer other sets of constructs, including those based on the theoretical positions outlined by Jung, Murray, Eysenck, and Gough. These positions are considered in the next section.

### **How to Measure: The Tools of Assessment**

The most widely used methods of assessing personality include self-report measures and observer rating scales. Self-report measures, in turn, include multitrait personality inventories, single-trait personality scales, and projective techniques.

#### ***Personality Inventories***

Personality inventories are questionnaires that provide scores on a number of traits or characteristics. These measures typically take 30 to 75 minutes to complete and are intended for administration to adults. Most inventories consist primarily of statements (e.g., “I would be uncomfortable in a foreign city”) or adjectives (e.g., “friendly”). Respondents are instructed to answer using a dichotomous format (e.g., true/false) or a 3-to-7-point (e.g., *agree strongly, agree, neither agree nor disagree, disagree, or disagree strongly*) format.

#### **The NEO Personality Inventory, Revised**

The NEO Personality Inventory, Revised (NEO PI-R) is the best-known and most empirically supported measure of the five factors. The NEO PI-R can be administered in a third-person form for generating observer ratings as well as the more familiar first-person form. In addition to measures of the five factors, the NEO PI-R also provides measures of 30 lower-level facet scales, such as Gregariousness (a facet of Extraversion), Trust (Agreeableness), and Aesthetics (Openness). A short form of the instrument, the NEO Five-Factor Inventory (NEO-FFI), provides scores only at the level of the five broad domains. In addition, a second abbreviated test, the NEO-4, is available for applications in which the measurement of Neuroticism is inappropriate. The NEO PI-R is an expansion of two earlier tests, the NEO (which did not

include measures of Agreeableness or Conscientiousness), and the NEO PI (which included facet scales for only the first three domains).

The NEO PI-R has been translated into some 25 languages, and it has been used extensively in studies ranging from descriptions of American presidents to cross-sectional studies of personality development. With respect to the latter, the five factors generally appear quite stable throughout adulthood. In vocational assessment, several studies indicate that the NEO PI-R complements, but does not replace, measures of vocational interest. Scores on the NEO PI-R Neuroticism scale have been shown to decrease during therapy, while Conscientiousness scores have increased during the course of a drug rehabilitation program. NEO PI-R domain scores also appear to be related to the psychologist’s assessments of treatment appropriateness and efficacy. Clients who score high on Openness are rated as benefiting from client-centered techniques, while those who score high on Neuroticism have been found to benefit from journaling and vocational techniques.

Unlike many other personality inventories, the NEO PI-R does not include indices of faking or invalidity beyond a few questions at the end of the test that directly ask if the respondent has answered honestly, accurately, and in the correct order. The rationale behind excluding validity scales includes empirical evidence that when protocols that are identified as “invalid” are excluded, test validity may be reduced rather than increased, suggesting that “invalid” protocols do, in fact, contain information. Individuals differ in the probability that they will respond in a less than honest fashion, and these individual differences may be meaningful.

#### **Other Measures of the Five Factors**

The five factors can be measured in a number of ways in addition to the NEO PI-R. Explicit measures of the five factors include the Hogan Personality Inventory (HPI), which is widely used in organizational settings, and two measures based on simple adjectives, the Goldberg Big Five Markers and the Interpersonal Adjective Scales-Revised. Additional measures of some or all of the characteristics are available that are not directly derived from the five-factor model. For example, Conscientiousness can be measured by the Rule-consciousness and Perfectionism scales of the Sixteen Personality Factor Questionnaire (16 PF),



the Organization and Responsibility scales of the Jackson Personality Inventory (JPI), the Control and Harm-avoidance scales of the Multidimensional Personality Questionnaire (MPQ), and scales including Responsibility and Achievement via Conformance on the California Psychological Inventory (CPI). However, the different measures of the five factors should not be considered interchangeable. For example, the externalizing dimension of the CPI—a form of Extraversion—is largely a measure of social skills rather than social interest. High scores on Agreeableness on the NEO appear to reflect more obsequiousness and less charm than high agreeableness scores on the HPI.

### **The Sixteen Personality Factor Questionnaire**

As with the measures of the five-factor model, the Sixteen Personality Factor Questionnaire (16 PF) was derived from factor analyses of traits selected from analyses of words appearing in the English language that describe personality. This measure, originally developed by Raymond B. Cattell in 1949 and presently in its fifth edition, now labels its measures using familiar terms (e.g., Warmth and Social Boldness) rather than the neologisms (e.g., Schizothymia and Threctia) that were used in earlier editions. The measure incorporates a multilevel approach to assessment; scores are provided on both medium-bandwidth primary dimensions and the five global factors of Extraversion, Anxiety, Tough Mindedness, Independence, and Self-Control. The 16 PF continues to include items that measure reasoning skills or intelligence as well as core characteristics of personality. This confounding of distinct constructs such as cognitive ability and personality in the scores obtained from the 16 PF is regarded as an undesirable feature by some psychologists.

### **The Eysenck Inventories and Related Measures**

A number of measures are based on models of personality that derive from a concern for both psychometric and biological parsimony. The most prominent of these is the family of measures derived by Hans Eysenck. The Eysenck Personality Questionnaire Revised (EPQR) is a 100-item instrument that measures the three broad factors of Extraversion, Neuroticism, and Psychoticism. The label for the last of these is at best

idiosyncratic, as high scorers on the measure are much more likely to be impulsive than to suffer from serious psychopathology. In addition to the three main factors, the EPQR includes a Lie scale that measures conformity, the desire to create a favorable impression, and the potentially invalidating tendency to “fake good.” A 48-item short form, the EPQRS, is also available.

The Zuckerman-Kuhlman Personality Questionnaire (ZKPQ) is similar in length to the EPQ-R, and measures five alternative factors: Impulsive Sensation Seeking, Neuroticism-Anxiety, Aggression-Hostility, Activity, and Sociability. It also includes a validity scale titled Infrequency. Impulsive Sensation Seeking has been found to be associated with a variety of risk-taking behaviors.

Cloninger's Temperament and Character Inventory (TCI) includes 240 items measuring four biologically based parameters (i.e., Novelty Seeking, Harm Avoidance, Reward Dependence, and Persistence) and three dimensions of character (i.e., Self-Directedness, Cooperativeness, and Self-Transcendence). The TCI is used primarily in psychiatry and medicine.

### **The California Psychological Inventory**

The California Psychological Inventory (CPI) is presently available in a 434-item version and an abbreviated 260-item form. Twenty-nine scales are included on both of these forms; all but two of the corresponding scales correlate .89 or higher.

The core constructs measured by the CPI are “folk concepts” whose relevance is demonstrated by their use in a variety of societies or cultures. Measures of these scales, alone and also in combination, are designed to predict how others will see the respondent and how the respondent will behave in consequential situations. Folk concept scales include measures of interpersonal orientation or social tendencies (such as Dominance and Sociability) and orientation toward rules and norms (such as Responsibility and Self-Control). These themes are also assessed in two broader “vector” scales, which conjointly form a fourfold typology. Alphas are extraverted, Betas are introverted, and both resonate to rules. Gammas and Deltas, extraverts and introverts, respectively, are skeptical of rules and resistant of the status quo. A third vector assesses degree of realization (i.e., the extent to which the potential embodied in a type is met).

Taken together, the vector scales form a structural model based on the premise that each of the four types



may contribute constructively to society, or struggle uniquely. Alphas may be benevolent leaders at high levels of realization, but at lower levels of realization they may appear tyrannical and authoritarian. Betas may appear to be saintly at higher levels of realization or constricted conformists at lower levels. At higher and lower levels, respectively, Gammas may be voices for progressive change or histrionic whiners, and Deltas may be visionary or suffer internal conflicts that lead to psychosis.

The typology is empirically useful in predicting meaningful life events. For example, among high school students, the typology is related to the likelihood of attending college. The rate of college matriculation is greatest for Alphas and lowest for Deltas. Similarly, there is a disproportionate representation of Alphas and Gammas among students enrolled in graduate programs in counseling psychology. While these findings are informative, the limitations of typologies discussed below in the section on measures based on Jung's model must be kept in mind.

In addition to the two central themes and the typology, the CPI also includes folk scales that assess academic and cognitive functioning (e.g., Achievement via Conformance and Achievement via Independence) and personal style (e.g., Flexibility and Psychological Mindedness or Insightfulness). The CPI also provides a number of scales that assess constructs such as Law Enforcement Orientation (LEO), Work Orientation, Managerial Potential, Leadership, and Creative Temperament. Many of these scales were empirically developed, using criterion groups or correlations with behavioral criteria.

The length of the CPI, even of the shorter version, may appear to be daunting, but the potential for tedium is moderated by the true/false response format and the use of engaging item content. For example, the Communitary scale, which exists in part to assess random or improbable responding, includes items that are intended to be ego-syntonic (e.g., "I would fight if someone tried to take my rights away" and "Education is more important than most people think"). The CPI is useful as a clinical tool for revealing the strengths of a client, as well as for predicting performance in a range of settings, from health care to corrections, and from academic to organizational.

### Measures Based on Murray's Model

Probably the most fertile theoretical basis for personality tests is Henry Murray's theory of needs.

Douglas N. Jackson's Personality Research Form (PRF Form E), the most prominent self-report needs assessment inventory, includes 352 items that assess 20 needs (e.g., Achievement, Affiliation, and Play). A substantial body of research attests to its validity for a variety of functions, including personnel selection and the assessment of leadership style. A second measure of needs, now largely of historical interest, is the Edwards Personal Preference Schedule (EPPS). The EPPS was unusual in its attempt to control for socially desirable or acquiescent test-taking styles by relying on a forced-choice response format. Ultimately, the elimination of variance attributable to response style reduced the validity of the instrument and it has fallen into relative disuse. Finally, the Adjective Check List consists of 300 adjectives that the respondent checks or leaves blank. Responses are scored to yield measures of 15 needs (e.g., Dominance, Exhibition, and Aggression).

### Measures Based on Jung's Model

Based on Carl Jung's theory of psychological types, the Myers-Briggs Type Indicator (MBTI) is among the most widely administered measures of personality. All three forms of the MBTI currently in use (the 126-item Form G, the 93-item Form M, and the 144-item Form Q) provide measures of Extraversion-Introversion (E-I), Sensing-Intuition (S-N), Thinking-Feeling (T-F), and Judging-Perceiving (J-P). These four dimensions are each treated dichotomously in interpreting the MBTI, and are combined to yield 16 types. This accounts in large part for the popularity of the measure. For example, describing a person as an ENFP—an Extraverted, iNtuitive, Feeling, Perceiving type—provides a potentially parsimonious and cognitively economical description, and also offers the person an identity-buttressing membership into an imagined community of like-minded people.

Typologies are compelling, and it is likely that the changes that have been seen in other tests, notably the structural model grafted on to the CPI, have occurred in part because of the success and popularity of the MBTI. Unfortunately, there are costs associated with the reduction of scores to simple dichotomies. In particular, the reduction of important dimensions of personality to dichotomies oversimplifies the rich diversity of personality that exists among individuals. Furthermore, most individuals will score near the mean on at least one of the four dimensions of the test. As a consequence, the type classification of most individuals is likely to change if the individuals are tested



at another time. These shortcomings seriously reduce the value—but not necessarily the popularity—of this approach to assessment.

The newest form in the MBTI family, form Q, provides measures of narrow facets (subscales) as well as a typological classification based on the four broad dichotomies. For Extraversion-Introversion, the core facet is Initiating-Receiving; for Judging-Perceiving, the core facet is Systematic-Casual.

While research indicates that the narrow facets provide additional information over and above what is provided by the broader measures, there is, as yet, little evidence regarding their specific content. The heart of the MBTI remains its typology, the popularity of which has led to a number of competing, and superficially similar, measures of Jungian type. These include the Grey-Wheelwright Jungian Type Survey, the Singer-Loomis Type Development Inventory, the Keirsey Temperament Sorter, and the Personal Preferences Self-Description Questionnaire.

#### **Measures Intended for the Measurement of Psychopathology**

The 338-item revised Minnesota Multiphasic Personality Inventory (MMPI-RF), scheduled for publication in late 2007, includes a set of Restructured Clinical (RC) scales that have been developed rationally on the basis of psychometric structure. The RC scales are shorter than the original clinical scales. More important, they are intended to separate the ubiquitous factor of generalized anxiety or “demoralization” from other, narrower concerns assessed in the instrument such as somaticization (i.e., a form of mental illness in which an individual manifests a psychiatric condition in the form of a physical complaint). This offers the potential for the RC scales to be less redundant and more informative than the original scales.

Another important feature of the MMPI-RF is its multilevel approach to the assessment of dysfunction. At the broadest level, three measures are included: Emotional/Internalizing (assessing emotional and mood disorders), Thought (assessing irrational cognitive processes), and Behavioral/Externalizing (assessing problems associated with under socialization or acting out). Beneath this, Somatic scales and Interest scales assess narrower problems such as Head Pain Complaints and Aesthetic-Literary interests, respectively. In addition, the MMPI-RF includes measures of dimensions of personality disorder, including Aggressiveness and Introversion. Empirical research is

needed to determine whether the Restructured Clinical scales offer an improvement over the prior measure.

#### **Single-Trait Personality Scales**

In addition to the comprehensive inventories considered above, personality assessment via self-report frequently is based on responses to personality scales that assess single traits. Examples include the Beck Depression Inventory, the Locus of Control scale (and related narrower measures, such as the Health Locus of Control scale), and instruments that assess psychache (i.e., unbearable psychological pain associated with suicidality), alexithymia (i.e., the inability to describe emotions), adult attachment, body image, attitudes toward eating, and various social, cultural, and political attitudes.

#### **Projective Measures: Sentence Completion Tests**

Projective techniques may be seen as a combination of behavioral assessment (what a person does), self-report (what a person says), and the judgment of an observer. This entry mentions only sentence completion forms, a type of projective test that appears particularly important in personality assessment. Sentence completion forms are semistructured measures in which respondents are asked to complete stems such as “My mother . . .” The best validated of these is Loevinger’s Washington University Sentence Completion Test, a measure of social and cognitive maturity that has been widely used in studies of personality development, particularly in the college years. A second sentence completion measure is the Rotter Incomplete Sentences Blank, which assesses emotional adjustment.

#### **Measures for Observer Ratings**

Psychologists often systematize their view of a client to clarify impressions of the client, to allow comparison between the client and real or prototypical others, and to assess progress during therapy. Numerous instruments are available for quantifying observer impressions of personality, including several of the measures considered above (e.g., the NEO PI-R). A number of rating scales are also used for this purpose. For example, the Structured Interview for the Five-Factor Model of personality (SIFFM) is a 120-item semistructured interview that provides measures of maladaptive and adaptive aspects of the five



factors. The SIFFM is particularly targeted at the measurement of personality disorders and related pathology.

The Q-sort is one noteworthy approach to the use of rating scales. A Q-sort consists of a set of ratings in which comparisons are made *ipsatively*, or between characteristics (e.g., Fred is more aggressive than he is ambitious). This contrasts with the more typical practice of making *normative* comparisons, which are comparisons between people (e.g., Fred is more aggressive than Erik).

Several personality measures use the Q-sort methodology. The California Q-set includes 100 items derived from clinical use. Raters are asked to assign items to 7 to 9 categories. Items assess numerous aspects of personality and defensive style (e.g., “Appears to have a high degree of intellectual capacity,” “Is uncomfortable with uncertainty and complexity,” and “Anxiety and stress find outlet in bodily symptoms”). Versions for describing both adults and children are available. A longer Q-set, the Shedler-Westen Assessment Procedure (SWAP-200), has been advanced as well. Q-sets are time consuming to complete because they require a series of paired comparisons between items in order to place ratings into a prescribed distribution. The impressive empirical results that have been found with Q-sets suggest that this time may be well spent.

### Current and Future Directions

Personality assessment is in a period of creative ferment, characterized by the creation of new measures and the revisions of existing ones, driven by advances in technology, and abetted by a culture that views testing, assessment, and accountability largely as instruments for the common good. Yet the contemporary success of personality assessment brings with it risks. For example, the explosion of the Internet has brought online personality measures of unknown validity into millions of homes. In some cases, these unscreened, unvalidated, and widely used measures may bring insight to those seeking self-exploration, but in many cases this will not be true. Unfortunately, public skepticism about the validity of personality tests, once attributable to the claims of astrologers, palmists, and phrenologists, is today encouraged by the widespread availability of amateurish personality inventories.

In formal assessment, no one instrument will be ideal for every application. The function of testing, the interests of the client and counselor, and the contexts of culture and community should guide the

selection, and, where needed, the development of measures. People are different, and the tools of personality assessment, properly used, will continue to assist counselors in understanding, capturing, and furthering human individuality.

Kevin Lanning

**See also** Affect (Mood States), Assessment of (v2); Behavioral Observation Methods, Assessment (v1); Behavior Rating Scales (v1); Cognition/Intelligence, Assessment of (v2); Computer-Assisted Testing (v2); Costa, Paul T., and McCrae, Robert R. (v2); *Diagnostic and Statistical Manual of Mental Disorders (DSM)* (v2); Goldberg, Lewis R. (v2); Jung, Carl (v2); Meehl, Paul E. (v2); Personality Theories (v2); Personality Theories, Five-Factor Model (v2); Personality Theories, Traits (v2); Projective Techniques (v2); Psychometric Properties (v2); Psychopathology, Assessment of (v2); Test Interpretation (v2)

### Further Readings

- Caldwell, A. B. (2006). Maximal measurement or meaningful measurement: The interpretive challenges of the MMPI-2 Restructured Clinical (RC) Scales. *Journal of Personality Assessment*, 87, 193–201.
- Costa, P. T., Jr., & McCrae, R. R. (1992). *NEO PI-R: Professional manual*. Odessa, FL: Psychological Assessment Resources.
- Costa, P. T., Jr., & Widiger, T. A. (Eds.). (2002). *Personality disorders and the five-factor model of personality* (2nd ed., pp. 351–375). Washington, DC: American Psychological Association.
- Gough, H. G., with Bradley, P. (1996). *CPI manual* (3rd ed.). Palo Alto, CA: Consulting Psychologists Press.
- Piedmont, R. L., & Ciarrocchi, J. W. (1999). The utility of the Revised NEO Personality Inventory in an outpatient, drug rehabilitation context. *Psychology of Addictive Behaviors*, 13, 213–226.
- Quenk, N. L., Hammer, A. L., & Majors, M. S. (2001). *MBTI Step II manual: Exploring the next level of type with the Myers Briggs Type Indicator Form Q*. Palo Alto, CA: Consulting Psychologists Press.
- Roberts, B. W., Chernyshenko, O. S., Stark, S., & Goldberg, L. R. (2005). The structure of conscientiousness: An empirical investigation based on seven major personality questionnaires. *Personnel Psychology*, 58, 103–139.
- Watkins, C. E., Jr., & Campbell, V. L. (Eds.). *Testing and assessment in counseling practice* (2nd ed., pp. 45–71). Mahwah, NJ: Lawrence Erlbaum.
- Widiger, T. A., & Trull, T. J. (2007). Plate tectonics in the classification of personality disorder: shifting to a dimensional model. *American Psychologist*, 62, 71–83.



Wood, J. M., Garb, H. N., Lilienfeld, S. O., & Nezworski, M. T. (2002). Clinical assessment. *Annual Review of Psychology*, 53, 519–543.

---

## PERSONALITY DISORDERS

---

Personality disorders (PDs) pose a major challenge to the modern profession of mental health care. Unlike depression, anxiety, and other disorders that are more commonly the focus of treatment, personality disorders are generally understood to be pervasive, inflexible, maladaptive, and enduring expressions of personality. People with PDs exact a heavy cost from themselves and society, as well as place considerable pressure on the mental health care system. The American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR)* is currently the most widely used diagnostic system to diagnose personality disorders, particularly in the United States. The International Classification of Diseases (ICD-10), maintained by the World Health Organization, is another important diagnostic system.

The *DSM-IV-TR* distinguishes among 10 PDs that are conceptually organized into three clusters, designated Cluster A (odd-eccentric), Cluster B (dramatic-erratic), and Cluster C (anxious-fearful). Cluster A includes paranoid, schizoid, and schizotypal PDs. Cluster B includes antisocial, borderline, histrionic, and narcissistic PDs. Cluster C includes avoidant, dependent, and obsessive-compulsive PDs. In addition, the *DSM* allows for the diagnosis of personality disorder not otherwise specified (PD-NOS), which can be given when a person meets general criteria for a personality disorder and traits of several PDs, but does not meet the criteria for any one specific disorder. This entry reviews what is known about the personality disorders in the *DSM-IV-TR*. The review will focus on the features, etiology, prevalence, comorbidity, course, and treatment of the various PDs.

### Features of *DSM-IV-TR* Personality Disorders

#### *Cluster A (Odd-Eccentric)*

##### **Paranoid Personality Disorder**

According to *DSM-IV-TR*, Paranoid PD (PPD) is characterized by a consistent pattern of distrust of the motives of other people. People with this disorder

assume that people will intentionally exploit, harm, or deceive them, and they often feel deeply injured by another person. They are frequently reluctant to become close to others out of fear that any personal information they reveal about themselves will later be used to hurt them. Individuals with this disorder can be severely sensitive to criticism and therefore are likely to feel attacked, threatened, or criticized by others. They might read hidden meanings or malevolent intentions into innocent remarks, mistakes, or compliments. It is also very difficult for a person with PPD to forgive others for perceived insults or injuries. Prolonged hostility, aggression, reactions of anger to perceived insults, and jealousy without adequate justification are also common.

##### **Schizoid Personality Disorder**

*DSM-IV-TR* notes that those with schizoid PD (SPD) are characteristically detached from and uninterested in social relationships. People with SPD may choose careers or hobbies that allow them to avoid contact with other people, and they typically are uninterested in developing intimate or sexual relationships. In addition, those with SPD have a flatness of affect that leads others to experience them as cold and aloof. Not only do they derive little pleasure from sensory or interpersonal experiences, they are also usually unmoved by the disapproval of others. They might claim that they do not experience strong emotions, whether positive or negative. Further, people with SPD may fail to respond to social cues, such as a smile, leading others to perceive them as self-absorbed, socially inept, or conceited.

##### **Schizotypal Personality Disorder**

According to *DSM-IV-TR*, schizotypal PD (STPD) is characterized by a pattern of marked interpersonal deficits, discomfort with close relationships, behavioral eccentricities, and distortions in perception and thinking. The *DSM* notes that individuals with STPD will often seek treatment for anxiety, depression, or other emotional problems. Although persons with this disorder may experience transient psychotic episodes, they must be distinguished from those with Axis I psychotic disorders that feature more persistent delusions and hallucinations. Ideas of reference are a common feature of STPD, as are odd beliefs such as magical thinking, extreme superstition, or a preoccupation with paranormal phenomena. In addition, people with STPD might have perceptual distortions such as bodily illusions or sensory alterations, and many



have odd thought and speech patterns. For example, their speech might be excessively vague, abstract, or loose, yet still maintain basic coherence. They often appear uncomfortable and act peculiar in social situations, and their affective expression is frequently constricted or inappropriate.

### **Cluster B (Dramatic-Eratic)**

#### **Antisocial Personality Disorder**

As defined by *DSM-IV-TR*, antisocial PD (ASPD) is a pervasive pattern of irresponsible behavior and disregard for the rights of others that begins by childhood or early adolescence. People with this disorder repeatedly engage in unlawful and/or reckless behavior. Frequently victimizing others and blaming their victims for their own fate, they typically lack remorse for having hurt or mistreated another person. Those with ASPD are prone to impulsiveness, irritability, and aggressiveness, which often leads to physical fights or assault, and they have a reckless disregard for the safety of themselves or others. In addition, they might repeatedly fail to honor work or financial obligations, or display other evidence of consistent and extreme irresponsibility. Manipulativeness, deceitfulness, and dishonesty are also central features of this disorder, often making collateral sources of information necessary for accurate diagnosis. In order to be diagnosed with ASPD, the *DSM* system requires that an individual be at least 18 years old and must have met at least some criteria for Conduct Disorder prior to age 15.

#### **Borderline Personality Disorder**

According to the *DSM-IV-TR*, individuals with borderline personality disorder (BPD) show a pattern of instability in various psychological and interpersonal domains. Their concept of self and feelings about self are markedly unstable, although thoughts about the self generally have a negative quality. Consonant with this characteristic, their beliefs, goals for the future, and social and sexual preferences may change often. These individuals' views of others also show extreme volatility; they frequently begin relationships by idealizing the other and assuming a closer relationship than normal. When the other pulls away or otherwise disappoints, the borderline individual can suddenly switch to demonizing him or her.

Individuals with BPD frequently show labile emotions, changing from relative calm to intense anger or dysphoria in response to very subtle cues from others, which tends to further exacerbate interpersonal problems. In addition, they frequently report chronic feelings of emptiness, diffuse anxiety, and irritability.

Behaviorally, those with BPD are frequently suicidal and prone to self-injury. While the rate of completed suicide is high in this population—around 10%—these behaviors frequently serve to regulate their chaotic emotions, communicate their feelings to others, and keep others from leaving them. Other behavioral symptoms of BPD include angry, hostile outbursts and impulsivity (e.g., reckless behavior, binge eating, or substance use), and transient psychotic symptoms.

#### **Histrionic Personality Disorder**

The *DSM-IV-TR* notes that the emotional expression of individuals with histrionic PD (HPD) is often excessive, theatrical, shallow, and rapidly shifting. Public displays of emotion or temper tantrums are common, yet they begin and end too quickly to be perceived as genuine in feeling. In addition, the speech of a person with HPD may be overly impressionistic in style, yet lacking in detail. For instance, strong opinions might be dramatically expressed without giving adequate reasons to support them.

#### **Narcissistic Personality Disorder**

According to *DSM-IV-TR*, the central features of narcissistic personality disorder (NPD) are pervasive grandiosity, a constant need for admiration, and a lack of empathy for others. An individual with NPD has a sense of self-importance and an attitude of arrogance that might manifest in boastfulness, pretentiousness, or disdain. An overestimation of one's own abilities and a devaluation of others are characteristic of this disorder. Also common is a preoccupation with fantasies about one's own brilliance, beauty, or expected success.

A person with NPD usually requires constant attention and admiration, and may become furious with others who do not shower them with compliments or accolades. They typically have fragile self-esteem, so their self-importance might alternate with feelings of unworthiness. They frequently either experience feelings of envy of other people, or imagine that others are envious of them. The sense of entitlement that is central to NPD often precludes the recognition of



others' abilities, needs, feelings, or concerns. Individuals with this disorder might discuss their own problems or concerns in lengthy detail, yet react with insensitivity or impatience to the problems of others. To others, these individuals appear cold, disinterested, disdainful, snobbish, or patronizing.

### **Cluster C (Anxious-Fearful)**

#### **Avoidant Personality Disorder**

According to *DSM-IV-TR*, persons with avoidant personality disorder (AVPD) are characterized by pervasive social inhibition and discomfort in social situations, feelings of inadequacy and low self-esteem, and hypersensitivity to criticism or rejection. Although they long for close relationships, they avoid activities that involve interpersonal contact and have difficulty joining group activities. Persons with this disorder assume that other people will be critical and disapproving. They act with restraint in social situations and have difficulty sharing intimate feelings for fear of criticism, disapproval, shame, or ridicule. They have a strong need for certainty and security that severely restricts their ability to become close to others, and they typically are not able to establish new friendships or intimate relationships without the assurance of uncritical acceptance.

People with AVPD frequently feel socially incompetent, personally unappealing, or inferior to others. Therefore, they are reluctant to engage in new activities and they tend to be shy, inhibited, and quiet to avoid attracting attention to themselves. In addition, they are hypervigilant about subtle cues that suggest criticism or rejection and typically feel extremely hurt when they detect such behavior.

#### **Dependent Personality Disorder**

According to the *DSM-IV-TR*, the central characteristic of dependent personality disorder (DPD) is a pervasive need to be taken care of that begins by early adulthood. People with this disorder have an exaggerated fear that they are incapable of doing things or taking care of themselves on their own, and therefore rely on other people (usually one person) to help them. They rely heavily on advice and reassurance from others in making decisions. Because of their lack of self-confidence, it is difficult for people with DPD to begin tasks on their own without being assured that

someone is supervising them. They may appear to others to be incompetent because they believe that they are inept and they present themselves as such.

*DSM-IV-TR* notes that because of their dependency on others, people with DPD often fail to learn basic independent living skills, and frequently find themselves in abusive or otherwise unbalanced relationships. It is not unusual for people with DPD to feel unrealistically fearful of being abandoned. They are typically passive and unwilling to disagree or become appropriately angry with the person on whom they depend. People with DPD usually feel highly uncomfortable being alone because of an exaggerated fear of helplessness or the inability to care for themselves. The end of an intimate relationship will often be followed by urgent efforts to replace the person with another source of closeness and support.

#### **Obsessive-Compulsive Personality Disorder**

The *DSM-IV-TR* describes obsessive-compulsive personality disorder (OCPD) as a pervasive pattern of perfectionism, orderliness, and inflexibility that begins by early adulthood. People with OCPD have an excessive need for control that interferes with their ability to maintain interpersonal relationships or employment. They are typically preoccupied with rules, lists, schedules, or other minor details, and their rigidity and stubbornness about these trivia often create difficulty for them in both work and personal relationships.

In addition, the *DSM* notes that individuals with OCPD often sacrifice personal relationships in favor of work, and become obsessively devoted to productivity. They hold both themselves and others to unrealistic standards of morality, ethics, or values. They are also reluctant to delegate tasks to others because they insist that everything be done their own way. The *DSM* further notes that individuals with OCPD might be reluctant to throw away worthless and unsentimental objects for fear that they might be needed at a later date. Furthermore, people with this disorder might hoard money and tightly control their spending, believing that money should be saved for a future catastrophe.

### **Etiology**

The empirical data on the etiology of PDs is extremely limited and complicated by the fact that PDs are a heterogeneous group of disorders. Most



theories of PDs acknowledge that they are at least partially genetically determined and that temperamental and behavioral abnormalities during childhood can precede their development. These predispositions are believed to interact with environmental experience to shape personality during the early years of development. Environmental factors are believed to range in severity and influence as a function of biological predispositions and protective factors. Trauma can often be considered a predisposing factor to the development of personality disorders; however, it is not necessary nor sufficient for the development of PDs.

The evidence for a genetic contribution to the development of personality pathology, while plausible and generally accepted, is mixed. A number of studies have focused on the heritability of personality traits that theoretically relate to PDs, such as neuroticism or extraversion. Few studies have examined the heritability of specific PD diagnoses. The heritability of specific PDs has been found to vary, with schizotypal PD most strongly linked to genetic influences, antisocial PD linked to both environmental and genetic factors, and borderline and narcissistic PDs typically showing the smallest estimates of heritability. Given the contradictory findings and limitations of the study designs, it is safe to say that the heritability of certain PDs like borderline and narcissistic, although reasonable to posit, is uncertain at this time, and there is clearer evidence for environmental contributions to the development of these disorders. Joel Paris suggested that the etiology of PDs is unlikely to be underpinned by simple, linear, narrow-causal processes; complex interactive processes among variables are likely to be involved in the etiology of PDs.

### Prevalence and Comorbidity

Prevalence estimates for *DSM-IV* personality disorders vary according to the definition of personality disorder and the type of sample used. For example, Myrna M. Weissman found that pre-*DSM-III* era epidemiologic studies of PDs yielded overall rates between 6% and 10% in the general population, but the *DSM-IV* estimated prevalence rates of 10% to 20%. Similarly, community studies typically have found lower estimates of PD prevalence than does research based on clinical samples. Community studies of the prevalence of *DSM-III* or *DSM-III-R* PDs (almost all of which were conducted in the United

States, Europe, and Australia) reported overall rates between 5.9% and 22.5%.

In contrast, studies using structured diagnostic assessments have found that 20% to 40% of psychiatric outpatients and about 50% of psychiatric inpatients meet criteria for a personality disorder. Even in primary care settings, Patricia R. Casey and Peter Tyrer found that about a third of people attending general practitioners (GPs) have a personality disorder. The vast majority of patients were not presenting for personality difficulties, but presented as problematic medical patients. Cluster C PDs are the most common PDs encountered in primary care settings. The tendency of personality disorders to co-occur with other psychiatric (and physical) diagnoses likely contributes to the discrepancy between community and patient estimates.

The most frequent personality disorders in community samples are dependent, borderline, schizotypal, and obsessive-compulsive PDs, whereas the least common are schizoid and avoidant PDs. In clinical samples, however, individuals with avoidant PD can be found frequently, as can those with most other PDs. Notably, individuals with schizoid PD are not found frequently in samples, probably because of the low prevalence of schizoid PD in the community and the ego-syntonic nature of its symptoms. It is important to note that personality disorders associated with more severe impairment or with disrupted social behavior (for example, schizotypal, paranoid, or antisocial PDs) often prompt inpatient care or intensive treatment in other settings, such as substance abuse treatment facilities.

Comorbidity is high between personality disorders and Axis I disorders as well as among personality disorders themselves, a fact that is generally considered problematic for the validity of the *DSM-IV* personality disorder diagnoses. In Cluster A, up to two-thirds of patients with paranoid PD in clinical samples meet criteria for another PD, most frequently the schizotypal, narcissistic, borderline, or avoidant PD. Paranoid PD co-occurs somewhat less frequently with Axis I disorders than do other PDs. Schizoid PD is consistently comorbid with schizotypal and avoidant PDs. Schizotypal PD is frequently comorbid with eating disorders and psychotic disorders on Axis I, and with borderline, avoidant, paranoid, and schizoid PDs on Axis II. In fact, Maria Grazia Marinangeli and colleagues estimated that schizotypal PD is the most frequently co-occurring PD, as it was significantly comorbid with all PDs except for avoidant and dependent in their study.



Within Cluster B, antisocial PD is frequently comorbid with borderline, narcissistic, histrionic, and schizotypal PDs. On Axis I, research has demonstrated that antisocial PD has a particularly strong association with substance use disorders. Borderline PD co-occurs consistently with antisocial PD; Marinangeli and colleagues found five Axis II disorders to be significantly comorbid with borderline PD. On Axis I, borderline PD frequently occurs alongside mood disorders and panic disorder. Histrionic PD is consistently comorbid with borderline and narcissistic PDs. Some studies have also found histrionic PD to co-occur substantially with antisocial and dependent PDs.

Cluster C disorders also show extensive patterns of comorbidity. Avoidant PD is often comorbid with dependent PD on Axis II, and with mood, anxiety, and eating disorders on Axis I. Dependent PD is substantially comorbid with mood, anxiety, and psychotic disorders on Axis I, and with borderline and avoidant PDs on Axis II. Dependent PD is also frequently comorbid with paranoid PD and obsessive-compulsive PD. The results of studies on the comorbidity of obsessive-compulsive PD (OCPD) with other disorders are inconsistent. The majority of patients with obsessive-compulsive disorder (OCD) do not meet criteria for OCPD. Further, for those with OCD with concurrent PD diagnosis, OCPD occurs no more frequently than any other PD.

### Course and Prognosis

PDs are thought to have an onset in late adolescence or early adulthood and are assumed to persist throughout the life span, although there is a relative paucity of empirical evidence to support these notions. Recent research suggests that personality can change significantly over time, and PDs might not be as temporally stable as once thought. However, research also indicates that different PDs have different levels of stability across the life span.

Generally, research has demonstrated that people with Cluster A disorders do not typically improve significantly over time; however, some treatment gains have been documented for persons with schizotypal PD. There is evidence that many patients with antisocial and borderline PDs recover as they grow older, although they typically continue to experience severe interpersonal dysfunction and other forms of

psychopathology. Narcissistic PD may also remit with age. Research has generally shown, however, that individuals with Cluster C disorders do not tend to recover as they age.

### Treatment Implications

Although patients with PDs are notoriously difficult to treat, a meta-analysis conducted by J. Christopher Perry and his colleagues suggested that psychotherapy is an effective treatment for PDs. Psychotherapy is associated with a rate of recovery that is seven times faster than the recovery rate typically observed when psychotherapy is not received. In general, longer treatments yielded greater effect sizes. Effect sizes in a meta-analysis indicate the overall strength of an effect. For example, an effect size of 0.8 would be considered large. Another recent meta-analysis by Falk Leichsenring and Eric Leibling found that psychodynamic therapy yielded a large overall effect size of 1.46, with effect sizes of 1.08 for self-report measures and 1.79 for observer-rated measures. This contrasted with cognitive-behavioral therapy, in which the corresponding effect sizes were 1.00, 1.20, and 0.87, respectively. However, such studies are difficult to interpret because the studies differ, even within the same therapy group, in terms of therapy content, patient diagnosis, length of treatments, outcome assessments, and other variables.

To date, there have been no controlled or uncontrolled outcome studies for histrionic, dependent, schizotypal, schizoid, narcissistic, passive-aggressive, or paranoid PDs. However, a number of studies have used samples that included a mixture of PDs, usually excluding patients with BPD. Although these studies generally show improvement in treated patients, particularly with the brief psychodynamic treatments, these studies are difficult to interpret in terms of specific PDs because they do not denote specific diagnostic cohorts.

There are a number of controlled studies for avoidant PD. Overall, these studies suggest that improvements can be found with treatments that employ social skills training alone or in combination with exposure and cognitive techniques; however, many patients did not show clinically significant improvement or generalization to other contexts. Several studies have examined particular treatments for Cluster C PDs with mixed results. The majority of psychotherapy outcome research for PDs has focused on borderline PD. A number of therapies



have received empirical support, including psychoanalytically oriented partial hospitalization, cognitive therapy, and dialectical behavior therapy.

There is strong evidence that the presence of PDs negatively affects the outcome of treatment for various Axis I disorders, such as major depression, anxiety, posttraumatic stress disorder, eating disorders, substance use disorders, and bipolar disorder. Given these findings, clinicians who consider Axis I mood disorder diagnoses or anxiety disorder diagnoses to be primary and PDs to be less relevant for treatment planning may be seriously mistaken.

PDs are highly prevalent, extensively comorbid with other psychiatric disorders, and difficult to treat. Although there are studies supporting the treatment efficacy for specific PDs, such as borderline PD and avoidant PD, many studies are difficult to interpret because they studied samples with mixed PDs. At present, the most conclusive evidence exists for cognitive-behavioral and psychodynamic treatments for borderline PD, behavioral treatment of avoidant PD, psychodynamic and cognitive therapy treatments for Cluster C disorders, psychodynamic treatment for mixed PDs, and supportive-expressive psychotherapy for opiate-addicted antisocial patients. Little, however, is known about the specific mechanisms of action in these treatments. Anthony Bateman and Peter Fonagy have suggested that common mechanisms of action to most tested treatments for PDs may include the provision of a coherent model in the context of a well-structured treatment, focused efforts at compliance to the treatment and connection with the therapist, and the explicit targeting of problematic symptoms.

Kenneth N. Levy, William D. Ellison,  
and Lori N. Scott

**See also** Cognitive-Behavioral Therapy (v2); *Diagnostic and Statistical Manual of Mental Disorders (DSM)* (v2); Dialectical Behavior Therapy (v2); Psychoanalysis and Psychodynamic Approaches to Therapy (v2); Psychopathology, Assessment of (v2)

## Further Readings

- American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed., Text rev.). Washington, DC: Author.
- Bateman, A., & Fonagy, P. (1999). Effectiveness of partial hospitalization in the treatment of borderline personality disorder: A randomized controlled trial. *American Journal of Psychiatry*, 156, 1563–1569.
- Girolamo, G. de, & Reich, J. H. (1993). *Personality disorders: Epidemiology of mental disorders and psychosocial problems*. Geneva: World Health Organization.
- Greenberg, M., Craighead, W., Evans, D., & Craighead, L. (1995). An investigation of the effects of comorbid Axis II pathology on outcome of inpatient treatment of unipolar depression. *Journal of Psychopathology and Behavioral Assessment*, 17, 305–321.
- Gunderson, J. G., Weinberg, I., Daversa, M. T., Kueppenbender, K. D., Zanarini, M. C., Shea, M. T., et al. (2006). Descriptive and longitudinal observations on the relationship of borderline personality disorder and bipolar disorder. *American Journal of Psychiatry*, 163, 1173–1178.
- Leichsenring, F., & Leibing, E. (2003). The effectiveness of psychodynamic therapy and cognitive behavior therapy in the treatment of personality disorders: A meta-analysis. *American Journal of Psychiatry*, 160, 1223–1232.
- Lenzenweger, M., Johnson, M., & Willett, J. (2004). Individual growth curve analysis illuminates stability and change in personality disorder features: The longitudinal study of personality disorders. *Archives of General Psychiatry*, 61, 1015–1024.
- Levy, K. N., Kelly, K. M., Meehan, K. B., Reynoso, J. S., Weber, M., Clarkin, J. F., et al. (2006). Change in attachment patterns and reflective function in a randomized control trial of Transference Focused Psychotherapy for borderline personality disorder. *Journal of Consulting and Clinical Psychology*, 74, 1027–1040.
- Linehan, M. M., Comtois, K. A., Murray, A. M., Brown, M. Z., Gallop, R. J., Heard, H. L., et al. (2006). Two-year randomized controlled trial and follow-up of dialectical behavior therapy vs. therapy by experts for suicidal behaviors and borderline personality disorder. *Archives of General Psychiatry*, 63, 757–766.
- Nigg, J., & Goldsmith, H. (1994). Genetics of personality disorders: Perspectives from personality and psychopathology research. *Psychological Bulletin*, 115, 346–380.
- Oldham, J. M., Skodol, A. E., Kellman, H. D., Hyler, S. E., Doidge, N., Rosnick, L., et al. (1995). Comorbidity of axis I and axis II disorders. *American Journal of Psychiatry*, 152, 571–578.
- Paris, J. (2003). Personality disorders over time: Precursors, course, and outcome. *Journal of Personality Disorders*, 17, 479–488.
- Perry, J. C., Banon, E., & Ianni, F. (1999). Effectiveness of psychotherapy for personality disorders. *American Journal of Psychiatry*, 156, 1312–1321.



- Shea, M. T., Stout, R. L., Gunderson, J. G., Morey, L. C., Grilo, C. M., McGlashan, T. H., et al. (2002). Short-term diagnostic stability of schizotypal, borderline, avoidant, and obsessive-compulsive personality disorders. *American Journal of Psychiatry*, 169, 2036–2041.
- Westen, D., & Shedler, J. (1999). Revising and assessing axis II, part II: Toward an empirically based and clinically useful classification of personality disorders. *American Journal of Psychiatry*, 156, 273–285.
- Zimmerman, M., Rothschild, L., & Chelminski, I. (2005). The prevalence of *DSM-IV* personality disorders in psychiatric outpatients. *American Journal of Psychiatry*, 162, 1911–1918.

---

## PERSONALITY THEORIES

---

Personality theories attempt to identify personal characteristics people share and to determine the factors that produce their unique expression by any given person. Sigmund Freud developed the first theory of personality, *psychoanalysis*, from his profound insight that emerged in the early 1890s as he treated patients with neurotic disorders: forces that exist in the unconscious determine human behavior. Over the next 40 years he formulated the most influential personality theory in the 20th century. Freud argued that people's behavior reflects the outcome of a lifelong struggle in which repressed unacceptable sexual and aggressive instincts in the id are redirected toward acceptable expression by the forces of reason in the ego and of conscience in the superego. These instincts sustain the self throughout life, at the cost, however, of directing aggression toward others.

Freud's ideas attracted numerous young European intellectuals in the early 20th century, the most prominent being Carl Jung and Alfred Adler. Both departed from his orthodoxy to develop their own theories, *analytical psychology* and *individual psychology*, respectively. Jung partitioned the psyche, as he called the mind, into the conscious ego, the personal unconscious, and the collective unconscious. He posited that inherent in each person is a lifelong process of individuation during which differentiation from others and a balancing of the opposing forces of the psyche (e.g., rationality/irrationality, masculinity/femininity) are sought. If attained, an integrated self emerges.

Adler reasoned that each individual struggles throughout life to overcome feelings of inferiority that

arise during the first few years of life as the child, helpless and completely dependent, compares itself to its more capable caretakers. The child responds to these feelings unconsciously by striving for superiority (personal competence), formulating rudimentary life goals that give this striving a focus, and structuring a style of life to attain these goals.

The ego, according to Freud, has no independent functions. It acts only as a mediator to satisfy the instinctual demands of the id. Freud's daughter, Anna, and Margaret Mahler expanded the concept of the ego in the mid-20th century to include functions that guide the person's competence in mastering life's demands, particularly those related to social interactions. Their work focused on the study and treatment of children and gave rise to *psychoanalytic ego psychology*.

Erik Erikson elaborated this concept further in the second half of the 20th century. He postulated that ego development is bound closely to changing social institutions and values. Central to his theory is the development of ego identity, a process that begins in adolescence and continues throughout life. Erikson reasoned that ego development occurs via a series of genetically predetermined stages (critical periods). During each stage specific developmental crises of increasing social complexity are faced. Society ensures that the process unfolds in the proper order and at the proper pace.

*Object relations theorists* elaborated the concept of the ego and transformed core psychoanalytic concepts. Prominent among these theorists were Melanie Klein, David W. Winnicott, and Heinz Kohut. They emphasized the enduring influence of interpersonal relations on a person's unconscious processes and the impact of these relations on the development of a person's inner world, especially on the infant's interpersonal strivings for safety, love, empathy, admiration, and trust. Harry Stack Sullivan, an *interpersonal theorist*, viewed the mother's relationship with the infant as crucial to the child's developing self system. Karen Horney, a *social psychoanalytic theorist*, emphasized the critical influence of the parents on the developing child's self-images and tendencies to move away from, toward, or against others.

From the 1930s to the 1950s, John Dollard and Neal E. Miller transformed Freud's psychoanalytic concepts into the language of stimulus-response psychology. Their work, *psychodynamic social learning theory*, produced the *frustration-aggression hypothesis*, a testable behavioral hypothesis of Freud's aggression



instinct, as well as behavioral formulations of Freud's main theoretical concepts. Following in this tradition, Albert Bandura, founder of *social cognitive theory*, argued that cognitive processes, especially observational learning, not direct reinforcement, play a vital role in a person's development. His perspective on the developing individual's behavior was multicausal—a person both acts on and reacts to the environment. The person's awareness of the nature of these interactions yields a sense of personal control or perceived self-efficacy. These theoretical perspectives contrast with those of the *radical behaviorists*, John B. Watson and B. F. Skinner, whose focus was on observable behaviors, reinforcement contingencies, and the reinforcement history that shaped the constellation of behaviors characteristic of any given individual.

A dramatically different perspective offered by the *humanistic self-actualization theorists* Abraham Maslow and Carl Rogers emphasized the process of personal self-growth. Central to Maslow's theory is a hierarchy of needs that ascends from basic needs (physiological, safety, belongingness and love, and esteem) to the highest need (self-actualization). The need for self-actualization guides the person toward truth, beauty, knowledge, justice, and unity. Rogers emphasized the person's subjective experience, the importance of personal freedom and choice, and the self-actualizing nature of human motivation. The actualizing tendency is undermined when parents' love is conditional upon the child behaving in approved ways. Conditional love produces an incongruity between the real self (the person's actual core experience) and the perceived self (the self-image), fostering unhealthy personality development.

Rollo May's *existential phenomenological psychoanalysis* shares a kinship with both the humanistic and psychoanalytic perspectives. He stressed the ongoing, continuously becoming aspects of human personality, human freedom, creativity and self-affirmation, the human capacity to interpret reality in ways to impart meaning to life, and the ultimate responsibility humans have for creating their own lives. Like Rogers and May, the *personal construct theory* of George A. Kelly considered subjective interpretations of reality as critical in determining a person's behavior, making sense of life, and developing ways in which to anticipate future events.

Historians of psychology trace the beginning of scientific inquiry in personality to the publication of Gordon Allport's *Personality: A Psychological*

*Interpretation* in 1937. Allport, the father of *trait theory*, unlike the other pioneering theorists, was a scientist, not a clinician. His research indicated that all people possess broad predispositions that cause them to behave in consistent ways across diverse situations and time. These traits give rise to behaviors that express them, and influence people's subjective experience. Allport viewed traits as real entities that exist inside a person to form an overlapping, interrelated network. They are distributed among all people, but are expressed uniquely by any given person. Development of a person's unique configuration of traits follows a path characterized by seeking a sense of purpose in life and coming to know the self.

Hans Eysenck, a *biosocial theorist*, used factor analysis to identify clusters of traits that formed three personality dimensions (neuroticism, extraversion, and psychoticism). His research revealed performance differences between individuals on laboratory tests (conditioning, motor skills, vigilance) of these dimensions that reflect variations in central nervous system (CNS) arousal. He theorized that the CNS is the primary source of human personality and that the three personality dimensions are phenotypic expressions of genotypic variations in the ascending reticular activating system or the subcortical brain structures of the limbic system and hypothalamus.

The pioneers in *personality theory* were grand theorists whose theoretical formulations, with Allport and Eysenck the exceptions, derived from clinical observations not from experimental studies. As such, these theories were built largely on principles that could not be tested or refuted. In the last half of the 20th century a widely accepted, scientifically based theory of personality emerged from factor analytic studies. The five-factor (or Big Five) model originated from research by several investigators, including a single publication in 1934 by Louis L. Thurstone, a series of investigations by Raymond B. Cattell in the 1940s, and another single publication in 1949 by Donald Fiske. Thurstone, a pioneer in the development of *factor analysis*, reported that five independent factors were identified in the ratings of 1300 raters who selected personal adjectives from among a list of 60 that described a person they knew well. Fiske also found five factors in an analysis of a set of 22 variables developed by Cattell. Indeed, work in the last half of the 20th century by Ernest C. Tupes, Raymond E. Christal, John M. Digman, Lewis R. Goldberg, Paul T. Costa, Jr., and Robert R. McCrae has consistently identified five broad categories of



human traits: Extraversion, Neuroticism, Conscientiousness, Agreeableness, and Openness to Experience (also called Intellect).

The study of personality across the last 120 years has produced an array of conceptual models that has enriched our understanding of human behavior. These models construe personality in radically different and seemingly inconsistent ways. In the first decade of the 21st century, however, Dan P. McAdams and Jennifer L. Pals proposed a model for integrating these divergent concepts into a coherent view of personality. Their conceptual framework of the general and unique aspects of human behavior is based on five principles. First, human nature is best explained by evolutionary theory, which provides the first principles for a scientific understanding of psychological individuality. Second, variations in a small set of broad dispositional traits, like those enumerated by the Big Five model, provide the most stable and recognizable aspects of psychological individuality. They represent the most common states individuals experience across situations and time. Third, characteristic adaptations in response to everyday social demands that may change dramatically over time account for the situation-specific behaviors of individuals not explained by traits. Fourth, integrative life narratives that individuals construct to give culturally linked meaning and identity to their lives further influence individual behavior. These narratives, essential for psychological growth and well-being, differentiate one person from all other persons. Finally, culture has its most profound impact on individual life narratives. An individual's cultural context determines the characteristic adaptations that will express any given trait, and account for individual uniqueness.

This new conceptual framework holds forth the promise of distilling the complexities of human nature into their fundamental essence, thereby allowing the scientific description of personality to avoid the hopeless complexity of past efforts.

*Theodore R. Bashore and Juanita R. Hernandez*

**See also** Adlerian Therapy (v2); Bandura, Albert (v2); Freud, Sigmund (v2); Jung, Carl (v2); Multicultural Personality (v3); Personality Theories, Behavioral (v2); Personality Theories, Cognitive (v2); Personality Theories, Evolutionary (v2); Personality Theories, Five-Factor Model (v2); Personality Theories, Phenomenological (v2); Personality Theories, Psychodynamic (v2); Personality Theories, Social-Cognitive (v2); Personality Theories, Traits (v2)

## Further Readings

- Costa, P. T., & Widiger, T. A. (Eds.). (2001). *Personality disorders and the five-factor model of personality* (2nd ed.). Washington, DC: American Psychological Association.
- Goldberg, L. R. (1993). The structure of phenotypic personality traits. *American Psychologist*, 48(1), 26–34.
- McAdams, D. P., & Pals, J. L. (2006). A new big five: fundamental principles for an integrative science of personality. *American Psychologist*, 61(3), 204–217.
- Monte, C. F., & Sollod, R. N. (2003). *Beneath the mask* (7th ed.). Fort Worth, TX: Harcourt.
- Pervin, L. A., & John, O. P. (Eds.). (1999). *Handbook of personality: Theory and research*. New York: Guilford Press.

## PERSONALITY THEORIES, BEHAVIORAL

Traditional models of behaviorism, represented by figures like John B. Watson and B. F. Skinner, are typically considered inconsistent with the concept of “personality,” which itself represents an unobservable construct. Such “radical” behavioral approaches emphasized the study of observable behavior, and thus any theory of personality was restricted to typical patterns of behavior exhibited by a particular individual based on his or her reinforcement history. More recently, and with the proliferation of behavioral and cognitive-behavioral counseling approaches, newer approaches have attempted to reconcile traditional models of behaviorism with a description of human personality. Traditional behavioral principles have been translated into behavioral approaches to counseling, as well as contributing to modern cognitive-behavioral therapies.

This entry begins with a description of the fundamental approaches to learning that represent the foundation of behaviorism. Skinner's personality theory, which has evolved into the modern study of behavior analysis, follows. John Dollard and Neal Miller's attempt to reconcile behaviorism and psychoanalysis is presented next, followed by the social cognitive approach represented by Albert Bandura and Julian Rotter. That is followed by an introduction to Arthur Staats's relatively recent theory of psychological behaviorism. Finally, a rudimentary description of several techniques used in behavior therapy is provided.



## Learning Approaches

### **Classical Conditioning**

Classical conditioning, typically attributed to Ivan Pavlov, focuses on the responses of an individual to a particular stimulus in the environment. The response is considered automatic on the part of the individual, with no cognitive interpretation of the stimulus or internal debate regarding how to respond. Watson, one of the first pioneers of behaviorism, further studied this form of stimulus-response learning.

In the classical conditioning paradigm, a previously neutral stimulus comes to elicit a response by serving as a signal for another stimulus that normally elicits that response. Pavlov conditioned the response of salivation in dogs to the sound of a tone by repeatedly preceding the presentation of food with the sound of the tone. The tone, originally a neutral stimulus, became a signal for the food, and thus elicited salivation similar to the actual presentation of the food.

Later, Watson showed that even emotional responses could be subject to classical conditioning. He worked with a child known as “Little Albert,” in whom Watson was able to condition a fear response to a white rat. Moreover, this response generalized to other stimuli that were white and furry, similar to the rat.

### **Operant Conditioning**

Operant conditioning emphasizes the effects of environmental contingencies, such as rewards (or reinforcement) and punishment, on the frequency of behavior. Edward Thorndike, in his attempt to formulate a series of “Laws of Learning,” articulated operant learning through the “Law of Effect,” which states that a behavior followed by a “satisfying state of affairs” is likely to occur more frequently. Skinner originated behavior analytic theory based on operant principles, and in fact developed a comprehensive approach to personality based on these same principles. Skinner focused primarily on reinforcement, which he defined as any consequence that increases the likelihood of a response. Moreover, the schedule of reinforcement—the frequency and timing of reinforcement for a given behavior—has ramifications for the frequency of the behavior’s occurrence, and the likelihood the behavior will continue to occur in the absence of reinforcement. Extinction of a response occurs when the response is no longer elicited due to a continuing absence of reinforcement.

Operant conditioning can also promote the development of more complex behaviors through a process

called *shaping*. Shaping involves the reinforcement of successive approximations of a complex target behavior. For example, to train a dog to roll over may require first rewarding the dog for laying down, then for rolling onto one side, then for rolling onto its back, then to the other side, and finally back onto its belly. Each step of the process is an end unto itself, earning reinforcement for the individual, and then becomes only the prerequisite for the reward at the next step, until the entire series of behaviors becomes necessary for the reinforcement.

## **Skinner's Personality Theory**

Skinner proposed that human behavior is shaped by a variety of consequences. These consequences, or contingencies, may be administered by another person (a parent, teacher, spouse, or boss), or may be naturally occurring in the environment. Each consequence affects the future likelihood of that behavior. Therefore, each individual has a unique history of such contingencies, and each develops a unique repertoire of behaviors of varying likelihood.

This contingency history approach is distinct from trait theories of personality that view each individual as having a set of traits, or characteristics, that “lead to” a set of behaviors. Traditional behaviorists reject the notion that an internal and amorphous mechanism is responsible for behavior. They believe the contingency or reinforcement history determines an individual’s behavioral tendencies.

### **Development**

For Skinner, the development of these behavioral tendencies occurs through gradual exposure to contingencies within an individual’s environment. Skinner also later incorporated the idea of imitation as a means of learning. Specifically, he asserted that a child might learn a behavior through imitation of a parent or peer, but only if the child’s prior imitations had been reinforced. In other words, a child would be more likely to imitate a behavior if he or she had been previously reinforced for imitating other behaviors. This mechanism increases the individual’s repertoire of behavioral tendencies still further.

### **Psychopathology**

Skinner asserted that all of an individual’s behaviors, including pathological behaviors, are learned



through these same mechanisms. Mentally ill individuals have learned a maladaptive response that leads to aversive consequences for the individual or for others because that response has been, and may continue to be, reinforced. In addition, an individual may have been unable to learn an appropriate response to a certain situation or stimulus, due to inadequate reinforcement, or due to never having performed the skill in a way that was reinforced.

## Walden Two

Skinner explored the hypothetical application of the principles of contingency management to an entire culture in his classic book *Walden Two*, published in 1948. In *Walden Two*, Skinner used this process of “cultural engineering” to create an idealized community in which crime, unemployment, and wars are a thing of the past. Skinner argued that such a society would be feasible in America, and it would solve societal problems if truly employed.

## Behavior Analysis

Modern behavior analysis is predicated on Skinner’s work. Behavior analytic theorists share Skinner’s emphasis on an individual’s reinforcement history as the determinant of his or her behavioral tendencies. The concept of personality implies a certain degree of consistency in an individual’s behavior; thus, behavior analysis posits that consistent behavioral tendencies are the result of consistent contingencies across similar situations over time, and across different situations.

The lack of consistent contingencies would lead to more unpredictable behavior. A lack of consistency in responding is a sign of a lack of stability in an individual’s “personality,” and thus of some degree of pathology. Behavior analysts advocate adjustments in contingencies as a means for individuals to “relearn” adaptive and more consistent ways of responding.

## Human Nature

Both Skinner and the behavior analytic view that ensues from his theory share certain assumptions and positions regarding dimensions of human nature. Among these are an emphasis on environmental influences and a deterministic view of behavior. While Skinner was not as radical as Watson, he did believe that environmental influences (“nurture”) could override

biological processes (“nature”). Behavior analysts share this belief. The element distinguishing the view of many behaviorists from other theorists is their belief that biological processes, while very important, are less observable than environmental influences, and thus less subject to measurement.

On the question of free will, Skinner did assert that humans have the power of self-control (i.e., free will), or the ability to manipulate their environment to manage their own behavior. Skinner’s position implies a bit more self-determination than the purely stimulus-response learning emphasized by Watson, but he maintained that even this process requires external contingencies. In sum, Skinner and the behavior analysts in general have leaned heavily toward the position that most human behavior is determined by environmental contingencies.

## Dollard and Miller’s Theory

Dollard and Miller attempted to reconcile the conflicting ideas in behavioral and psychoanalytic theories by reformulating Freudian concepts in behavioral terms. They relied heavily on Clark Hull’s concepts of habits and drives. Habits are connections between stimuli and responses. Drives are aversive stimuli that impel a behavior. The ensuing behavior reduces the drive and is thus negatively reinforced. In a departure from the more radical behaviorism of Watson, Dollard and Miller suggested that drives can be either external (such as a need for money or a diploma) or internal (such as hunger or loneliness), thereby introducing the idea that even nonobservable elements may be included in a behavioral theory.

Dollard and Miller further suggested that certain stimuli in the environment serve as cues—consistent with what Skinner called discriminative stimuli—that determine where and when a behavior will occur. Each cue may prompt a range of potential behaviors. These potential behaviors form a response hierarchy based on the relative likelihood of each response in that situation. Each potential response’s position in the response hierarchy is effected in part by the individual’s particular drives when the cue is present. The changing of response probabilities due to differing situations is what Dollard and Miller consider the process of learning.

## Conflict

Freud’s psychoanalytic theory focuses heavily on intrapsychic conflict. Dollard and Miller studied



conflict as it pertains to response hierarchies. They suggested that each type of conflict represents choices between goals. An approach-approach conflict occurs when an individual must choose between two equally desirable goals. These goals may conflict because the individual has two competing drives, such as choosing between studying for a test or going out with friends. An avoidance-avoidance conflict occurs when the individual must choose between two undesirable outcomes, such as studying for an exam or failing. An approach-avoidance conflict involves a single response that has both a desirable and an undesirable outcome, such as working at a high-paying but unpleasant job. Finally, in a double approach-avoidance conflict, the individual has to choose between two different responses, each of which has both a desirable and an undesirable outcome. For example, a job applicant may have to choose between the high-paying but unfulfilling job and a lesser-paying but more interesting position.

Like Freud, who claimed that neurosis could result from inadequate resolution of conflicts, Dollard and Miller suggested that pathology could ensue if the individual has difficulty with these conflicts. For example, some individuals may become immobilized by conflict or choose to escape the decision by maladaptive means.

### ***Frustration and Aggression***

Dollard and Miller first formulated the frustration-aggression hypothesis in 1939. They asserted that frustration, which occurs when there is unexpected interference with a goal-directed response, is always the cause of aggression. Generally, the more frustrated the individual, the greater the amount of aggression he or she will express. This approach mirrored Freud's position that aggression serves as a cathartic release of tension.

Also consistent with Freud's theory was Dollard and Miller's work on displaced aggression. Specifically, they agreed that individuals who are unable to respond to the original stimulus will respond to the most similar available stimulus. For example, if your boss makes you work late on an evening when you had other plans, you may not express aggression toward your boss because of a fear of punishment. Instead, you will express aggression toward someone who is in some way similar to your boss when the opportunity (cue) occurs.

### ***Critical Training Periods***

Dollard and Miller attempted to convert Freudian developmental stages into more behavioral terms. The result was what they called critical training periods. Three of the four training periods mirror Freudian psychosexual stages of development, and are thought to affect personality development. The feeding situation, which roughly corresponds to the Freudian oral stage, involves stimulus generalization; infants who learn that their hunger drive will be alleviated by others develop the belief that they will be able to satisfy their other drives. Moreover, in this training situation, the infant may develop secondary drives learned through association with these primary drives. For example, the drive of intimacy may be developed through the close, comfortable relationship between infants and their mothers during feeding.

The cleanliness situation, akin to Freud's anal stage, involves a similar emphasis on toilet training. Difficulty during toilet training may be met by parental disapproval and punishment. The child may interpret the disapproval as focused on themselves rather than their behavior, and thus develop anxiety. This anxiety may generalize to other situations in which developing persons perceive themselves as inadequate or unlovable.

Dollard and Miller suggested that early sex training, corresponding to Freud's phallic stage, involves anxiety associated with initial expressions of sexuality and sexual behavior. Specifically, behaviors such as masturbation are typically called dirty, perverted, or wrong. Again, this association may be generalized to other sexual behaviors, and to fulfillment of the sexual drive overall.

Finally, Dollard and Miller asserted that a child who becomes frustrated may become angry and aggressive. Aggressive behaviors by children are typically met with some form of punishment. The result is an approach-avoidance conflict because the child who experiences frustration must either express that anger and get punished or suppress the anger. Chronic suppression of anger may ultimately lead to development as a passive, unassertive adult.

### **Social Cognitive Theories**

Traditional behavioral approaches have eschewed the cognitive processes that occur within humans as being unobservable. Theorists from this perspective have as



a whole believed not that these processes are insignificant but simply that they are not measurable, and thus not subject to scientific inquiry. Social cognitive and social learning approaches are based on many of the same principles as behavioral theories, but include the cognitive element that behaviorists have omitted. The primary figures associated with this approach are Julian Rotter, Walter Mischel, and Albert Bandura.

### **Reciprocal Determinism**

Social-cognitive theory and its distinction from purely behavioral theories are exemplified by Bandura's concept of reciprocal determinism. Bandura posited that behavior, the environment, and the cognitive processes within an individual have a mutually interactive relationship. Instead of a unidirectional stimulus-response relationship, these three variables all affect one another.

These cognitive processes are what Mischel called *person variables*. Generally, social cognitive theorists de-emphasize traits, which imply greater stability across situations, in favor of the processes that enable individuals to adapt to specific environmental conditions and circumstances. An individual's competencies involve what he or she is capable of doing. Encoding strategies reflect how an individual cognitively represents information. The individual also has expectancies regarding how likely he or she believes an action will result in a particular outcome. Such outcomes will each have a particular subjective value assigned by the individual. Finally, the individual engages in a self-regulatory process that includes planning an action or series of actions, executing those actions, and adjusting the actions as he or she evaluates the progress made toward the goal.

Bandura also described the variable of self-efficacy, or the individual's perception of his or her ability to perform a behavior in a given situation. Self-efficacy can be considered to be general, such as an overall confidence in one's ability to perform actions as needed. More specifically, however, self-efficacy refers to confidence in a specific situation. For example, an individual may feel comfortable sitting at home answering questions to a television quiz show; the individual's confidence in his or her ability to do so in front of an audience and cameras with prize money on the line may be different.

Rotter is best known for his work on the concept of locus of control, or the explanation an individual has for events and outcomes. Persons who attribute

outcomes to factors outside themselves (e.g., luck, divine providence, or another person) have an external locus of control. Those who attribute outcomes to their own efforts or abilities have an internal locus of control. Generally, having an external locus of control is associated with poorer psychological and physical health.

### **Vicarious Learning**

Another distinction between the social cognitive approach and purely behavioral models of personality is the stipulation that learning can occur without a direct experience of classical or operant conditioning. The process can happen vicariously, according to social learning theorists, and imitation need not be reinforced for observational learning to occur.

Bandura is perhaps best known for his work on observational learning (i.e., learning by watching behavior). His Bobo Doll experiments showed that children could learn aggressive play behaviors by watching an adult model such behaviors against a blow-up clown doll. Examples of observational learning are evident whenever an individual learns how to cook a meal by watching a cooking show, learns how to change a flat tire by watching a mechanic, or is persuaded to buy a product by a celebrity on a television commercial.

Both classical and operant conditioning can occur by observation. Vicarious conditioning occurs when an individual becomes conditioned to a stimulus by viewing another individual being conditioned to that same stimulus. Vicarious reinforcement occurs when an individual becomes more likely to engage in a behavior after seeing someone else rewarded for that behavior.

### **Pathology**

According to the social cognitive view, most pathology results from dysfunctional expectancies. An individual may, to a maladaptive extent, overestimate or underestimate the likelihood of a particular outcome of a behavior. For example, a shy person may avoid social gatherings for fear of rejection or embarrassment, or a shoplifter may believe that he or she will never be caught and arrested.

Consistent with other behavioral theories, social cognitive theory posits that maladaptive behaviors and appropriate behaviors result from similar learning processes. We may learn appropriate behaviors through vicarious reinforcement, but we can also learn maladaptive behaviors through vicarious reinforcement



(i.e., seeing someone else run a red light successfully, and then doing so as well).

## **Psychological Behaviorism**

In recent years, Staats has criticized traditional behaviorism's emphasis on learning principles that apply to animals. He regards these principles as insufficient to explain human behavior. Staats's psychological behaviorism is predicated on the notion that humans learn new behaviors in the context of previously learned behavioral repertoires.

Staats has stated that individuals develop basic behavioral repertoires (BBRs) that facilitate later learning. Personality is the individual's combination of basic behavioral repertoires. These initial BBRs are learned through the interaction of stimulus events and the individual's sensory and perceptual processes.

Like traditional behavioral theorists, Staats has asserted that personality develops and changes through a series of learning experiences. But psychological behaviorism emphasizes the context of the individual's prior learning. Specifically, individuals develop BBRs based on their experiences with environmental stimuli. Their biological condition at the time of this learning plays an important mediating role. Later, individuals' biological conditions may be different, thus affecting their BBR, when a second stimulus event is experienced and prompts a behavior. This process demonstrates both the situational nature of behavior and the more generalized nature of personality. While somewhat stable, the BBRs can be modified or supplemented through later learning, thus reflecting the adaptability of human personality.

## **Behavior Therapy**

Behavior therapy involves the use of learning principles to modify maladaptive behaviors. Behavior therapy focuses on the acquisition of necessary skills to obtain reinforcement (such as in social skills training), the learning of more adaptive responses to environmental stimuli (as in systematic desensitization), and the modification of environmental factors to promote adaptive behaviors (as in contingency management).

### ***Social Skills Training***

Social skills training is used to promote adaptive interpersonal behaviors to facilitate the acquisition of social reinforcement. Therapy clients reporting loneliness,

depression, or anxiety may have inadequately developed skills to promote satisfactory interpersonal relationships. These individuals do not engage in appropriate eye contact, facial expressions, tone of voice, and other conversational skills, many of which are more typically learned in the natural environment. In therapy, clients may engage in role-play activities where the therapist first models the appropriate skills, and then encourages the client to demonstrate. Real-world assignments to test these new skills are instrumental in helping clients to apply these skills to genuine situations and to gain genuine social reinforcement.

### ***Systematic Desensitization***

Systematic desensitization is most applicable to situations in which an individual experiences a disproportionate or dysfunctional level of anxiety to a stimulus or situation. The process relies on counterconditioning (i.e., the development of a response—relaxation—that is incompatible with anxiety). During relaxation training, clients are taught a series of exercises to relax the mind and body. Relaxation training may involve imagery (i.e., teaching clients to picture themselves in a tranquil, placid scene). Clients also develop a hierarchy of fear-inducing situations, and rank them according to the level of anxiety they cause.

Once a client has become adept at relaxation and has completed the hierarchy, the therapist leads the clients through each step in the hierarchy. The client attempts to maintain the relaxation response in the context of each situation on the list. This process may occur through imagery or in real-life exposure.

### ***Contingency Management***

Contingency management entails the manipulation of reinforcement and punishment to increase the frequency of desirable and adaptive behavior. This approach can use simple contingency plans, such as rewarding a child with a cookie for eating his or her dinner, or more complex point systems or token economies, such as those used in many schools and institutions. Withdrawal of reinforcement through time-out is also a form of contingency management.

## **Relevance**

Behavioral approaches to personality began with the radical behavioral approach of Watson, which was largely incompatible with an internal, nonobservable



construct such as personality, but they have evolved over time. Skinner's behavior analysis is still relevant, as are more modern approaches such as Staats's psychological behaviorism, which is largely consistent with those earlier approaches. Behavioral approaches provide the theoretical foundation for the wealth of effective techniques that today are used as part of a behavioral approach to counseling.

David T. Wasieleski

**See also** Bandura, Albert (v2); Behavior Therapy (v2); Cognitive-Behavioral Therapy and Techniques (v2); Counseling Theories and Therapies (v2); Individual Therapy (v2); Meaning, Creation of (v2); Personality Theories (v2); Personality Theories, Social Cognitive (v2); Person-Environment Interactions (v2); Skinner, B. F. (v2)

### Further Readings

- Bandura, A. (1973). *Aggression: A social learning analysis*. Englewood Cliffs, NJ: Prentice Hall.
- Bolling, M. Y., Berry, C. M., & Kohlenberg, R. J. (2006). Behavioral theories. In Thomas, J. C., Segal, D. L., & Hersen, M. (Eds.), *Comprehensive handbook of personality and psychopathology*. Vol. 1: *Personality and everyday functioning* (pp. 142–157). Hoboken, NJ: Wiley.
- DeGrandpre, R. J. (2000). A science of meaning: Can behaviorism bring meaning to psychological science? *American Psychologist*, 55, 721–739.
- Dollard, J., & Miller, N. E. (1950). *Personality and psychotherapy: An analysis in terms of learning, thinking, and culture*. New York: McGraw-Hill.
- Farmer, R. F., & Nelson-Gray, R. O. (2005). Personality and behavior theory: Toward the reconciliation of an apparent incompatibility. In R. F. Farmer & R. O. Nelson-Gray (Eds.), *Personality-guided behavior therapy* (pp. 3–31). Washington, DC: American Psychological Association.
- Follette, W. C., Bach, P. A., & Follette, V. M. (1993). A behavior-analytic view of psychological health. *The Behavior Analyst*, 16, 303–316.
- Hergenhahn, B. R., & Olson, M. H. (2003). *An introduction to theories of personality* (6th ed.). Upper Saddle River, NJ: Pearson Education.
- Logan, C. A. (2002). When scientific knowledge becomes scientific discovery: The disappearance of classical conditioning before Pavlov. *Journal of History of the Behavioral Sciences*, 38, 393–403.
- Skinner, B. F. (1948). *Walden two*. New York: Macmillan.
- Skinner, B. F. (1987). Whatever happened to psychology as the science of behavior? *American Psychologist*, 42, 780–786.

- Staats, A. W. (2003). A psychological behaviorism theory of personality. In T. Millon & M. J. Lerner (Eds.), *Handbook of psychology: Personality and social psychology* (Vol. 5, pp. 135–158). Hoboken, NJ: Wiley.

## PERSONALITY THEORIES, COGNITIVE

Cognitive theories of personality focus on the processes of information encoding and retrieval, and the role of expectations, motives, goals, and beliefs in the development of stable personality characteristics. This approach differs from personality theories that emphasize either the conditions within which personality develops (e.g., behavioral theories) or the trait structures that are revealed in those various conditions (e.g., evolutionary and trait theories). As such, cognitive theories of personality are particularly relevant for counseling psychology because of their core assumption that lasting personality change can occur as a result of rational analysis and insight.

Personality theories are often categorized as either *nomothetic* (i.e., personality is understood in terms of an individual having greater or lesser amounts of traits that are common to all people) or *idiographic* (i.e., each individual has a unique personality structure and may possess traits that others do not possess). Taking a nomothetic approach, a personality theory can be used to generalize about an individual or to categorize the person. For example, a person can be said to have a particular trait or style. On the other hand, personality theories that take an idiographic approach attempt to describe the specific individual in such a way as to show how this one individual is different from all other individuals. Cognitive theories of personality are both nomothetic and idiographic. Nomothetic theorists have demarcated dimensions of individual difference such as cognitive styles. Idiographic theorists have developed complex descriptions of individuals cognitively embedded within their own life contexts.

### General Components of Cognitive Personality Theories

Most cognitive theories of personality focus on the ways in which personal knowledge and judgment are developed. Often this development occurs in a distorted fashion because it is necessary for people to adapt to their environment. Humans desire to be consistent in their beliefs and behaviors so that they can



predict the outcome of their actions. They are also motivated to gain social approval from others and to enhance their perception of themselves. This can result from a process of comparing one's self with those of others or a process of comparing what one believes is one's actual self with an imagined ideal self. Cognitive personality theorists have focused their efforts on describing the development of cognitions that explain the world and the individual's concept of self in it, and they have also developed some understanding of variations in cognitive styles that predict individual differences.

## History

Early ideas related to cognitive theory can be traced back to the Greek Stoic Epictetus, who claimed that processes of rational judgment were at the basis of all emotion, be it happiness or suffering. He stated that events in and of themselves have no moral or ethical meaning. Moral judgment and choice are the consequences of how people come to interpret and understand events.

At the turn of the 20th century, William James championed the idea that no psychological theory is complete that does not allow for a mechanism by which thought will regulate actions. James emphasized the role of the focus of attention in determining behavior. He also anticipated the concept of cognitive schemata by characterizing the stream of consciousness as anticipating and adapting to current events by comparing current experiences to past experiences.

Early work in social cognition forms a basis of current cognitive personality theory. Fritz Heider, an early social psychologist, emphasized that people act with others on the basis of their conceptions of themselves and of others. Heider developed the notion of *phenomenal causality*, which is the perception of causality that leads to judgment and action. Heider's ideas led to the development of the field within social psychology known as *attribution theory*, which is the study of the determinants of phenomenal causality or causal attributions. One important dimension of causal attributions is that of internal (or dispositional) versus external (or situational) attributions. People's judgments and conceptions of an event are largely determined by their beliefs regarding whether people act according to internal dispositions or because of situational pressure. Heider's ideas are often called *naïve psychology* in that the person is described as

acting according to his or her own personal theory of psychology regarding others.

## Kelly's Theory of Personal Constructs

George A. Kelly's theory of personal constructs is most frequently cited as the first modern cognitive personality theory. Kelly proposed and elaborated upon the metaphor of "person as scientist." Drawing on the theories of Heider and attribution researchers, Kelly proposed that people use observations to develop beliefs about themselves and their world. These observations are organized into *personal constructs*, which were described by Kelly in terms very similar to the current concept of cognitive schemata. Cognitive schemata are meaningful organizations of related pieces of knowledge. Kelly proposed that people make predictions and interpretations regarding their experience on the basis of their personal constructs (or *schemata*), and they endeavor to behave in a manner that is consistent with their personal constructs.

Kelly proposed that personal constructs develop and change through processes that are similar to assimilation and accommodation. As described by the cognitive developmental theorist Jean Piaget, assimilation is the process by which people integrate new information into the existing body of information they already possess. Accommodation is the process by which people change or modify their existing knowledge based on the information gained from new experiences. Like Piaget, Kelly viewed cognitive development as a continuing interplay between assimilation and accommodation. For example, children learn to catch a large ball by holding out their arms a certain distance apart as the ball is thrown. Later, when a smaller ball is thrown, they will hold out their arms the same distance apart (assimilation) but fail to catch the ball. They will need to accommodate the new information that the size of the ball must determine the distance apart that they spread their arms (i.e., their catching schema).

Kelly proposed that individuals are motivated to maintain a hierarchical structure of personal constructs that is consistent with the world, as they perceive it. Anxiety results when information does not conform to the expectations generated by their constructs. This leads to a need to change or reorganize their cognitive structure (accommodation), or to force the discordant experience to fit their preexisting construct hierarchy (assimilation). Often assimilation



requires less cognitive effort than accommodation. Rigidly adhering to assimilation via “obsolete” constructs by refusing to expend the effort to accommodate, or being unable to accommodate, can lead to irrational behavior.

### ***Locus of Control***

Julian Rotter developed a social learning theory that emphasized the role of the cognitive expectancy of reward in determining behavior. The major contribution of this theory to the psychology of personality was the proposal of a generalized cognitive expectancy that Rotter called *locus of control*. Individuals differ to the extent that they generally believe their own actions are related to personal outcomes. Those with an *internal* locus of control have a strong expectation that success or failure will result from their own efforts. Those with an *external* locus of control generally believe that success or failure is determined by fate, chance, or the will of others.

Currently, psychologists believe individuals can have different locus of control beliefs for different aspects of their life. For example, an individual could have an internal locus of control regarding social relationships and an external locus of control regarding his or her health. One domain that has been predictive of therapy outcome is the individual's locus of control beliefs concerning illness or health outcomes. Causal attributions also determine whether events are believed to be stable or transient. For example, a stable causal attribution might be, “I did poorly on the algebra test because I have never been very good at math.” A transient attribution could be, “I did poorly on the algebra test because I did not get enough sleep last night.” Finally, causal attributions may be general (i.e., relevant to many experiences) or specific (i.e., applicable only to a single instance). For example, a stable causal attribution might be, “I didn't dance well because I have never been coordinated.” A specific attribution could be, “I didn't dance well because I have never liked dancing.”

### ***Cognitive Style***

Herman A. Witkin observed that individuals differ in their general modes of intellectual and perceptual functioning along a number of dimensions. Some of the dimensions that have been shown to be useful predictors of individual differences are tolerance for ambiguity, impulsivity versus reflectivity, field dependence

versus field independence, cognitive complexity versus simplicity, and the more motivational “need for cognition.” Tolerance for ambiguity relates to open- versus close-mindedness and the ability and individuals' willingness to accommodate their schemata to new experience. Impulsivity versus reflectivity refers to the extent to which one will consider consequences of acts and alternatives before acting. Field dependence versus independence refers to a global as opposed to analytic style of perceiving. Field-dependent perceptions are influenced by the context within which they occur. Field-independent perceptions are more analytical and somewhat independent of the context within which they occur. Cognitive complexity versus simplicity refers to the usual number of interrelated schemata that are applied to experiences. Need for cognition refers to individual differences in the desire to be challenged to think and reflect. It is currently believed that many of these dimensions along which individuals differ are genetically based or at least congenital and somewhat difficult to modify.

### ***Bandura's Social Cognitive Theory***

Albert Bandura expanded cognitive personality theory by describing processes of observational or vicarious learning and the role of belief structures such as self-efficacy. Bandura agreed that people develop and change as a consequence of the direct rewards and punishments they receive from the environment. These rewards and punishments occur as a consequence of their actions (the basis of operant conditioning). However, we also learn by observing others (models) and noting the consequences that result from their behavior.

The study of observational learning led psychologists to distinguish between the factors that influence the vicarious acquisition of knowledge and the factors that influence the actual performance of some behavior. Among the factors that influence the vicarious acquisition of knowledge are the strength and valence (i.e., emotional value) of the observed consequences of the behavior, the similarity of the model (i.e., person performing or demonstrating the action) to the observer, and the social status of the model. In contrast, the person's self-efficacy beliefs influence the actual performance of some behavior. *Self-efficacy* is a person's beliefs regarding what should be done to achieve a desired goal, and the person's beliefs regarding his or her ability to perform those actions.



The first set of beliefs relates to the individual's locus of control expectancies, but by themselves these beliefs will not determine whether the goal-seeking behavior will be performed. The critical factor is the individual's beliefs regarding his or her ability to perform the necessary behavior successfully.

Self-efficacy beliefs depend on a number of factors, including previous direct experience, observational learning, social persuasion, and self-assessment and interpretation of current and past emotional states. Conditions that lead to the development of healthy self-efficacy include the positive factors of family interactions (warmth, support, and challenge), and peer networks (similar models, access to activities, and social motivation), as well as negative factors such as competition and stress. Like locus of control, self-efficacy is largely domain specific (e.g., academic self-efficacy, social self-efficacy, and athletic self-efficacy can all differ for a given person).

According to Bandura, a complete understanding of the person involves recognition of the reciprocal interaction of personal (cognitive and affective) factors with environmental factors. Bandura labeled this concept *reciprocal determinism*. By this he meant that personal factors can be influenced by environmental factors such as rewards, punishments, and information from models, but behavior and personal factors also cause changes in the environment and in other individuals. Because of the human ability to symbolize personal experience and to think ahead about the expected consequences of personal actions, each individual has the capability to self-reflect, leading to the potential for self-directed changes in behavior. Self-efficacy beliefs are crucial to making self-directed changes because they are most functional when they are accurate. When efficacy is high but skills are poorly developed, harm and trauma can occur. When efficacy beliefs are low, even when skill level is high, personal growth will not occur and there will be little motivation for change.

### **Mischel's Cognitive-Affective Personality System**

Explaining and predicting the consistency and inconsistency of individuals across the wide variety of situations that confront them on a daily basis is a problem for personality theory in general. Walter Mischel pointed out that personal variables such as traits and dispositions are often not by themselves as predictive of behavior as variables external to the person such as the demands of

the situation. In a somewhat selective review of the literature, Mischel concluded that personality information was predictive of only a very small percentage of the variation of behavior in situations. This argument stimulated the field of personality research to elucidate the interaction of the person within the situation as opposed to focusing on person variables.

In recent years, Mischel and colleague Yuichi Shoda have made progress in describing dynamic interactions of situations with personal variables (self-efficacy beliefs, personal goals, and emotional reactions) into an integrated theory called the *cognitive-affective personality system*. This approach recognizes that persons differ in the aspects of a situation on which they focus and in the way in which they encode a particular element of a situation. The resulting theory emphasizes the interaction of situations, encoding processes, memories, beliefs, expectancies, and behavior in a reciprocally determinative dynamic. This idiographic system can be considered a model for the most complete cognitive theory of personality. A person's cognitive existence cannot be considered independently of the current situation, the individual's past history, and his or her expectations for the future.

## **Cognition and Emotion**

Cognitive theories of personality have made important contributions to counseling and psychotherapy by demonstrating the ways in which cognition can cause or modify positive or negative emotion. Aaron T. Beck's method of *cognitive-behavioral therapy* and Albert Ellis's *rational emotive behavior therapy* both emphasize the ways in which distorted beliefs (mostly attributional beliefs) directly lead to experiences of negative emotion such as anxiety and depression. A long-standing debate concerns whether all human emotions more complex than simple sensory pleasure or pain are a result of cognitive processes or are merely congruent with them. In actuality, most cognitive theories of personality emphasize the presence of evolutionarily prepared (i.e., automatic) reactions and temperaments and the importance of the individual's perception and interpretation of his or her own biological reactions during events.

### **Self-Discrepancy Theory**

Self-discrepancy theory is a form of dissonance theory that states that people are motivated to maintain a



consistency among their self-perceptions and beliefs. The humanistic psychologist Carl Rogers proposed that incongruence between the self as experienced and the ideal self is a source of human suffering. Support for this position is buttressed by the many studies that have found successful counseling outcomes characterized by reductions in this incongruence. E. Tory Higgins incorporated ideas of expectancy into the self-discrepancy model. He demonstrated that discrepancies between people's current self-appraisals and their self-constructs as they wish to be (the ideal self) lead to feelings of dejection and depression. In contrast, discrepancies between people's current self-appraisals and how they believe others expect them to be (ought self) lead to agitation and anxiety. A number of moderators of the strength of this effect have been identified, including the amount of the discrepancy, factors that increase or decrease the salience of the discrepancy, and the importance of the discrepancy to the individual.

### ***Entity Versus Incremental Judgments of Self***

Carol Dweck has demonstrated how a person's perception of self as static or as capable of growth has dramatic effects on both emotions and motivation. Dweck distinguishes between two forms of belief that people may hold regarding their efficacy. The first, or entity view, regards any ability such as intelligence as fixed or stable. Persons taking an entity view within any domain of ability (entity theorists) will develop goals that avoid failure, are measured by absolute performance standards, and are low risk. A person can also perceive his or her efficacy incrementally. An incremental theorist regards abilities as changeable or improvable through challenge and work. Incremental theorists develop relative or mastery goals and are less motivated by fear of failure. Entity theorists are performance oriented, while incremental theorists are learning oriented. Entity theorists are more likely to be judgmental regarding themselves and others and to experience helplessness, depression, and anxiety.

## **Cognitive Personality Theory in Counseling**

Cognitive personality theory is applicable to counseling in two ways. First, psychologists perform cognitively based personality assessments in order to select the most appropriate treatment methods for an

individual client. Second, cognitive personality theories provide the theoretical underpinning for interventions designed to achieve long-standing changes in personality.

### ***Assessment***

Counselors have access to a large number of assessment devices that measure cognitive style and other cognitive individual difference dimensions beyond intelligence factors. These can be useful while thinking of the counseling experience as an educational enterprise requiring the need to assess the "learning style of the client." Motivational factors can also be assessed. For example, understanding the client's health locus of control can inform the choice of methods. Other assessment devices, developed mainly for use in cognitive-behavioral therapy, assess dysfunctional beliefs in various domains.

A large number of cognitive assessment instruments have been developed. In general, each test contains a list of self-related statements, and clients are asked the extent to which they endorse each statement as "true" or "descriptive" of them. For example, a psychologist could administer the following self-statement inventories to assess anxiety disorders: (1) the Body Sensations Questionnaire to assess perception of anxiety symptoms, (2) the Anxiety Sensitivity Questionnaire to assess dysfunctional beliefs regarding anxiety symptoms, (3) the Agoraphobic Cognitions Questionnaire to assess the presence of thoughts related to agoraphobia, or (4) the Anxious Self-Statement Questionnaire to assess self-related negative cognitions regarding personal performance. These and the many other available instruments are easy to give and to score. They can be used to inform the therapist's choice of an intervention strategy or to assess progress in treatment. Unfortunately, although most of these instruments have strong content validity (i.e., they cover most of the domain that experts believe to be relevant), they have not been subjected to the kinds of reliability and statistical stability testing that characterize other psychological tests, such as ability and achievement tests.

Other procedures that elicit the client's patterns of thoughts and beliefs are variations on the method of the Daily Record of Dysfunctional Thoughts. In this procedure, the client fills out a structured diary form reporting problematic situations and the thoughts, expectations, and beliefs that accompany his or her distress.



A more idiographic approach is necessary when assessing the person–situation interaction. There are two domains of situations that are immediately most relevant. The first involves the targeted problem situations that will be the focus of the counseling intervention. The daily diaries help to develop an assessment of the client's expectancy and belief patterns that may be problematic. Another long-standing instrument for this kind of assessment is George A. Kelly's Role Construct Repertory (Rep) test. As originally constructed, the Rep test compares and contrasts schemata regarding other individuals, but it can be modified to compare situations. Asking the client to compare groups of three concepts at a time and explain how two of the concepts are the same reveals personal constructs. This comparison, of course, reveals how the client views those two concepts as different from the third. For example, in the original Rep test, a client's best friend can be compared to the client's father and favorite teacher. In a situational Rep test, a client's most feared situation could be compared with the client's most compelling situation and most embarrassing situation.

The second situational domain to be cognitively assessed is that between the individual client and counselor. Clients enter counseling with different perceptions, beliefs, and expectations regarding therapy. These can be assessed with instruments similar to those described above. Expectations and beliefs regarding therapy have been found to be highly related to the therapeutic alliance. This, in turn, is one of the *common factors* (i.e., effective components of successful therapy) that are highly related to therapeutic outcome.

### ***Cognitive Theories of Personality Change in Counseling***

A large amount of work has been directed toward the development of methods to treat personality disorders using cognitive-behavioral therapy. Personality disorders themselves are not generally recognized as reliably identifiable entities within most established cognitive theories of personality. Nevertheless, the often successful attempts to modify long-standing patterns of living toward more adaptive and stable patterns are encouraging. The efforts indicate that therapeutic interventions that focus on changing dysfunctional beliefs can be used to modify personality. The dysfunctional beliefs that have received the most

attention include those regarding feelings of hopelessness, skill enhancement, and attitude toward treatment. Effective cognitive therapy interventions have been developed to deal with each of these issues. Furthermore, cognitive and behavioral interventions that address generalized belief structures such as self-efficacy have been used in therapy with success. The successful pairing of cognitive and behavioral techniques reinforces the view that cognitive elements of personality are best conceived as imbedded in a dynamic interaction of biological, cultural/social, and behavioral interactions.

### **Future Directions**

Cognitive theories of personality have made important contributions to psychology by explaining complex person–situation interactions, incorporating the powerful role of attributional belief systems, and delineating many of the cognitive dimensions that are critical in understanding individual differences. Nevertheless, a great deal of cognitive psychology has not yet been integrated fully into cognitive personality theories. Probably the most important oversight concerns the factors involved in decision making and choice behavior. For example, individual differences in the heuristic biases that influence decision making and many elements of the cognitive science of memory (e.g., the factors influencing retrieval bias) have not been incorporated into cognitive personality theories. The next decade will most likely see the integration of neglected areas such as these into cognitive theories of personality, just as the findings of cognitive science itself will become incorporated into comprehensive biopsychosocial personality perspectives.

William B. Scott

*See also* Cognition/Intelligence, Assessment of (v2); Cognitive-Behavioral Therapy and Techniques (v2); Cognitive Therapy (v2); Locus of Control (v3); Personality Assessment (v2); Personality Theories, Social Cognitive (v2); Rational Emotive Behavior Therapy (v2); Reframing (v2)

### **Further Readings**

Bandura, A. (1986). *Social foundations of thought and action: A social cognitive theory*. Englewood Cliffs, NJ: Prentice Hall.



- Beck, A. T., Freeman, A., Davis, D. D., & Associates. (2003). *Cognitive therapy of personality disorders* (2nd ed.). New York: Guilford Press.
- Dweck, C. S. (2006). *Mindset: The new psychology of success*. New York: Random House.
- Higgins, E. T. (1987). Self-discrepancy: A theory relating self and affect. *Psychological Review*, 94, 319–340.
- Kelly, G. A. (1955). *The psychology of personal constructs*. New York: Norton.
- Mischel, W., Shoda, Y., & Mendosa-Denton, R. (2002). Situation-behavior profiles as a locus of consistency in personality. *Current Directions in Psychological Science*, 11, 50–54.
- Rasmussen, P. R. (2005). *Personality-guided cognitive-behavioral therapy*. Washington, DC: American Psychological Association.

## PERSONALITY THEORIES, EVOLUTIONARY

Evolutionary personality psychology suggests that human personality variation is a meaningful and relevant source of human diversity, and that different combinations of heritable personality traits biologically prepare individuals to exploit the different social niches they inhabit. Human personality variation relates to numerous important life outcomes, including life history traits such as sexuality, sociality, fertility, morbidity, and mortality. The effects of personality variation upon these fitness-relevant demographic parameters renders such variation subject to both natural and sexual selection. Furthermore, the adaptive value of any given personality trait is relative to that circumscribed portion of the environment which the individual habitually inhabits (i.e., the individual's physical and social niche), and in which the individual is functioning. Any given personality trait can be evaluated as an adaptive function or harmful dysfunction by determining its match to the particular social niche a person occupies within a particular social environment.

This entry explains the complex mix of genetic and environmental influences on human personality variation by applying a combination of the predictions of *Brunswikian evolutionary developmental theory* and *developmental plasticity theory*. This entry also considers the significance of personality disorders from the perspectives of the *mismatch hypothesis* and the *harmful dysfunction hypothesis*.

## Personality Variation

Most evolutionary personality psychologists have concluded that individual differences in personality traits are adaptive in nature and therefore the result of natural and sexual selection. Differences in personality traits allow people within human social groups to differ in the effectiveness with which they can play different roles within human societies. Personality differences are of utmost importance because humans must detect and react to the personality traits of others to successfully navigate the social landscapes in which humans reside. The individual differences seen in personality are the result of adaptation to different niches available within human social groups. This reduces competition among group members. Although some members who are similar in personality may compete for certain roles within a society, their degree of specialization means that they will not be required to compete against all group members.

For example, in our modern society, certain people who possess higher levels of intelligence, conscientiousness, and motivation (e.g., willingness to spend many years studying) may be good candidates for careers as neurosurgeons. Other individuals who possess higher levels of impulsive sensation-seeking and lower levels of neuroticism (and are thus less prone to fearfulness) might be better suited than others to become deep-sea welders. While both occupations could be considered highly stressful and highly specialized, they require different types of personality characteristics. Furthermore, even within fairly narrowly defined types of careers, different individuals will gravitate toward distinct roles and physical locations within those careers. Some people will strive to become brain surgeons in extremely prestigious hospitals, whereas others will be satisfied to hold less prestigious positions in order to be able to pursue other interests, such as spending time with family and friends. The same could be said for deep-sea welders. Although all deep-sea welders might be viewed as more risk taking than the average person in any population, some will naturally gravitate toward more dangerous jobs than others. Those more reckless and impulsive individuals might also engage in such dangerous practices as smoking cigarettes within oxygen-filled decompression chambers upon resurfacing. These are modern-day examples from Western industrial society, used here for purposes of illustration, but different roles that best suit different types of individuals can be found in any human society.



The evolution of a diversity of individual traits to fit a variety of different social niches might be ultimately due to frequency-dependent selection. Frequency-dependent selection occurs when the fitness value of any particular trait is dependent on its prevalence in the population. For example, as the number of individuals possessing a certain phenotype (i.e., the observable physical, biochemical, and behavioral characteristics of an organism) increases, the adaptive value of possessing an alternative phenotype increases. At the Thanksgiving table, the more people who prefer the white meat of the turkey, the better it is for those who prefer the dark meat, because there will be more of that available. Thus, social competition drives individuals into different social niches. Filling these alternative niches offers some release from social competition.

The variation in personality documented in nonhuman animals appears to be almost entirely confined to social species. Niche-splitting (i.e., the fragmentation of the ecological space into more specialized niches) within a species leads to character displacement (i.e., the differentiation of individual traits to adapt to these different niches). The cost of deviating from the species-typical optimum (e.g., eating the dark meat when the white meat is actually better) is compensated by the benefit of release from competition (e.g., getting all the dark meat). The result for the population is an “ideal free distribution” of alternative behavioral phenotypes in which the balance of costs and benefits are equalized among competing individuals. For example, there is a tradeoff between territory size and territory quality, where resource-rich territories are generally smaller than resource-poor territories (e.g., the same amount of money will buy less land in New York than in Arizona). The resulting dispersion of individual phenotypes away from the modal norm of response for the species will thus create bell-shaped curves along different dimensions of personality.

### Evolutionary Developmental Theory

Brunswikian evolutionary developmental theory proposes that when ecological conditions are variable over evolutionary time, natural selection favors organisms that are phenotypically flexible enough to adapt by means of learning from environmental contingencies (i.e., the potentially different consequences of the same behavior in different ecological contexts). However, according to developmental plasticity

theory, this ability depends critically on the presence of reliable and valid cues that signal which alternative phenotype it is best to adopt in that particular time, space, and ecology. When reliable and valid cues are absent, natural selection favors the production of genetically diverse individuals that possess a wider variety of the different phenotypes that might be required to fit the locally and temporally varying conditions. Because many cues are often neither completely reliable and valid nor unreliable and invalid, Brunswikian evolutionary developmental theory describes these cues as possessing an ecological validity coefficient ranging between 0 and 1.

Combining these two theories leads to the prediction that individuals will manifest both sufficient developmental plasticity and sufficient genetic diversity to collectively fill all the available niches. Human personality traits such as the Big Five personality traits (i.e., Openness to Experience, Conscientiousness, Extraversion, Agreeableness, and Neuroticism) have heritability coefficients ranging from 30% to 50%. Heritability coefficients indicate the proportion of the phenotypic variation in a population that is attributable to genetic variation among individuals. The remainder of the variance is attributable to environmental influences and measurement error. Therefore, the combination of partial heritability and partial environmentality observed in human personality variation conforms precisely to the predictions of the combination of these two theories. Where environmental cues are only partially reliable and valid, as might very often be the case, a combination of genetic diversity and developmental plasticity should become the optimal adaptive strategy.

### Behavioral Flexibility

An inability to adapt one's behavior to the different situations that one encounters in life can be considered the very definition of a personality disorder. For example, in the absence of a personality disorder, an extraverted person would still be much more likely to behave in a more introverted manner at a funeral than they would in a bar. In contrast, a personality-disordered individual would not be able to adjust his or her behavior to be situationally appropriate.

Nevertheless, personality traits are somewhat static in nature, even in normal (nondisordered) individuals. This is variously called the temporal stability and the cross-situational consistency of personality traits.



This means that, although personality differences are adaptive, an individual's behavioral flexibility may be constrained by the combination of personality traits that he or she possesses. Personality traits differ in their potential to deal effectively with particular environmental contingencies. For this reason, individuals vary in their ability to exploit the range of possibilities inherent in the situations that they might encounter.

Although some individuals might be more biologically prepared than others to behave in a particular way, they will still demonstrate some adaptive flexibility in their behavior by selecting situations that are more favorable to the expression of their genetically constrained behavioral dispositions. For example, individuals tend to gravitate toward the types of environmental situations that are most suitable for their personalities. Extraverts are more likely to be found at parties, while introverts are more likely to avoid such social situations. Thus, the cost of any constraints imposed by the possession of individual personality traits can be overcome by the benefits entailed in the selection of suitable social and ecological niches.

### Personality Disorders

These theories of the adaptive significance of traits within circumscribed social niches provide an explanation of the normal human range of variation in personality traits. Two somewhat overlapping frameworks have been offered to explain the existence of personality disorders. One view is that disorders are the result of a mismatch between inherited characteristics and current environmental conditions. The *mismatch hypothesis* suggests that the rapid rate of change in the human physical environment (e.g., from rural agricultural to high population density industrial) and social environment (e.g., from extreme social stratification represented by slavery and male superiority to more equalitarian norms) may not have allowed for a good fit between evolved personalities and current conditions, even within the lifetime of an individual. Natural selection simply has not had enough time to build up mechanisms that allow adaptation to these rapid changes occurring within historical time. However, this argument seems to be flawed in many respects. It implies that personality disorders did not exist before the rapid social change began. Furthermore, it ignores the overwhelming evidence that some personality disorders are due to biochemical imbalances.

An alternative perspective is that some variations are ill suited for particular environments. The *harmful dysfunction* hypothesis suggests that personality disorders may be due to a mismatch between organism and physical environment, or the result of sociocultural constraints that limit the effective functioning of otherwise effective mechanisms. For example, specific traits that are deemed unacceptable by society due to cultural norms or traditions may be labeled "abnormal," "disordered," or "dysfunctional" even if the traits are functioning as they were "designed" to function by natural or sexual selection. Universal standards have been shown to exist across cultures for disgust, fear, landscape preference, mate choice, and cheater detection. Hence, it is not a stretch to imagine that the same mechanisms may be at work in both the production of personality variation and in the manner in which personality traits are interpreted by others.

The psychiatric diagnosis of antisocial personality disorder (APD) can be used to illustrate these perspectives. APD is a disorder characterized by egocentric grandiosity and Machiavellianism (a tendency to deceive and manipulate others for personal gain); a smooth, glib capability to lie; shallow emotional affect; dominance; impulsivity; insensitivity to risk; goal directedness, sometimes with a lack of social emotions; and an overall lack of regard for the moral or legal standards in the local culture. The pervasive pattern of disregard for the rights of others that characterizes APD raises the question of whether this is in fact a real disorder or a group of interrelated behaviors that may be valued or devalued based on their environmental or social utility. For example, a "cheater phenotype" may increase an individual's overall reproductive success within certain ecological niches. Many "psychopaths" are known philanderers, with a history of several failed marriages and offspring by multiple partners. It is only when a mismatch between cultural constraints (e.g., norms, customs, and laws) interacts with the behaviors associated with APD that any harm or dysfunction is manifest.

The connection between the mismatch hypothesis and harmful dysfunction models of personality disorders is important in determining which physical or behavioral characteristics are truly abnormal from an evolutionary perspective. Thus, an evolutionary psychological perspective not only bridges the perceived gap between biology and culture, but it also gives a potentially workable etiology (i.e., a theory of



causation) that connects physical and behavioral disorders within a broader theoretical framework.

*Aurelio José Figueredo, Geneva Vásquez,  
and Jon Adam Sefcek*

**See also** Personality Disorders (v2); Personality Theories (v2); Personality Theories, Behavioral (v2); Personality Theories, Five-Factor Model (v2); Personality Theories, Traits (v2); Person–Environment Interactions (v2)

### Further Readings

- Figueredo, A. J., Hammond, K. R., & McKiernan, E. C. (2006). A Brunswikian evolutionary developmental theory of preparedness and plasticity. *Intelligence*, 34(2), 211–227.
- Figueredo, A. J., Sefcek, J. A., Vasquez, G., Brumbach, B. H., King, J. E., & Jacobs, W. J. (2005). Evolutionary personality psychology. In D. M. Buss (Ed.), *Handbook of evolutionary psychology* (pp. 851–877). Hoboken, NJ: Wiley.
- Hare, R. D. (1993). *Without conscience: The disturbing world of the psychopaths among us*. New York: Guilford Press.
- Mehl, M. R., & Pennebaker, J. W. (2003). The sounds of social life: A psychometric analysis of students' daily social environments and natural conversations. *Journal of Personality and Social Psychology*, 84(4), 857–870.
- Wakefield, J. C. (1992). The concept of mental disorder: On the boundary between biological facts and social values. *American Psychologist*, 47(3), 373–388.
- West-Eberhard, M. J. (2003). *Developmental plasticity and evolution*. New York: Oxford University Press.
- Williams, G. W., & Nesse, R. M. (1991). The dawn of Darwinian medicine. *Quarterly Review of Biology*, 66(1), 1–22.

---

## PERSONALITY THEORIES, FIVE-FACTOR MODEL

---

The five-factor model of personality (FFM; often referred to as the Big Five model) is an empirically derived approach that organizes the structure of personality into five broad factors: Neuroticism, Extraversion, Openness to Experience, Agreeableness, and Conscientiousness. Numerous studies have been conducted on the model and many of these lend support for the existence of the five factors across a wide

range of cultures. The five factors have been linked to numerous life outcomes, such as career and relationship trajectories, coping, health-related behaviors, well-being, and maladjustment.

### History

The origins of the FFM can be traced to William McDougall's proposal in 1932 that personality could be broadly conceptualized as being composed of five factors. Not long after, in 1934, Louis Leon Thurstone used factor analysis to reduce 60 trait adjectives down to five factors. In 1936 Gordon Allport and H. S. Odbert identified 18,000 terms in an English dictionary that could be used to describe an individual, later reducing this list to 4,000 words. Approximately 10 years later, Raymond Cattell condensed this list to 35 clusters, with 12 underlying dimensions. Cattell and his colleagues added 4 more dimensions to these 12 and developed the Sixteen Personality Factor Questionnaire (16 PF).

In the 1960s, two psychologists, Ernest C. Tupes and Raymond E. Christal, used Cattell's scales in a study of Air Force trainees. Their analysis of the data suggested the presence of five broad factors. Warren Norman replicated these five factors in 1963 and they became known as the "Norman Five."

Despite their convergence on five factors, these works remained relatively unnoticed until the late 1970s and early 1980s when several lines of independent research sparked renewed interest. Among these were studies conducted by Robert R. McCrae and Paul T. Costa, Jr., whose names have since become synonymous with the FFM or Big Five model of personality structure. Building upon the work of their predecessors, Costa and McCrae developed the NEO Personality Inventory (NEO PI) to measure the five traits. Although many different measures of the FFM have been developed, Costa and McCrae's NEO Personality Inventory-Revised (NEO PI-R) remains the most widely used and researched.

### Description and Measurement

The results of repeated independent studies have yielded interpretations consistent with the five factors named by Costa and McCrae. Neuroticism (N, sometimes referred to by its polar opposite as Emotional Stability) represents the tendency to experience psychological distress (e.g., anxiety, irritability) and to display maladaptive responses. Extraversion (E, sometimes called Surgency)



refers to a predisposition to experience positive affect (e.g., joy, passion) and to an interpersonal style that is energetic, enthusiastic, and assertive. Openness to Experience (O, sometimes called Openness to Intellect, and sometimes abbreviated as Openness) reflects a tendency to be curious and imaginative, and to seek novel experiences and ideas. Agreeableness (A, sometimes called Friendly Compliance) involves a trusting, caring, and forgiving interpersonal style. Conscientiousness (C, sometimes referred to as Dependability) pertains to an individual's level of organization, dependability, and persistence in pursuing goals.

Using measures such as the NEO PI-R, psychologists can describe an individual's personality according to these five dimensions, often referring to people as "high" or "low" on a given trait. For instance, others would most likely characterize a person who is high in Conscientiousness as dependable, reliable, hardworking, and highly motivated. Some measures of the FFM also include facet subscales that further subdivide each of the traits into more specific components.

### Multicultural Considerations

Numerous cross-cultural studies suggest that the traits described by the FFM may be universal (i.e., observed across a wide range of cultures). Using self-report and/or ratings from collaterals (e.g., friends, family, and coworkers), all five factors have been replicated in numerous linguistic and cultural contexts, including, for instance, Germany, Canada, Finland, Poland, and the former Soviet Union. However, it is important to note that, even though all five dimensions have been observed cross-culturally, the actual meaning of factors may differ across cultures. For instance, the Openness factor appears to encompass intellect as a key component when assessed in the American English, German, and Dutch languages. In the Italian language, this factor seems to convey a rebellious component.

In addition, it is possible that other traits, not included in the FFM, are important to understanding personality. For example, Interpersonal Relatedness, which involves a desire for harmony in relationships, has been observed to be important in Chinese cultures and among multiethnic individuals. Furthermore, numerically identical scores on a given scale, such as Extraversion, may actually reflect lower (or higher) levels of the trait in one culture as compared to another.

Greater within-culture variability is observed in self-reported trait scores among European as compared to Asian samples. This could be due to a tendency for Asians to avoid extreme responses, which, in turn, results in a narrower range of scores. Individual differences might also be attenuated in collectivistic cultures in which individuals sometimes de-emphasize their unique attributes to avoid "standing out" as "different." It is also possible that individual differences are simply less salient in more collectivistic cultures.

### Five-Factor Theory

McCrae and Costa have proposed a five-factor theory based on the large body of research on the FFM. The factors are included as part of a concept labeled *basic tendencies* in the theory. Rather than explaining the development of the factors themselves, the theory attempts to account for research findings on the FFM.

Basic Tendencies include personality traits and other biologically based components such as cognitive ability, perception, and sexual orientation. Although Basic Tendencies are primarily genetically based, they are also influenced by other biological mechanisms such as diseases, pharmacological interventions, and prenatal influences.

The theory also postulates Characteristic Adaptations. These result from the interaction of Basic Tendencies with External Influences (the social and physical environment, including cultural and historical context). Characteristic Adaptations include an array of psychological features, such as skills, interests, attitudes, beliefs, plans, goals, habits, self-concept, and how an individual experiences social roles and relationships. The influence of Basic Tendencies on behavior or experience is mediated by the influence of Characteristic Adaptations.

Another concept, the Objective Biography, refers to everything the individual thinks, does, or feels, and, as such, is referred to as the "output" of the personality system. The Objective Biography includes such things as one's career-related behaviors, emotional reactions, and relationship history.

Although five-factor theory is still in its infancy, it was formulated on the basis of a large body of empirical literature on the development of personality. The theory readily accounts for the stability of personality observed in numerous studies. Cross-cultural studies



also lend support to the theory. However, the theory remains to be adequately tested.

### **The Five Factors Across the Life Span**

Research indicates that personality traits, including the Big Five, tend to remain remarkably stable after age 30. Nevertheless, there is evidence of broad patterns of personality change that occur at predictable points during the life span. For instance, compared to older adults, college-age individuals tend to score higher on Neuroticism, Extraversion, and Openness, and lower on Conscientiousness and Agreeableness. These patterns of change have been observed across a wide range of cultures. Another finding that has been observed in several cultures is that women tend to score higher than men in Neuroticism, Openness, and Agreeableness.

Research on the FFM has demonstrated links between an individual's personality traits and life course. Neuroticism is the trait most clearly linked to psychological adjustment. Men who are high, versus low, in Neuroticism are more likely to develop psychological disorders. They also tend to smoke more and are more likely to demonstrate poor adjustment throughout the life span. For example, they experience greater career and marital disruption, and report lower levels of morale and life satisfaction. Men who are high on Neuroticism are also more likely to report experiencing a midlife crisis, and neuroticism in both husbands and wives is predictive of divorce.

The remaining traits appear to be associated with several positive and some negative outcomes. For instance, those high in Extraversion tend to enjoy higher income levels and greater job satisfaction, and may be more likely to emerge as leaders. Open individuals demonstrate greater evidence of creative potential and openness has been linked to higher scores on measures of intelligence, although research findings are somewhat inconsistent in this regard. High levels of openness are sometimes related to bizarre (e.g., psychotic) thinking, but open individuals may be more likely than less open individuals to seek mental health treatment when needed. Agreeable individuals often report that their goals are meaningful and they may experience more effective social relationships than those who are less agreeable. Agreeableness is often highly valued in service-related occupations. Conscientiousness is associated with increased income levels, job status, and job satisfaction. Conscientious

individuals also appear to be less likely to abuse drugs and alcohol, but extreme Conscientiousness may be linked to obsessive-compulsive features.

### **The Five-Factor Model and Coping**

Several studies have examined how personality traits relate to coping methods. Neuroticism is associated with various forms of psychopathology, such as depression, anxiety disorders, personality disorders, and somatic complaints. It appears that neurotic individuals are poor at coping, in part, because they tend to create their own distress. For instance, neurotic individuals often interpret ambiguous circumstances in more threatening ways, are more easily upset, and are prone to dramatizing minor issues. Other ineffective coping strategies associated with Neuroticism include passivity, self-blame, hostile reactions, and wishful thinking.

Conversely, Extraversion is associated with a tendency to experience positive affect, while less often experiencing negative affect. Since extraverts tend to interact more with others, it is reasonable to conclude that they are more likely (than introverts) to seek others during stressful times. Extraverts are frequently able to assess problems in a more positive light, and display more active and effective coping mechanisms.

Conscientious people are likely to use well-organized plans that aid them in coping with stress. Agreeable people may turn to social support networks to help alleviate their distress. Although Openness appears to be largely unrelated to mood and well-being, those who are more open might be expected to use their imagination to identify creative ways to cope with stressors. Overall, however, Conscientiousness and Neuroticism seem to be the best predictors of coping style.

### **The Five-Factor Model and Health Behaviors**

The FFM may be predictive of health behaviors, such as smoking, physical activity, and diet. For instance, among women, high levels of Neuroticism, Extraversion, and Openness have been linked to less healthy habits, whereas high levels of Agreeableness and Conscientiousness have been linked to healthier attitudes and behaviors. Similarly, men who are more neurotic practice fewer healthy habits, whereas those who are more conscientious and agreeable



demonstrate healthier attitudes. Conscientiousness in particular is related to longevity, which may be a function of engaging in fewer unhealthy behaviors.

Three of the five factors are linked to risky sexual behaviors. Behaviors that place one at greater risk of HIV infection (e.g., lack of condom usage) are associated with higher levels of Neuroticism and lower levels of Conscientiousness. In addition, those who are low in Openness may be prone to denying the possibility that they could become infected.

### Implications for Counseling Practice

The FFM was developed to describe normal, as opposed to pathological, personality traits. Thus, the model and its associated measures, including the NEO PI-R, appear to be well suited for an approach that emphasizes client strengths and normal, developmental concerns. The NEO PI-R, which is usually completed in 30 to 40 minutes, lends itself well to brief therapy approaches. An interpretive report is available that provides a narrative description of the client's personality and identifies potential implications regarding several clinically relevant areas (e.g., mood and psychological adjustment, coping mechanisms, interpersonal styles, cognitive processes, and motivation). In addition, collateral ratings from spouses, peers, and others may be useful, particularly within the context of marriage and family counseling.

Because measures of the FFM are not inherently focused on psychopathology, scores on the five traits can readily be discussed with clients. Such results can be useful in identifying clients' strengths and in tailoring interventions to individual clients. For instance, those who score high on Openness often engage in the spontaneous use of humor to cope with stress, whereas those low on Openness are more inclined to use faith-based coping strategies, such as prayer. Extraverted individuals might prefer group and talk-oriented therapies, whereas introverts might benefit from more directive, task-oriented approaches. Open individuals could be expected to respond well to novel, innovative approaches, whereas those lower on this trait might prefer conventional approaches that provide more structure and direction.

Counselors might also find the FFM useful in predicting clients' responses to counseling. For instance, Conscientious clients might be inclined to diligently follow treatment recommendations, and Agreeable individuals might be expected to be more cooperative

and trusting and, hence, to develop rapport quickly. In contrast, Neurotic individuals are inclined to hold unrealistic expectations, and might benefit from assistance with setting clear, realistic goals at the outset of treatment.

The FFM can also be useful in career counseling. The five broad factors are related to John Holland's six vocational interest types (i.e., Realistic, Investigative, Artistic, Social, Enterprising, and Conventional). Generally, Extraversion is associated with Enterprising and Social interests, Openness is related to Artistic and Investigative interests, and Agreeableness is associated with Social interests. However, examination of the five traits at the more specific facet level may prove most useful when assisting clients with career-related decision making. For instance, those who score high on the Ideas facet of Openness might find Investigative careers to be most satisfying, whereas those who score high on the Aesthetics facet of Openness might find Artistic careers more rewarding.

Although the NEO PI-R was not specifically designed to measure psychopathology, scores on the NEO PI-R correlate with measures of mental disorders. As such, the instrument might be useful in alerting counselors to signs of psychopathology. For instance, Neurotic individuals may be more vulnerable to developing psychological disorders. Counselors working with clients who score high on this trait might consider following up with further assessment to examine for psychopathology.

It should be noted that, although these recommendations are based on existing empirical evidence regarding the FFM, counseling process and outcome research that is specifically focused on examining the preceding predictions is needed. Additionally, it is important to attend to multicultural factors when integrating knowledge of the FFM into counseling practice. Despite extensive cross-cultural research on the FFM, it should not be assumed that the model generalizes to all cultures. Therefore, counselors would do well to consider each client's unique background when using the FFM as a framework for conceptualizing clients' presenting concerns.

*Kimberly Stark-Wroblewski and Laura Ann Glass*

*See also* Costa, Paul T., and McCrae, Robert R. (v2); Multicultural Personality (v3); Personality Assessment (v2); Personality Theories (v2); Personality Theories, Traits (v2); Trait-Factor Counseling (v4)



### Further Readings

- Costa, P. T., Jr., & McCrae, R. R. (1992). *Revised NEO Personality Inventory (NEO-PI-R) and NEO Five-Factor Inventory (NEO-FFI) professional manual*. Odessa, FL: Psychological Assessment Resources.
- Costa, P. T., Jr., & Widiger, T. A. (Eds.). (2002). *Personality disorders and the five-factor model of personality* (2nd ed.). Washington, DC: American Psychological Association.
- De Raad, B. (1998). Five big, Big Five issues: Rationale, content, structure, status, and crosscultural assessment. *European Psychologist*, 3, 113–124.
- McCrae, R. R. (2005). Personality structure. In V. J. Derlega, B. A. Winstead, & W. H. Jones (Eds.), *Personality: Contemporary theory and research* (3rd ed., pp. 192–216). Belmont, CA: Thomson Wadsworth.
- McCrae, R. R., & Allik, J. (Eds.). (2002). *The five-factor model of personality across cultures*. New York: Kluwer Academic/Plenum.
- McCrae, R. R., & Costa, P. T., Jr. (1991). The NEO Personality Inventory: Using the five-factor model in counseling. *Journal of Counseling and Development*, 69, 367–372.
- McCrae, R. R., & Costa, P. T., Jr. (2003). *Personality in adulthood: A five-factor theory perspective* (2nd ed.). New York: Guilford Press.
- Miller, T. R. (1991). The psychotherapeutic utility of the five-factor model of personality: A clinician's experience. *Journal of Personality Assessment*, 57, 415–433.
- Sullivan, B. A., & Hansen, J. C. (2004). Mapping associations between interests and personality: Toward a conceptual understanding of individual differences in vocational behavior. *Journal of Counseling Psychology*, 51, 287–298.
- Trobst, K. K., Wiggins, J. S., Costa, P. T., Jr., Herbst, J. H., McCrae, R. R., & Masters, H. L., III. (2000). Personality psychology and problem behaviors: HIV risk and the five-factor model. *Journal of Personality*, 68, 1233–1252.
- Watson, D., & Hubbard, B. (1996). Adaptational style and dispositional structure: Coping in the context of the five-factor model. *Journal of Personality*, 64, 737–774.

---

## PERSONALITY THEORIES, PHENOMENOLOGICAL

---

Phenomenological approaches to personality take human experience or *subjectivity* as their primary focus. Phenomenological theorists assert that obtaining accurate knowledge of another person requires

understanding how that person experiences the world. Personal experience constitutes immediate reality. A secondary focus of phenomenological theories is *the self*. The self is thought of as a cognitive-affective structure through which experience is filtered.

### Basic Tenets

William James's famous distinction between the "I" (subject) and the "me" (object) can be used to understand all phenomenological approaches to personality. The "I" refers to experience as it occurs for an individual (e.g., what it feels like to win an award). The "me" refers to how a person thinks about her- or himself as an object of knowledge (e.g., what someone thinks about her- or himself for having won an award). In the phenomenological model, the "I" and the "me" interact to give an individual's self-consciousness its particular form.

Phenomenological theorists focus on two kinds of subjective experience. The first is how people experience themselves in relation to others. An example is how a young girl experiences herself as her parents express disapproval of her behavior. People's positive and negative experiences with others contribute to how they learn to value themselves, sometimes called *self-regard*. Carl Rogers was particularly concerned with *conditions of worth*—or expectations that others have in order for a person to be acceptable to them. If a person receives the message that certain thoughts and feelings are unacceptable to others, he or she may become uncomfortable having those experiences and distort them. When that occurs, experiences of the person's own spontaneous inclinations are not integrated into his or her self-concept and the "me" becomes less genuine or *inauthentic*. Such a constrained self is not free.

The second kind of experience is what might be called *internal monitoring*, or people's intuitive sense of their own inclinations. According to phenomenological theory, experiences that reflect a person's truer inclinations always exist in some form and can be recovered, leading to a more authentic sense of the self. Put another way, everyone has an inherent and consciously accessible potential to develop in a healthy way, and people can always learn to connect with that potential. Somewhat incorrectly, psychologists commonly consider this focus on self-actualization to be synonymous with phenomenological theory.

American phenomenological theories are also referred to as humanistic theories because they



emphasize the inherent goodness of the individual. In the work of Carl Rogers, personal experience is valued as uniquely genuine and wholesome. People may commit atrocious acts and be quite bad, but Rogers and like-minded humanists reject the notion of an inherent or inborn badness.

The strain of phenomenological theory that stresses the human capacity for self-actualization has considerable overlap with 19th-century Romanticism, which focused on the truth value of individual intuition in contrast to the rationally discovered laws of science. Like the Romantics, the proponents of a self-actualization approach are suspicious of an exclusively scientific perspective, particularly one that focuses on technical details and ignores meaning.

## Existentialism

A more European version of phenomenological theory, referred to as existentialism, also studies human experience and subjectivity, but the experiences upon which it focuses are loneliness, isolation, and death. Existential theorists believe that such ultimate concerns can be sources of a deeper personal meaning. The awareness of death in particular is considered to be uniquely human.

Existentialist theorists also point out that some people seek constraint. They choose to distort their own experience in order to narrow their world and feel safer. They regard actively choosing a constrained self as self-deception and *bad faith*.

## Strengths and Weaknesses

An important contribution of phenomenological theories is their focus on personal meaning, health, and growth. In many ways they are the immediate ancestors of what is currently called *positive psychology*. Phenomenological theorists are also psychology's original advocates of the personality trait known as Openness to Experience. A related contribution of phenomenological theories is their emphasis on the uniqueness of individual persons. This uniqueness is easily lost in the statistical methods of scientific psychology that focus on average types. The narrative tradition in modern psychology emphasizes the individualist aspect of the phenomenological model by telling stories about people. These stories are supposed to contain information that is left out of statistical summaries. Finally, the common tenet of

self-structure, where experiences congruent with that structure are accepted and experiences incongruent with that structure are rejected, has gained credence in both psychodynamic and social-cognitive theories of personality.

An important criticism of phenomenological theory highlights its tendency to suggest that individual perception and emotional intuition has some special relationship with truth. In contrast, many psychologists and philosophers cogently argue that the degree of personal conviction with which a belief is held has limited bearing on its accuracy. History offers many examples of propositions that people believed in deeply, but that turned out to be false, such as flat earth theory. Modern science with its emphasis on skepticism and experimental research has taught us to see beyond common sense and individual perception. In the scientific style of reasoning, personal experience has to be mediated by critical analysis.

Since the 17th century, the scientific outlook has contributed to the Western world's "progressive" character. Criticisms based on Romantic ideas can stand in opposition to the thinking that perpetuates this character. Rogers was quite cognizant of this problem early in his career, although in his later years he seemed to increasingly emphasize individual intuition.

## Empirical Support

Evaluating the "validity" of phenomenological theories of personality is a substantial challenge because phenomenological theory and the scientific tradition work from altogether different theories of knowledge. Phenomenological approaches are primarily interested in capturing the subjective reality of individual human beings. They propose that abstract concepts such as self-actualization, authenticity, meaning, and spirituality are essential to understanding what it means to be human. Concepts such as these are considered to be legitimate by phenomenology's standards of validity because they appear in qualitative analyses of human subjectivity. However, the ability to evaluate the validity of phenomenological constructs using quantitative empirical hypothesis testing is limited.

Despite problems in establishing the scientific validity of phenomenological postulates, empirical research does offer some support for Rogers's personality theory. According to social psychologists, individuals seek out data that verify their preexisting



self-concept, even if that self-concept is negative, as in the case of clinically depressed individuals. These behaviors highlight the importance of the self as an organizer of perceptual experiences, but they also cast doubt on the universality of seeking positive regard. Similarly, cognitive psychologists have shown that self-schemas affect how individuals process incoming information, what information they are likely to remember, and what feedback they are likely to accept about themselves. These scientifically confirmed processes offer evidence for the existence of a self-system that is quite similar to what Rogers postulated.

There is also support in clinical psychology. Marsha Linehan, an expert on borderline personality disorder (BPD), has studied the detrimental effects of *invalidating environments*. In an invalidating environment the subjectivity of a child is actively rejected and devalued. Negative emotions such as anger and sadness are especially devalued. This devaluation renders the child incapable of trusting his or her own subjective perceptions once he or she has reached adulthood. Linehan's formulation of BPD as involving intolerance of negative affect invokes claims similar to those of Rogers, such as a belief in the power of early interpersonal environments to foster healthy personality development and the value of accepting experiences as they occur.

### Implications

Phenomenological psychology's concepts such as self-actualization, authenticity, and congruence have considerable utility in the realm of personality theory and offer a persuasive depiction of human psychological life, but such concepts can become marginalized in the world of quantitative research due to their esoteric nature. Despite the widespread acceptance of the importance self-structure, phenomenological approaches are on the periphery of contemporary personality research. Even so, phenomenological methods of inquiry, such as narrative case studies, continue to provide rich, contextualized information about individual personality.

*Peter Zachar and Tres Stefurak*

*See also* Constructivist Theory (v2); Costa, Paul T., and McCrae, Robert R. (v2); Dialectical Behavior Therapy (v2); Humanistic Approaches (v2); Narrative Therapy (v2); Personality Theories (v2); Positive Psychology (v2); Rogers, Carl R. (v2)

### Further Readings

- Gendlin, E. T. (1982) *Focusing* (2nd ed.). New York: Bantam.
- Kohut, H. (1977). *The restoration of the self*. New York: International Universities Press.
- Linehan, M. (1987). Dialectical behavior therapy for borderline personality disorder: Theory and method. *Bulletin of the Menninger Clinic*, 51(3), 261–276.
- Markus, H. (1977). Self-schemata and processing information about the self. *Journal of Personality and Social Psychology*, 35(2), 63–78.
- Rogers, C. R. (1951). *Client-centered therapy*. Boston: Houghton Mifflin.

---

## PERSONALITY THEORIES, PSYCHODYNAMIC

---

The set of theories of personality development that are referred to collectively as psychodynamic or psychoanalytic vary dramatically in their specifics, but share a common lineage and several core concepts. Scholars agree that Sigmund Freud, the famous and controversial Austrian neurologist who wrote the first comprehensive theory of personality development, laid the foundation for all subsequent psychoanalytic theories. Similarly, the fundamental principles that tie psychodynamic theories together can be traced back to Freud's theory of psychoanalysis.

Aspects of personality development common to all psychodynamic theories are (1) the existence and importance of the unconscious and (2) the significance of childhood relationships and experiences in shaping personality. Psychodynamic theories are often further categorized according to other features they share, but there is no consensus on how various theories should be grouped. Moreover, many advocates of a psychoanalytic approach contend that, although various factions may disagree on the abstract theory that guides their understanding of personality, their therapeutic techniques or "clinical theories" are much more similar than different. Nevertheless, a common delineation of the major schools of thought is (1) Freudian, (2) ego psychology, (3) object relations theories, and (4) self psychology.

It is appropriate to add a new category to this traditional list to account for theories that have emerged in recent decades. These theories, which will be broadly referred to here as *contemporary psychodynamic theories*, are reinterpretations, integrations, and expansions



of the older theories. They are innovative in that they are informed by contemporary ideas such as systems theory, pluralism, feminism, and social constructivism.

## Freudian Theory

Freud's theory of psychoanalysis is also referred to as *classical* or *traditional psychoanalytic theory*. Certain components of Freud's comprehensive theory are sometimes also singled out and, although not technically correct, used as if they were synonymous with the whole of Freudian theory. The most common of these are *drive theory* and *structural theory*. Drive theory refers to Freud's focus on instinctual drives toward pleasure and aggression as principle motivators of human behavior. Structural theory refers to Freud's initial description of a tripartite configuration of the mind—consisting of id, ego, and superego.

Despite vehement detractors over the past century, Freud's influence has been so great that a basic understanding of his theory is necessary for any student of contemporary Western thought. It is important to remember, however, that psychoanalytic theory has evolved over time, and very few (if any) analysts today would consider themselves strict "Freudians." Instead, contemporary Freudians maintain much of Freud's theoretical foundation, but also incorporate the advances proposed by numerous followers and dissenters of Freud over the past 100 years.

Freud proposed that the human mind or psyche is primarily unconscious or out of conscious awareness. Moreover, a healthy and mature psyche is comprised of the id, ego, and superego, with the ego orchestrating an appropriate balance of id and superego activity. Freud also described developmental stages whereby infants progress from an id-dominated and superego-less state to a more balanced psyche when the superego forms at 5 or 6 years of age.

### The Id

The id is the only psychic structure that is fully present at birth. It translates the organism's needs into essential instinctual drives or wishes that are the primary motivators of behavior. The instincts that play the biggest role in Freud's theory are the drives for life and death, which are often oversimplified as sexual and aggressive drives, respectively. More precisely, however, the life instinct seeks self-preservation and species preservation; the psychic and emotional

energy associated with this drive is called *libido*. Freud theorized that a death drive, a wish for a natural dissolution to an inorganic state, must be programmed into all living things because the natural course of life is death. A primary defense against the anxiety stirred by the death instinct is aggression, which is sometimes even directed at the self (as seen in some forms of depression).

The conceptualization of the movement and power of the id's quest for wish fulfillment as a type of energy was inspired, in part, by advances in the field of thermodynamics in the 19th century. For example, Freud's description of how libidinal energy requires release is akin to how compressed physical energy is continually pushing against whatever is containing it.

Although the word *libido* became associated with sexual pleasure among the general public, Freud proposed that libidinal energy was tied to many other life-sustaining needs (e.g., eating). The part of the body that is the focus of libidinal pleasure (i.e., an erogenous zone) changes over time. In infancy, the erogenous zone is the mouth. Indeed, Freud labeled the first stage of psychosexual development the *oral stage*. He believed that proper attention to the oral needs of an infant (i.e., birth to 18 months) is necessary for healthy development. Infants who have every oral need instantly gratified are apt to be too dependent on their mothers and not resolve the psychological conflicts of this stage. Their "fixation" in the oral stage can result in dependent personality traits as adults. Infants who have their oral needs met inconsistently are liable to experience anxiety that becomes a more permanent aspect of their character. Freud also theorized that personality traits such as insatiability, cynicism, and argumentativeness had their roots in problematic experiences during the oral stage.

### The Ego

Freud proposed that the ego (or "I") begins to develop as infants use their connection with external reality to manage id drives. The ego is considered the core of the self and the part of the psyche that usually deals with external reality. Unlike the id and superego, the ego is primarily conscious. Eventually, the ego also mediates the conflict between the id and the superego, primarily through defense mechanisms such as denial, repression, and projection. Optimally, as children progress through each psychosexual stage, the ego develops more mature psychological defenses



(e.g., humor) to manage their id impulses while discharging libidinal energy. In addition, they learn other nondefensive mechanisms (e.g., frustration tolerance) to foster self-preservation. These latter functions of the ego are central in the theories that make up the branch of psychoanalysis known as *ego psychology*.

At about 18 months of age, the physical development of the toddler brings about a change in the erogenous zone. From 18 months until about 3 years of age, children are in the *anal stage*, when the anal area is the main source for the expression of libidinal energy. Freud believed that exploring and gaining control over bodily processes (e.g., toilet training) are essential for successful progression through the anal stage. Aggressive urges are often expressed as desires to gain control over others as well. Numerous potential problems that give rise to maladaptive personality traits can occur in the anal stage. For example, children who are shamed about their bodily processes may react with self-loathing or poor self-esteem. Freud also coined the term *anal retentive* to describe the overcontrolled personality type who is preoccupied with cleanliness and order. The *anal expulsive* personality, on the other hand, is crass and destructive.

### **The Superego**

From about age 3 to 5 or 6, children must navigate the *phallic stage*. For several reasons, this part of Freud's psychoanalytic theory is the most controversial. First, it ignores social taboos against thinking of children as sexual beings and suggests that incestuous feelings, albeit unconscious, are normative. In addition, many of Freud's conclusions related to this stage are considered sexist and homophobic. Third, because gender-role differences and the development of the superego are explained by events of the phallic stage, it is considered the most central to his theory and, therefore, attracts more critical attention.

Freud proposed that during the phallic stage the genitals become the primary source of sensual pleasure, although Freud differentiates this from the genital pleasure experienced by adults. Instead, pre-school-age children discover their genitals during this stage and often learn that touching themselves feels pleasurable. Freud theorized that if parents react with anger or judgment, their sons might fear that their penis would be lopped off as a punishment (which, from a boy's perspective, would also explain why his sisters lacked penises). Freud referred to this fear as

*castration anxiety* and suspected that, if not worked through, castration anxiety could cause problems with adult sexual functioning (i.e., either sexual inhibition or promiscuity).

For boys, the most important aspect of the phallic stage is the necessity to resolve what Freud referred to as the *Oedipus complex*. This developmental challenge was named for the protagonist in the ancient Greek play *Oedipus the King*, by Sophocles. As the tragic story goes, a young man who does not know he was adopted kills a man whom he later learns to be his father and marries a woman whom he later learns to be his mother. Freud proposed that normal psychosexual development leads boys to want their mother for themselves and to have hostility toward their father for frustrating this goal. Castration anxiety, however, motivates boys to displace their yearning for their mother onto other females—first girls and then women. For Freud, the Oedipal struggle ends when a boy identifies with and internalizes his father. Thus, the intrapsychic and idealized paternal authority figure is the core of the male superego.

According to Freud, the development of the superego in females is less direct and, by design, less successful, than it is in males. Freud, taking a "male as normative" perspective, theorized that castration anxiety is the best motivator of superego development; and, girls, because they do not have penises, cannot experience castration anxiety. Instead, Freud assumed that a girl in the phallic stage tends to wonder why she does not have a penis and this concern gives rise to *penis envy*. Penis envy can never be fully resolved, but indirect solutions such as marrying a man or bearing a son are possible. The first step down this path is for a girl to become more like her mother so that she can eventually attract a husband. Thus, for girls, the process of internalizing one's mother results in the formation of the superego.

The superego is a vital part of Freud's tripartite personality structure. The superego consists of two components—the *conscience* and the *ego ideal*. The former comprises the moral standards learned from parents, society, and various people or institutions that are considered moral authorities. The latter is the internalized image of one's perfect self and how one should emulate parents and other authority figures. In a sense, the conscience activates when a person is behaving in a manner contrary to his or her values, while the ego ideal activates when people reach a goal they are proud of or, alternatively, when they fail to reach a goal.



As a psychic structure that evolved to defend against Oedipal wishes, the superego can be thought of as opposite of the id. The id is concerned with fulfilling wishes and pleasing the self, while the superego is focused on denying the self and/or pleasing others. In short, the id is governed by the “pleasure principle” and the superego operates by the “morality principle.” The ego uses the “reality principle” to dissipate the resulting tension of the id–superego dichotomy.

Not surprisingly, personality problems can result from a superego that is either too weak or too strong. A weak (or nonexistent) superego results in a person who has no moral compass and may be involved in criminal activities. People with overdeveloped superegos, on the other hand, typically have personality traits such as perfectionism, overachievement, an excessive sense of responsibility, and chronic guilt about their perceived failings.

Once a child reaches age 5 or 6, he or she moves into a stage of psychosexual quiet because the libido is repressed (i.e., remains unconscious). Freud proposed that this “latency” period allows school-age children to focus on other important aspects of development such as intellectual growth, physical mastery, and social relationships. Freud did not write much about the *latency stage* or the *genital stage*, the final stage of development that begins at puberty. With regard to the formation of personality, Freud’s classical drive theory is essentially focused on events that end with the phallic stage.

A number of Freud’s followers had doubts about some aspects of traditional psychoanalytic theory. Some of the intellectuals and clinicians who were initially drawn to Freud’s innovative way of understanding human behavior followed unquestioningly, but many strove to develop or improve the theory. Some of this latter group, such as Freud’s daughter Anna, considered themselves loyal Freudians, but are now categorized differently. Other theorists, such as Carl Jung, disagreed with some of Freud’s ideas and were, in a sense, no longer welcome in Freudian circles. A third type of Freudian descendant is those psychoanalysts who actively rejected some or most of Freud’s theory and set out to develop their own. Some of these innovators developed theories that are so different from Freud’s that they are not classified under the psychoanalytic umbrella. A good example of a psychoanalyst who followed such a path is Fritz Perls, the founder of Gestalt Therapy. The remainder of this entry, however, focuses on the men and women who

extended Freud’s ideas and proposed theories of personality that have enough in common with that lineage to be considered psychoanalytic.

## Ego Psychology

In general, theorists who are considered ego psychologists focus on the motives and functions of the ego and give less attention to the drives of the id. The most prominent ego psychologists are Anna Freud, Heinz Hartmann, and Erik Erikson. Anna Freud is best known as the founder of child psychoanalysis and for the extension of her father’s notion of ego defenses. Her student, Erik Erikson, was inspired by both Sigmund and Anna Freud and developed a theory of psychosocial stages that cross the life span.

Erikson retained the structure of Freud’s first four psychosexual stages and added four adolescent and adult stages of his own. He theorized that the types of developmental challenges that individuals encounter are related to the social environment and, if not mastered, can have negative effects throughout life. For example, from about 18 months to 3 years, toddlers face the challenge of developing more autonomy from caregivers. Achieving autonomy can be facilitated by parents who allow more autonomy and do not criticize their child. If independence is thwarted, however, the child is likely to experience feelings of shame and doubt that can make it even more difficult for the child to master subsequent stages. Furthermore, the feelings of shame and doubt can affect the child’s developing personality and lead to traits such as inhibition and indecisiveness.

Hartmann viewed the development of the ego as the key to mental health. In addition to bolstering ego functions such as reality testing, judgment, and affect regulation, Hartmann argued that psychoanalysis should aim to expand analysts’ “conflict-free ego sphere.” That is, the more people are able to reason, think, and remember without emotional interference, the better they will be able to adapt to their environment.

## Object Relations Theories

According to object relations theorists, it is a drive for relationships, rather than id impulses, that shapes personality and motivates behavior. The term *object relations* refers to the largely unconscious internalized perceptions that children develop about their relationships with significant others in their life. The British theorists who are most often associated with this branch



of psychoanalytic theory are Melanie Klein, W. R. D. Fairbairn, and Donald W. Winnicott. The most notable American object relations theorists are Edith Jacobson, Margaret Mahler, and Otto F. Kernberg. Although all of these theorists are considered object relations theorists, each of their theories is unique. For example, Mahler wrote a comprehensive theory about the development of object relations from birth to age 3. She was particularly interested in the processes that allowed children to separate from their mothers and develop individuality. In addition to the internalization of how relationships are imagined by the child, Mahler's complex theory explains how children develop a stable self-concept as well as a concept of others.

Kernberg extended Mahler's ideas and wrote about a third level of internalization—the perception of the how self and other are related—which is now a central aspect of object relations theory. These templates for “self,” “other,” and “relationships” are largely responsible for how a person feels and acts in relation to him- or herself and other people. For example, the child who perceives that he or she is “good” based on his or her relationships with early caregivers will have a positive self-concept and expect to be treated well in later relationships.

Winnicott did not propose a formal theory, but he was perhaps the most influential of the early object relations theorists because he was able to present his ideas to a lay audience. It is because of Winnicott that terms such as *good enough mother*, *transitional object*, and *true self and false self* are widely known.

Another theorist who deserves mention here is John Bowlby, who developed attachment theory. Although Bowlby trained as an analyst and was strongly influenced by Anna Freud and Klein, his most innovative work emerged from his knowledge of ethology. He focused on the role of the mother–infant attachment bond in shaping a child's “internal working model” of self, other, and relationships. The ability of researchers to assess the type of attachment bond toddlers have with their caregivers has led to a tremendous amount of empirical research on attachment theory.

### Self Psychology

Heinz Kohut developed self psychology, the branch of psychoanalytic theory that took the biggest turn away from Freud's focus on the tripartite personality structure. Instead of discussing the development of and conflicts between the id, ego, and superego, Kohut focused on the interpersonal experiences that facilitate or derail the development of the “self.” The self is the core of

personality and the achievement and maintenance of a cohesive sense of self is the most important psychological function. As inherently social beings, infants and children require relationships that provide certain experiences in order to develop a healthy self. Similar *selfobject experiences* are required to maintain self-esteem over the course of life, although people can learn to provide themselves with some adequate selfobject experiences through creative endeavors, religion, and the like.

Two important selfobject functions are *mirroring* and *idealizing*, which help a person to feel known, valued, and admired, forming the core of the person's self-esteem. Kohut also wrote about the selfobject function that helps people feel interpersonally connected; he called this *twinship*.

Another key aspect of Kohut's theory is the notion that a type of narcissism or self-absorption is necessary for the normal development of a secure sense of self. Kohut labeled this particular facet of psychic structure the *grandiose self*. The other part of the *bipolar self* is the internalized parent, also referred to as the *idealized selfobject*. Over time, if parents are adequate selfobjects for the child, a healthy and cohesive self will develop. Adequate selfobjects provide a balance of mirroring (i.e., empathic approval), which supports the grandiose self, and mild empathic failures (e.g., disappointing or setting a limit with the child), which frustrates the grandiose self. Problems arise if either the grandiose self or the idealized selfobject does not develop normally. For example, without a strong idealized selfobject, people typically cannot soothe themselves when they are emotionally upset. Instead, they may turn to harmful things (e.g., alcohol) to serve this purpose.

### Contemporary Psychodynamic Theories

Theorists who have been influenced by the work of postmodern philosophers, more recent political movements, and advances in neuroscience are continuing to develop psychoanalytic theory. While the term *postmodern* means different things across disciplines and to different scholars, here it refers to a recognition that what is “real” to a person is not unitary or objective, but pluralistic and subjective. The postmodern paradigm shift means analysts and psychodynamic psychotherapy clients are no longer conceptualized as clinical specimens that can be observed and understood by an objective and neutral analyst. Instead, postmodern psychoanalysts view the therapeutic encounter as a co-construction of reality in which the subjective



experience of both parties is valid. Moreover, each person's subjective experience is necessarily embedded in the culture, context, and relationships of his or her environment and must be considered in that light. This innovative metatheory is referred to as *intersubjectivity theory*. Key figures in this movement (and the name of their theories) include Roy Shafer (action language), Irwin Z. Hoffman (dialectical constructivism), and Robert D. Stolorow (intersubjective systems theory). In addition, Jessica Benjamin and Juliet Mitchell have contributed a feminist perspective to intersubjectivity theory.

Another postmodern theorist who has made a tremendous impact on the field is Stephen A. Mitchell, who, along with Jay R. Greenberg and Lewis Aron integrated components of various theories and synthesized a postmodern relational theory of psychoanalysis. Mitchell, in particular, argued that *relational theory* should supplant classical psychoanalytic theory, which he considered obsolete. Relational theory and intersubjectivity theory are closely allied and often grouped together as postmodern psychoanalytic theories.

The newest frontier of psychoanalytic theory appears to be the presentation of research in neuroscience to validate or renovate psychoanalytic theory. Leaders in this area include psychoanalysts Glenn O. Gabbard and Drew Westen and neuroscientists Eric Kandel and Paul Grobstein.

Patricia L. Kaminski

**See also** Adlerian Therapy (v2); Attachment Theory (v4); Constructivist Therapy (v2); Defenses, Psychological (v2); Ego Strength (v2); Free Association (v2); Freud, Sigmund (v2); Jung, Carl (v2); Personality Theories (v2); Psychoanalysis and Psychodynamic Approaches to Therapy (v2); Transference and Countertransference (v2)

## Further Readings

- Benjamin, J. (1988). *The bonds of love: Psychoanalysis, feminism, and the problem of domination*. New York: Pantheon.
- Bowlby, J. (1969). *Attachment and loss. Vol. 1: Attachment*. New York: Basic Books.
- Brenner, C. (1982). *The mind in conflict*. New York: International University Press.
- Cassidy, J., & Shaver, P. R. (Eds.). (1999). *Handbook of attachment: Theory, research, and clinical applications*. New York: Guilford Press.
- Freud, S. (1958). *The standard edition of the complete psychological works of Sigmund Freud* (Vols. 1–23). London: Hogarth Press.

- Gabbard, G. O. (2004). *Psychodynamic psychiatry in clinical practice* (4th ed.). Washington, DC: American Psychiatric Publishing.
- Gabbard, G. O. (2006). A neuroscience perspective on transference. *Psychiatric Annals*, 36, 283–288.
- Greenberg, J., & Mitchell, S. A. (1983). *Object relations in psychoanalytic theory*. Cambridge, MA: Harvard University Press.
- Hoffman, I. Z. (2001). *Ritual and spontaneity in the psychoanalytic process: A dialectical-constructivist view*. Hillsdale, NJ: The Analytic Press.
- Kandel, E. R. (2005). *Psychiatry, psychoanalysis, and the new biology of mind*. Washington, DC: American Psychiatric Publishing.
- Kohut, H. (1971). *The analysis of the self*. New York: International Universities Press.
- Kohut, H. (1977). *The restoration of the self*. New York: International Universities Press.
- Mitchell, S. A. (1988). *Relational concepts in psychoanalysis: An integration*. Cambridge, MA: Harvard University Press.
- Mitchell, S. A. (2000). *Relationality: From attachment to intersubjectivity*. Hillsdale, NJ: The Analytic Press.
- Mitchell, S. A., & Aron, L. (1999). *Relational psychoanalysis: The emergence of a tradition*. Hillsdale, NJ: The Analytic Press.
- Person, E. S., Cooper, A. M., & Gabbard, G. O. (Eds.). (2005). *The American Psychiatric Publishing textbook of psychoanalysis*. Arlington, VA: American Psychiatric Publishing.
- Renders, R., & Mellman, L. (2006, July). *Highlights of the psychoanalytic literature: A topical reading list*. Retrieved from <http://www.apsa.org/Portals/1/docs/fellowship/FellowBiblio.pdf>
- St. Clair, M., & Wigren, J. (2003). *Object relations and self psychology: An introduction* (4th ed.). Belmont, CA: Wadsworth.
- Stern, D. (1985). *The interpersonal world of the infant: A view from psychoanalysis and developmental psychology*. New York: Basic Books.
- Stolorow, R. D., Brandchaft, B., & Atwood, G. E. (1995). *Psychoanalytic treatment: An intersubjective approach*. Hillsdale, NJ: The Analytic Press.

## PERSONALITY THEORIES, SOCIAL COGNITIVE

Developed over nearly five decades by Albert Bandura, social cognitive theory—which emphasizes the reciprocal interaction of behavior, cognitive, and



other personal factors, and environmental influences on human functioning—has been carefully derived from empirical findings and subjected to repeated tests within many areas of human functioning. This reciprocal process of theory development and testing has, over the years, yielded multiple versions of this continuously evolving theoretical perspective. It is important to understand some background regarding the conceptual and empirical underpinnings of the theory before describing the theory as it stands today.

## Background

Social cognitive theory had its origins in the 1950s and 1960s with the paradigm shift from psychodynamic approaches to psychotherapy to psychotherapeutic interventions increasingly based on learning theories. In fact, Bandura was instrumental in moving psychotherapy from a predominantly intrapsychic, talk-based intervention toward more active, learning-based interventions that relied heavily on performance and mastery. A hallmark of learning approaches was the reliance on observable behavior and framing hypotheses that are open to refutation.

A landmark in this evolution toward learning-based interventions was Bandura and Richard H. Walters's seminal book *Social Learning and Personality Development*, which was published in 1963. It built upon John Dollard and Neal Miller's earlier social learning theory and argued for the importance of modeling and self-regulatory processes in behavior change. In his 1969 *Principles of Behavior Modification*, Bandura further developed this emerging *social learning theory* of human behavior. The word *social* as it is used here refers to observational learning and the attendant self-regulatory processes inherent in learning vicariously from models. Further empirical and theoretical work enhanced and expanded this social learning theory approach to behavior change throughout the 1960s and 1970s.

The range of learning theory-based therapies expanded dramatically at this time and included theorists and researchers whose work was characterized under the rubric of *behavior modification*. Although this work generally relied on Skinnerian principles and eschewed intrapsychic phenomena, Bandura's research and theoretical writings were based on broader conceptions of human functioning. Bandura's early approach to therapy encompassed Skinnerian learning by response consequences, but also emphasized learning

through observation, cognitive control, and the reciprocal determination of behavior. In Bandura's theory, the origins of personal functioning lay in the complex, ongoing, and reciprocal interaction of behavioral, environmental, and personal determinants. "Personal" influences in this model include the role of cognitive and affective variables, including self-regulatory mechanisms that enable people to guide their own behavior.

The early empirical tests of social learning theory conducted by Bandura and his colleagues focused mainly on modeling interventions with phobic disorders. Guided mastery, the treatment approach studied and refined in this line of inquiry, has proven remarkably robust and effective when applied to a broad range of phobias and anxiety disorders. It is based on the assumption that people avoid what they fear, and that avoidance can instill higher levels of anxiety about the feared object. This technique consists of systematic and repeated exposure to the feared object or situation, planned carefully such that early exposures are mild, and more intense exposures are only introduced upon extinction of anxiety associated with milder levels of exposure. This is accomplished by having the therapist, in real time, "guide" the client through the different levels of exposure, using encouragement and modeling to promote a gradual approach to the feared object or situation.

For example, people with snake phobias were exposed, at a distance, to a snake in a cage, and led through a series of steps that brought them into closer and closer contact, over time, with the caged snake, until eventually they could touch and even handle the formerly feared object. The guide in this intervention would go first at each stage, modeling approach behavior, and providing encouragement and whatever other aid was necessary. The aides and prompts were reduced and eventually eliminated as mastery increased and anxiety and fear decreased. Although clinical phobias of this type were sometimes critiqued as being far removed from the problems of real counseling clients, in fact this general procedure has been proven effective for a wide range of clinical problems, including such intransigent disorders as agoraphobia, with treatment effects often shown to generalize to areas of functioning beyond anxiety reduction.

Over the years it was established that a purely behavioral explanation of the effects of participant modeling and guided mastery was sorely inadequate. As Bandura examined the treatment components that directly produced change, he became increasingly



intrigued with the role of client beliefs about their personal competence that appeared to underlie the effectiveness of social modeling interventions. Bandura labeled these pivotal beliefs about personal competence *self-efficacy* in his landmark 1977 article “Self-Efficacy: Toward a Unifying Theory of Behavioral Change.”

### Self-Efficacy Theory

As originally proposed by Bandura, *self-efficacy expectations* refer to a person's beliefs concerning his or her ability to successfully perform a given task or behavior. Self-efficacy expectations determine whether a behavior, task, or course of action will be initiated and also influence the persistence and the amount of effort expended in pursuing a task or course of action. Efficacy precepts are therefore postulated by Bandura to be central mediators of behavior and behavior change. In this view, successful psychological interventions, regardless of their specific elements, are successful through their ability to enhance efficacy expectations. Efficacy expectations are also situation specific. Self-efficacy is not viewed as a trait, nor is it viewed as a global personality characteristic. Rather, it is a specific cognitive judgment made with regard to a specific task, behavior, choice, or course of action. Furthermore, self-efficacy often predicts future behavior better than does past performance, primarily because the effects of past behavior are mediated by cognitive judgments in the form of efficacy beliefs. A central premise running throughout Bandura's work is that people create and produce rather than simply foretell their future behavior. In other words, people are human agents, capable of directing their own behavior, and not merely hapless bystanders to environmental events or intrapsychic processes.

Efficacy expectations vary on the dimensions of level or magnitude, strength, and generality. Where behaviors can be rank ordered in terms of a hierarchy of difficulty, *level* of efficacy expectations refers to the difficulty level in that hierarchy that a person feels he or she can master. Of course, many behaviors of great import are complex and cannot be so ordered. But when tasks can be ranked in terms of the challenge presented, the level dimension of efficacy expectations is crucial. For example, the level of mathematics self-efficacy can be measured by assessing which mathematics courses a person feels confident of mastering, and can predict the point at which specific students

begin avoiding mathematics, for example, in high school when math is no longer required.

*Strength* of self-efficacy expectations refers to how confident an individual is in his or her expectations of succeeding at a given task or course of action, whatever the level. For example, whereas the level of mathematics self-efficacy might indicate the most challenging math course an individual thinks he or she can master in high school (e.g., Algebra II), strength would indicate the robustness or confidence of the individual's belief in being able to succeed at that course (e.g., on a scale ranging from no confidence to total confidence). Because individuals with high and strong efficacy expectations have confidence in their ultimate success, they are likely to initiate challenging tasks, make choices, persist in endeavors, and ultimately succeed in their chosen courses of action. A lack of confidence or weak self-efficacy regarding a behavior or behavioral domain leads an individual to avoid those behaviors for which efficacy is low and weak, undermines effort expenditure and persistence, and may also produce anxiety in relation to the behaviors for which efficacy is low and weak.

Self-efficacy strength affects not only choice, effort, and persistence but also influences thought patterns, attributions, and emotional reactions. For example, people with low and weak self-efficacy tend to doubt themselves, judge challenges to be unrealistically difficult, and tend to ascribe failure to their lack of ability. All of these thought patterns can produce debilitating negative emotions. Individuals holding high and strong efficacy beliefs, conversely, judge even difficult tasks as within their ability range, are more likely to organize their abilities well and mobilize resources necessary to ensure success, and tend to attribute success to their own efforts.

Finally, *generality* of self-efficacy expectations refers to the range of associated behaviors that are affected by the level and strength of efficacy beliefs. That is, generality indicates whether self-efficacy with regard to a particular behavior is circumscribed (limited to that specific behavior) or applies to related behaviors. For example, success on a challenging mathematics test may produce high and strong efficacy expectations for succeeding only in that course (e.g., Algebra II) or may generalize to expectations for success in other mathematics courses (e.g., pre-Calculus and Calculus) as well.

In addition to postulating this core mechanism by which behavior change occurs, Bandura also specified



four sources of information through which self-efficacy expectations are learned and by which they can be modified. These sources of information include performance accomplishments, that is, experiences of successfully performing the behaviors in question; vicarious learning or modeling (observing similar others); verbal (or social) persuasion, for example, encouragement and support from others; and physiological arousal (physical and emotional states), for example, anxiety in connection with the behavior.

Of these four sources of efficacy information, performance accomplishments are hypothesized, based on empirical observations and social learning theory, to exert the strongest influence. Mastery experiences and performance accomplishments are hypothesized to influence behavior through the strong and resilient changes they produce in efficacy beliefs. Conversely, personal failures are less likely to produce performance decrements or undermine efficacy in the face of previous successful performance accomplishments and a consequent strong self-efficacy. Modeling or vicarious learning alone is likely to exert a less potent influence on efficacy beliefs than will performance-based experiences. Decreasing debilitating anxiety and lowering other forms of negative arousal can also strengthen self-efficacy. And finally, verbal encouragement or discouragement (later referred to as *social persuasion*), although alone a weaker source of efficacy information than the other three sources, may have a strengthening or undermining effect on efficacy beliefs as well.

Because of its major role in mediating choice, performance, and persistence, self-efficacy can be useful not only in understanding and predicting behavior but also in designing interventions to change behavior. Anxiety, for example, is viewed by Bandura as a “co-effect” of self-efficacy expectations in that the level of anxiety is seen to covary inversely with the level and strength of self-efficacy expectations; as self-efficacy expectations are increased, anxiety should decrease, and vice versa. Thus, interventions focused on increasing self-efficacy expectations via attention to the sources of efficacy information should increase approach versus avoidance behavior, enhance competence, and, concurrently, decrease anxiety in relationship to the behavior.

Finally, in this first major article delineating the theoretical underpinnings of self-efficacy theory, Bandura made an important distinction between efficacy and outcome expectations. Whereas self-efficacy expectations are an individual’s cognitive judgments about his or her ability to successfully engage in a behavior or

perform a task, outcome expectations are judgments about the consequences of successfully performing the task. That is, self-efficacy beliefs address the questions, “Can I do this?” or “How confident am I that I can do this?” In contrast, outcome expectations involve the question, “What will happen if I do this?” Efficacy expectations are usually a primary influence on behavior, always important and usually primary, but outcome expectations can also be important under certain conditions. People are more likely to choose to engage in an activity not only to the extent that they view themselves as competent at performing the activity but also to the extent to that they expect their efforts to lead to valued, positive outcomes (e.g., social and self-approval, tangible rewards).

Efficacy and outcome expectations also interact with actual, or measured, ability in some predictable ways. A person with strong self-efficacy and high outcome expectations will engage in determined, confident action that is likely to be successful and personally satisfying, assuming that efficacy expectations are reasonably consistent with actual performance capabilities. Efficacy expectations that are unrealistically low compared to potential performance can be debilitating, but efficacy expectations that are somewhat high compared to available objective indicators of performance can be empowering and produce enhanced performance. This is probably often the case in individuals labeled by others as “overachievers.”

When self-efficacy is high and strong but outcome expectations are negative, self-efficacy may lead an individual to efforts at overcoming and changing aspects of the environment that fail to produce positive outcomes, in essence attempting to change his or her environment. Conversely, in the face of negative outcome expectations (or environmental unresponsiveness), an individual with low and weak self-efficacy may tend to give up easily and become despondent. An individual with both low self-efficacy and low outcome expectations is most likely to be apathetic, foregoing efforts to engage in the behavior or to change the outcomes associated with successful performance.

In addition to efficacy and outcome expectations, goals are also identified as important to the self-regulation of behavior. By setting goals, people help to organize and guide their own behavior, and to sustain it in the absence of more immediate payoffs and despite inevitable setbacks. Social cognitive theory posits that goals are importantly tied to both self-efficacy and outcome expectations: People tend to set goals that are



consistent with their views of their personal capabilities and of the outcomes they expect to attain from pursuing a particular course of action. Success or failure in reaching personal goals, in turn, provides valuable information that helps to alter or confirm self-efficacy beliefs and outcome expectations.

Although the work of Bandura and his colleagues initially focused on the role of self-efficacy expectations in the genesis and treatment of clinical syndromes such as phobias, the potential of self-efficacy theory to contribute to the understanding of, and intervention in, a variety of other clinical and counseling areas was quickly recognized. In the late 1970s and 1980s researchers began applying self-efficacy theory to a multitude of issues, such as addictive behaviors, depression, stress, health promotion, and education and instruction. In the field of counseling, Gail Hackett and Nancy Betz first extended self-efficacy theory to understanding the career development of women and the career domain more generally. Applications of self-efficacy theory were found to have considerable utility for the understanding of gender differences in academic major and occupational choice, mathematics self-efficacy, and career decisions; the performance of students in science and engineering; the educational and career behavior of racially and ethnically diverse students; and the work adjustment of adults.

### Social Cognitive Theory

With the publication in 1986 of his work *Social Foundations of Thought and Action: A Social Cognitive Theory*, Bandura formally introduced a fully developed social cognitive theory, which encompassed and extended his previous work on social learning and self-efficacy theories. In fact, *self-efficacy theory* remained the most crucial element in his theoretical model of human functioning. In his 1997 book, *Self-Efficacy: The Exercise of Control*, Bandura defined self-efficacy expectations as “beliefs in one’s capability to organize and execute the courses of action required to manage prospective situations” (p. 2). The shift in label from social *learning* to social *cognitive* theory represented not a break or radical departure from previous conceptualizations but, rather, the evolution, maturation, and considerable further refinement of many of the concepts that had been previously introduced, along with some additions and the increasing recognition of the primacy of cognitive capabilities in human functioning. Essentially, the label change reflected the fact that

Bandura’s theorizing had moved considerably beyond its earliest social learning underpinnings.

In his description of social cognitive theory in 1986, Bandura emphasized the triadic and reciprocal interaction of behavior, cognitive, and other personal factors, and environmental influences on human functioning. Furthermore, social cognitive theory rests on the recognition of the vital importance of four basic human capabilities in understanding human behavior: symbolizing capability, forethought capability, vicarious capability, and self-regulatory capability.

Symbolizing capability refers to people’s ability to form cognitive representations of their worlds, allowing them to build internal models to guide future action. Forethought is the ability to anticipate the future, including imagining the possible consequences of actions, which can provide motivation for pursuing courses of action that do not have immediate payoffs. Vicarious capabilities refer to the ability to learn from observation. People not only can learn in an imitative sense, reproducing observed behavior, but also can learn rules and expectations, and can absorb lessons from the consequences experienced by models. This can significantly reduce the amount of time necessary for learning. And finally, people learn from the direct environmental consequences of their actions and the expectations of others and self-regulate their behavior. Self-defined standards and expectations develop which then govern behavior just as effectively as do external contingencies.

Self-reflection is an integral part of the self-regulatory process, and a uniquely human capability that profoundly affects human behavior. People’s ability to analyze their own experiences, examine their thoughts and feelings, and make choices about their behavior is a crucial aspect of human functioning. And, as noted earlier, self-efficacy expectations and related self-referential thoughts are central to any understanding of human functioning. Also included under self-regulatory capabilities are self-monitoring, self-evaluation, development of internal standards such as performance goals, social referent functions such as comparisons with others, valuation of activities (e.g., interests), performance appraisals, and performance attributions.

### Applications

The research literature on the applications of social cognitive theory in counseling and clinical psychology has grown exponentially. Evidence is also accumulating for



the usefulness of social cognitive theory in intervening across domains of human functioning, including a wide range of counseling concerns.

One productive example of the applications of social cognitive theory is its extension to the area of cognitive functioning and academic performance. Studies of children's efficacy beliefs and school performance consistently demonstrate the central role of efficacy judgments in predicting academic achievement. Research on the role of the four sources of self-efficacy information has also yielded results supportive of social cognitive theory's propositions. Studies of school performance have included investigations of teacher efficacy and learner academic efficacy, that is, self-efficacy with regard to achievement in specific school subjects.

Academically oriented studies have also focused on the role of social cognitive factors in the self-regulation of learning, self-appraisal skills, coping with setbacks, persistence, effort, motivation, and task choice. Bandura himself has studied the role of the collective efficacy of teachers in student learning outcomes. More broadly, applications of social cognitive theory have guided studies of, and interventions with, physical activity and sports, healthy functioning, various medical conditions, alcohol and drug abuse, organizational performance, political efficacy, decision making, and mastery of occupational roles, to name but a few of the areas of study.

In the field of counseling psychology, there have been several notable and sustained applications of social cognitive theory. For instance, the theory has been used as a basis for studying subjective well-being (an aspect of psychological wellness), counselor development, and research productivity. The most extensive application of social cognitive theory in counseling psychology lies in the area of career development. Robert Lent, Steven Brown, and Hackett's social cognitive career theory (SCCT) builds on earlier research on self-efficacy and seeks to explain three interrelated aspects of career development: (1) how basic academic and career *interests* develop, (2) how educational and career *choices* are made, and (3) how academic and career *success* is obtained. Central variables of Bandura's social cognitive theory form the core building blocks of SCCT—self-efficacy beliefs, outcome expectations, and goals. According to SCCT, these beliefs play key roles in interest development, choice, and performance.

Career-related self-efficacy refers to an individual's personal beliefs about his or her capabilities to

perform successfully particular educational or vocational behaviors or courses of action. A person might, for instance, feel very confident in being able to accomplish tasks for successful entry into, and performance in, scientific fields, but feel much less confident about his or her abilities in social or enterprising fields, such as sales. Career-related outcome expectations refer to the expected consequences of attempting particular educational or vocational pursuits. Personal goals may be defined as a person's intentions to engage in a particular activity (e.g., to pursue a given academic major) or to attain a certain level of performance (e.g., to receive an A in a particular course).

In SCCT, interests in career-relevant activities are seen as the outgrowth of self-efficacy and outcome expectations. Interests, along with self-efficacy and outcome expectations, incline people to set and pursue particular academic and career goals. Success (or failure) in the goal pursuit process then serves as a source of performance feedback, helping to revise or stabilize self-efficacy and outcome expectations in a continuous loop. SCCT also incorporates a wide array of additional factors (e.g., abilities, culture, social supports, and barriers) that have been found to influence career development, highlighting the central paths through which individual, behavioral, and environmental factors jointly determine academic and career outcomes.

*Gail Hackett and Robert W. Lent*

*See also* Bandura, Albert (v2); Cognitive-Behavioral Therapy and Techniques (v2); Cognitive Therapy (v2); Personality Theories (v2); Self-Efficacy/Perceived Competence (v2); Social Cognitive Career Theory (v4)

### Further Readings

- Bandura, A. (1969). *Principles of behavior modification*. New York: Holt, Rinehart, & Winston.
- Bandura, A. (1977). Self-efficacy: Toward a unifying theory of behavioral change. *Psychological Review*, 84, 191–215.
- Bandura, A. (1977). *Social learning theory*. Englewood Cliffs, NJ: Prentice Hall.
- Bandura, A. (1986). *Social foundations of thought and action: A social cognitive theory*. Englewood Cliffs, NJ: Prentice Hall.
- Bandura, A. (1997). *Self-efficacy: The exercise of control*. New York: Freeman.
- Bandura, A., & Walters, R. H. (1963). *Social learning and personality development*. New York: Holt, Rinehart, & Winston.



- Betz, N. E., & Hackett, G. (1981). The relationship of career-related self-efficacy expectations to perceived career options on college men and women. *Journal of Counseling Psychology*, 28, 399–410.
- Hackett, G. (1985). The role of mathematics self-efficacy in the choice of math-related majors of college women and men. *Journal of Counseling Psychology*, 32, 47–56.
- Hackett, G. (1995). Self-efficacy in career choice and development. In A. Bandura (Ed.), *Self-efficacy in changing societies* (pp. 232–258). New York: Cambridge University Press.
- Hackett, G., & Betz, N. E. (1981). A self-efficacy approach to the career development of women. *Journal of Vocational Behavior*, 18, 326–336.
- Hackett, G., & Byars, A. M. (1996). Social cognitive theory and the career development of African American women. *The Career Development Quarterly*, 44, 322–340.
- Lent, R. W. (2005). A social cognitive view of career development and counseling. In S. D. Brown & R. W. Lent (Eds.), *Career development and counseling: Putting theory and research to work*. New York: Wiley.
- Lent, R. W., Brown, S. D., & Hackett, G. (1994). Toward a unifying social cognitive theory of career and academic interest, choice, and performance [Monograph]. *Journal of Vocational Behavior*, 45, 79–122.
- Lent, R. W., Brown, S. D., & Hackett, G. (2000). Contextual supports and barriers to career choice: A social cognitive analysis. *Journal of Counseling Psychology*, 47, 36–49.
- Lent, R. W., Hackett, G., & Brown, S. D. (1999). A social cognitive view of school-to-work transition. *The Career Development Quarterly*, 44, 297–311.
- Pajares, F., & Urdan, T. (Eds.). (2006). *Self-efficacy beliefs of adolescents*. Greenwich, CT: Information Age.

---

## PERSONALITY THEORIES, TRAITS

---

Traits may make up the most readily recognizable component of personality. Very simple at base, traits describe what individuals are like, often with single words such as *adventurous* or *kind*. Although traits are used commonly, both in daily life and in research, surprisingly little is known about how traits work or how they influence behavior. Instead, psychology was dominated by 70 years of skepticism that traits influence behavior, or for that matter that traits even exist. Finally, after many years of empirical investigation, psychologists now know that traits do in fact relate to consistent behavior, although this consistency is not easily discernible in behavior on any

given occasion. Furthermore, personality psychologists have discovered how traits may be organized, that traits predict a host of important life outcomes, and that traits increase in stability from adolescence through adulthood.

Traits are an important concept in counseling psychology for at least three reasons. First, the personality of clients infuses the counseling process, and traits make up a major component of personality. Second, traits are highly relevant to life success, to adjustment, and to affective and personality disorders. Third, traits constitute a useful gateway to understanding clients and to clients understanding themselves.

### What Are Traits?

There has not yet been sufficient research to determine the nature of traits or their underlying mechanisms, that is, how they work. Personality psychologists take their starting point in common sense and in the everyday ways people describe each other. From there, they diverge, and there are still multiple competing definitions of traits and theories about how they work.

### Agreement About What Traits Are

Despite these disagreements, there are at least five issues on which most trait theories agree. First, traits describe individuals and emphasize the style or manner in which individuals act, think, and feel. For example, bolder individuals act, think, and feel in a bolder manner. Second, traits are characteristics on which people differ from each other. For example, some individuals are bolder than others. Third, individuals most likely do not differ in whether or not they have the trait but rather in the degree to which they have the trait. For example, although it may be convenient to speak of bold people and timid people, it is more likely that individuals differ all along a continuous dimension of boldness.

Fourth, traits endure for at least some extended time. For example, describing someone as a bold individual is more accurate if that individual is bold for more than just a moment. Finally, traits are broad descriptions of some kind of regularity, generality, or coherence in behavior, thought, and feeling. This generality may refer to the way the individuals act across different situations, to the way they act in significant, defining situations, or to a wide range of ways they act. For example, bolder individuals engage in a variety of



bold actions, such as stating opinions, taking risks, and making decisions.

In sum, trait theories generally agree that traits describe differences between people in their styles of acting, thinking, and feeling, on continuous dimensions that show at least some enduring stability and broad generality. To call someone bold is to say that he or she behaves, thinks, and feels in bolder ways than others do, and that he or she has done so for some period of time in a variety of situations with a variety of actions.

### Three Foci of Theories About the Nature of Traits

Theories addressing the nature of traits typically focus on one of three aspects of traits. The first type of theory focuses on underlying causal forces that constitute the traits, in order to explain trait-relevant behavior. For example, Gordon W. Allport proposed one of the early and prominent theories of the causal forces underlying traits. He claimed that traits are neurocognitive structures that lead individuals to interpret a range of situations as being equivalent to each other and relevant to the trait. Although subsequent theories have proposed other causal forces, there has not been enough research yet to explain how traits cause behavior. Unresolved issues include how many causes underlie traits and the relative strengths of those causes. Also unknown is whether a given trait has the same effect in every situation, or has different effects in different situations depending on the unique features of that situation.

A second type of theory does not necessarily deny explanatory causal forces, but rather focuses attention on the behavior patterns that result from traits. For example, the density-distributions approach characterizes a person's trait by his or her entire distribution of trait-relevant behaviors, rather than by only his or her most frequent or typical way of acting. This theory finds that most individuals regularly and routinely manifest nearly all levels of most traits in their daily behavior. For example, most individuals have a normal distribution of how bold their behaviors are that ranges from very timid to very bold.

Instead of trying to explain or describe behavior, the final type of theory focuses on how the different traits relate to each other in people. One prominent such theory, the Big Five theory, concerns which traits co-occur in the same individuals to what extent. For

example, boldness and adventurousness co-occur in the same individuals but they do not co-occur frequently with calmness and security.

### Which Traits Should Be Used to Describe Individuals?

The search for traits is a search for descriptions of individuals that point out styles of acting, thinking, and feeling. These styles should be present in multiple behaviors of a given individual but present to different degrees in different individuals. It turns out that there is an overabundance of such candidates. The English language contains over 18,000 potential words for traits (e.g., the letter *a* alone provides *acerbic*, *angelic*, *active*, *adventurous*, *argumentative*, *agreeable*, *anal*, *arduous*, *ardent*, *able*, *addled*, *aloof*, *affable*, *amiable*, and many more). Adding multiword phrases, such as *can dish it out but can't take it* reveals a potentially infinite number of traits. This overabundance makes a comprehensive description of an individual seem almost impossible. Furthermore, the existence of differently named traits that might actually mean something similar (e.g., kind, charitable, gracious, and humane) creates wasted efforts. Thus, there arose a need to organize traits into a manageable structure.

Raymond B. Cattell and others applied a creative solution in the early part of the 20th century. They used the statistical technique of factor analysis to identify redundant traits, that is, those traits that usually co-occur in people. For example, if each individual has the same level of boldness as he or she has of adventurousness, then these two traits are redundant. This technique revealed the astonishing finding that eliminating redundancies reduced the number of traits from 18,000 down to only 5. For example, the traits of being bold, assertive, adventurous, talkative, dominant, and many others can be subsumed under the trait of Extraversion. The five subsuming traits, called the Big Five, are Extraversion, Agreeableness, Conscientiousness, Emotional Stability (which is also known as its opposite, Neuroticism), and Intellect. Subsequent research has shown that most other theoretically derived traits fit into the Big Five as well.

There are other significant theoretical claims about which traits are the most important. Hans J. Eysenck proposed that Psychoticism, Extraversion, and Neuroticism are the three most important traits. Jack Block proposed that Ego-Control and Ego-Resiliency



are two traits that are central to human functioning and adaptation. The interpersonal circumplex model proposed that the two traits of Dominance and Agreeableness are the most important interpersonal traits.

### Are Traits Real?

For almost 70 years, psychologists debated whether traits make much difference in people's behavior. Some argued that traits are such weak determinants of behavior relative to the immediate situation that a given individual will act very differently from occasion to occasion. Others countered that traits are such powerful determinants of behavior that each individual will act in a consistently similar way from occasion to occasion. When similarity of behavior across multiple occasions was finally assessed, it turned out that each person's behavior indeed varied a great deal from moment to moment, as much as mood varied across occasions and more than people differed from each other. For example, the typical person changed rapidly back and forth from introverted to extraverted within the course of just 2 weeks. This evidence suggested that situations are very powerful in determining momentary behavior. People's everyday intuition that traits do exist and are powerful may be based on the fact that they see the people they know in a limited range of situations. People then overgeneralize from the few instances of behavior they witness.

However, it turns out that each person has a mean or average way of acting around which he or she varies. Furthermore, measuring each person's average in successive weeks revealed these averages to be almost perfectly consistent from week to week. For example, a person's average level of Extraversion is usually the same week after week.

Thus the two positions can be integrated: Each person has his or her own different and very stable average around which he or she varies quite a bit from occasion to occasion. The stable averages reveal individuals' traits and the variability around the averages reveals their responses to situations. Interestingly, people also differ in how much they vary around their average, and this too is stable from week to week.

These findings demonstrate that individuals have enormous flexibility in how they act, think, and feel in the moment, yet still have consistent behavioral

tendencies (i.e., traits). Isolated actions do not define a person, and some people are more variable than others.

### Do Traits Matter?

While the debate raged about whether traits exist, correlational studies were quietly accumulating evidence that traits have large and diverse relationships to many of the important outcomes in life, including happiness, objective events, and even death.

Regardless of how happiness, or psychological well-being, is defined, it is strongly predicted by the Big Five traits. Happiness—defined as positive affect (e.g., excitement and enthusiasm)—is predicted more strongly by Extraversion than by any other variable, including health, money, and relationships. Happiness—defined as the absence of negative affect (e.g., little anxiety or stress)—is predicted more strongly by Emotional Stability than by any other variable. Happiness—defined as life satisfaction, the cognitive judgment of one's overall life quality—is predicted by all five traits.

Traits also predict objective outcomes. Job performance, across all levels of job complexity, is predicted by Conscientiousness. Marriage quality, conflict, abuse, and ultimately marriage dissolution, are all predicted strongly by Emotional Stability and Agreeableness. Mental health disorders have been related to all Big Five traits. Even length of life is predicted by Conscientiousness, as effectively as it is predicted by high blood pressure and high cholesterol. People higher in Conscientiousness may live as much as 5 years longer than those lower in Conscientiousness. This potentially very important finding has generated much recent research in trying to verify it and identify the causal mechanisms underlying personality's relationship to length of life.

### Can Traits Change?

Given that traits have such important life consequences, it is imperative to determine whether traits can be changed. Research has established that there is at least some genetic influence on individuals' trait levels. However, it is important not to confuse genetic influence with inability to be changed.

Researchers have accumulated extensive evidence about how traits change naturally. Longitudinal studies measure participants' traits at one age and then



years or decades later measure the same participants' traits again. These studies have converged on two general findings. First, there is evidence of slight overall mean level changes from adolescence to older adulthood. Slight decreases occur in Emotional Stability (or Neuroticism), Extraversion, and Intellect and slight increases occur in Agreeableness and Conscientiousness, Ego-Control, Delay of Gratification, and Ego-Resiliency. Second, there is substantial change in people's relative positions on personality traits during adolescence and emerging adulthood. Relative-position changes are changes when some individuals increase on the trait and others decrease, changing their positions relative to each other. For example, many adolescents become less neurotic as they grow into their 20s but some become more neurotic. As individuals grow older, however, there is increasingly less relative-position change.

These descriptive studies reveal only the natural developmental changes that occur in traits. There have been few systematic efforts to change traits, so it is unclear what would happen if a systematic effort were undertaken to, for example, change an individual's level of Emotional Stability. However, the large amount of variability in the typical individuals' trait-relevant behavior suggests that change is possible. Most individuals already routinely and regularly act at most levels of most traits, suggesting that they have at least some capacity to express traits at different levels.

### Future Directions

Several unresolved questions about traits have important implications for personality and for the quality of life. First, the nature of traits must be determined. This issue refers to the causal forces underlying traits, the patterns of behavior that are implicated by trait standing, and how traits relate to other personality components such as motives and beliefs. Second, the understanding of the organization of traits needs to be advanced. The cross-cultural generalizability of organizational schemes, their appropriateness for all individuals, and the inclusion of as yet undiscovered traits all require additional research. Third, the causal mechanisms underlying the influence of traits on life outcomes must be determined in order to provide more effective opportunities for intervention. Finally, the potential and means for change in personality

traits should be identified, given the significance of traits in life.

William Fleeson

*Author's Note:* Preparation of this entry was supported by National Institute of Mental Health Grant R01 MH70571.

**See also** Costa, Paul T., and McCrae Robert R. (v2); Cultural Values (v3); Goldberg, Lewis R. (v2); Personality Assessment (v2); Personality Disorders (v2); Personality Theories (v2); Personality Theories, Five-Factor Model (v2); Personality Theories, Social Cognitive (v2); Person–Environment Interactions (v2); Psychological Well-Being, Dimensions of (v2); Trait-Factor Counseling (v4)

### Further Readings

- Allport, G. W. (1937). *Personality: A psychological interpretation*. New York: Henry Holt.
- Block, J. (1971). *Lives through time*. Berkeley, CA: Bancroft.
- Cattell, R. B. (1973). *Personality and mood by questionnaire*. San Francisco: Jossey-Bass.
- Epstein, S. (1979). The stability of behavior: On predicting most of the people much of the time. *Journal of Personality and Social Psychology*, 37, 1097–1126.
- Fleeson, W. (2001). Toward a structure- and process-integrated view of personality: Traits as density distributions of states. *Journal of Personality and Social Psychology*, 80, 1011–1027.
- McCrae, R. R., & Costa, P. T., Jr. (2005). *Personality in adulthood: A five-factor theory perspective* (2nd ed.). New York: Guilford Press.
- Mischel, W., & Shoda, Y. (1995). A cognitive-affective system theory of personality: Reconceptualizing situations, dispositions, dynamics, and invariance in personality structure. *Psychological Review*, 102, 246–268.
- Ozer, D. J., & Benet-Martinez, V. (2006). Personality and the prediction of consequential outcomes. *Annual Review of Psychology*, 57, 401–421.
- Roberts, B. W., & DelVecchio, W. F. (2000). The rank-order consistency of personality traits from childhood to old age: A quantitative review of longitudinal studies. *Psychological Bulletin*, 126, 3–25.

## PERSON–ENVIRONMENT INTERACTIONS

Plato proposed the earliest person–environment (P–E) interaction model in *The Republic* around 360 B.C. He suggested that men be assigned to jobs based on



their abilities and personality because each man is ideally suited to perform the tasks necessary for success on a single job. For example, guardians of the city must have the abilities to see the enemy quickly and pursue the enemy swiftly. This seemingly simple matching model underlies modern theories in many areas of psychology and it has led to advances in research and practice.

### The P–E Interaction Model

Although many variations of the P–E interaction model exist, all emphasize the relation between two parallel aspects of the person and environment. One aspect concerns the desires of the person and the ability of the environment to fulfill those desires. The person's desires are described by various P–E models as needs, goals, values, interests, and preferences. Although some theoretical differences exist among these constructs, in P–E interaction theory they invariably refer to the attractiveness of the environmental attributes to the person. Hereafter, they are referred to as *desires*. The properties of the environment that correspond to the desires of the person are operationalized as reinforcers, benefits, satisfiers, and payoffs; henceforth, these are termed *supplies*.

The other aspect concerns the relation of the person's abilities to the demands of the environment. The relevant abilities are referred to in P–E interaction models as aptitudes, education, experience, skills, intelligence, and *g* (i.e., general mental ability). The corresponding environmental demands are referred to as environmental climate, workload, ability requirements and task requirements. These are termed *abilities* and *demands*, respectively.

Most P–E interaction models quantify the quality of the match between the person's desires and the environmental supplies and use that information to predict some outcome. Terms for the match between individuals and environments are congruence, correspondence, and P–E fit.

P–E fit is thought to produce varied outcomes including (a) reduced stress, strain, anxiety, absenteeism, turnover intentions, and turnover; (b) improved physical health, psychological health, emotional stability, adjustment, goal-setting behavior, coping, adaptation, attitudes toward learning, and vocational choice; and (c) increased creativity, motivation, performance, occupational success, commitment, tenure, satisfaction, and morale.

Although P–E interaction models have been criticized as “static” because they emphasize relatively stable aspects of the person and environment, most depict the development of P–E fit as a dynamic process that evolves over time.

### Illustrative P–E Interaction Models

The idea that P–E fit is an important moderator of outcomes is a central theoretical construct in numerous models in vocational, counseling, educational, social, industrial/organizational, and management psychology. All P–E interaction models incorporate the structural components described above. They differ primarily in their focal desire and ability dimensions. P–E models in vocational, social, and leisure psychology illustrate the model's breadth and diversity.

#### Vocational Psychology

P–E interaction models have been used most extensively in vocational psychology. Frank Parsons's theory of vocational choice was the first application of P–E interaction theory in psychology. In 1909, he suggested that vocational choice is dependent on the abilities and temperament of the worker, the demands of the job, and the logical relations between the two. During the Great Depression, University of Minnesota psychologists Donald G. Paterson and John G. Darley directed research at the Minnesota Employment Stabilization Research Institute that firmly established the usefulness of P–E interaction models in vocational psychology. They demonstrated that matching employees to occupations using aptitude test batteries, interviews, and information about occupational ability requirements led to a more effective and stable labor force.

During the 1950s and 1960s, three students of Paterson and Darley further refined the P–E interaction model. Lloyd H. Lofquist and René V. Dawis theorized that work adjustment is a function of the fit between the individual's work personality and the work environment. According to the theory of work adjustment (TWA), optimal work adjustment occurs when the worker possesses the skills necessary for success on the job and the benefits provided by the job satisfy the psychological needs of the individual.

John L. Holland postulated the existence of six basic personality types and six corresponding work environments: Realistic, Investigative, Artistic, Social, Enterprising, and Conventional (RIASEC). Optimal



vocational adjustment occurs when individuals are employed in occupations that match their personality type. Holland proposed a hexagonal arrangement of the RIASEC personality types to make his theory easy for practitioners to understand and apply. His hexagonal congruence model has profoundly influenced occupational classification, interest measurement, and career counseling. The TWA and hexagonal congruence theory are the most thoroughly investigated and widely applied P–E interaction models ever developed.

Numerous other P–E interaction models have been proposed in vocational, industrial/organizational, and management psychology, but many of them merely reiterate some aspect of the TWA. Although these theories use different labels for their focal desires, supplies, abilities, and demands, the dynamic relations among the constructs and the predictions derived from these theories are indistinguishable from those of the TWA.

### **Social Psychology**

Social psychologists and society in general are interested in the factors that underlie attraction and love. The results of efforts to identify the critical components of interpersonal attraction suggest the operation of a P–E dynamic. The attraction a person feels for another person (i.e., the “environment” in this sense) is a function of the similarity (i.e., P–E fit) of their attitudes, values, and personality. Attraction is a function of the individual’s desire for validation of his or her attitudes, values, and personality, and the confirmation supplied by another’s adoption of similar traits. As is true in vocational adjustment and other areas of behavior, the perception of similarity is more important in predicting attraction and love than an objective measure of similarity.

The influence of similarity explains why individuals are less likely to be attracted to people from a different race or culture. However, people are more attracted to individuals from a different race or culture that share their attitudes and values than to individuals from their race and culture who have different attitudes and values. Over the years, social psychologists have investigated the romantic notion that “opposites attract” using a rich diversity of approaches, but the evidence consistently shows people are attracted to those they perceive to be similar to themselves. People are generally inclined to dislike those who differ from them in attitudes and values.

### **Leisure Psychology**

The P–E interaction model also underlies two theories of leisure behavior. Mihaly Csikszentmihalyi proposed a theory that focuses on a single skill–challenge dimension of P–E fit. He suggested that a heightened state of psychological awareness (“flow”) occurs when the skills of the individual match the challenge of the activity. Boredom occurs when the individual’s skills are greater than those needed to meet the challenge. Frustration, anxiety, or fear occurs when the individual does not possess the skills required for success in the activity.

Howard E. A. Tinsley and Diane J. Tinsley’s *theory of transcendent leisure experience* postulates that individuals differ in their psychological needs (i.e., desires) and abilities, and activities differ in the needs they satisfy (i.e., their supplies) and the abilities necessary for successful performance (i.e., their demands). Satisfaction is a function of the match (i.e., P–E fit) between the needs and abilities of the individual and the supplies of the leisure activity. Transcendent leisure experiences occur only when an optimal P–E fit is achieved.

### **Efficacy of the P–E Interaction Model**

More than 100 studies of P–E interaction models have been reported in the vocational psychology literature alone. Other relevant studies have appeared in the leisure psychology, social psychology, and educational psychology literature. The primary focus has been on the fit between the desires of the individual and the supplies of the environment. Only a few studies have examined the relation between the individual’s abilities and the environment’s demands. Satisfaction is the most frequently investigated outcome, followed by stress.

Typically, the fit of the individual to the environment is calculated by subtracting the desires of the individual from the supplies of the environment. Using this metric, a positive score indicates an oversupply, while a negative score indicates a deficit. With few exceptions, fit is positively related to criteria such as satisfaction, involvement, and trust, and negatively related to criteria such as absenteeism and turnover. The research literature supports the unequivocal conclusion that the P–E interaction model provides a valid and useful way of thinking about the interaction between individuals and their environments.



## Flaws in P–E Interaction Research

Despite this optimistic summary, numerous shortcomings are apparent in the P–E interaction research. Many of these may contribute to an understatement of the efficacy of the model. Flaws that most likely vitiate the support for the P–E interaction model include sampling inadequacies, lack of commensurate measurement, use of fit indexes, use of regression analysis, and lack of longitudinal research. The lack of cross-validation and a confirmatory bias also contribute to weaker tests of P–E models.

### *Sampling Inadequacies*

Most P–E interaction research typically samples individuals from a single or very small range of environments (i.e., occupations, college majors, or leisure activities). Furthermore, most studies focus on attributes that workers desire or outcomes that environments value. For the most part, undesirable attributes and outcomes have been ignored. These sampling anomalies restrict the range of individual desires and abilities, the range of environmental demands and supplies, and the range of P–E fit scores. The effect is to attenuate the empirical relation between P–E fit scores and outcome measures and understate the support for P–E interaction theory.

### *Lack of Commensurate Measurement*

General attitudes (e.g., attitudes toward helping) and general personality measures (e.g., altruism) do not predict specific behaviors (e.g., helping in a specific situation); accurate prediction requires greater specificity. Evaluations of P–E interaction models require commensurate measurement of the desires and abilities of the individual, the supplies and demands of the environment, and the predicted outcome. Measurement is commensurate when the same dimensions are measured for the individual, the environment, and the outcome, and the relations among these elements are examined for each specific attribute. For example, a measure of salary “fit” (actual salary level minus desired salary level) can be expected to predict satisfaction with salary, but not necessarily general satisfaction and certainly not satisfaction with coworkers or supervisors. Very little of the P–E interaction research has satisfied this critical requirement.

## *Use of Fit Indexes*

The common practice of combining information about the person and the job to produce a single overall estimate of P–E fit (i.e., a fit index) has led to the development of dozens of fit indexes. Fit indexes discard valuable information. For example, algebraic difference indexes discard information about the person’s and environment’s absolute level on the dimensions measured. Absolute and squared difference indexes further discard directional information (i.e., whether supply exceeds demand or vice versa). Furthermore, fit indexes are inherently ambiguous because they discard information about the relative contribution of each factor so the value obtained could be the result of any one of a large number of specific patterns of scores. Finally, fit indexes are less reliable than the components from which they are calculated because the unreliability of the separate components is magnified in calculating the index. Therefore, fit indexes always contain less information, are less reliable, and explain less variance in the criterion than the basic data from which they are calculated. Their widespread use results in the systematic underestimation of the efficacy of P–E interaction models.

## *Reliance on Regression Analysis*

P–E interaction research often uses regression analysis to predict criterion (i.e., outcome) scores. Hit rate analysis is preferable to regression analysis for P–E interaction research. Regression analysis treats any deviation of the predicted outcome from the actual outcome, no matter how trivial, as error, whereas hit rate analysis attempts to predict membership in broadly defined, but conceptually meaningful, groups. The meaningless discrepancies that multiple regression treats as errors can be ignored by hit rate analysis. While regression analysis considers only the magnitude of errors of prediction, hit rate analysis also allows users to consider the possibility that different types of errors may differ greatly in their social and practical consequences and in their conceptual implications for the validity of P–E interaction models. Regression analysis attempts to minimize the overall “amount” of prediction error; hit rate analysis allows scholars and practitioners to minimize the overall “cost” of prediction error.

## *Longitudinal Research*

Many P–E interaction models postulate interactions between desire-supply fit and ability-demand fit.



Furthermore, over time, persons and environments shape (i.e., influence) each other. Longitudinal research is necessary to test these possibilities. The dynamic features of P–E interaction models have been ignored so completely that we cannot even guess as to the optimal or minimally adequate follow-up intervals. This is critical because individuals quickly incorporate fortuitous consequences into the norms they use when judging future situations. For example, college students used to an annual income of \$15,000 will adjust quickly to an income of \$55,000 on their first job. Thereafter, an income of \$45,000—thrice their college income—will be seen as inadequate. Longitudinal research is necessary to test the dynamic interactions postulated by P–E interaction theories.

### Cross-Validation

Multivariate data analysis techniques such as regression analysis and hit rate analysis capitalize on sample specific quirks in the data to maximize the outcome variance explained. Cross-validating the results of multivariate analyses (i.e., applying the prediction formula to an independent sample of data) is necessary to determine whether meaningful, replicable relations exist between the predictors and criterion. Unfortunately, cross-validations of P–E interaction results are seldom reported.

### Confirmatory Bias

A confirmatory bias occurs when investigators fail to examine alternatives that would disconfirm the model under analysis. Research on the P–E interaction model provides a good example of this bias. Scholars have not compared the performance of the P–E interaction model against that of alternative models such as the present status model.

The P–E interaction model uses information about the relation between the desires of the person and the supplies of the environment, for example, to predict an outcome such as satisfaction. The more parsimonious present status model suggests that the attributes of the person are irrelevant. It attempts to predict satisfaction using only information about the environmental supplies. In short, the present status model postulates that the environment affects the satisfaction of all persons in the same way (i.e., regardless of their desires, people's satisfaction is directly related to the level of supplies the environment provides).

There is some evidence that the present status model predicts as well as the P–E interaction models under some circumstances. The circumstances under which this might occur are not clear, however, because most researchers have overlooked this possibility.

### Future Directions

The P–E interaction model provides a valid and useful way of thinking about the interactions between individuals and their environments, but further conceptual development, research using longitudinal designs, and adoption of a conceptually sound approach to data analysis are necessary to advance our understanding of the dynamic interaction between persons and environments.

Howard E. A. Tinsley

**See also** Counseling Theories and Therapies (v2); Csikszentmihalyi, Mihaly (v2); Dawis, René Villanueva (v4); Holland, John L. (v4); Holland's Theory of Vocational Personalities and Work Environments (v4); Leisure (v2); Lofquist, Lloyd Henry (v4); Personality Theories, Traits (v2); Person–Environment Fit (v4); Theory of Work Adjustment (v4); Tinsley, Howard E. A. (v4); Trait-Factor Counseling (v4); Weiss, David J. (v2)

### Further Readings

- Assouline, M., & Meir, E. (1987). Meta-analysis of the relationship between congruence and well-being measures. *Journal of Vocational Behavior*, 31, 319–332.
- Dawis, R. V., & Lofquist, L. H. (1984). *A psychological theory of work adjustment*. Minneapolis: University of Minnesota Press.
- Edwards, J. R. (1991). Person-job fit: A conceptual integration, literature review, and methodological critique. In C. I. Cooper & I. T. Robertson (Eds.), *International review of industrial and organizational psychology* (Vol. 6, pp. 283–357). Chichester, UK: Wiley.
- Holland, J. L. (1997). *Making vocational choices: A theory of vocational personalities and work environments* (3rd ed.). Odessa, FL: Psychological Assessment Resources.
- Kristof, A. L. (1996). Person-organization fit: An integrative review of its conceptualizations, measurement, and implications. *Personnel Psychology*, 49, 1–49.
- Parsons, F. (1909). *Choosing a vocation*. Boston: Houghton Mifflin.
- Paterson, D. G., & Darley, J. G. (1936). *Men, women and jobs: A study in human engineering*. Minneapolis: University of Minnesota Press.



- Rounds, J. B., Dawis, R. V., & Lofquist, L. H. (1987). Measurement of person-environment fit and prediction of satisfaction in the theory of work adjustment. *Journal of Vocational Behavior*, 31, 297–318.
- Rounds, J. B., & Tracey, T. J. (1990). From trait-and-factor to person-environment fit counseling: Theory and process. In W. B. Walsh & S. H. Osipow (Eds.), *Career counseling: Contemporary topics in vocational psychology*. Hillsdale, NJ: Lawrence Erlbaum.
- Tinsley, H. E. A. (1993). Special issue on the theory of work adjustment. *Journal of Vocational Behavior*, 43, 1–4.
- Tinsley, H. E. A. (2000). The congruence myth: Analysis of the efficacy of the person-environment fit model. *Journal of Vocational Behavior*, 56, 147–179.
- Tinsley, H. E. A. (2000). The congruence myth revisited. *Journal of Vocational Behavior*, 56, 405–423.
- Tranberg, M., Slane, S., & Ekeberg, S. E. (1993). The relation between interest congruence and satisfaction: A meta analysis. *Journal of Vocational Behavior*, 42, 253–264.
- Walsh, W. B., Craik, K. H., & Price, R. H. (1992). *Person-environment psychology: Models and perspectives*. Hillsdale, NJ: Lawrence Erlbaum.

---

## PESSIMISM

---

*See* OPTIMISM AND PESSIMISM

---

## PHYSICAL ACTIVITY COUNSELING

---

Lack of regular physical activity poses a health risk, but for many people, becoming more active is a difficult goal to achieve. Physical activity counseling offers a method of helping individuals increase their physical activity levels. It adopts a person-centered approach to help individuals find ways that physical activity can be included in everyday life. Counselors must develop appropriate counseling skills as well as knowledge about physical activity. Such counseling can take place in a variety of settings, including health services, workplaces, and schools.

### Physical Inactivity as a Public Health Concern

Physical inactivity is a public health problem worldwide. Major health improvements could be achieved

if the majority of most Western populations achieved the minimum recommendations of 30 minutes of moderate activity, such as walking, on most days of the week. Strategies to promote increases in physical activity at a population level are wide ranging and include government policy, environmental changes such as increasing the number of bike paths, promotional activities led by organizations such as schools and workplaces, activities that focus on groups such as exercise classes, and individual approaches such as mailing people information or meeting with them on an individual basis to counsel about how they might achieve more physical activity in their lives.

Historically, individual approaches to increasing physical activity levels focused on sport and structured exercises that were “prescribed” to clients. Exercise prescriptions were formulated for various groups of the population such as older adults, people with type 2 diabetes, and pregnant women. However, reviews of interventions aimed at promoting physical activity have shown that a person-centered approach is likely to be more effective than a “one size fits all” prescription. In the early days of the use of the person-centered approach, a term such as *exercise consultation* or *exercise counseling* may have been used. Exercise was usually defined as a structured activity, such as attending a gym or an exercise class, with an aim of increasing fitness levels. The current preferred term is *physical activity counseling/consultation* because of the shift toward everyday activities such as walking or gardening, being considered important.

### Approaches to Physical Activity Counseling

Most approaches to physical activity counseling assume that individuals move through stages of decision making and behavior change. At one end of the spectrum, there are people who are regularly active and need encouragement to stay active; at the other end of the spectrum, there are people who have not considered being more active and who need information about the benefits an active life might bring to them. In the middle of the spectrum are individuals who are thinking about change or who may have tried to change, but have not succeeded. Sometimes moving through stages happens spontaneously or through self-help procedures. However, health professionals, such as exercise psychologists, can assist people to move through stages.



Specific guidelines about using a person-centered approach to increasing activity levels have been published. These guidelines are based on the available knowledge of what assists people in making exercise behavior change and suggest the following steps:

*Step 1: Determine physical activity history.* Discuss the reasons that the client has for wanting to increase activity. Take note of when the client was last active, the kinds of activities he or she might like now, and a measure of recent physical activity (e.g., a 7-day recall of activity).

*Step 2: Discuss decision balance.* Ask the client to consider what the pros and cons of increasing activity are for him or her. If there are more cons than pros, ask the client to consider how to minimize some of the cons.

*Step 3: Ensure social support.* Determine with the client what kind of support he or she might need and who can provide it.

*Step 4: Negotiate goals.* Help the client set realistic and time-phased goals for gradually increasing activity up to a level they have determined (e.g., “In 4 weeks’ time I would like to be walking for 30 minutes more on at least 3 days of the week”). Write these goals down.

*Step 5: Discuss relapse prevention.* If there is time or if the counseling session is with someone who is already active, then discussion on how to prevent relapse from regular activity should take place. Identifying situations in which relapses back to more sedentary living are seen to be likely, such as holidays, changing jobs, or increased family responsibilities, is a first step in preventing relapse. The client must also consider how to avoid the relapse or minimize the effect of these risky situations.

*Step 6: Provide information on local opportunities.* All information on relevant local activities, such as walking paths, swimming pools, and classes, should be on hand to supplement discussion as required.

The counseling will take 45 to 60 minutes if all six steps are dealt with in one session. Some approaches are very intensive, requiring clients to meet weekly or monthly, while other approaches have been successful with as little as two counseling sessions backed up with supporting phone calls.

Another approach to physical activity counseling comes from a general health behavior change style known as motivational interviewing. Motivational interviewing is a person-centered style that can be applied to any health-enhancing behavior, such as

trying to stop smoking, change diet, or increase physical activity. The focus of this style is to help clients think about the ambivalence they have concerning changing the behavior in question. For example, in considering the adoption of physical activity, a sedentary person may express the views that “being more active will be good for helping me lose weight,” but also believe that “physical activity is time consuming and hard work.” Counseling in the style of motivational interviewing requires the client to focus on three key issues:

1. Importance: Why should I change? Is it worthwhile?
2. Confidence: Can I change? How will I cope if . . . ?
3. Readiness: Should I do it now? What about other issues?

## Skills Required

The person doing the counseling must have excellent communication and reflective listening skills, and empathy for the people who are seeking help. Specific training in general counseling skills is a prerequisite for a physical activity counselor. Counselors must also be knowledgeable about physical activity for general and clinical populations, including any contraindications for particular groups. Finally, counselors must understand the various theories of behavior change and the various factors that will influence whether or not a person will succeed in becoming more active.

## Settings for Using Physical Activity Counseling

The primary care setting offers an opportunity to counsel people who are not achieving the minimum levels of physical activity and help them become more active.

Many clinical conditions can be improved, in terms of increased quality of life and reductions of mortality or morbidity related to the condition, by patients’ increasing their level of physical activity. Thus, outpatient and follow-up clinics for a range of conditions could provide a physical activity counseling opportunity. The strongest evidence of the benefits of increasing physical activity levels is for cardiovascular disease, type 2 diabetes, depression, certain cancers, and osteoporosis. However, there are very few clinical conditions in which increasing physical activity



would *not* be beneficial. Other locations that provide physical activity counseling opportunities include workplaces, private and public fitness and health facilities, neighborhood walking groups, slimming classes, schools, colleges, and adult education centers.

### Future Needs

There is a need to increase the evidence base on the effectiveness of physical activity counseling approaches for different segments of the population. In addition, more detailed knowledge is needed about which elements of the counseling process are linked to behavior change. Finally, the optimal duration and the frequency of counseling sessions required for long-term behavior change are not yet known.

Nanette Mutrie

*See also* Adventure Therapy (v1); Exercise and Sport Psychology (v1); Health Belief Model (v1); Intrinsic Motivation (v2); Physical Health (v2)

### Further Readings

- Dunn, A. L., Marcus, B. H., Kampert, J. B., Garcia, M. E., Kohl, H. W., & Blair, S. N. (1999). Comparison of lifestyle and structured interventions to increase physical activity and cardiorespiratory fitness—A randomized trial. *Journal of the American Medical Association*, 281(4), 327–334.
- Kahn, E. B., Ramsey, L. T., Brownson, R. C., Heath, G. W., Howze, E. H., Powell, K. E., et al. (2002). The effectiveness of interventions to increase physical activity—A systematic review. *American Journal of Preventive Medicine*, 22(4), 73–108.
- Kirk, A. F., Mutrie, N., MacIntyre, P. D., & Fisher, M. B. (2004). Promoting and maintaining physical activity in people with type 2 diabetes. *American Journal of Preventive Medicine*, 27(4), 289–296.
- Loughlan, C., & Mutrie, N. (1995). Conducting an exercise consultation: Guidelines for health professionals. *Journal of the Institute of Health Education*, 33(3), 78–82.
- Rollnick, S., Mason, P., & Butler, C. (1999). *Health behavior change: A guide for practitioners*. Edinburgh: Churchill Livingstone.
- U.S. Department of Health and Human Services. (1996). *Physical activity and health: A report of the surgeon general*. Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion.

World Health Organization. (2004). *Global strategy on diet, physical activity, and health*. Geneva: Author.

---

## PHYSICAL HEALTH

---

Health concerns, even those that are not life threatening, profoundly affect people's emotional, social, sexual, and vocational functioning and cause disruptions in valued life goals and roles. Counseling psychology's core emphasis on enhancing optimal development across the life span is especially helpful when considering the interaction of disease with normal developmental processes, as well as during the long-term course of many chronic diseases and health concerns. The concept of the healthy personality, rather than the medical model of a person with disease or deficits, provides a much-needed perspective in the ongoing development of health counseling psychology. The influence of the famous 17th-century philosopher René Descartes, who believed that the mind and the body were separate entities, has been felt for centuries as Western countries have continued to bifurcate mental and physical health services. Yet it is difficult to talk about mental health issues without addressing issues of physical health. Likewise, chronic illnesses have psychological and psychosocial components. In spite of the interaction between the physical and psychological, both physical and mental health professionals often ignore the connection between these two areas.

The etiology of health problems has been conceptualized using different theoretical models, including the biomedical, psychosocial, and more recently the biopsychosocial models. Many practitioners and scholars view the biomedical model as too closely aligned with a body focus with its emphasis on disease symptoms, medication, and genetics; and the psychosocial model as too closely aligned with a mind focus with its emphasis on mood, behaviors, and relationships. In contrast, the biopsychosocial model attempts to bridge the gap between these two models by eliminating the dichotomy between mind and body that devalues the complexity of factors that contribute to health status.

### A Biopsychosocial Model of Health Status

George Engel's biopsychosocial model was the first to systematically consider the effect of psychological and



social factors in conjunction with biological factors in predicting health outcomes. Representing a radical departure from viewing health and chronic disease as due primarily to biomedical factors, this model recognized the effect of psychosocial factors such as stress, coping skills, culture, environment, and context that lead to a more complete understanding of both body and mind. More recently, Mary Ann Hoffman and Jeanine Driscoll extended this model by conceptualizing health status as ranging on a continuum from illness to wellness. Unlike Engel's model, which conceptualizes health as the presence or absence of disease or illness, this concentric model recognizes the reciprocal nature of biopsychosocial factors and views health status, or wellness, as not wholly defined as being free of disease or disability. Instead, the focus is on the quality of the individual's life because individuals may have symptomatic complaints, but may still perceive they have a high quality of life due to coping mechanisms, social support, or institutional supports.

One piece of evidence for the biopsychosocial model is the high rate of comorbidity or co-occurrence of physical and psychological conditions in clients. Physical conditions can lead to psychological outcomes or can covary with these outcomes. The corollary is true in that mental health issues can have physiological ramifications. In other words, mental health acts as both a precursor and an outcome of physical health problems. For example, it is well documented that negative emotions can intensify a range of health threats or diseases that may be influenced by the immune system—most notably, cardiovascular disease. Other research has shown that the effects of depression go beyond the negative effect on quality of life. Individuals who are chronically depressed for at least 6 years have nearly a 90% greater risk of developing cancer within the following 4 years. Eating disorders are largely viewed as a problem with psychosocial origins, but they cause significant physical ramifications. Conversely, anxiety and depression are more often found in those with chronic physical illnesses than in those without physical ailments.

Lifestyle factors such as smoking, poor dietary habits, risk taking, and lack of exercise often lead to illnesses and injuries. These illnesses can add strain to an already stressed and busy life and may lead to further illness and the onset of chronic disease. On the other hand, the presence of positive social supports may be as important as the presence of risk factors in maintaining and preventing premature death from disease. Finding positive aspects in response to a

negative or traumatic life event can serve a protective function for a person's health status. Following the diagnosis of a health problem such as cancer or HIV disease, finding benefits in refocusing on life's priorities, reconnecting with significant others, or making important lifestyle changes has been linked to increased quality of life, more positive emotions, and better health outcomes. These studies show that the mere presence of disease or illness does not necessarily lead to negative outcomes or a poor quality of life. Rather, the interplay between physical health factors and psychological factors is complex and often crucial in determining health status or outcomes.

## Counseling and Health Status

Counseling can provide insight into physical health issues by illuminating challenges, risks, strengths, and resources. The economic and the psychosocial costs of disease or poor health are enormous; illness and chronic diseases can lead to costs such as pain, loss of self-image, loss of valued roles, and changes in lifestyle. Direct costs include the tangible aspects of disease such as medical expenditures and loss of income and time. Indirect costs, those costs that are difficult to assess, include reduced productivity in work and home roles, reduced social and community interactions, strain for significant others who provide care, and strain on community resources. The interaction of physical and psychological factors is apparent from a recent national health initiative, Healthy People 2010, that identified 10 areas of major health concerns. These concerns include physical and psychological risk factors of physical activity, overweight and obesity, tobacco use, substance abuse, sexual behavior, mental health, injury and violence, environmental quality, immunization, and access to health care. Though mental health is considered a category in itself, each of the other health issues has either psychosocial contributors or consequences, which has implications for counseling.

Counselors routinely assist clients with reducing or eliminating harmful behaviors such as smoking or substance use, in identifying barriers to change, and in determining strategies to achieve more healthy lifestyles, such as using behavior modification to change eating or exercise habits. For example, increased physical activity has been shown to be beneficial for health outcomes and also can significantly reduce depressive symptoms. Psychological factors such as chronic and acute stress, negative emotions,



social support availability, ways of dealing with conflict, coping style (including playfulness), and hostility can affect health and immune functioning and resiliency. Negative emotions that arise from stress can lead to inflammatory responses that pose multiple health-related problems such as arthritis and other autoimmune disease, cardiovascular disease, and some cancers. This has been referred to as distress-related immune dysregulation and likely poses a core mechanism that underlies many health risks. Psychological interventions may be effective in alleviating distress-related immune dysregulation.

When working with individuals, it is also important to consider the multiple levels of influence on health and health behaviors. Some scholars suggest the importance of looking at micro-level variables like biology, physiology, genetics, and behavior; meso-level variables like family structure, social support, and work obligations; and macro-level variables like physical accommodations, societal factors, access to care, interventions, and social policy. This multi-layered ecological approach complements a biopsychosocial model of health and wellness.

A holistic health integration of body and mind that incorporates multiple levels of influence appears to be most beneficial when working with distressed individuals. Recognizing that health disparities are pronounced along lines of gender, race and ethnicity, income, education level, disability status, geographical location, and sexual orientation, counselors can advocate for the consideration of and attention to these cultural factors in the overall treatment of physical and mental health. In moving toward a greater integration of physical and mental health issues, counselors can help individuals utilize their psychosocial resources to buffer the effects of chronic illness and to help those who are physically well maintain their health status.

*Mary Ann Hoffman and Nicole E. Taylor*

**See also** Chronic Illness (v1); Cigarette Smoking (v1); Eating Disorders (v2); HIV/AIDS (v1); Physical Activity Counseling (v2); Psychological Well-Being, Dimensions of (v2); Quality of Life (v2); Stress (v2); Stress Management (v2)

### Further Readings

Engel, G. (1977, April 18). The need for a new medical model: A challenge for biomedicine. *Science*, 196, 129–136.

Hoffman, M. A., & Driscoll, J. M. (2000). Health promotion and disease prevention: A concentric biopsychosocial model of health status. In S. D. Brown & R. W. Lent (Eds.), *Handbook of counseling psychology* (3rd ed., pp. 532–567). New York: Wiley.

Kiecolt-Glaser, J. K., McGuire, L., Robles, T., & Glaser, R. (2002). Emotions, morbidity, and mortality: New perspectives from psychoneuroimmunology. *Annual Review of Psychology*, 53, 83–107.

Kiecolt-Glaser, J. K., McGuire, L., Robles, T., & Glaser, R. (2002). Psychoneuroimmunology: Psychological influences on immune function and health. *Journal of Consulting and Clinical Psychology*, 70, 537–547.

U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Health Statistics. (2005). *Healthy people data 2010: Tracking the health of the nation*. Available at <http://www.cdc.gov/nchs>

---

## POSITIVE PSYCHOLOGY

---

*Positive psychology* is a term that refers to efforts to organize and synthesize the psychological study of positive psychological experiences. Throughout much of its history, the field of psychology has focused on efforts to understand the nature, causes, and cures for human dysfunction. Psychologists have generated an enormous body of knowledge about human emotions, thoughts, and behaviors, such as depression, stereotyping, and violence. Martin Seligman, the psychologist most closely associated with positive psychology, dedicated a portion of his time as president of the American Psychological Association to writing about the potential for psychology to contribute to an understanding of how to help children thrive, how to create rewarding occupational experiences, how to create vital and beneficent social institutions, and how to provide every person with the opportunity to achieve a life worth living. In some sense, then, positive psychology was proposed to be a shift in perspective for the field of psychology.

Seligman and others, particularly Mihaly Csikszentmihalyi, Ed Diener, and Christopher Peterson, identified several core tenets of positive psychology. These tenets include a focus on positive traits, positive subjective experiences, and positive institutions, as well as an adherence to rigorous scientific standards for evaluating current knowledge and generating new knowledge about these areas. Positive psychology cannot be thought of as a theory or even a specialty area of



psychology like counseling, biological, cognitive, or social. It is better defined as an organizational movement that seeks to bring together and highlight commonalities among several disciplines. It is also a motivational movement, seeking to encourage increased scientific efforts and resources toward understanding and facilitating optimal human functioning.

## Historical Background

Psychology was originally a branch of philosophy. It emerged as its own discipline through early work on perception and sensation, as well as personality and psychological dysfunction. Early in the history of psychology, there were many examples of “positive psychology,” including making people’s lives more productive and meaningful, identifying and encouraging giftedness in children, and helping people find niches within the vocational world that best suited their unique talents. Following World War II, the founding of the Veterans Administration (VA; now Veterans Affairs) and National Institute of Mental Health (NIMH) led to an increasingly narrow focus on diagnosing and treating mental illness. These governmental initiatives greatly expanded the opportunities available to psychologists, and led to growth in the field. Treating psychological dysfunction and mental illness was the fundamental priority of psychologists in the VA system. Similarly, the NIMH prioritized research that sought to understand and improve treatment in these same areas. The field as a whole was heavily influenced by these postwar changes, and before long, the focus on dysfunction and pathology dominated the discipline.

Counseling psychology also emerged as a discipline in the years following World War II, and counseling psychology’s interests have historically maintained a balance between understanding the nature and treatment of psychological maladies and understanding and cultivating character strengths. Among subfields of psychology, counseling psychology has been notable for the extent to which its interest in character strengths has been supported. Several examples of this support can be found in vocational approaches, such as those of Frank Parsons and E. K. Strong, which attempted to identify people’s abilities and aspirations and match them with jobs that would be satisfying to them. Within the broader field, the humanistic movement began to influence views on human nature. The humanistic perspective highlighted people’s natural tendencies to seek personal growth and generally drew

attention to the multitude of strengths people possessed. The existentialist movement within psychology also drew attention to the human capacity to overcome adversity and create meaningful experiences from what the existential theorists regarded as the random, and often challenging, stream of life. Leading proponents of these perspectives, such as Abraham Maslow, Carl Rogers, Viktor Frankl, Rollo May, and Gordon Allport, influenced the way in which psychologists regarded the human being, and elevated the importance of the human capacity for growth and psychological strength, even during the period that was dominated by research, theory, and practice emphasizing human weaknesses and afflictions.

Donald Super introduced the term *hygiology* (the study of human psychological health) in the 1950s, and in the 1980s, Erich Fromm discussed *eudaimonia* (achieving one’s potential) and Aaron Antonovsky proposed a model of *salutogenesis* (the study of human psychological health processes). These ideas have influenced a small number of psychologists in various niches of the psychology profession, but the rapid growth and pervasive influence of positive psychology sets it apart from earlier efforts to motivate the field to understand similar positive aspects.

The last years of the 20th century in the United States were marked by one of the broadest and most prolonged periods of economic expansion in the country’s history. This period of time, between wars in the Persian Gulf region of the world, was also relatively peaceful in the United States, preceding the terrorist attacks of September 11, 2001. On a sociocultural level, Seligman introduced his ideas about positive psychology at a time in American history when a large segment of the population was experiencing notable wealth and optimism. Thus, the time might have been especially ripe for the introduction of a research agenda focusing on how average people could become great and how generally content people could flourish and become fulfilled.

Positive psychology has been quite successful in its efforts to stimulate discussion, organize disparate fields of study, and articulate a burgeoning research agenda. In a 2005 report, Seligman and colleagues noted that hundreds of articles and books have been published both in the academic and popular press since 2000. Furthermore, although the principal scientific focus has been devoted to factors associated with character strengths and living the good life, a profusion of therapeutic and quasi-therapeutic applications



has mushroomed in recent years, each promising to apply “the science of positive psychology” to various psychological and occupational dysfunctions. In contrast to the research applications of positive psychology, the therapeutic applications are still awaiting empirical scrutiny.

## Key Concepts

Many scientific pursuits fit under the positive psychology umbrella, which explains some of its broad appeal. Thus, defining what areas represent positive psychology is a challenging task. The study of character strengths and well-being are two important foci in positive psychology.

### *Character Strengths*

Among the core features of positive psychology is a focus on positive human traits. Traits are the stable characteristics of people’s thinking, feeling, motivation, and behavior that, in a sense, define who they are. One of the most ambitious projects within positive psychology is to develop a catalogue of the traits that are highly valued in nearly every culture without being constrained to any particular time period. Peterson and Seligman have called these identified traits, character strengths and virtues. A virtue is a class of traits that contains several strengths. For example, the virtue of Wisdom contains strengths that mark a person’s excellence in the area of understanding the world and life, and serving as a source of sage advice to others. Several criteria have been designated to classify traits as strengths. A partial list of the criteria for strengths includes: contributing to various fulfillments that constitute the good life; being morally valued in its own right, even in the absence of obvious beneficial outcomes; not devaluing others by its expression; having no opposite that could be desirable (e.g., the opposite of flexibility could be considered steadfastness, therefore flexibility is not a character strength); and being embodied in consensual paragons. To date, 6 virtues marked by 24 strengths have been included in the initial classification system, although psychological traits might be added or removed as research progresses.

The strengths differ greatly in terms of the amount of research attention they have received. Strengths such as spirituality and self-control have been the subject of hundreds of studies, whereas others, such as modesty or humility, have not. Some of this research

has been conducted using an instrument designed to measure the full range of strengths, the Values in Action Inventory of Strengths, designed by Peterson and colleagues. This research generally suggests that possessing character strengths is associated with happiness and being liked by others. There has been little research validating the Values in Action Inventory of Strengths, so caution is warranted in considering the findings of research that has used it. Most of the extant research has been conducted using measures of traits that predated their inclusion in the character strengths project. For example, counselors are likely to be familiar with the work on hope conducted by C. R. Snyder. Over dozens of studies, hope has emerged as an important factor in predicting happiness, distress tolerance, as well as therapy outcomes. Thus, like positive psychology itself, the study of character strengths represents a wide body of work that has existed for decades, as well as a new way of looking at, unifying, organizing, and promoting that work.

### *Well-Being Research*

An enormous body of research has demonstrated the link between the frequency and magnitude of positive emotions, like joy, love, contentment, and gratitude, and the degree to which people feel satisfied with their lives and experience physical health and life longevity. Other work has focused on how people think creatively, solve problems, succeed in group negotiations, and many other characteristics of optimal personal and social functioning. The subjective experience of positive emotions is often accompanied with observable physiological reactions, such as changes in facial expression, deactivation of the body’s stress response, and changes in the location and pattern of the brain’s activity. Because these connections are so pervasive and tantalizing, understanding how to encourage the experience of positive emotions is a central pursuit in positive psychology.

Researchers are also attempting to understand whether some types of positive emotions have different effects. For instance, biting into a chocolate cupcake is likely to give people sensory pleasure. However, if that was the first cupcake one’s child ever baked, that pleasure might be accompanied by pride. Thus, while both are positive emotions, pride in one’s child might be a more meaningful and deeper emotion than pleasure. Researchers have also demonstrated the importance to the sustained well-being of positive



emotions like curiosity, and the state known as *flow*, in which time passes unnoticed as people expand their existing skills by taking on more difficult challenges.

Beyond emotional approaches to well-being, researchers have also investigated the judgments people make about their lives as a whole. A large amount of research has focused on the factors associated with life satisfaction, or the intellectual judgment that one's life is good. Those with certain personality types (more extraverted and social) or who have developed certain kinds of relationships (close and positive) are usually more satisfied with their lives.

Researchers have also investigated the factors associated with how meaningful people feel their lives are. Lives can be experienced as meaningful for many reasons. Meaning in life refers to people's perceptions that their lives matter, that their lives are understandable, signify something, or have a purpose or mission. Research has shown that those who feel their lives are meaningful are happier, less distressed, and report less substance abuse and suicidal ideation.

## Therapeutic Applications

Michael Fordyce was the first scientist to systematically explore how to increase people's happiness, reporting a number of successful efforts in the *Journal of Counseling Psychology* in the late 1970s and early 1980s. Similar efforts have been made recently to demonstrate how various ideas central to positive psychology can be adapted to benefit human welfare and happiness. Seligman and colleagues reviewed some of the progress of their research on improving people's lives through several experiential means. According to their preliminary findings, taking time to count one's blessings, as well as making an effort to use one's signature character strengths in daily life was associated with more happiness and less depression. Other researchers have reported that expressing gratitude and committing acts of kindness were associated with happiness as well.

## Future Directions

Positive psychology is likely to move in several important directions. First, research efforts will continue to look for ways in which people's happiness can be increased. Most of this work will be done with typical, generally happy people. Second, research will increasingly focus on therapeutic applications.

Positive psychology has occasionally been criticized for focusing on happiness to the neglect of unhappiness. Research into clinical applications of positive psychology research will undoubtedly increase, probably in combination with empirically supported treatments for known presenting complaints. Third, positive psychology research will increasingly consider "the Good Life" from a multicultural and transcultural perspective. Most of psychological research, and positive psychology research, has been conducted by Western individuals on Western participants using constructs derived from Western perspectives. Diverse perspectives will undoubtedly be helpful, and indeed necessary, to understanding how to best foster human strengths and optimal functioning.

*Michael F. Steger and Todd B. Kashdan*

*See also* Happiness/Hardiness (v2); Hope (v2); Job Satisfaction and General Well-Being (v4); Multiculturalism (v3); Optimism and Pessimism (v2); Personality Theories, Traits (v2); Psychological Well-Being, Dimensions of (v2); Quality of Life (v2)

## Further Readings

- Kahneman, D., Diener, E., & Schwartz, N. (Eds.). (1999). *Well-being: The foundations of hedonic psychology*. New York: Russell Sage Foundation.
- Linley, P. A., & Joseph, S. (Eds.). (2004). *Positive psychology in practice*. Hoboken, NJ: Wiley.
- Lopez, S. J., Magyar-Moe, J. L., Peterson, S. E., Ryder, J. A., Krieshok, T. S., O'Byrne, K. K., et al. (2006). Counseling psychology's focus on positive aspects of human functioning. *The Counseling Psychologist*, 34, 205–227.
- Peterson, C., & Seligman, M. E. P. (Eds.). (2004). *Character strengths and virtues: A handbook and classification*. Washington, DC: American Psychological Association and Oxford University Press.
- Seligman, M. E. P., & Csikszentmihalyi, M. (2000). Positive psychology: An introduction. *American Psychologist*, 55, 5–14.
- Seligman, M. E. P., Steen, T. A., Park, N., & Peterson, C. (2005). Positive psychology progress: Empirical validation of interventions. *American Psychologist*, 60, 410–421.
- Snyder, C. R., & Lopez, S. J. (Eds.). (2002). *Handbook of positive psychology*. New York: Oxford University Press.
- Walsh, W. B. (Ed.). (2003). *Counseling psychology and optimal human functioning*. Mahwah, NJ: Lawrence Erlbaum.



## POSITIVIST PARADIGM

Positivism emerged as a philosophical paradigm in the 19th century with Auguste Comte's rejection of metaphysics and his assertion that only scientific knowledge can reveal the truth about reality. It was later formally established as the dominant scientific method in the early part of the 20th century by members of the Vienna Circle, including Gustav Bergmann, Rudolf Carnap, Herbert Feigl, Philipp Frank, Karl Menger, Otto Neurath, and Moritz Schlick.

The Vienna Circle sought to construct a *unified scientific world-conception* that rejects the use of philosophy as a means of learning about the true nature of reality. Unfortunately, it failed as a coherent philosophy of science because of a critical inconsistency between its theory of "reality" and its theory of "knowledge."

Positivism adopted David Hume's theory of the nature of reality (i.e., philosophical ontology). Hume believed that reality consists of atomistic (micro-level) and independent events. He believed in the use of the *senses* to generate knowledge about reality (i.e., scientific method). He thought that philosophical and logical reasoning could lead us to "see" nonexistent links between events occurring simultaneously. However, positivism also adopted René Descartes's epistemology (i.e., theory of knowledge). Descartes believed that *reason* is the best way to generate knowledge about reality. His deductive method implies that events are ordered and interconnected, and therefore reality is ordered and deducible. This internal inconsistency eventually undermined the validity of positivism.

The positivist paradigm asserts that real events can be observed empirically and explained with logical analysis. The criterion for evaluating the validity of a scientific theory is whether our knowledge claims (i.e., theory-based predictions) are consistent with the information we are able to obtain using our senses. Positivist research methodology (methodological individualism) emphasizes micro-level experimentation in a lablike environment that eliminates the complexity of the external world (e.g., social, psychological, and economic linkages between unemployment, and crime or suicide). Policies are then prescribed based on conclusions derived via the "scientific method" (e.g., job training for the unemployed, antidepressants for the suicidal, and jail time for the criminal). Psychologists now realize that this yields results that have internal validity (i.e., the relations observed in the experiment are valid within

that context). While the results obtained using experimental methods provide valuable insights into the nature of reality, those results may lack external validity. That is, the relations observed in the laboratory may not be the same in the more complicated external world where a much greater number of factors interact.

A positivist dealing with complex social problems such as unemployment and crime would be concerned with their visible manifestations (i.e., the unemployed individual or criminal who can be sensed or perceived) rather than with the underlying causal mechanisms that are invisible to us. Hence, positivist prescriptions tend to treat the symptoms rather than the root cause of the problem.

Positivism exerted an important influence on scientific practice in the social sciences for decades in the early 20th century. This was especially true in the natural sciences where laboratory experiments can closely approximate the real world environment, thus allowing for accurate predictions. In the social sciences, however, human volition and uncertainty make the laboratory experiment less reliable. Ultimately, its internal inconsistency resulted in the abandonment of positivism in favor of scientific approaches such as *critical multiplism*, which is based on the belief that no one approach is ever sufficient for developing a valid understanding of a phenomenon. The application of critical judgment in investigating multiple research questions using multiple measures, samples, designs, and analyses are necessary to permit a convergence on a valid understanding of a phenomenon.

Fadhel Kaboub

**See also** Behavioral Observation Methods, Assessment (v1); Evidence-Based Treatments (v2); Empirically Based Professional Practice (v1); Psychometric Properties (v2); Qualitative Methodologies (v1); Quantitative Methodologies (v1)

### Further Readings

- Descartes, R. (1998). *Discourse on method and meditations on first philosophy* (4th ed.; Donald A. Cress, Trans.). Indianapolis, IN: Hackett. (Original work published 1637)
- Hume, D. (1993). *An enquiry concerning human understanding* (2nd ed.; Eric Steinberg, Ed.). Indianapolis, IN: Hackett. (Original work published 1777)
- Neurath, O. (1973). The scientific conception of the world: The Vienna Circle. In M. Neurath & R. Cohen (Eds.), *Empiricism and sociology*. Boston: Reidel.



## POSTTRAUMATIC STRESS DISORDER

Posttraumatic stress disorder (PTSD) is a psychiatric disorder characterized by profound disturbances in cognitive, behavioral, and physiological functioning that occur following exposure to a psychologically traumatic event. According to the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR)*, the diagnosis applies to individuals who develop a constellation of symptoms after experiencing, witnessing, or being confronted with an event involving perceived or threatened loss of life, serious injury, or loss of physical integrity and that evoked fear, helplessness, or horror (e.g., military combat, sexual or physical assault, serious accidents, and major disasters). The symptoms of PTSD are organized under three clusters: (1) reexperiencing (e.g., intrusive thoughts, nightmares, flashbacks, and psychophysiological reactivity to reminders of the trauma), (2) avoidance and emotional numbing (e.g., avoiding stimuli associated with the trauma and inability to experience a full range of emotions), and (3) hyperarousal (e.g., hypervigilance, exaggerated startle response, and sleep disruption). By definition, the symptoms must persist for more than 1 month after the trauma and produce clinically significant distress and/or impairment.

### Prevalence and Etiology of Trauma and PTSD

Epidemiological studies have found that 40% to 90% of the general population in the United States experience a traumatic event meeting the PTSD stressor criterion at some point during their lifetime. After trauma exposure, the probability of developing PTSD is estimated to be approximately 10% in the general population, although higher rates (i.e., closer to 25%) have been observed after traumatic events involving violence or life threat such as rape and military combat. Numerous factors contribute to the probability of developing the disorder, with the nature and severity of the event being the most important factor. In addition, psychosocial factors such as a family history of psychiatric illness, childhood trauma or behavior problems, and the presence of psychiatric symptoms prior to the trauma appear to mediate the relationship between trauma exposure and the subsequent development of PTSD. Individual difference factors also play a role. After controlling for trauma exposure, the rate of PTSD in women is approximately twice as

high as the rate for men. Research suggests that personality traits such as neuroticism and negative emotionality represent vulnerabilities for the development of the disorder, whereas characteristics such as hardiness function as resilience factors.

Terence M. Keane and David H. Barlow adapted Barlow's model of anxiety and panic to promote an understanding of the variables involved in the development of PTSD. This conceptual model suggests that biological and psychological vulnerabilities underlie the development of PTSD. When an individual is exposed to a traumatic life event, a true biological and psychological alarm occurs leading to both conditioning of stimuli present at the time of the event and to cognitions that incorporate anxious apprehension of a recurrence of the traumatic event. These emotionally charged stimuli then promote the development of avoidance strategies in order to effectively minimize the experience of aversive emotional reactions. The emergence of PTSD is a function of these variables as well as the strength of the social support system of the individual and his or her coping abilities in the aftermath of trauma exposure.

### Assessment of PTSD

A comprehensive clinical assessment of PTSD should include administration of structured diagnostic interviews, self-report psychometrics, and an evaluation of trauma across the life span. Several structured interviews are available and the Clinician-Administered PTSD Scale for the DSM-IV and PTSD module of the Structured Clinical Interview for the DSM-IV are standards in the field. Self-report instruments can also assist in diagnosis or provide efficient, low-cost methods for research and screening purposes. Of these, several were constructed specifically for assessing PTSD (e.g., Mississippi Scale for Combat-Related PTSD; PTSD Checklist; PTSD Diagnostic Scale) and others were derived from existing items of major inventories such as the Minnesota Multiphasic Personality Inventory-2 (MMPI-2). Finally, instruments such as the Potential Stressful Events Interview and the Traumatic Stress Schedule can be used to evaluate trauma exposure across the life span. Virtually all of the available diagnostic measures of PTSD possess excellent psychometric properties.

### Treatment of PTSD

Treatment for PTSD typically involves the use of psychotherapy, pharmacotherapy, or both. Of the



psychotherapies, exposure-based approaches (e.g., systematic desensitization, flooding, prolonged exposure, imaginal and in vivo exposure, and implosive therapy) have received the most attention and empirical support to date. The central element of these techniques involves the gradual exposure of the client to trauma-related cues to desensitize and extinguish problematic emotional and physiological reactions. The therapeutic mechanism has been conceptualized within the framework of classical conditioning: repeated exposure to trauma-related cues (e.g., trauma-related images evoked from memory) in the absence of the feared negative consequences (e.g., the trauma itself) reduces the conditioned fear, anxiety, and avoidance characteristics of PTSD.

A second promising category of empirically validated treatments for PTSD is cognitive restructuring therapies, such as cognitive processing therapy. Based on cognitive therapy principles, this approach is designed to identify and modify dysfunctional trauma-related beliefs and to teach specific behavioral and cognitively based coping skills. The procedure may also involve tasks that include an element of exposure such as writing or describing the trauma to disclose trauma-related cognitions. Controlled studies that directly compare treatments for PTSD provide strong evidence for the efficacy of these cognitive-behavioral therapies.

Pharmacological treatment of PTSD is primarily designed to treat symptom clusters of PTSD, rather than the entire syndrome or any underlying physiological dysregulation. Several classes of antidepressants have been found to be modestly effective, including monoamine oxidase inhibitors and tricyclics, with selective serotonin reuptake inhibitors (SSRIs) having the strongest body of empirical support. The SSRIs are currently the first choice of psychopharmacological treatment for PTSD. Presently, studies are underway to examine the effectiveness of cognitive-behavioral therapies and SSRIs when administered jointly. In addition, trials examining augmentation strategies to assess the efficacy of SSRIs with atypical antipsychotic medication are also underway to determine the relative efficacy of these medications in combination.

*Mark W. Miller and Terence M. Keane*

**See also** Behavior Therapy (v2); Cognitive-Behavioral Therapy and Techniques (v2); Cognitive Therapy (v2); Coping (v2); *Diagnostic and Statistical Manual of Mental Disorders (DSM)* (v2); Disasters, Impact on Children (v1); Panic Disorders (v2)

## Further Readings

- American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed., Text rev.). Washington, DC: Author.
- Blake, D. D., Weathers, F. W., Nagy, L. N., Kaloupek, D. G., Klauminser, G., Charney, D. S., et al. (1990). A clinician ratings scale for assessing current and lifetime PTSD: The CAPS-1. *Behavior Therapist*, 18, 187–188.
- First, M. B., Spitzer, R. L., Gibbon, M., Williams, J. B. W. (1997). *Structured Clinical Interview for DSM-IV Axis I Disorders—Clinician Version (SCID-CV)*. Washington, DC: American Psychiatric Press.
- Keane, T. M., & Barlow, D. H. (2001). Posttraumatic stress disorder. In D. H. Barlow, *Anxiety and its disorders* (2nd ed., pp. 418–453). New York: Guilford Press.
- Miller, M. W. (2003). Personality and the etiology and expression of PTSD: A three-factor model perspective. *Clinical Psychology: Science and Practice*, 10, 373–393.
- Resick, P. A., Nishith, P., Weaver, T. L., Astin, M. C., & Feuer, C. A. (2002). A comparison of cognitive-processing therapy with prolonged exposure and a waiting condition for the treatment of chronic posttraumatic stress disorder in female rape victims. *Journal of Consulting and Clinical Psychology*, 70, 867–879.
- Wilson, J. P., & Keane, T. M. (2004). *Assessing psychological trauma and PTSD* (2nd ed.). New York: Guilford Press.

---

## PROBLEM-SOLVING APPRAISAL

---

Problem-solving appraisal refers to a person's self-appraisal of his or her problem-solving abilities and attitudes (i.e., his or her self-evaluated capacity to resolve problems). Ever since John Dewey's influential 1933 publication of *How We Think*, there has been a strong focus in psychology on how people cope with their daily life problems and major life events. Much of the earliest research examined laboratory problems involving water jars and strings. More recent research has also examined how people grapple with stressful personal problems, such as relationship and career problems. Not surprisingly, applied problem solving that focuses on real-life personal problems has received a great deal of attention in counseling psychology. In 1965, John Krumboltz proclaimed that the central reason for the existence of the counseling profession was because clients needed professional assistance with problems that they were unable to resolve on their own.



More than 120 studies have been conducted on problem-solving appraisal using the Problem Solving Inventory (PSI). This entry provides a brief history of psychological research on problem solving and explains how that has led to a focus on the construct of problem-solving appraisal. Then this entry summarizes what is known about the influence of problem-solving appraisal on psychosocial adjustment, physical health, coping, and educational and career-related issues, as well as other implications.

### Historical Overview of Applied Problem Solving

The earliest applied problem-solving research focused on discreet thought processes, such as sensitivity to problems, causal thinking, and the generation of alternatives. Early models of problem solving posited a stage-sequential process, and they assumed that problem solvers would rationally progress through stages such as identifying the problem, generating alternatives, and making decisions. More recently, however, psychologists have shifted their attention to higher-order or metacognitive variables that affect how and whether a person will even attempt to solve a particular problem.

People respond to personal problems in different ways. Some people tend to attack the source of the problem. Others become very anxious and try to regulate their negative emotions associated with the stress of a problem rather than to resolve the problem itself. Some people tend to problem solve in a very systematic and persistent fashion, while others tend to make sporadic and inconsistent attempts to resolve problems. In short, some people bring a great deal of resources to resolving their problems, but others have significant problem-solving deficits. An important individual difference that influences applied problem-solving behavior is a person's problem-solving appraisal.

The PSI is the most widely used measure of problem-solving appraisal. The PSI consists of 35 items, each having 6 possible responses that vary from 1 = *strongly agree* to 6 = *strongly disagree*. The instrument provides measures of (a) Problem-Solving Confidence, defined as one's beliefs in his or her problem-solving abilities; (b) Approach-Avoidance Style, defined as one's general tendency to approach or avoid different problem-solving activities; and (c) Personal Control, defined as one's beliefs in his or her emotional and behavioral control while solving problems. An

extensive body of empirical research supports the construct, convergent, and discriminant validity of the PSI across a range of populations and cultures.

### Psychosocial Adjustment

In the past 25 years, a broad range of studies have suggested that problem-solving appraisal is associated with general psychological and social adjustment, depression, hopelessness and suicide potential, anxiety and worry, alcohol use and abuse, eating disorders, childhood adjustment, and childhood trauma. This entry focuses on the first four areas.

#### General Psychological and Social Adjustment

Individuals who have a negative (as opposed to a positive) problem-solving appraisal tend to be less well adjusted psychologically, to have more personal problems, and to experience more difficulty establishing a personal identity separate from their parents. In addition, they have fewer social skills and experience more social distress. There appears to be a dysfunctional pattern in which avoiding their problems leads to lower problem-solving confidence, and subsequently, lower psychological adjustment. The more positively individuals appraise their problem solving, the higher their levels of psychological and social adjustment.

#### Depression

A positive problem-solving appraisal is associated with lower levels of depression. Individuals' negative appraisal of their problem-solving talents is strongly predictive of depression for those experiencing high levels of stress, but not for those experiencing low levels of stress. Thus, people with a negative problem-solving appraisal are at a higher risk of depression when they are under high stress. Having a positive assessment of their problem-solving ability provides individuals with some protection against depression when they are confronted with high levels of stress.

#### Hopelessness and Suicidality

A negative problem-solving appraisal is associated with feelings of hopelessness and suicidal ideation. A person's problem-solving confidence, in particular, is a relatively strong predictor of his or her feelings of



hopelessness. Individuals with a negative (as opposed to positive) problem-solving appraisal who are under high levels of stress tend to experience higher levels of hopelessness. Thus, problem-solving appraisal is a consistent predictor of hopelessness and suicidality.

### **Anxiety and Worry**

People with a negative appraisal of their problem-solving abilities tend to experience higher levels of anxiety in general, and especially when under stress. In particular, problem-solving confidence and a sense of personal control were most strongly associated with both anxiety and worrying.

### **Physical Health**

Problem-solving appraisal is associated with a range of physical health indexes including: (a) physical health complaints and health promotion, (b) physical health complications, and (c) physical limitations.

Problem-solving appraisal is related to health expectancies, specific health complaints (e.g., chronic pain and cardiovascular problems), and health problems in general. People with a negative (as opposed to a positive) appraisal of their problem-solving skills report more health complaints, lower health expectancies, and fewer health promotion behaviors. An individual's feelings of personal control strongly relate to his or her physical health complaints. There is even some evidence that problem-solving appraisal demonstrated greater sensitivity than two standard neuropsychological problem-solving measures in (a) differentiating traumatic brain injured (TBI) patients from uninjured groups, (b) detecting treatment changes in the TBI patients' problem solving, and (c) predicting independence and integration in the community of TBI patients. In short, problem-solving appraisal is a useful predictor of self-reported health and behavioral health indicators.

### **Coping**

Problem-solving appraisal is related to cognitive and affective coping activities when dealing with stressful life problems. Specifically, there is a consistent association between a positive problem-solving appraisal and problem-focused coping (i.e., approaching and attempting to alter the cause of a stressful problem). A negative appraisal is more strongly related to

task-inhibiting and emotion-focused self-statements and a tendency to feel powerless when dealing with interpersonal problems. In addition, problem-solving confidence and the approach-avoidance style appear to be the strongest contributors to reported problem-focused coping activities. A sense of personal control was particularly related to self-reported disengaging, denial, and emotion-focused coping.

People's strategies for seeking and using helping resources are also related to their appraisal of their problem-solving skills. A positive (as opposed to negative) problem-solving appraisal is associated with more awareness of the availability of helping resources, higher rates of utilization, and more satisfaction with those resources. A more positive problem-solving appraisal also predicts more positive training experiences (e.g., problem-solving training) and better personal and career counseling outcomes. Thus, problem-solving appraisal is strongly associated with various coping activities and is predictive of associated cognitive and affective coping operations as well as outcomes of utilizing various helping resources.

### **Educational and Vocational Issues**

Individuals' appraisal of their problem-solving abilities is related to the presence of educational and vocational issues. Specifically, problem-solving appraisal is related to test anxiety, test irrelevant thinking, study skills in at-risk students, education level, and age, but not to measures of intelligence and academic aptitude. Consistent with several vocational theories (particularly maturity models), problem-solving appraisal is related to vocational identity, career decision-making variables (e.g., decision-making strategies), career planning (e.g., level of knowledge and certainty, multiple career roles for women), personality consistency, and differentiation of some types of career-undecided students. For example, people with a negative (as opposed to positive) appraisal of their problem-solving skills report lower levels of vocational identity, less certainty in their decisions about a career, less knowledge about career choices, and more dependent and intuitive decision-making strategies. More specifically, approaching problems is associated with rational decision-making and dependent decisional strategies; problem-solving confidence is related to rational and intuitive decision making; and lack of personal control is related to a need for more information for making



career decisions. Thus, problem-solving appraisal is consistently and strongly associated with both career planning and decision making.

### Implications

People's appraisal of their problem-solving ability is related to a wide range of psychological adjustment and physical health indexes, to the approach they use in coping with stressful problems, and to their resolution of educational and vocational issues. There is a robust relationship between problem-solving appraisal and measures of psychological adjustment (e.g., depression, anxiety, hopelessness, and suicidal ideation). Generally speaking, people who have a more positive appraisal of their problem-solving skills are more likely to report a positive self-concept, higher levels of self-efficacy, more social support, and lower levels of depression, anxiety, suicidal ideation, social uneasiness, and irrational beliefs. They report positive health expectancies and fewer health complaints and problems. They use problem-focused strategies to cope with stressful events and have a greater awareness, utilization, and satisfaction of coping resources. They use rational career decision-making styles, have a more well-developed vocational identity, possess greater knowledge and certainty in career planning, and experience less career indecision.

In essence, people's appraisal of their problem-solving capability is useful for understanding a broad range of human behavior, and in many (but not all) cases problem-solving appraisal appears to overlap with actual problem-solving skills. That is, based on countless problem-solving trials, people's appraisal of their problem-solving capabilities is often consistent with their actual performance in problem solving. Thus, how people evaluate their problem-solving capabilities is in general consistent with the implementation of their problem-solving skills across a range of stressful personal problems. However, there are some exceptions. For instance, some people overestimate or underestimate their problem-solving abilities for a variety of reasons, resulting in a mismatch between their problem-solving appraisal and performance. There may be complex interactions between a person's appraisal of his or her problem-solving skills and personality characteristics (e.g., sociopathic personality styles) and life situation (incarcerated adults, substance abuse). Thus, problem-solving appraisal should not be considered as synonymous with problem-solving skills.

Considerably more research has chosen to examine problem-solving appraisal, rather than other applied problem-solving inventories, in racial/ethnic minority groups in the United States and other countries (e.g., Canada, China, England, Italy, Jordan, South Africa, Taiwan, and Turkey). Nonetheless, what is known about problem-solving appraisal is based on primarily White U.S. samples. More information is needed before researchers can be sure they understand the similarities and differences in real-life problem solving across cultures.

Knowing how people appraise their problem-solving capabilities is clearly useful in understanding human psychological, physical, and vocational adjustments. In counseling, understanding how clients appraise their problem-solving capabilities can help to assess clients' strengths as well as diagnose weaknesses relative to their presenting problems, or identify students at risk. Problem-solving appraisal provides a useful perspective for promoting an understanding of clients' problem-solving style and useful information in developing successful interventions to help clients resolve troublesome problems. Given that problem-solving appraisal is learned after countless trials, it also implies that people's self-appraisal of their problem-solving skills is amenable to change. There are many promising possibilities for applied interventions to enhance problem-solving appraisal and ability to cope with stressful life events, and thereby to enhance people's life satisfaction and well-being.

*P. Paul Heppner, Yuhong He,  
Chia-Lin Tsai, and Yi-Jiun Lin*

**See also** Career Maturity (v4); Career Planning (v4); Cognitive Information Processing Model (v4); Coping (v2); Heppner, P. P. (v2); Hope (v2); Physical Health (v2); Psychological Well-Being, Dimensions of (v2); Reframing (v2); Self-Efficacy/Perceived Competence (v2); Self-Esteem (v2); Stress (v2); Stress Management (v2); Vocational Identity (v4)

### Further Readings

- Heppner, M. J., Lee, D., Heppner, P. P., McKinnon, L. C., Multon, K. D., & Gysbers, N. C. (2004). Examining the role of problem-solving appraisal in the process and outcome of career counseling. *Journal of Vocational Behavior*, 65, 217–238.
- Heppner, P. P. (1988). *The Problem Solving Inventory (PSI): Manual*. Palo Alto, CA: Consulting Psychologists Press.



- Heppner, P. P., & Baker, C. E. (1997). Applications of the Problem Solving Inventory. *Measurement and Evaluation in Counseling and Development*, 29, 229–241.
- Heppner, P. P., & Lee, D. (2002). Problem-solving appraisal and psychological adjustment. In C. R. Snyder & S. J. Lopez (Eds.), *Handbook of positive psychology* (pp. 288–298). New York: Oxford University Press.
- Heppner, P. P., & Wang, Y. (2003). Problem-solving appraisal. In S. J. Lopez & C. R. Snyder (Eds.), *Positive Psychology Assessment: Handbook of Models and Measures* (pp. 127–138). Washington, DC: American Psychological Association.
- Heppner, P. P., Witty, T. E., & Dixon, W. A. (2004). Problem-solving appraisal and human adjustment: A review of 20 years of research using the Problem Solving Inventory. *The Counseling Psychologist*, 32, 344–428.
- Priester, M. J., & Clum, G. A. (1993). Perceived problem-solving ability as a predictor of depression, hopelessness, and suicide ideation in a college population. *Journal of Counseling Psychology*, 21, 119–123.
- Rath, J. F., Hennessy, J. J., & Diller, L. (2003). Social problem solving and community integration in post acute rehabilitation outpatients with traumatic brain injury. *Rehabilitation Psychology*, 48, 137–144.
- Witty, T. E., Heppner, P. P., Bernard, C. B., & Thoreson, R. W. (2001). Problem solving appraisal and psychological adjustment of chronic low back pain patients. *Journal of Clinical Psychology in Medical Settings*, 8, 149–160.

---

## PROJECTIVE TECHNIQUES

---

Psychologists use a number of methods to assess psychopathology and personality, including structured and unstructured interviews, brief self-rated and clinician-rated measures (such as the Beck Depression Inventory), projective techniques (e.g., the Rorschach Inkblot Technique), self-report personality inventories (e.g., the Minnesota Multiphasic Personality Inventory-2; MMPI-2), behavioral assessment methods (e.g., observational techniques and diary measures), outcome and treatment monitoring measures (e.g., the Outcome Questionnaire-45), and measures completed by peers or significant others (e.g., the Peer Inventory of Personality Disorders). This entry describes research findings on the most scientifically controversial of these instruments, namely, projective techniques.

In comparison with other assessment methods, a clinician using a projective technique typically presents a client with an ambiguous stimulus (e.g., an

inkblot), or asks the client to generate a response following open-ended instructions (e.g., “Draw a person”). Thus, for projective techniques, stimuli tend to be ambiguous and the nature of response options tends to be varied. The primary logic underlying these tests is the *projective hypothesis*—in the process of making sense of an ambiguous stimulus, the respondent presumably “projects” important aspects of his or her personality onto that stimulus. The test interpreter then works “in reverse” to infer the respondent’s personality traits.

Projective techniques can be placed into five broad categories: (1) *association techniques* including inkblot tests, (2) *construction techniques* including human figure drawing tests and story creation tests such as the widely used Thematic Apperception Test (TAT), (3) *completion techniques* including sentence completion tests, (4) *arrangement or selection tests* including the Szondi Test and the Luscher Color Test, and (5) *expression techniques* such as handwriting analysis, projective doll play, and puppetry.

A common argument made for using projective techniques is that they can circumvent a client’s conscious attempts to create a specific impression on these tests, as well as the client’s unconscious defenses. Clients may not know how to answer in a healthy or sick way when presented with an ambiguous stimulus such as an inkblot, so they will not be able to purposely overreport or underreport psychopathology. Similarly, when given an open-ended task such as drawing a human figure, clients may not be able to intentionally draw a figure that suggests that they have more or less psychopathology than they really have.

If clients’ responses are shaped by their personality traits and psychopathology, then projective techniques may be able to yield valuable information about the clients. In fact, a goal of using projectives is to learn things about clients that the clients themselves do not know. Proponents of projective techniques typically claim that the test results yield important insights into their clients’ unconscious processes.

Despite the claims made for projective techniques, the percentage of clinical psychologists using projective tests declined from 72% in 1986 to 39% in 2003. The decline in the popularity of projective techniques may be partly due to criticisms that have been leveled at them, which are described below. It can also be traced to the advent of managed care, which has made psychological testing, especially testing with questionable scientific support, less financially remunerative.



The scientific research on the three most popular projective instruments: the Rorschach, the TAT, and human figure drawings are described below. This entry concludes by addressing whether projective techniques can be used to circumvent a client's defenses and evaluate unconscious motivations and conflicts.

### Rorschach

Developed by the Swiss psychiatrist Hermann Rorschach in the 1920s, the Rorschach consists of 10 inkblots that are each printed on a separate card. During the first phase of the test (the response phase), the client is handed the cards one at a time and instructed to say what each blot resembles. In general, clients are allowed to give as many or as few responses as they wish. On average, clients make about 21 responses for the 10 cards.

During the second phase (the inquiry phase), each response is reviewed as the psychologist asks questions to clarify the nature of each response. For example, the psychologist tries to determine the exact location of the perception, and whether it was affected by the color or shading of the card or by other factors. Currently, the most widely used system for administering, scoring, and interpreting the Rorschach is Exner's Comprehensive System (CS).

The controversy surrounding the Rorschach is complex and touches on a number of topics. Two of the most contentious topics are the adequacy of the normative data and evidence of the instrument's validity.

Clinicians interpret test results for individual clients by comparing their test responses with normative data, that is, with those obtained for some meaningful comparison group (e.g., the general public or a group having a specific psychiatric diagnosis). Normative data were obtained for the Rorschach by administering it to individuals in the general community. Recent evidence indicates that the Comprehensive System norms are in error.

When results for relatively normal individuals were compared with results for the CS normative samples, the relatively normal individuals deviated markedly in a direction that supposedly indicates that they have serious psychopathology. Thus, interpreting the Rorschach using the CS norms tends to make many normal individuals look emotionally disturbed. This is likely to have harmful consequences. For example, clients in psychotherapy can be persuaded that they have problems they do not really have. Similarly, in forensic settings, clients may be given the Rorschach

as part of a psychological evaluation. If they are described as having mental problems they do not really have, this could have deleterious consequences such as loss of custody of their children or denial of parole.

Validity describes whether tests measure what they are claimed to measure. There is general agreement among proponents and critics that at least some Rorschach scores are valid for their intended purposes. In particular, Rorschach scores are correlated with measurements of thought disorder, interpersonal dependency, and treatment outcome. They can also be correlated with diagnoses of mental disorders that are characterized by thought disorder such as schizophrenia. In addition, there is evidence that Rorschach scores are correlated with diagnoses of organic brain damage and measurements of hostility and anxiety.

At the same time, Rorschach advocates and Rorschach critics agree that many CS scores that clinicians interpret have not been studied adequately. These include the Coping Deficit Index, Obsessive Style Index, Hypervigilance Index, active-to-passive movement ratio, D-score, food content, anatomy and X-ray content, Intellectualization Index, and Isolation Index. In general, however, they disagree on the adequacy of the validity evidence. Critics judge a Rorschach score to have been adequately validated only if positive findings have been independently replicated, studies have been appropriately designed, and results for a test score have been consistently positive. Rorschach advocates are less explicit about the criteria they use, and at times they have defended the Rorschach on the basis of their clinical experiences.

### Thematic Apperception Test

The Thematic Apperception Test (TAT), developed by Henry Murray and his student Christiana Morgan, consists of 31 cards, with a picture of an ambiguous situation on each card. For example, one picture shows a young woman grabbing the shoulders of a young man who seems to be pulling away from her. Respondents are instructed to look at each card and construct a story describing (a) the events occurring on the card, (b) what happened before, (c) what will happen in the future, and (d) what the characters are thinking and feeling. When testing a client, clinicians typically administer between 5 and 12 of the cards. The specific cards selected for administration varies greatly across examiners.

Rules have been developed for scoring TAT protocols, but clinicians rarely use these scoring systems.



In general, validity is unimpressive when clinicians make judgments using the TAT, but better when judgments are made using formal scoring systems.

The best known scoring system for the TAT was developed by David McClelland, John Atkinson, Russell Clarke, and Edgar Lowell in 1953 to assess Henry Murray's need for achievement. The scores generated by this system correlate modestly with real-world measures of achievement. The Social Cognition and Object Relations Scale, which can be used to assess object relations (i.e., mental representations of other people), also has received empirical support. Results have been mixed for other scoring systems, including the Defense Mechanisms Manual (a TAT-based index of the defense mechanisms of denial, projection, and identification).

Although a few TAT scoring systems appear to be promising, none of the scoring systems are appropriate for clinical use because adequate norms are not available. Norms are needed so that psychologists will not (a) diagnose psychopathology when it is not really present or (b) overlook psychopathology when it is present. Without adequate TAT norms the meaning of the TAT scores is not clear.

### Human Figure Drawing Methods

Human figure drawing techniques include the Draw-A-Person, House-Tree-Person, Draw-A-Family, and Kinetic Family Drawing tests. The most frequently used version of the above drawing techniques is the Draw-A-Person test. Clients are simply instructed to draw a picture of a person, and afterward they are given a new sheet of paper and are instructed to draw a person of the opposite sex. For the House-Tree-Person test, a client may be instructed to draw a house, tree, and person all on one sheet of paper, or the client may be instructed to draw the house, tree, and person separately on three sheets of paper. For the Draw-A-Family, clients draw a picture of their whole family; for the Kinetic Family Drawing, clients are requested to draw a picture of their whole family "doing something." In each instance the drawings are interpreted for signs of psychopathology.

There are two major approaches to scoring and interpreting human figure drawings. The *sign approach* draws inferences from isolated drawing features. For example, if a human figure drawing has large eyes, a clinician might infer that the client is suspicious or paranoid. Results for the sign approach have been largely negative; the overwhelming majority of

validity coefficients have been negligible or zero. The *global approach* scores a number of features of a drawing and sums them to obtain a total score. Validity has been modest for the global approach. In particular, positive results were obtained when the Draw-A-Person: Screening Procedure for Emotional Disturbance was used to differentiate children and adolescents with conduct and oppositional disorders from normal children and adolescents.

### Use of Projective Techniques

There is ample reason for skepticism concerning most widely used projective techniques. The lack of evidence of validity and of adequate normative data are stumbling blocks for many of the routine clinical uses of the Rorschach, TAT, and human figure drawing techniques. For example, in one study, Rorschach protocols were distributed to 90 psychologists who had completed formal Rorschach training. They were instructed to assign protocols to several diagnostic categories, including "normal." Most protocols came from psychiatric patients, but some came from nonpatient adults. More than 75% of the normal adults were diagnosed as having mental disorders. For example, 12% were diagnosed as having major depression and 43% were diagnosed as having a personality disorder.

However, the results are not uniformly negative. Some Rorschach and human figure drawing scores are valid, as are some TAT scoring systems. If used cautiously, these scores can help clinicians describe some important psychological characteristics. For example, a client with a thought disorder may not be able to hide this condition on the Rorschach. Furthermore, the Washington University Sentence Completion Test (WUSCT), a measure of ego development (a construct that captures the complexity with which individuals view the world), has demonstrated impressive construct validity in a series of studies. Ironically, the WUSCT is almost never used in clinical practice, although it seems to have adequate norms and it is the most extensively validated projective technique.

There is a breach between clinical practice and scientific findings. Clinicians should not use a projective technique because it seems to work in their clinical practice. It can be difficult for clinicians to learn from clinical experience because accurate feedback is often unavailable, and also because their memories and cognitive processes are fallible. For example, clinicians who make a diagnosis typically do not receive objective feedback on the accuracy of the diagnosis. Because it



can be difficult to learn from experience, clinicians should be guided by the scientific literature when deciding how to select and interpret projective techniques.

*Howard N. Garb, Scott O. Lilienfeld,  
and James M. Wood*

**See also** Constructivist Theory (v2); Empirically Based Professional Practice (v1); Evidence-Based Treatments (v2); Free Association (v2); Narrative Therapy (v2); Psychoanalysis and Psychodynamic Approaches to Therapy (v2); Psychometric Properties (v2); Test Interpretation (v2); Therapist Interpretation (v2); Underdiagnosis/Overdiagnosis (v2)

### Further Readings

- Exner, J. E. (2002). *The Rorschach: Basic foundations and principles of interpretation* (4th ed.). New York: Wiley.
- Garb, H. N. (2005). Clinical judgment and decision making. *Annual Review of Clinical Psychology*, 1, 67–89.
- Hamel, M., Shaffer, T. W., & Erdberg, P. (2000). A study of nonpatient preadolescent Rorschach protocols. *Journal of Personality Assessment*, 75, 280–294.
- Lilienfeld, S. O., Wood, J. M., & Garb, H. N. (2000). The scientific status of projective techniques. *Psychological Science in the Public Interest*, 1, 27–66.
- McClelland, D. C., Atkinson, J. W., Clark, R. A., & Lowell, E. L. (1953). *The achievement motive*. New York: Appleton-Century-Crofts.
- Meyer, G. J., & Archer, R. P. (2001). The hard science of Rorschach research: What do we know and where do we go? *Psychological Assessment*, 13, 486–502.
- Naglieri, J. A. (1988). *Draw A Person: A quantitative scoring system*. San Antonio, TX: Psychological Corporation.
- Shaffer, T. W., Erdberg, P., & Haroian, J. (1999). Current nonpatient data for the Rorschach, WAIS-R, and MMPI-2. *Journal of Personality Assessment*, 73, 305–316.
- Wood, J. M., Nezowski, M. T., Lilienfeld, S. O., & Garb, H. N. (2003). *What's wrong with the Rorschach? Science confronts the controversial inkblot test*. San Francisco: Jossey-Bass.

---

## PSYCHOANALYSIS AND PSYCHODYNAMIC APPROACHES TO THERAPY

---

It has been over a century since Sigmund Freud first introduced psychoanalysis to the world and since

“Anna O,” one of the earliest and most famous psychoanalytic patients, described the treatment she was receiving as “the talking cure.” Since those pioneering days of psychoanalysis, the influence of this theory can be seen in the myriad theories that have come into being either as extensions of psychoanalytic ideas or as reactions to them. *Psychoanalysis* is a form of treatment in which the client typically lies on the psychoanalyst’s couch and “free associates,” while coming multiple times per week over the course of several years. *Psychodynamic psychotherapy* utilizes the constructs that inform psychoanalysis proper, but clients typically sit facing their therapists and are seen for one or two appointments per week. Treatments are often of shorter duration and some interventions may be of only a few weeks. More generally, however, psychoanalytic concepts are used in a variety of treatment contexts, including group psychotherapy, assessment, and crisis intervention. Thus, psychoanalysis has been profoundly influential in mental health interventions far beyond the classical format of the patient on the couch.

Psychoanalytic theory is simultaneously a developmental theory, a personality theory, and a theory of intervention. Freud’s original instinctual theories emphasized the role of sexuality and aggression. Since that beginning, psychoanalysis has evolved in significant new directions. Significant developments include object relations theory (which emphasizes the way in which people’s history of relationships form part of their psychology and shape them in profound ways), ego psychology (which emphasizes the complex relationship between the evolving ego and reality), separation-individuation theory (which describes the trajectory from psychological symbiosis to a sense of autonomy), self psychology (which theorizes about narcissism as a normal developmental line and about the emotional forces that create and shape people’s sense of self), and relational and interpersonal models (which emphasize the interpersonal context of the therapeutic situation and its role in resolving conflicts).

Each of these psychoanalytic theories evolved from Freud’s original framework and each emphasizes different aspects of psychological development or different ways of intervening therapeutically. Today *psychoanalysis* or *psychoanalytic treatments* refer to this collection of concepts and theoretical positions that have evolved over the past century. Within psychoanalytic theory, there are schools that favor one of these views over others, and practitioners whose work may be more informed by one of these



approaches over the others. These psychoanalytically informed therapies represent a complex set of assumptions and processes. They tend to be less directive or concretely problem solving in spirit than many other therapeutic approaches. Instead, they tend to emphasize the importance of insight and self-understanding as key curative elements in psychotherapy. Nevertheless, the different psychoanalytic schools are all derived from the core tenets of psychoanalytic theory and most psychoanalytic practitioners are conversant in all of these languages even if they emphasize one approach over the others in their own work.

### Core Assumptions

Notwithstanding this diversity of theoretical positions, psychoanalytic therapies tend to share certain core assumptions, such as the importance of the dynamic unconscious, the role of psychological defenses in mental functioning, and the importance of childhood experiences in shaping personality, including the conflicts that are the basis for psychopathology. The most central and fundamental of these shared constructs is the concept of the dynamic unconscious. One of Freud's earliest observations, the dynamic unconscious centers on the idea that there are thoughts, feelings, memories, and experiences about which people are unaware or not fully aware that form part of their psychology. Unlike some theories of unconscious perception and cognition, however, the key to the psychoanalytic use of this concept is its emphasis on psychodynamic processes. In other words, it is not only that there are memories, thoughts, and feelings that exist outside of conscious awareness, but also that these influence human motivation and behavior. Furthermore, individuals have a powerful need to keep these thoughts and feelings out of awareness because their emergence into consciousness is all too often associated with problematic feelings such as anxiety, guilt, and shame. Thus, unconscious conflicts form the basis of our motivational processes and they play a complex role in every person's life. This is true not only of specific symptomatic or pathological behaviors and patterns, but also of creative and other adaptive activities such as the choice of intimate partners, careers, and hobbies. The centrality of these unconscious processes makes them a key component to therapeutic efforts to address the problems of human living.

A closely related set of assumptions centers on the role and function of psychological defenses such as

repression, denial, projection, displacement, and identification in emotional functioning. Anna Freud posited in her classic 1936 book, *The Ego and the Mechanisms of Defense*, that defenses were involved in both normal and pathological functioning. This groundbreaking work clarified the ways in which all people use defenses adaptively as part of their engagement with the reality around them. However, when defenses become entrenched, rigid, and immutable, they lead to symptomatic and broader pathological outcomes. For example, a child may not recognize the accumulating evidence that there is no Santa Claus for a time. Use of the defense of denial allows him or her to maintain the fantasy that there are magical, all-knowing, and kind people who love and take care of us and bring special, desired gifts. In the normal course of development, reality eventually imposes itself and children give up such magical beliefs. However, a child who grows up in a home that is emotionally depriving and harsh might not be able to outgrow the use of denial as a mechanism for clinging to wished-for realities. Such a child might give up the belief in Santa Claus (because to not do so would invite ridicule from peers and others), but continue to use denial in the context of relationships. This inappropriate use of denial could make it difficult for the child to see problematic qualities in others, thereby making him or her vulnerable to destructive relationships throughout life.

A third and related perspective that is shared by psychodynamic approaches is a strong commitment to a developmental framework. Psychodynamic approaches assume that experiences across the span of development, but especially in early childhood, play a vital role in shaping personality. For this reason, psychodynamic therapists pay close attention to their clients' developmental histories. They seek to understand potentially important experiences, such as the attainment of developmental milestones, and events such as the birth of siblings, serious childhood illnesses, divorces, important family moves, the loss of important childhood attachments, and the psychological qualities and idiosyncrasies of the clients' primary childhood caretakers. It is assumed that such experiences must be explored and their imprint on the adult personality must be understood if the therapist is to help clients with their concerns. Such variables may work together in complex ways. For example, the age at which particular events take place will play a role in the child's capacity to understand and therefore on how its implications are absorbed. The same event (e.g., the death of a parent,



the divorce of one's parents, or being the victim of sexual molestation) may have a different psychological impact depending on when it transpired and whether the child's primary caregivers help the child manage the painful overwhelming experience or compound its deleterious effects.

This developmental perspective incorporates a variety of thematic interpretations as to the relevant or important issues that govern a child's development. The earliest and best known of these is Freud's formulation of the first 6 years of development as progressing from oral, to anal, to oedipal phases, at which point, Freud theorized, the key components of personality development were in place. Freud argued that specific issues and challenges govern each of these phases. The oral phase, roughly the first 18 months of life, revolves around issues of nurturance, the stability of caregivers, and dependency. The anal phase, during the next 18 months, is ostensibly about the attainment of toilet training but, more to the point, is about the struggle for autonomy and independence. The oedipal phase, between 3 and 6 years of life, is about the consolidation of gender identity and identifications with parents. Complications in one of these phases lead, through fixation, to the issues central to that phase becoming implicated in personality structure and, for some, symptomatology.

The other schools that have been noted (ego psychology, object relations, separation-individuation theory, self psychology, and the relational and interpersonal schools) each tend to examine other developmental themes in greater depth. For example, ego psychology is especially interested in people's ability to "test" reality adequately and regulate their emotions. Object relations theory examines how a person's history of interpersonal relations structures his or her sense of self and others. Separation-individuation theory focuses on the struggle between a person's wish to be dependent and his or her wish to be independent and autonomous. Self psychology looks at the evolution of a coherent sense of self and the ways in which people need and use others to organize themselves. Finally, the relational and interpersonal schools are especially attuned to how people re-create past relational patterns in current relationships, including therapeutic relationships.

Together, these models inform psychodynamic therapists about ways of understanding the issues, conflicts, and concerns that their clients bring into treatment. In effect, they provide a set of thematic guidelines that allow clinicians to understand these concerns as they

arise in the clinical setting, and they help the clinician decide whether and how to communicate these understandings to the client. Because of this relation between theory and clinical inference, a strong association exists between psychoanalytic conceptualizations and clinical process. Psychoanalysis, as a developmental and personality theory, is much more closely linked to clinical practice than are other theories.

The final core assumption of psychoanalytic theory is that childhood experiences become structured into stable, enduring psychological processes. In other words, individuals are the product of their developmental experiences. Therefore, paying close attention to a variety of clinical data in the present (e.g., symptoms, dreams, fantasies, and patterns of behavior in relationships and in other contexts) enables the clinician to discern important features of childhood experiences that may only be partly remembered (if remembered at all) and only partly understood. Thus, an important goal of psychoanalytic clinicians is to better understand aspects of their clients' past from the ways in which they operate in the present.

### Key Elements of Psychodynamic Treatment Approaches

The dynamic unconscious, the role of defenses, and the developmental perspective are central to most schools of psychoanalytic treatment. They form a conceptual framework from which a psychodynamic therapist operates in an effort to understand a client's concerns and to intervene constructively. In addition, all psychoanalytic schools of thought rely heavily on several other key concepts: free association, transference, countertransference, and the working alliance.

*Free association* refers to the "basic rule" of psychoanalysis, namely, that the client's task is to say what comes to mind during therapy sessions as opposed to having an overly structured, goal-oriented approach. The assumption is that, like a fish net, material that is unconscious is always interconnected. Inviting clients to talk about whatever occurs to them without censoring their thoughts insures that conflictual or objectionable material that comes into consciousness will be spoken.

*Transference* refers, in a narrow sense, to the ways in which the therapeutic relationship is a re-creation of important prior relationships. Psychodynamic therapists assume that, via projection, clients re-create the relationship paradigms that governed their relationships with



key attachment figures during the crucial period of childhood (especially over the first 5 or 6 years). A client who had a harsh and punitive father, for example, may come to believe that the therapist is judgmental and critical of the client. The client may misread the therapist's reactions precisely because the client developed this schema for relationships in response to the harsh attitudes that were present and pervasive in earlier relationships. This history makes these same feelings, now projected onto the therapist, feel "real" in the therapeutic situation when, in fact, the therapist is working hard to be thoughtful and nonjudgmental.

Transference can be a rich means for understanding the effects of important relationships in the client's past. As the therapist understands these past, formative relationships and conveys them to the client via interpretations, the client develops insight into how they are continuing to affect their present functioning. This allows clients to come to recognize how their experiences in their present relationships have been distorted by the influence of childhood experiences, and to change the way they relate to others.

*Countertransference* refers to the feelings that the therapist experiences within the therapeutic situation. Initially, Freud viewed countertransference feelings as obstacles to therapeutic progress that were derived from the therapists' own unresolved neurotic conflicts. These unconscious conflicts were assumed to create blind spots in the therapist, making it difficult for the therapist to listen to or to clearly understand the client's concerns. When protracted, such countertransference feelings implied that the therapists needed to be in therapy to help them understand the source of the feelings that were interfering with their therapeutic effectiveness. In fact, historically, it was considered indispensable for a psychoanalytic therapist to have been in treatment as part of his training. Didactic psychotherapy would presumably help therapists experience and understand the issues and conflicts that might interfere with their effectiveness with their clients. Psychoanalytic institutes still require their candidates to be in analysis.

By the 1960s, psychoanalytic theorists had begun having reservations about this restrictive definition of countertransference. For one thing, it was acknowledged that it is common for therapists to have feelings about their clients and about the issues that their clients discuss in treatment. Furthermore, theorists had begun to understand that therapists' feelings were often a rich source of information regarding what was occurring in

therapy. Rather than view countertransference as an impediment to the therapeutic process, psychoanalytic therapists began using their countertransference feelings as tools to help them engage with their clients more effectively, and as potential sources of information about the thoughts, feelings, and concerns which their clients were often unable to put into words.

This does not mean that all such feelings are constructive. On the contrary, it is still recognized that therapists' unconscious conflicts may interfere with their therapeutic effectiveness and may play a destructive role when these are not understood. Nevertheless, countertransference is now viewed almost universally as a vital source of material for understanding what is going on within therapy.

The *working alliance* refers to the collaborative relationship that is established in therapy between the therapist and client. The alliance must be nurtured with care throughout the process of therapy, in part because therapy does not always make the client feel good. For example, exploring past experiences that are attached to deeply painful feelings requires sensitivity and tact on the part of the therapist. Trust between the therapist and client must be established if the client is to endure the painful elements of the process. Experiences that may cause the client to feel considerable shame or guilt may be playing a vital role in the client's emotional life, but they may be the hardest things for the client to discuss in therapy precisely because of how they make the client feel. The working alliance helps the client feel safe enough to explore such difficult issues within the context of the therapeutic relationship, notwithstanding the fact that such an airing of thoughts, feelings, and experiences may temporarily make the client feel badly. It is also true, however, that for many clients there is a great deal of relief in the fact that the therapist is a warm, empathic person interested in the client's concerns. This, too, reinforces the working alliance.

The working alliance is nurtured in several ways. One is via the therapist's assuming a nonjudgmental stance toward the client's material. This stance is related to Freud's dictum that the therapist's role is that of a blank screen, or of a well-polished mirror to reflect the client's concerns. Similarly, Anna Freud described the therapist's ideal position within the therapeutic situation as equidistant from the id, the ego, and the superego. Some of these suggestions have brought the criticism that psychoanalytic therapists are too detached. However, the intent is to direct therapists toward a neutral posture vis-à-vis their clients.



This helps clients understand that their therapist is not going to respond judgmentally toward the experiences and feelings they bring into therapy.

Another way in which the working alliance is nurtured is through the creation of a stable, reliable therapeutic structure, also known as *the frame*, within which the therapy takes place. For example, psychoanalytic therapists tend to be mindful about beginning and ending sessions on time and about letting their clients know in advance about anticipated disruptions (e.g., vacations or other events) that mean that sessions will be cancelled. Generally speaking, psychoanalytic clinicians do not talk about themselves during appointments. For example, the focus remains on the client and the client's life. Similarly, most psychoanalytic therapists do not take phone calls during appointments and in other ways take pains to prevent intrusions into their sessions. These steps are understood to safeguard the therapeutic situation and they alert the client to the fact that the therapist takes the work (and the client's life) seriously. They help foster an understanding that the therapy and the therapeutic relationship exist as a stable process on which the client can rely. Strict adherence to confidentiality and to limiting therapist-client interactions to the therapy sessions also serve to create a therapy structure within which the client feels "held." In short, the frame helps foster an experience of the treatment as a safe context, and of the therapist as a reliable ally.

No review of psychoanalytically informed therapies would be complete without a discussion of *dream interpretation*. Freud considered dreams to be the royal road to the unconscious, and in the early years of psychoanalysis clinicians and their clients often devoted multiple sessions to a concerted effort to decode the meaning of a single dream. Contemporary therapists are less likely to spend as much time on a single dream as they did in Freud's day, although the meaning of a particular dream may be clarified over the course of further work. However, the view that dreams are an important source of information about the client's unconscious remains central. Freud viewed the content of dreams as standing on two legs: the present and the past. From the present a dreamer might draw from a day residue—that is, feelings, images, and situations that the dreamer has been negotiating at the moment. The dream also draws upon the past, from the organizing conflicts with which the dreamer continues to struggle.

Typically, the client is asked to free-associate (i.e., say what comes to mind spontaneously) about the

different images, themes, feelings, or situations that appear in the dream. Freud was adamant that a dream could not be understood without the dreamer's associations. He eschewed cookbook approaches to dream interpretation in which specific images might be automatically understood as linked to specific contents. The therapist attempts to make sense of the dream in relation to these associations and in relation to what the therapist has learned about the client over the course of the treatment.

Psychoanalytic notions of helpful interventions tend to revolve around two key ideas: the role of insight in therapy and the role of the therapeutic relationship as a curative agent. Insight was considered to be the lynchpin of therapeutic cure throughout the formative years of psychoanalytic theorizing. Freud's initial formulations relied on an understanding of traumatic experiences that were theorized to be unconscious (and maintained there by repression and other defenses), so gaining insight (i.e., making these unconscious memories, feelings, and anxieties conscious) was seen as a central component of the therapeutic cure. While it is often assumed that insight is an intellectualized process, Freud emphasized that an intellectual understanding, devoid of feelings and emotional engagement, was not sufficient to help clients resolve their concerns.

The role of insight in therapeutic process led psychoanalysts and psychodynamic therapists to place great importance on the role of interpretation in helping clients to resolve their emotional conflicts. *Interpretation* is a technical term for a therapist's formulation, offered to the client during the therapeutic process, of how a client is unconsciously defending against thoughts, feelings, and impulses, or of what it is that the client is defending against. In other words, an interpretation is the means by which therapists attempt to help clients better understand themselves. This perspective is seated, more broadly, in values such as the value of knowing oneself and of being honest with oneself and others. Thus, insight, and the process of better understanding the forces that have shaped one's emotional life, is a key component in the psychoanalytic process.

More recently, the importance of the therapeutic relationship itself, rather than insight alone, has become an increasingly central construct for understanding how it is that therapists help their clients resolve their concerns. Psychodynamic therapists, especially those from the relational and interpersonal schools, now give



greater weight to the working alliance. The interaction that occurs in the interpersonal field between the therapist and client can become a rich source of material for understanding how the client engages the world and a rich context within which to resolve their concerns. This is especially true if the therapeutic relationship is one in which the therapist is empathically attuned and skillful in using the relationship to understand the client's issues. Learning about healthier forms of engagement within the therapeutic relationship often translates into healthier relationships in clients' lives outside of the consulting room.

*Ricardo Ainslie*

**See also** Adlerian Therapy (v2); Constructivist Theory (v2); Counseling Theories and Therapies (v2); Defenses, Psychological (v2); Ego Strength (v2); Free Association (v2); Freud, Sigmund (v2); Jung, Carl (v2); Personality Theories (v2); Personality Theories, Psychodynamic (v2); Self-Disclosure (v2); Therapist Interpretation (v2); Therapist Techniques/Behaviors (v2); Transference and Countertransference (v2); Working Alliance (v2)

### Further Readings

- Ellman, S. (2002). *Freud's technique papers: A contemporary perspective*. New York: Other Press.
- Greenberg, J., & Mitchell, G. (1983). *Object relations in psychoanalytic theory*. Cambridge, MA: Harvard University Press.
- Levy, S. (1984). *Principles of interpretation*. New York: Jason Aronson.
- McWilliams, N. (1994). *Psychoanalytic diagnosis: Understanding personality structure in the clinical process*. New York: Guilford Press.
- McWilliams, N. (2004). *Psychoanalytic psychotherapy: A practitioner's guide*. New York: Guilford Press.
- Pine, F. (1985). *Developmental theory and clinical process*. New Haven, CT: Yale University Press.
- Pine, F. (1990). *Drive, ego, object, and self*. New York: Basic Books.

---

## PSYCHOEDUCATION

---

Psychoeducation combines psychotherapy with education to help participants deal with a targeted problem in their life. It has been implemented in a variety of settings, ranging from mental health clinics to

occupational training. Psychoeducation focuses on providing valuable information to clients, and helping them improve awareness, skills, and communication related to the target problem. Therapists serve as “facilitators” by setting the intervention goals and modifying the presentation of information to meet clients' needs. Psychoeducation can be used with diverse cultural and ethnic groups, and can be adapted to a number of presentation formats. Empirical evidence has shown that psychoeducation is an effective intervention that improves clients' lives by increasing knowledge, developing skills, and improving relationships.

This entry describes psychoeducation—what it is, how it differs from other modes of therapy, its basic principles and treatment components, how it is conducted, and its mechanisms of action. The entry discusses the development of psychoeducation and provides examples of the diverse settings in which this type of treatment can be used. In addition, it discusses the role of therapist as facilitator and addresses cultural concerns in psychoeducation, and concludes with a summary of the evidence supporting the use of psychoeducation.

### What Is Psychoeducation?

#### **Development of Psychoeducation**

The development of psychoeducation is related to the passage and implementation of the Community Mental Health Act of 1963, which resulted in deinstitutionalization. This act was developed to provide a more normalized way of living for individuals experiencing psychological disturbances who could be maintained on medications and treated through services in their community. Although the act was well intended, a majority of the community-based treatment was provided by overworked and understaffed community facilities. This resulted in poor or no treatment for many individuals. Deinstitutionalization failed in meeting its lofty goals and essentially abandoned those it was designed to help. This dilemma stimulated efforts to educate families on how to best care for relatives experiencing mental health difficulties. Psychoeducation was developed to fill the gap resulting from the negative effects of deinstitutionalization.

Another factor that promoted the development of psychoeducation was the shift in zeitgeist from a belief that mental illness was a result of family factors (i.e., “family blaming”) to alternative explanations of



psychopathology. This in turn led to more family-focused treatments such as psychoeducation.

### ***Definition of Psychoeducation***

Psychoeducation is a form of therapeutic intervention that combines psychotherapy and education. It can be used with individuals, families, and groups, and implemented on its own or as a supplemental treatment to other ongoing interventions (e.g., medication management and family therapy).

Psychoeducation works by increasing knowledge and improving skills. When administered in a group format, it also provides social support. Psychoeducation applies therapeutic interventions from other theoretical models (e.g., cognitive-behavioral therapy [CBT], systems approaches, client-centered therapy) and combines them with specific information relevant to the presenting concern of the client (e.g., symptoms of a particular disorder, navigating the education or mental health system, medication side effects, healthy eating or sleeping habits).

### ***Settings That Employ Psychoeducation***

Psychoeducation can be provided in a variety of settings, including hospitals, jails, the military, schools, businesses, career centers, mental health centers, and even over the Internet using chat room/discussion groups or individual contact. The treatment focus varies according to the setting and client's presenting concern. For example, psychoeducation could be used when working with the family of a child having a medical illness that affects the child's social, emotional, educational, and family functioning; when working with a husband and wife seeking marital counseling or parenting skills; or when assisting an employee to meet specific job demands.

Psychoeducation can be provided in individual, family, or group formats. Each has its distinct advantages and disadvantages. An individual format allows more time to devote to topic areas most relevant to the client, and it provides increased flexibility in covering material. A drawback is the client is not exposed to individuals with the same concerns and is therefore less likely to have an "I'm not the only one" experience. Furthermore, the client is not exposed to a social group that facilitates social learning, the development of new relations, or exposure to alternative points of view and experiences.

Family psychoeducation allows the client to address concerns affecting the family unit, and it provides increased opportunities for members to learn the same skills and assist each other with practicing and applying them. Working with the family allows members to support each other, facilitate ongoing skill practice outside of sessions, and foster consistency of the skill. A major disadvantage is the lack of opportunity to meet other families experiencing the same difficulties.

Group approaches provide opportunities for social learning, development of an additional support system, networking, and reinforcement for positive change. However, group approaches have less flexibility in scheduling, they lack the ability to focus exclusively on any one client's needs, and some clients are uneasy sharing personal information in a group setting. All of the modalities of psychoeducation discussed here are effective.

Specific types of psychoeducational groups include educational/task groups, educational/guidance groups, training/work groups, training/relations groups, and training/social skills groups. Educational/task groups emphasize a client's understanding of a particular topic (e.g., civic organizations or task forces). In contrast, educational/guidance groups help clients cope with life situations such as divorce. Training/work groups are developed by employers to provide information that will assist employees to meet work demands (e.g., supervising difficult workers). Training/relations groups focus on the development of communication and interpersonal skills. Finally, training/social skills groups work to increase social skills using education, self-exploration, didactic work, and practice. These interventions can also be provided in an individual format.

### ***Components of Psychoeducation***

Psychoeducation consists of sharing information with the client that is relevant to the specific area of concern (e.g., the presenting problem) in addition to applying the tenets of various therapeutic modalities. For instance, a therapist might use behavioral and cognitive approaches to help a client develop alternative responses to events and to address the client's cognitive distortions related to these events. The therapist would also present topic-relevant information to increase the client's understanding of cognitive distortions, and use skill-building techniques (e.g., communication and problem-solving skills) to increase the client's ability to successfully apply the information.



## ***Format and Duration***

In individual or family psychotherapy, the therapist and client develop client-specific activities. Psychoeducation uses a “fixed but flexible” model. Treatment begins by focusing on a specific topic (e.g., improving a family and child’s management of mood disorders or improving an employee’s success in a job situation). Session content is prearranged; the “course outline” is typically shared with the client at the first session. However, new topics the client presents can be integrated into the prepared session content.

Session content can be presented verbally through discussion, presentation, and/or demonstration; through role playing; by video; or by invited guest presenters or lecturers. Information is typically provided in more than one medium. For example, if the therapist verbally describes and processes information with the client, written materials that elaborate on or summarize the topics and information might also be provided. This provides exposure via a variety of modalities, enhancing the likelihood the client will integrate and recall the information. Practicing new techniques via role-plays allows the therapist to process with the client any foreseen obstacles to completing the between-session project. Reviewing the project at the next session is paramount.

Session length and treatment duration typically are established at treatment onset. For example, a college student wishing to improve study skills might attend one 2-hour session. In contrast, an employee might attend five 1-hour sessions on managing stress in the workplace. Some psychoeducational treatments allow one or more “flex” sessions to be used as needed to address specific concerns of the client.

## ***Group Settings***

Psychoeducation can be provided in individual or group settings with minor adjustment to the materials. Most important, materials must be developmentally appropriate, topics must be relevant, and session length must be sufficient for the number of participants. Basic information can be presented simultaneously to individuals who differ in their understanding and experience of the topic. This approach mimics Lev Vygotsky’s zone of proximal development, whereby the client’s ability to use the information presented is facilitated by the client’s prior experiences and problem-solving skills, under appropriate guidance of a competent therapist or capable peers.

In a group setting, information can be presented to all clients simultaneously. The therapist can then individually tailor the amount of additional information that is needed for each client. When conducting psychoeducation in a group format, the therapist should be familiar with the process of group interventions as well as each client’s presenting concerns that may affect the group process.

## ***Treatment Goals***

Treatment goals, like the treatment itself, are predetermined. Goals can be general or specific. For instance, a general goal might be to improve overall family functioning by addressing interaction and communication style. A specific goal might be to decrease the frequency of a negative work event. In group formats, the general goal may be similar for each client, but specific goals are idiosyncratic.

## ***Cultural Concerns***

Skilled culturally sensitive therapists are aware of specific cultural concerns that may influence clients’ willingness to seek psychoeducational services, their level of participation, and whom they might wish to bring to sessions as part of their family. Additionally, therapists are aware of issues pertinent to various cultural and ethnic groups. Although this topic cannot be fully addressed herein, some examples of issues to consider are described below.

When providing psychoeducation to Native Americans, it is important to recognize that healers and community leaders are important and therefore may be brought to sessions or might assist in helping the client with the intervention. Asian Americans may prefer a logical and structured approach to treatment, as opposed to a flexible approach that focuses on affective issues. Thus, psychoeducation with its focus on skill building and problem solving may be a treatment of choice. African Americans view the family in broader terms than the “nuclear family” view of Caucasians; therefore, when inviting family members to attend sessions it might be appropriate to include aunts, uncles, or grandparents in the invitation. Similarly, Latino/a families might include extended and nonblood relatives as part of the immediate family system.

When working with immigrant and first-generation minorities, it is important to avoid using children as interpreters, even though they may be more skillful in



the majority language than their parents. This can cause significant problems and complications in exchanging information and impede the outcome of treatment.

## How Psychoeducation Works

### *Therapist's Facilitator Role*

The role of the therapist and the therapist–client relationship in psychoeducation differs from that in more traditional forms of counseling and psychotherapy. In psychoeducation, the therapist serves as facilitator and teacher. While counseling and psychotherapy often focus on remediation of a problem, psychoeducation often pays equal or greater attention to the prevention of problems and the development of strengths. The therapist is largely responsible for determining the goals and activities of psychoeducation and for tailoring the intervention to the needs, motivations, and relative strengths and weaknesses of each client.

### *Stages of Psychoeducation*

Most psychoeducation models have common traits and techniques. Programs typically begin with a comprehensive assessment of client needs, strengths, and weaknesses. This allows the therapist to form a collaborative alliance with the client while gaining valuable understanding of how to best tailor the intervention to fit the client. Building on the client's strengths allows for a focus on the present. The client's past experiences are also incorporated into treatment to identify areas for improvement.

The next stage usually involves a didactic component. This can be fairly structured (e.g., a classroom lecture) or more informal (e.g., group discussion). As transfer of information is a primary function, this phase is often a large proportion of the psychoeducational intervention. Additionally, it is frequently integrated with other steps in a program, rather than presenting the educational information in one stand-alone module.

### *Outcome of Psychoeducation*

Psychoeducation makes a difference in people's lives by enabling them to improve their own (or a loved one's) health, abilities, relationships, or functioning. Psychoeducation attains this goal by providing relevant information to clients about a problem,

illness, or source of distress that is present in their life. Improved knowledge about a problem allows clients to better utilize methods of reacting to it. This leads to a decrease in the stress, conflict, or impairment caused by the problem. Psychoeducation also changes clients' lives by increasing their skills in areas such as communication, problem solving, coping, medication adherence, modification of routines, environment adjustment/management, and social connections.

Jarrod M. Leffler, Matthew E. Young,  
and Mary A. Fristad

*See also* Client Attitudes and Behaviors (v2); Cognitive-Behavioral Therapy and Techniques (v2); Community-Based Health Promotion (v1); Counseling Theories and Therapies (v2); Empowerment (v3); Expectations About Therapy (v2); Facilitative Conditions (v2); Help-Seeking Behavior (v3); Homework Assignments (v2); Self-Help Groups (v2)

### Further Readings

- Brown, N. W. (1998). *Psycho-educational groups*. Philadelphia: Accelerated Development.
- Fristad, M. A., Goldberg-Arnold, J. S., & Gavazzi, S. M. (2003). Multi-family psychoeducation groups in the treatment of children with mood disorders. *Journal of Marital and Family Therapy*, 29, 491–504.
- Goldstein, M. J., & Miklowitz, D. J. (1995). The effectiveness of psychoeducational family therapy in the treatment of schizophrenic disorders. *Journal of Marital and Family Therapy*, 21, 361–376.
- Iodice, J. D., & Wodarski, J. S. (1987). Aftercare treatment for schizophrenics living at home. *Social Work*, 32, 122–128.
- Lukens, E. P., & McFarlane, W. R. (2004). Psychoeducation as evidence-based practice: Considerations for practice, research, and policy. *Brief Treatment and Crisis Intervention*, 4, 205–225.
- McFarlane, W. R., & Cunningham, K. (1996). Multiple family groups and psychoeducation: Creating therapeutic social networks. In J. V. Vaccaro & G. H. Clark (Eds.), *Practicing psychiatry in the community: A manual*. Washington, DC: American Psychiatric Press.
- Simon, C. (1997). Psychoeducation: A contemporary approach. In T. R. Watkins & J. W. Callicutt (Eds.), *Mental health policy and practice*. Thousand Oaks, CA: Sage.
- Sue, D. W., & Sue, D. (1990). *Counseling the culturally different: Theory and practice* (2nd ed.). New York: Wiley-Interscience.



Williams, C. A. (1997). Psychoeducation. In N. K. Worley (Ed.), *Mental health nursing in the community*. St. Louis, MO: Mosby.

## PSYCHOLOGICAL WELL-BEING, DIMENSIONS OF

Psychological well-being (PWB) is a theory of positive psychological functioning that focuses on the human capacity to develop, function effectively, and flourish. Theoretical beliefs about what constitutes PWB derive from the philosophical and psychological writings of Abraham Maslow and Carl Rogers.

For Maslow, human behavior was characterized by movement toward self-actualization and, at the same time, limited by more basic processes such as physiological and safety needs. Actualization is attainable only if basic needs were met. Rogers shared the perspective that self-actualization is an inherent possibility and posited that certain interpersonal conditions, such as empathy, respect, and genuineness, facilitate movement toward self-actualization. Thus, consistent with Maslow and Rogers, current PWB theory holds that the development of human potential involves two processes: (1) the inherent human drive for self-actualization, and (2) the creation of the conditions under which that drive might be optimized. These views form the philosophical foundation of counseling psychology.

Three types of studies provide the empirical foundation of PWB theory: (1) factor analytic studies of the organization among individual characteristics of well-being, (2) developmental studies of the changes in well-being across the life span, and (3) neurophysiological studies of the biological correlates of expressions of well-being. One of the more well-developed measures of PWB incorporates six theory-driven dimensions: positive self-evaluations, a sense of continued growth and development, the belief that life is purposeful, the possession of quality relations with others, the capacity to manage one's surroundings effectively, and a sense of self-determination. Data from national surveys, longitudinal studies, and experimental laboratory studies have indicated that PWB indicators are influenced by broad social factors such as age, gender, socioeconomic status, race, and culture; PWB changes as individuals are confronted with life challenges and

transitions; and PWB indicators are associated with diverse health outcomes.

Conceptually PWB is related to subjective well-being (SWB), although not identical to it. SWB is related to judgments of relative happiness and quality of life, whereas PWB has more to do with the management of the existential challenges of life such as having meaning in one's life and growing and developing as a person.

A challenge for mental and physical health professionals is to integrate the psychological evidence concerning the complex, multidimensional nature of PWB into effective primary and secondary prevention programs. The goals are to help normally functioning individuals optimize their lives and to minimize the negative effects of illness or psychopathology. Thus, interventions that are provided to normal functioning people may promote even higher functioning and inoculation against dysfunction. Interventions for people with psychopathology or illness might focus on developing resilience skills; that is, the ability to bounce back to normal functioning or to exceed prior functioning.

Psychologists are presently focused on developing an understanding of the multiple pathways that lead to resilience and how these pathways change throughout life. It is upon this knowledge base that intervention programs to maintain and improve well-being are being constructed.

*Thomas V. Merluzzi and Anthony D. Ong*

*See also* Developmental Counseling and Therapy (v2); Facilitative Conditions (v2); Happiness/Hardiness (v2); Hope (v2); Job Satisfaction and General Well-Being (v4); Physical Health (v2); Positive Psychology (v2); Quality of Life (v2); Resilience (v2); Rogers, Carl R. (v2); Ryff, Carol D. (v2)

### Further Readings

- Keyes, C. L., Shmotkin, D., & Ryff, C. D. (2002). Optimizing well-being: The empirical encounter of two traditions. *Journal of Personality and Social Psychology*, 82, 1007–1022.
- Ryff, C. D. (1989). Happiness is everything, or is it? Explorations of the meaning of well-being. *Journal of Personality and Social Psychology*, 57, 1069–1081.
- Ryff, C. D., & Singer, B. (1996). Psychological well-being: Meaning, measurement, and implications for psychotherapy research. *Psychotherapy and Psychosomatics*, 65, 14–23.



---

## PSYCHOMETRIC PROPERTIES

---

Appraisal of human characteristics—such as achievement, ability, proficiency, attitude, belief, or another construct—is routinely accomplished through administration of a test, which is itself often carefully developed and administered by standardized protocols. Examinees and other test users are usually interested only in the results yielded by a test administration; generally they are not attuned to characteristics or technical features of the instrument itself. Still, many persons who use test results realize that the usefulness and appropriateness of test-score interpretation is a direct result of the test's internal characteristics. The internal attributes of a test are technically termed its *psychometric properties*. Psychometric properties are characteristics of tests and other measures of human characteristics that identify and describe attributes of an instrument, such as its reliability or appropriateness for use in a particular circumstance.

Most commonly, psychometric properties provide information about a test's appropriateness, meaningfulness, and usefulness—in other words, its validity. As illustration, suppose a test is advertised as a measure useful for diagnosing a personality disorder such as schizophrenia. The test's psychometric properties provide test makers and users with evidence of whether the instrument performs as portrayed.

Although numerous psychometric properties exist for describing the technical qualities of tests, they are not catalogued into a convenient, definitive list. Instead, whenever a particular feature of a test is described in terms of scientific standards (i.e., not just mentioned in casual conversation), it may be considered as a psychometric property. In its most general usage, therefore, *psychometric property* as a scientific term refers to some essential attribute of the test.

Psychometric properties focus on particular features of a test. Some properties provide evidence as to the quality of the whole instrument, while others provide evidence about its constituent parts, its sections, or even its individual items. For example, when looking at a whole test, a psychometric property could indicate whether the instrument measures a single construct or many. The attribute of a test measuring only a single dimension—or more than one dimension if that is the case—is a psychometric property of the complete instrument. Another psychometric property of the whole test could indicate whether the instrument appraises the target construct equally well for women

and men. This is a psychometric property of sex (or gender) equality. Still other psychometric properties provide evidence of whether a test measures a construct consistently (i.e., reliability). These examples illustrate some common psychometric properties of an entire test: its dimensionality, its equality, and its reliability.

Psychometric properties also exist for individual test questions (i.e., items). Indicators of a particular test item's difficulty, its ability to discriminate among people having differing amounts of the construct being measured (i.e., discrimination), and the likelihood that the correct answer could be chosen by guessing are each a psychometric property of an item.

Another feature for psychometric properties is that they are generally—but not exclusively—expressed quantitatively. Often an index, a coefficient, or some other numerical quantity is given to convey the property. Many students and professionals are familiar with a reliability coefficient, for example. The reliability coefficient is a numerical value. “Reliability” is the psychometric feature for the test, but it is expressed as a quantitative value. So, too, most other psychometric properties are indicated numerically. However, a quantitative value is not always the best means of conveying a particular psychometric property. Validity, for instance, is a complex phenomenon that cannot be meaningfully reduced to a single index or value. Validity is the overarching psychometric property, but a thorough discussion that summarizes an extensive body of evidence is necessary to describe test validity.

It is important to investigate and learn about a test's psychometric properties for two reasons. First, this information is necessary for sound test construction. Psychometricians and other professionals who develop tests need to evaluate and describe how a test functions so that it can be built to a specified level of quality. Second, knowing about the psychometric properties of a test provides evidence that information obtained using the instrument can provide a sound basis for decision making. Psychologists, counselors, educators, policy personnel, and many others often base their decisions, at least in part, on the information garnered from tests. The evidence that supports such decisions is found in a test's psychometric properties. Without knowing how well a test functions, interpretations are suspect.

### Distinguishing Psychometric Properties From Statistics

Psychometric properties are not statistics per se, but they are generally represented by quantitative values.



These values are often calculated using statistical procedures. For example, consider more carefully the notion of *reliability*, which refers to the consistency of measurement. Reliability indicates whether one would obtain consistent information if one applied a testing procedure to a population of individuals or groups on repeated occasions. The idea of how consistently a test operates across several administrations is a psychometric property of a test. A statistical procedure is used to calculate a reliability coefficient or reliability index.

Furthermore, many psychometric properties cannot be expressed through a single value, like a coefficient or index. Many important properties of tests are broad concepts, like their factor structure. Unearthing information about the factor structure of a test typically requires a research design (often a complex design) and information about the factor structure of a test cannot be conveyed by a single value. Thus, statistics are used to calculate values that permit a concise, coherent statement about the psychometric property, but the statistics do not represent the psychometric property. Instead, the concept (e.g., the factor structure for the test) is the psychometric property.

### Test Validity and Psychometric Properties

In a very general sense, all psychometric properties are gauges of a test's validity. *Validity* refers to the degree to which evidence and theory support the interpretations of test scores. One way to think of validity is to imagine how the scores on a test provide information that is useful, appropriate, and meaningful for a particular decision. A decision that is based on supported evidence is valid, and the test is judged to be valid for that particular decision. All psychometric properties provide information (either directly or indirectly) that indicates the test's usefulness for making interpretations, and hence all psychometric properties provide information about a test's validity.

### Types of Psychometric Properties

Table 1 lists some common psychometric properties of tests. Note that the table presents both item statistics and test statistics, the two categories for psychometric properties mentioned above. Under Item Statistics the list includes several indicators of psychometric properties, including item difficulty, item discrimination, and item fit statistics. Each of these characteristics of test items is a psychometric property and each can be

expressed in multiple ways. Item difficulty, for instance, can be a  $p$  value, an item response theory (IRT) fit statistic, or another index not shown in Table 1. The  $p$  value is the proportion (percentage) of examinees that responded correctly to the item on a given occasion. The IRT fit statistic provides an indication of the appropriateness of the question for an examinee when the examiner wishes to administer only items that are theoretically suited to each examinee's overall ability in the proficiency being appraised. Items that are too difficult and those too easy for an examinee are best omitted because they likely provide little information beyond that which can be garnered by presenting only items matched to the examinee's ability. As indicated in Table 1, a variety of numerical values are available for most psychometric properties, each of which has a unique meaning.

Table 1 also indicates a number of properties (e.g., centrality, dispersion, distribution, and reliability) that pertain to whole tests (see the Test Statistics column).

**Table 1** Common statistics used to represent psychometric properties

<i>Item Statistics</i>	<i>Test Statistics</i>	<i>Group Examinee Statistics</i>
<b>Difficulty</b>	<b>Centrality</b>	
p-value	Mean	Sex or gender
IRT difficulty parameter	Std. error of the mean	Ethnic heritage (race)
Delta	Median	Education level
	Mode	Training
	Sum	Employment indices
<b>Discrimination</b>	<b>Dispersion</b>	Experience
Biserial $r$	Std. deviation	Other variables
Point-biserial $r$	Variance	
Polyserial $r$	Range	
Upper v. lower	Minimum	
IRT discrim. parameter	and maximum	
	Std. error	
<b>Other</b>	<b>Distribution</b>	
IRT "fit" stats	Skewness	
Chi square	Kurtosis	
Std. error	<b>Reliability</b>	
	Cronbach's Alpha	
	Test-retest	
	Split-half	
	Other $r$ s	



Again, each psychometric property can have a number of expressions. The psychometric property of centrality provides information about the relative status of the population of examinees on the construct being measured. For example, the population of gifted high school students might be expected to have a relatively high mean, median, mode, and sum, and a relatively low standard error of the mean on a test designed to measure readiness for college. Administration of this test to a sample of gifted high school students, therefore, provides an opportunity to determine whether the test yields results that make sense.

The property of dispersion is close to being the opposite of centrality in tests. Dispersion indicates how variable the examinees are on the appraised attribute. A heterogeneous (i.e., highly variable) group will obtain a wide array of scores; a homogeneous (i.e., very similar) group of examinees will obtain scores that differ only by a small amount.

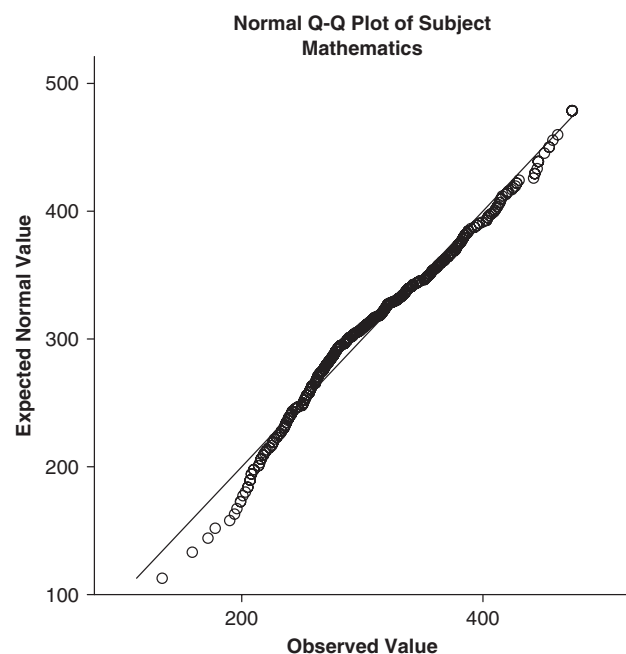
The psychometric property of distribution refers to the distribution of scores relative to a normally distributed population. In a normal population, the distribution of scores around the median is symmetric. That means that each half of the distribution of scores is a mirror image of the other half of the distribution. When graphed, a normal distribution yields a bell-shaped curve, evidencing zero skew. When the scores are not symmetric, the distribution will be either positively skewed (i.e., have too many low scores) or negatively skewed (i.e., have too many high scores). Kurtosis indicates the peaked nature of the distribution. When the population is symmetric, the number of high and low scores matches the number expected and the peak (i.e., kurtosis) is zero. High-peaked distributions have fewer high and low scores than expected and a kurtosis value greater than zero. Low-peaked distributions have more high and low scores than expected and a negative kurtosis value. Reliability has already been discussed.

Psychometric properties are often displayed in a graphic form when the precise values are less important than conveying the meaning of the properties. Figure 1 is an example that displays a Q-Q plot illustrating the psychometric property of normality in a mathematics test. Normality is another type of expression of the normal values explained for Table 1. The base of the plot is the range of scores on the test (i.e., from below 200 to above 400 in Figure 1). These observed values are plotted against a residual value. The residual value is the difference between the observed value and a value that would be expected if

the population were perfectly normal. Thus, this figure shows how much the observed values deviate from the values that would occur in a normal population.

To interpret normality in a Q-Q plot, notice how the test values (shown as circles) align themselves with the near-45 degree regression line, going from lower left to upper right. In this figure one can see that low-ability examinees (on the lower left near the starting point of the regression line) are not normally distributed. Most of the examinees at the other ability levels are close to normal. However, another slight deviation from normality occurs for the highly able examinees, shown by the circles deviating from the line at the upper right. In test development work, exploring the property of normality for a group of examinees is a common and exceedingly useful procedure. As can be seen in Figure 1, graphic displays of information about psychometric properties often provide clear interpretations of the essential point by eliminating the complexity that occurs when the statistical values are reported in detail.

Figure 2 illustrates a more complicated graphic that conveys a myriad of technical information about a test. The curve line in Figure 2 represents the pattern of responses of a population of examinees to one test item. The lower axis, known as the  $x$  axis or the abscissa, is labeled "Ability" and its scale is symmetric around zero. In other words, a zero on this scale is the median ability of the examinee group. The median



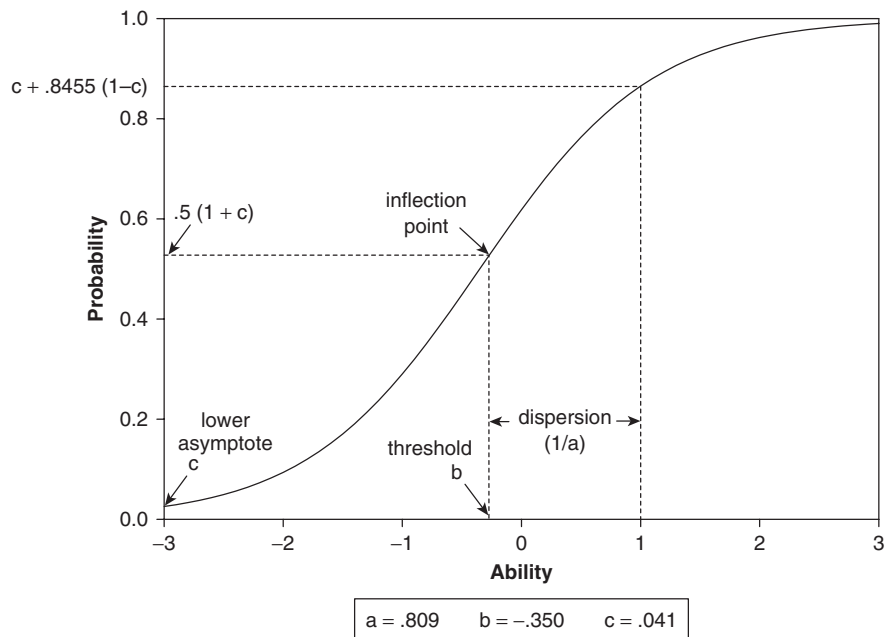
**Figure 1** Graphic illustrating the psychometric property of normality



is the central value; half of the examinees scored higher than the median and half scored lower than the median. The numeric values to the left and right represent standard deviations from the median. Examinees at  $-3.0$  scored very low on the ability being measured and those at  $+3.0$  scored quite high on the ability being measured. The vertical scale on the left, known as the  $y$  axis or the ordinate, ranges from 0.0 to 1.0. This dimension indicates the probability an examinee of that ability level will make a correct response to the item. As can be seen, the probability of a correct response ranges from 0% (0.0) to 100% (1.0). The curved trace line for the item illustrates that persons of low ability have only a low probability of responding correctly to the item. As ability increases, however (moving from left to right along the  $x$  axis), the probability of a correct response to the item grows correspondingly.

Figure 2 also illustrates that the growth is not perfectly linear. If the growth were perfectly linear, the item trace line would be at a 45-degree angle. Instead, the lazy S-shape line illustrates that at very low and very high ability levels, the curve begins to flatten out. That shows that persons in those low and high ability groups all have about the same probability of responding correctly to the item. Thus, the curve tells users that the item is good for distinguishing among people of differing ability levels provided they do not fall into the very high or very low ability group (i.e., their ability is between  $-1.5$  and  $+1.5$  standard deviations from the median). The item is not very useful for distinguishing among people at the lowest and highest ability levels. Still, the overall figure does provide a useful illustration of displaying multipart and refined psychometric properties for tests and their items.

Although Figure 2 contains more psychometric information than can be conveniently explained here, the point to garner from this figure is a realization that psychometric properties are often complex and represent sophisticated concepts, but sometimes they can



**Figure 2** Item Characteristic Curve showing the relation of item difficulty to item discrimination across the full range of ability levels

Source: Osterlind, S. J. (2006). *Modern measurement: Theory, principles, and applications of mental appraisal*. Upper Saddle River, NJ: Prentice Hall. Reprinted with permission.

be represented clearly and simply using graphical displays.

## Evaluation

Psychologists use tests in research and practice to measure constructs that are not readily observable (e.g., agreeableness, need for cognition, and empathy). The scores yielded by a test often provide a basis upon which psychologists make decisions. Because of the importance of test data, it is essential to evaluate the psychometric properties of the instruments psychologists use. The internal properties of the instruments that psychologists use are known as their psychometric properties. An evaluation of the psychometric properties of an instrument allows psychologists to use the instrument with confidence that it will provide reliable, valid, meaningful information that can be used in making decisions.

Steven J. Osterlind

**See also** Academic Achievement (v2); Achievement Gap (v3); Achievement, Aptitude, and Ability Tests (v4); Assessment (v4); Cognition/Intelligence, Assessment of (v2); Intelligence Tests (v3); Meehl, Paul E. (v2);



Positivist Paradigm (v2); Quantitative Methodologies (v1); Test Interpretation (v2); Translation and Adaptation of Psychological Tests (v1)

### Further Readings

- American Educational Research Association, American Psychological Association, National Council on Measurement in Education. (1999). *Standards for educational and psychological testing*. Washington, DC: American Educational Research Association.
- Brennan, R. L. (Ed.). (2006). *Educational measurement* (4th ed.). Westport, CT: Praeger.
- Embretson, S. E., & Reise, S. P. (2000). *Item response theory for psychologists*. Mahwah, NJ: Lawrence Erlbaum.
- Hambleton, R. K., Robin, F., & Xing, D. (2000). Item response models for the analysis of educational and a psychological test data. In H. E. A. Tinsley & S. D. Brown (Eds.), *Handbook of applied multivariate statistics and mathematical modeling* (pp. 553–581). San Diego, CA: Academic Press.
- Marcoulides, G. A. (2000). Generalizability theory. In H. E. A. Tinsley & S. D. Brown (Eds.), *Handbook of applied multivariate statistics and mathematical modeling* (pp. 527–551). San Diego, CA: Academic Press.
- Osterlind, S. J. (2006). *Modern measurement: Theory, principles, and applications of mental appraisal*. Upper Saddle River, NJ: Prentice Hall.
- Rao, C. R., & Sinharay, S. (Eds.). (2007). *Handbook of statistics, 26: Psychometrics* (Vol. 26). Oxford, UK: Elsevier.
- Thorndike, R. M. (2005). *Measurement and evaluation in psychology and education* (7th ed.). Columbus, OH: Merrill.
- Tinsley, H. E. A. (1992). Psychometric theory and counseling psychology research. In S. D. Brown & R. W. Lent (Eds.), *Handbook of counseling psychology* (2nd ed., pp. 37–70). New York: Wiley.
- van der Linden, W. J., & Hambleton, R. K. (Eds.). (1997). *Handbook of modern item response theory*. New York: Springer.

and symptoms, have as their common thread a significant impairment in mental functioning that causes distress or disability. However, no one sign or symptom is usually sufficient to describe a given mental disorder. Rather, a cluster of related signs and symptoms are necessary that are associated with the distress or disability that is presented. The acquisition of reliable, accurate accounts of those critical features of psychopathology is the goal of any assessment of psychopathology.

Widely known criteria for the various forms of psychopathology appear in the American Psychiatric Association's *Diagnostic and Statistical Manual for Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR)* and the World Health Organization's *International Classification of Diseases, Clinical Modification (ICD-10-CM)*. The assessment of psychopathology may at first appear to involve a rather straightforward appraisal of the relative "fit" of these criteria to the particular history and behavioral repertoire of the individual being assessed. This view suggests that appraisal involves little more than decisions about whether one or more sets of these criteria are represented in the information gathered about an individual. If so, the diagnosis (i.e., form of psychopathology) associated with those criteria is assigned to represent the individual's psychological problem(s).

However, the reality is more complicated than the above suggests. Before psychologists can assess the fit of any set of criteria to an individual, they must make a number of decisions regarding the assessment process itself. These include an evaluation of their ability to accurately judge the presence or absence, quality, and quantity of the criteria. In other words, psychologists must evaluate the reliability, validity, and usefulness of the information to be used in assessing the criteria and the context in which the information will be used before the information is accepted for use. Additionally, the perspective taken, for instance, whether the focus is on direct behavioral examples or inferred (i.e., not directly observable) processes, must be taken into account. The ideas and biases of the assessor must be carefully considered. Finally, the information, be it a diagnosis or behavioral description, must be accurately conveyed to the appropriate referring source to actually aid the person being assessed. This has led to the development of a wide range of

---

## PSYCHOPATHOLOGY, ASSESSMENT OF

---

Psychopathology can be thought of as the expression of mental impairment in the form of psychological signs and symptoms. Specific disorders subsumed under psychopathology, while having specific signs



assessment tools that include unstructured and structured interviews, self-report inventories, measures of cognition, projective techniques, behavioral descriptors, and many more.

## The Clinical Interview

### *Unstructured Interviews*

The interview is one of the most basic components of all forms of psychological assessment, including the assessment of psychopathology. Interview formats vary across a continuum from unstructured to highly structured. The unstructured interview is what people most often think about when describing the interview process, though *unstructured* is probably a misnomer. It is essentially a data-gathering process in which information is most often collected face-to-face with a client through an interactive series of questions and answers that can vary greatly from client to client. Typically, questioning follows a format beginning with open-ended questions that can provide information about the content provided, but also about the process the client uses to respond. Questions gradually become more and more close ended during the interview to help fill in needed specific information about the client. The unstructured interview is also used to obtain information from other sources, such as family members or others who can comment on the client's actions.

Whether structured or unstructured, most diagnostic interviews are designed to obtain essential information about many aspects of the person's life situation, such as those listed in Table 1. There are a number of advantages of unstructured interviews, including their flexibility in both the content and the range of information to be sampled. When the psychologist is not limited to what may be asked, or in what manner questions may be asked, important information can be followed up as it unfolds during the interview. Another advantage is the "ecological validity" of the behaviors sampled during the observation of and interaction with the client. Ecological validity pertains to how well the information gathered truly assesses what is important to the client's functioning in the "real" world. Information is more likely to be individualized and specific to the client during an unstructured, and thus unhampered, interview. Disadvantages can include the potential for uneven

and incomplete collection of necessary information by the clinician, as for example when a psychologist spends a great deal of time evaluating reports of depression and fails to fully assess other issues, such as anxiety. Later, comparing only this incomplete set of information with the specific criteria used to make a differential diagnosis can compound an oversight such as this. Nevertheless, a wealth of information can be gathered due to the flexibility of the unstructured clinical interview. Through focused follow-up and probing, many symptom criteria can be directly screened and explored with the client or with collateral sources.

### *Structured Interviews*

In contrast, structured interviews are those that use a specific set of questions to obtain information that is directly related to a set of criteria of particular interest. Structured interviews were developed to reduce the elements of clinical judgment inherent in unstructured interviews. Structured interviews permit the generation of "objective" ratings. This has several advantages. It allows comparisons between cases on essentially the same information. Furthermore, having objective ratings allows psychometric testing of the interview itself in terms of assessing the interview's reliability and validity. A number of structured interviews varying from the global to the specific have been developed for use in diagnosis.

An early, structured-interview strategy was developed by John P. Feighner and colleagues in 1972 to identify the primary psychiatric disorders then described in the *Diagnostic and Statistical Manual (DSM)* of the American Psychiatric Association. In the late 1970s, an influential group of researchers including Robert Spitzer and Jean Endicott altered and expanded these criteria to develop the Research Diagnostic Criteria (RDC). This work, in turn, formed the basis for the Schedule for Affective Disorders and Schizophrenia, or SADS. Over the years, the SADS became one of the most widely used and respected structured interviews for diagnosis, and it has been particularly useful in research settings where consistency in diagnosis is essential. The *DSM* has undergone several revisions and these structured interviews have been modified to reflect the changing criteria for the various forms of psychopathology, leading most



**Table 1** Standard interview information

<i>Type of Information</i>	<i>Examples</i>
Demographic	Date of interview; date of birth; gender; race/ethnicity; education; marital status; birth/rearing origins
Family History	Medical; psychological; educational; cultural milieu; economic milieu
Early History	Birth complications; developmental milestones; early health; early sociability/within-family adjustment
School-Age	Initial and long-term academic adjustment; academic history; achievement/problems; social relationships with family, peers, and authority; health
Adolescence and Early Adulthood	Social relationships with family, peers, others; academic successes/failures; sexual adjustment; legal issues; substance use; career aspirations; health
Adulthood	Interpersonal relationships; satisfaction; employment; career success/failure and satisfaction; health and medical history; substance use; socioeconomic status family support; other support systems
Current Functioning	Mental status; basic and independent activities of daily living—dressing, grooming, house care, cooking, shopping, telephone use, paying bills, dealing with cash, handling a checking account; direct observations—dress/grooming, mobility, gestures, friendliness/approach, effort, cooperativeness; description of typical day
Current Problem(s) and Problem History	Antecedent and precipitant events; description and nature of difficulties; extent and affect of problem(s); coping strategies; sense of efficacy/ability to change
Mood/Affect	General aspects; helplessness; hopelessness; duration/changes
Thought Content	Verbal productivity; verbal continuity; delusions; paranoia; hallucinations; unusual thoughts/fears; impulse control
Thought Processes	Preoccupations; reasoning; insight
Suicidality/Homicidality	Plan; means; intent; history

recently to the Structured Clinical Interview for the *DSM* (SCID) and its revisions. Somewhat in parallel development, the Diagnostic Interview Schedule (DIS) is based on a combined set of criteria from the *DSM* and RDC and it allows diagnosis based on either criteria set.

What these structured interviews all have in common is their dependence on a priori selection criteria for making decisions regarding diagnoses. They differ in their specificity and breadth, and in the amount of clinical judgment and expertise needed to use them effectively. The DIS is very structured, containing very specific questions, and can be used with a high degree of reliability by trained nonprofessionals. The SADS is

semistructured and it requires the extensive use of clinical judgment in making diagnostic decisions. Typically, only experienced mental health professionals use it. The SCID falls somewhere between these extremes, although it is best used by a trained clinician.

Structured and semistructured interviews are currently underutilized in the clinical assessment of psychopathology. This is attributable, in part, to the fact that they were originally developed for use in research. In addition, many psychologists have not been specifically trained in their use. However, the increased reliability of the newer forms of structured interview suggests that psychologists would benefit from incorporating them into their assessment tool kit.



## Instruments Used in Assessing Psychopathology

Many tests have been used to gather information about clients' psychological and mental health other than direct interviews. Tests specific to addressing the presence and severity of psychopathology include both projective methods and objective self-report inventories.

### *Projective Techniques*

The most common projective techniques in use today were actually developed many years ago. They include the Rorschach Inkblot test, developed in 1921, the Thematic Apperception Test, which dates from 1943, and a number of projective drawing techniques.

*The Rorschach Inkblot Test.* The Rorschach Inkblot test is a 10-plate set of bisymmetrical inkblots. By their nature, the inkblots provide an ambiguous set of stimuli to the client. For each individual plate, the clients are simply asked to tell the assessor what the inkblots remind them of. Thus, without further instruction, clients are placed in a position that necessitates the use of their own personal perceptual experiences to place an organizational structure and context onto these otherwise ambiguous stimuli. In this way, the organization of the material becomes a behavioral example of the way clients approach and organize the world with which they interact.

The Rorschach has been used extensively and many categories of response type have been developed, particularly regarding the determinants of what goes into individual percepts. These include the use of form, color, symmetry, and even textural cues. The core elements needed to interpret any Rorschach response are *what* the response is, *where* it is located, and *why* or what makes it look that way. The interpretation of these elements as they represent organizational strategies and methods has been used to provide information about people's interpersonal style, motivation, emotional processes, and even their cognitive abilities. While controversial because of arguments regarding its reliability and validity, the Rorschach is still commonly used by many clinicians. Effective use of the Rorschach requires extensive training in its administration and, in particular, in the interpretation of responses to the Rorschach materials.

*Thematic Apperception Test.* The Thematic Apperception Test (TAT) was originally developed in conjunction

with Henry Murray's need-press theory of personality. It is made up of a series of pictures that show characters in a variety of ambiguous situations. Examinees are instructed to make up an oral story about each picture. The rationale underlying the TAT is that the stories told by examinees in their search for some meaning in the ambiguous pictures represent projections of the examinees' past experiences and present needs. Thus, somewhat similar to the Rorschach, the test uses ambiguous stimuli to elicit samples of the ways the examinee organizes the world. Unlike the Rorschach, the TAT makes use of a sample of specifically focused instructions that are repetitive across picture stimuli. Thus the examiner can elicit samples of similar or "thematic" situations by selecting particular subsets of cards to present. The examiner follows an interpretive strategy that focuses on the characters and settings in the stories told by the examinee, as they are likely to reflect the examinee's placement of self into them. The protocol data thus elicited are presumed to provide a representation of personality content and character structure.

*Projective Drawing Tests.* Projective drawing techniques used in the assessment of psychopathology are generally one of two types, Draw-A-Person or Draw-A-House. In both, clients are asked to draw freehand one or more pictures of themselves, significant others, their family, their home, or a similar object. The basic premise is to provide an environment that elicits information about a person's feelings about the *targeted* stimuli (e.g., self, family member). The examinee is thought to project his or her own perceptions of these targeted stimuli onto the drawings. Assessment relies on an accurate interpretation of the elements of the drawings as they relate to the client's thoughts and feelings. Artistic talent is irrelevant. Rather, it is the configuration and style of the elements that is evaluated. For example, poor drawing symmetry may be reflective of insecurity or inadequacy, low levels of detail may be suggestive of withdrawal or depression, and large head size may be suggestive of expansiveness and aggression.

*Projective Test Summary.* Projective tests have had a long history of use in the assessment of psychopathology. However, the reliability and validity of projective tests has been a long-standing controversy. At a minimum, the use of these tests calls for significant training and experience, and even the most skilled



clinician must take great care to avoid potential judgment biases.

### **Objective Self-Report Inventories**

Objective self-report inventories have been widely used for close to 70 years and continue to enjoy great popularity. Two of the most commonly used measures are the Minnesota Multiphasic Personality Inventory (MMPI) and the Millon Clinical Multiaxial Inventory (MCMI).

*The Minnesota Multiphasic Inventory.* The MMPI-2 was originally designed as a diagnostic tool to identify specific *DSM* disorders. However, the findings from more than six decades of research on the instrument have expanded its use to include multiple behavioral and symptom correlates based on patterns of responding across its many subscales. In brief, the MMPI-2 consists of 557 true/false items that are scored to yield scores on 10 primary clinical scales. These primary scales retain their original labels (e.g., Hypochondriasis, Depression, Hysteria, Psychopathic Deviate), however, they are no longer interpreted as stand-alone scales but as reflective of a pattern of symptoms and behaviors shared by common groups.

The MMPI-2 also contains several “validity” indexes, including the K (Correction) scale and the L (Lie) scale, and a host of content-based and supplementary scales. Content-based scales are those that have been composed of items that, at face value, appear to represent domains of similar content. Examples include scales of Anxiety, Obsessiveness, Social Discomfort, and Family Problems. Supplementary scales are those that have been created by combining items, usually based on statistical rationales, to represent an area of clinical interest. Examples of supplemental scales include Repression, Ego Strength, Marital Distress, and Gender Role Identification.

Current interpretation strategies usually revolve around pattern analysis of scale elevations. Specific sets of scale score patterns are then associated with likely behavioral response patterns that have been seen in others with similar patterns. These symptom sets are then used to determine the fit of the examinee to specific diagnostic criteria. For example, people who obtain high scores on both Clinical Scale 2 (Depression) and Clinical Scale 9 (Introversion) have been shown to often be ruminative, worried about achievement, and self-centered. They often report

feeling tense and anxious, and may engage in episodes alternating between excessive activity and apathy. They are sometimes diagnosed with depression or bipolar disorder.

The MMPI-2 has been criticized along several grounds. Given that it was originally established to identify severe psychopathology, it is viewed as limited in its ability to describe less severe pathology or normal personality characteristics. Additionally, despite its “objective” standing, the practice of interpreting patterns of scale scores leaves it open to clinical biases similar to those of the projective techniques. Nevertheless, the MMPI-2 has been shown to be extremely helpful in the diagnosis of a number of mental disorders, and it remains an efficient method of gathering diagnostic information.

*Millon Clinical Multiaxial Inventory.* The newest iteration of the MCMI, the MCMI-III, is a 175-item, true/false self-report questionnaire designed to assess psychopathology, personality characteristics, and emotional adjustment. It is used for both diagnosis and character descriptions. Originally developed in 1977, the instrument has gone through several revisions, the most recent being in 1994. It currently includes 24 scales that are closely associated with the *DSM-IV-TR* diagnostic categories. As with the *DSM-IV-TR*, these scales are grouped in two broad categories. Axis I scales are those that are thought to reflect primary disorders of thought such as depression, anxiety, and schizophrenia. Axis II scales are those that are thought to reflect more enduring trait characteristics and are represented by the personality disorders such as borderline personality disorder or avoidant personality disorder. The MCMI-III includes four Modifying Indexes—Validity, Disclosure, Desirability, and Debasement. These scales are used to either invalidate the test due to inappropriate responding (Validity Index) or to modify the existing clinical scales by taking into account additional variables including the examinee’s response openness (Disclosure Index), response defensiveness (Desirability Index), and symptom exaggeration (Debasement Index).

The MCMI is based on Theodore Millon’s personality theory, which describes personality traits in terms of relatively enduring patterns of interpersonal coping styles. Personality styles evolve from the interaction between a person’s perceived sources of reinforcement and his or her avoidance of pain. These factors are moderated by the person’s tendency to



actively or passively manipulate his or her environment to obtain favorable outcomes. For example, the categories of Pleasure versus Pain and Self versus Other are activated by either an Active or Passive way of obtaining satisfaction. According to Millon, all personality disorders are derivations of these combinations. Millon would thus identify an avoidant personality as influenced by sensitivity to pain as a negative reinforcer, an emphasis on the self as the source of reinforcement more than others, and using an active strategy to expose oneself to these factors.

Millon described the more severe clinical syndromes (e.g., *DSM* Axis I disorders such as schizophrenia or bipolar disorder) as acute reactions. Pathology is associated with ingrained personality styles that have become extremely rigid and inflexible, leading to greater impairment. Thus, when interpreting MCMI-III profiles, the psychologist will first pay attention to the Axis II (enduring trait) scales, followed by the Axis I scales.

The MCMI-III is also unique in its reliance on “base rates” of known diagnostic disorders to establish fit. In other words, the MCMI-III takes into account the prevalence of any given diagnostic category (e.g., antisocial) within the general population. Relatively rare disorders need a greater number of scale items to indicate their presence compared to more “common” disorders.

Because of the overlap of the MCMI-III with the *DSM*, its diagnostic interpretation is relatively straightforward. Overall, the MCMI-III has been shown to be predictive of *DSM* diagnostic categories.

**Additional Self-Report Inventories.** Other self-report inventories used by psychologists include the California Psychological Inventory (CPI), the Sixteen Personality Factors test (16PF), and the Psychological Assessment Inventory (PAI). Developed by Harrison Gough, the CPI 434 is a 434-item true/false test similar in construction to the MMPI but developed to identify a more “normative” range of personality characteristics. It currently has 20 scales that fall into 4 broad categories: self-related, social-related, achievement-related, and interest-related. True to its intent, the CPI 434 provides data on personality style rather than personality disorder. Thus, it is used most often in industrial-organizational settings and employment settings and is popular in executive and leadership identification. There is also the CPI 260, which is a shorter version of the CPI 434.

The 16 PF was developed to measure the 16 primary factors that personality psychologist Raymond Cattell used to describe the personality characteristics of individuals. The 16 PF, now in its fifth edition, consists of 185 multiple-choice items that form 16 bipolar clinical scales. Bipolar scales yield scores that range from one extreme to the other on the dimension being measured. For example, the Reasoning scale is anchored from *concrete* to *abstract*; the Emotional scale is anchored from *reactive* to *emotionally stable*. In addition, global scores on Extraversion, Anxiety, Tough-Mindedness, Independence, and Self-Control are derived from the clinical scales. The test has been widely used to measure both normal and deviant personality styles. It is used in traditional clinical settings for diagnostic and treatment decisions, as well as in vocational settings.

The PAI is a 344-item inventory that consists of items having four response options (*false*—not at all true, *slightly true*, *mainly true*, *very true*). The PAI consists of 4 validity scales (Inconsistency, Infrequency, Negative Impression, Positive Impression), 11 scales directly assessing criteria associated with major mental disorders (e.g., depression, mania, and anxiety), 2 scales evaluating interpersonal relations (Dominance and Warmth), and 5 scales that yield treatment-based predictions (e.g., Suicidal Ideation and Treatment Rejection). It has been validated on both clinical and nonclinical populations and can be used with either population. The instrument yields separate standard scores (in this case, *T* scores) for comparison to both populations. The PAI has gained solid use over the approximate 15 years of its existence and is relatively easy and straightforward to interpret.

### **Behavioral Assessment Tools**

A basic tenet of behaviorism and learning theory is that all behavior is learned. That includes pathological behavior. Some of this learning occurs as a result of stimulus-response relationships that are learned over time within a particular environmental context. Other behaviors are learned vicariously (i.e., by observing others and copying their behavior). The behavioral assessment of psychopathology relies on this basic tenet and focuses on a quantitative approach to describing problem behaviors that make up psychopathology. Thus, the major methods of behavioral assessment focus on the size, the strength, and the number of the problem variables assessed. As in other assessment methods, the behavioral assessment of psychopathology



focuses on acquiring reliable and valid data. However, the data are typically restricted to directly observable or at least verbally describable phenomena that can be quantified. Behavioral assessment tools are quite varied and they are often quite specific and tailored to the circumstances of the individual.

Behavioral interviewing is a primary tool of behavioral assessment. Behavioral interviews focus on operationally defining problem behaviors and on elucidating the relationships between those behaviors and precipitating events (antecedents) and resultant consequences. Since the ultimate goal of behavioral assessment is to change problem behaviors, the focus tends to be on the more immediate antecedents and consequences of problem behaviors. Less attention is given to obtaining detailed historical information about life events such as childhood experiences.

Behavioral assessment also emphasizes the direct observation of problems and the use of behavioral assessment checklists. Behavioral checklists are tools that assist in quantifying specific behaviors. They are typically short, specific to particular disorders, and easy to complete. Behavioral checklists are most often completed by clients, but can be used in a question-and-answer format by an examiner. They can be extremely helpful for gathering self-reported symptom information that can be compared to a normative distribution.

Examples of widely used behavioral checklists include the Beck Depression Inventory (BDI) and Beck Anxiety Inventory (BAI), and the State-Trait Anxiety Inventory (STAI). The second edition of the BDI (BDI-II) is a 21-item self-rating scale consisting of items that cover a broad range of depression-related symptoms. Like most behavioral checklists, it takes only a few minutes to complete and because the responses represent examinees' ratings of specific behaviors, it provides a description of the kinds of symptoms a client reports. The BDI and other checklists can be summed up for comparison to different populations, and thus it gives an indication of the severity of depressive symptoms. The BAI is a similar tool that assesses the presence and severity of specific symptoms of anxiety.

The STAI is a well-established behavioral checklist developed by Charles Spielberger that focuses on behaviors related to both stable, relatively enduring trait-based features of anxiety, and situational, state-based features of anxiety. The State Anxiety and Trait Anxiety scales each consist of 20 items that offer four response alternatives (*not at all*, *somewhat*, *moderately so*, *very much so*) for describing the extent to which

features of anxiety are personally descriptive. The State scale asks respondents to answer in terms of how they feel at the moment, while the Trait scale directs them to answer in terms of how they generally feel. The STAI is easy to complete and has been shown to be a good indicator of self-perceived anxiety.

The Symptom Checklist-90-R (SCL-90-R) is a broader-based tool that uses relatively few items to form behavior-based scales that have been associated with specific diagnostic categories. Developed by Leonard Derogatis, the SCL-90-R scales assess nine primary symptoms (e.g., depression, hostility, obsessive-compulsive, psychoticism) and three global indexes of overall distress. Its relative comprehensiveness, brevity, and easy-to-use checklist format make it a useful tool for psychologists.

### Clinical Judgment in Assessing Psychopathology

It is critical that psychologists be sure that the information they are obtaining provides an accurate reflection of the client's circumstances when gathering assessment information. Most psychologists make their own decisions regarding the accuracy, impact, relative weight, and usefulness of the information they gather, but the ability of clinicians to do this has been a point of controversy. In 1954 Paul Meehl questioned the ability of psychologists to make accurate inferences (i.e., predictions) from the assessment information they obtain. Since that time numerous studies have shown that the use of statistical algorithms to make predictions yields greater accuracy than clinical judgment.

Danny Wedding and David Faust have described a number of clinical biases that lessen the accuracy of an assessment of psychopathology. These include hindsight bias, or the tendency once something is known to believe that the outcome could have been more easily predicted than is the actual case. Confirmatory bias is the tendency to look for evidence supporting one's early hypotheses while tending to overlook evidence that would be contrary to those hypotheses. Overreliance on salient data is another bias often attributable to the assessment process. This occurs when one pays greater attention to information that appears more "impressive" and ignoring less dramatic information. The underutilization of base rates is another limitation to which psychologists are prone. Base rates (i.e., the prevalence or frequency with which an event occurs in



the population) provide important information about the likelihood of observing a given disorder, but psychologists often ignore base rate data. Another judgment shortcoming Wedding and Faust point out in assessment is the common failure to analyze covariation. By this they mean that the likelihood that an observed relationship (e.g., an increase in depressive features and a new marriage) could be influenced by an additional factor (e.g., a job change). Finally, the cognitive limitations inherent in all persons, (e.g., limited working memory capacity, limits in complex processing, and inaccuracies of information manipulation) also limit the ability of psychologists to make accurate predictions from assessment data.

Skilled psychologists are aware of these biases and take steps to minimize them. Specifically, they use comprehensive structured or semistructured interview techniques and assessment tools that have been empirically proven to be both reliable and valid. This reduces the likelihood that relevant information will be overlooked, resulting in an overreliance on narrow description. To minimize hindsight and confirmatory biases, they give careful attention to data that both support and do not support tentative conclusions. They base diagnoses on specific criteria to reduce the influence of cognitive biases and stereotyping due to factors such as gender, age, and ethnicity. In addition, they recognize that memory is a reconstructive process that provides numerous opportunities for biases to influence psychologists' conclusions and minimize this problem by attempting to minimize their reliance on their own memory. Attending to base rates and understanding the population with which psychologists work can effectively guide expectations regarding the amount of evidence necessary for a diagnosis and insuring data collection specific to that population. Finally, skilled psychologists seek feedback regarding the accuracy and usefulness of their judgments to help shape and refine their diagnostic process.

Research has shown that actuarial-based assessment tools have almost uniformly proved to be more accurate than clinical judgment alone. Nevertheless, the clinical assessment of psychopathology has remained a judgment call. Thus, it is vitally important that psychologists base their judgments on the most reliable and valid tools available, and that they understand the limitations of their judgments.

L. Stephen Miller

*See also* Affect (Mood States), Assessment of (v2); Behavior Rating Scales (v1); Behavioral Observation Methods,

Assessment (v1); Clinical Interview as an Assessment Technique (v2); Clinical Presenting Issues (v2); *Diagnostic and Statistical Manual of Mental Disorders (DSM)* (v2); False Memories (v2); Functional Behavioral Assessment (v1); Mental Status Examination (v2); Projective Techniques (v2); Quantitative Methodologies (v1); Test Interpretation (v2); Therapist Interpretation (v2)

### Further Readings

- American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed., Text rev.). Washington, DC: Author.
- Dawes, R. M., Faust, D., & Meehl, P. E. (1989). Clinical versus actuarial judgment. *Science*, 243, 1666–1674.
- Exner, J. E. (1991). *The Rorschach: A comprehensive system: Vol 2. Current research and advanced interpretation* (2nd ed.). New York: Wiley.
- Exner, J. E. (1993). *The Rorschach: A comprehensive system: Vol 1. Basic foundations* (3rd ed.). New York: Wiley.
- Graham, J. R. (2006). *MMPI-2: Assessing personality and psychopathology* (4th ed.). New York: Oxford University Press.
- Meehl, P. E. (1954). *Clinical versus statistical prediction: A theoretical analysis and a review of the evidence*. Minneapolis: University of Minnesota Press.
- Millon, T., & Davis, R. D. (1996). *Disorders of personality: The DSM-IV and beyond*. New York: Wiley.
- Spitzer, R. L., & Williams, J. B. W. (1983). *Instruction manual for the structured clinical interview for DSM-III (SCID)*. New York: New York State Psychiatric Institute.
- World Health Organization. (2007). *International Classification of Diseases, Clinical Modification*. Geneva: Author.

---

## PSYCHOPHARMACOLOGY, HUMAN BEHAVIORAL

---

Drugs play an increasingly large role in civilization, and especially among the patients or clients who are seen by mental health professionals. The drugs that counselors may encounter fall into two major categories, therapeutic and recreational. Therapeutic drugs may facilitate the clinical goals of the patients, but can also present unique problems that must be addressed in the therapeutic setting. Drugs used for nontherapeutic reasons may contribute to the problems of the patient, or otherwise interfere with the therapeutic relationship. The major classes of medical



and nonmedical drugs that counselors are likely to encounter in their practice are discussed in this entry, including their primary effects and side effects, and the clinical issues that may arise.

### Therapeutic Drugs

The most widespread therapeutic drugs include those used to treat anxiety disorders, depression, psychotic illnesses, and attention deficit/hyperactivity disorder (AD/HD). Agents used in treating these disorders can interact with psychosocial treatments. A psychotropic medication provides symptomatic relief that may increase the effectiveness of psychosocial treatment. For example, a patient suffering from an acute psychiatric illness may be withdrawn, apathetic, and unable to interact with the counselor. Medications ameliorate these symptoms so that the patient can then develop the skills and abilities necessary for a functional recovery. On the other hand, under some circumstances psychotherapeutic agents may hinder the delivery and application of psychosocial treatment, as in the case of drugs with severe sedative and amnesia-causing actions. Therefore, counselors consider the side effects of common psychotherapeutic drugs, and the possibility that these effects may present further psychological problems that must be addressed.

Anxiolytic (antianxiety) agents are among the most frequently prescribed psychiatric medications. Benzodiazepines, such as diazepam (Valium) and alprazolam (Xanax), are widely used for the treatment of generalized anxiety and panic disorders. At low doses, these drugs produce calming effects and mild sedation. Therefore, they are prescribed to treat both daytime anxiety and insomnia. At high doses, these drugs prolong sleep and, in the presence of other central nervous system (CNS) depressants, they can cause life-threatening respiratory depression (slowed breathing). The main side effects of these drugs are drowsiness, confusion, and impaired coordination. Benzodiazepines also have strong memory-impairing effects.

Although these drugs are effective for a variety of anxiety-related problems, there is some concern regarding their long-term use and potential for dependence. Some patients report that physical and psychological withdrawal symptoms make it difficult to stop taking benzodiazepines. Patients may also experience short-term rebound anxiety after stopping their medication. The risk of dependence on benzodiazepines is greater in individuals with severe mental illness or

co-occurring substance-use disorders. Nevertheless, the long-term risk-benefit ratio of benzodiazepines in other patient populations remains controversial. Newer nonbenzodiazepine anxiolytic agents, such as sertraline (Zoloft), appear to have a better risk-benefit ratio.

Antidepressants are also widely prescribed, and may be used with psychosocial treatment. Currently, the first line of treatment for major depression are selective serotonin reuptake inhibitors (SSRIs) such as fluoxetine (Prozac), sertraline (Zoloft), and escitalopram (Lexapro). These drugs may also be used to treat anxiety disorders such as panic disorders and obsessive-compulsive disorder.

Antidepressant effects of SSRIs are typically manifest only after at least 2 weeks of treatment. Side effects include nausea, anorexia, insomnia, sexual dysfunction including loss of libido and failure of orgasm, and increased suicidal thoughts in the first month of treatment. The use of some SSRIs with children and adolescents is contraindicated as there is some evidence that they increase suicidal thoughts in this age group.

Another class of agents used to treat depression is tricyclic antidepressants, although their use is usually reserved for individuals who do not respond to treatment with SSRIs. Tricyclics nonselectively block reuptake of both serotonin and norepinephrine and are more likely than SSRIs to produce side effects, including sedation and impaired psychomotor performance on tasks requiring attention, low blood pressure, confusion, and difficulty coordinating movements. Overdose with tricyclics is dangerous, particularly in combination with alcohol.

An important category of psychiatric medications is antipsychotic drugs, also called neuroleptics. These drugs are used to treat schizophrenia, psychotic depression, and mania. The two major classes of neuroleptics are referred to as *typical antipsychotics* (e.g., haloperidol such as Haldol), and *atypical antipsychotics* (e.g., clozapine such as Clozaril and, risperidone such as Risperdal). These drugs produce immediate sedation and are considered major tranquilizers. However, their antipsychotic action is delayed and requires up to 3 weeks treatment before effects are seen.

Despite their beneficial effect in reducing psychotic symptoms such as thought disorders, hallucinations, and delusions, these drugs also produce sedation, apathy, and reduced initiative and cognitive functioning. Patients' dislike of these side effects may lead to nonadherence with medication and relapse.



These drugs also produce motor disturbances including Parkinson-like tremor, muscular rigidity, and sudden spasms of the head, neck, limbs, or trunk. These motoric effects are more pronounced in typical antipsychotics than in atypical ones.

Stimulant medications used for the treatment of AD/HD are a further class of therapeutic agent used in the clinic, especially with children and adolescents. These include methylphenidate (Ritalin, Concerta), amphetamine (Adderall), dextroamphetamine (Dexedrine), and atomoxetine (Strattera). These drugs reduce hyperactivity, increase attention span, and improve concentration, vigilance, and activity in AD/HD patients. However, they also have some adverse effects, including palpitations (abnormal heart beats), insomnia, weight loss, tics, and impotence. These agents also have a potential for abuse. Although they do not cause euphoria or feeling high at therapeutic doses, they can produce cocaine-like effects when crushed and injected. Despite concerns to the contrary, there is little evidence that treatment with AD/HD drugs leads to later drug abuse. Children treated with stimulant medications are *less* likely to develop later substance abuse problems.

### Abused Drugs

Agents used recreationally, including illegal substances and prescription medications, can adversely affect counseling care. Problematic drug use can generate psychological problems, exacerbate underlying psychiatric disorders, and interfere with attempts to change behavior. Therefore, screening for drug abuse is essential as part of the initial evaluation of any new client.

Psychiatric diagnoses of substance abuse and dependence are made using specific objective criteria listed in the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR)*. The main criteria for substance abuse are drug use that interferes with performing work, domestic, or social duties; exacerbates interpersonal or social problems; causes legal problems; and/or is used in a situation that is physically dangerous. The criteria for substance dependence include additional features such as tolerance or withdrawal, a loss of control over use, and persistent use in spite of knowledge of its detrimental effects. Briefer diagnostic tools are available to the clinician, such as the four-item CAGE questionnaire used to assess alcohol abuse (i.e., "Have you ever felt you should Cut down on your

drinking?"; "Have people Annoyed you by criticizing your drinking?"; "Have you ever felt bad or Guilty about your drinking?"; and "Have you ever had a drink first thing in the morning (as an 'Eye opener') to steady your nerves or get rid of a hangover?").

Counselors may take several steps to address the issue when drug use has been identified as a problem. The first and traditionally the hardest step is to help the individual to recognize that his or her pattern of use causes or intensifies existing problems. The second step is to work with the client on his or her motivation to change. Only then can steps be taken to decrease use. If dependence exists, the individual may be referred to an addiction service. For example, in the case of severe alcoholism, or dependence on opiates and sedative drugs, withdrawal symptoms can be life threatening and may require inpatient treatment. Counselors' knowledge of the current status of psychosocial and pharmacological treatments available to treat substance abuse enables them to select the approach that is most appropriate for the client. Options may vary according to the specific drug of abuse. Because drug dependence is a chronic, relapsing disorder, most substance abuse clients require continued monitoring, even after long periods of successful abstinence. More broadly, this means it is important for counselors to ascertain whether *any* client has previously had a drug problem, whether or not he or she presents with drug-related complaints. The most prevalent drugs of abuse are alcohol, marijuana, stimulants, sedatives, and painkillers.

Alcohol is one of the most widely accepted forms of recreational drug use. Alcohol is a CNS depressant that was used as a general anesthetic until the late 19th century. At low doses, it produces feelings of well-being, reduces anxiety, and reduces behavioral and social inhibitions. At moderate doses, it impairs motor function and reaction times. Higher doses of alcohol produce severe motor and sensory depression, and at toxic concentrations unconsciousness, coma and lethal respiratory depression may occur. The withdrawal syndrome associated with alcohol dependence is severe and can cause fatal seizures.

Marijuana is derived from the *Cannabis sativa* plant, which contains cannabinoid compounds such as delta-9 tetrahydrocannabinol (THC), cannabidiol, and cannabinol. Cannabinoids typically increase heart rate and blood pressure and produce feelings of relaxation, heightened sensory awareness and distorted perception of time. However, marijuana also produces



impairments in memory and some individuals experience panic reactions and paranoia, even at relatively low doses. Long-term use may produce dependence, and there are anecdotal reports that prolonged use can produce apathy (“amotivational syndrome”) or exacerbate psychotic symptoms.

Stimulant drugs, such as amphetamine, methamphetamine, Ecstasy, and cocaine, are frequently used as recreational drugs by young adults. These agents stimulate the CNS, thus increasing motor activity and producing excitement. At high doses, stimulants increase body temperature and produce repetitive stereotyped behaviors, insomnia, and anorexia. Repeated use of high doses of stimulants may produce a form of psychosis that closely resembles schizophrenia. Anxiety and paranoia are common adverse effects associated with the use of stimulant drugs.

MDMA (3,4 methylenedioxymethamphetamine), or Ecstasy, is a synthetic drug that has both stimulant and hallucinogenic properties. Throughout the 1990s, it was a popular drug in the youth culture for its euphoric and energizing effects and enhancement of tactile sensations. MDMA also increases empathy, but there have been reports that long-term use is associated with depression.

Caffeine, which is also a mild stimulant drug, is the most widely consumed psychoactive drug in the world. It is present in coffee, tea, soft drinks such as Coca-Cola, and chocolate. Although low doses are benign, increasing alertness and decreasing fatigue, caffeine can also produce nervousness at high doses or even at low doses in sensitive individuals. Caffeine may worsen existing anxiety disorders and precipitate panic attacks, particularly in individuals with panic disorder.

Sedative drugs, such as the barbiturates amobarbital (Amytal) and phenobarbital (Nembutal), are misused for their intoxicating effects. Typically, they are used in conjunction with other drugs, either to augment the pleasurable effects of those drugs (e.g., alcohol) or to counteract their unpleasant effects (e.g., to decrease nausea among opiate users). Low doses of barbiturate drugs produce relaxant effects similar to alcohol and higher doses impair motor coordination and produce sedation. Barbiturate overdose produces unconsciousness and death via respiratory failure. The risk of physical dependence on barbiturates is high even with relatively short-term use of high doses, and abrupt withdrawal may be fatal. Benzodiazepines are also used recreationally by a relatively small subset of young adults. As previously noted, despite public

concern about their potential for misuse, the prevalence of abuse or dependence is low in clinical use and their safety profile is excellent.

Another class of abused drugs is opioids, such as heroin, oxycodone (OxyContin), and codeine (Tylenol with codeine). These drugs are CNS depressants that produce feelings of euphoria, but also sedation, nausea, vomiting, and constipation. Overdose with opioid drugs is particularly dangerous because it can result in coma and death by respiratory failure. Tolerance to these drugs develops rapidly and users must increase the dose to obtain the same effect. Physically dependent individuals who discontinue opioid use may experience irritability, weight loss, fever, nausea, diarrhea, and insomnia. Psychological dependence produces an intense craving for the drug upon abstinence that lasts for many months after detoxification. Oxycodone is an opioid drug used to treat pain that is twice as potent as morphine, and recently there has been a sharp rise in abuse and diversion of this drug for illicit use.

Hallucinogenic drugs, including d-lysergic acid diethylamide (LSD), mescaline, and psilocybin, cause sensory distortion or hallucinations that may be visual, auditory, tactile, gustatory, and/or olfactory in nature. The positive subjective effects of hallucinogens include stimulation, increased sensory awareness, and increased associative and creative thinking. Users describe their experiences as enlightening and life changing. There have been trials of hallucinogenic drugs to treat alcoholism and the pain and depression associated with terminal cancer. However, reactions and experiences vary across individuals and hallucinogens are equally likely to cause acutely unpleasant sensory experiences. Adverse effects of hallucinogens include panic reactions, prolonged psychosis, depression, and so-called flashbacks whereby transient perceptual disturbances recur weeks or months after intoxication.

## Counseling Considerations

Mental health professionals licensed to prescribe drugs and those who specialize in the treatment of substance abuse are familiar with the beneficial effects and adverse side effects of the most commonly used drugs. They are knowledgeable about the advantages and potential drawbacks of treating psychological disorders using a combination of psychopharmacological and psychotherapeutic interventions. Potentially, the use of drugs may increase the effectiveness of psychosocial



treatment. They can reduce psychiatric symptoms so that patients are more available to treatment, and in some disorders may strengthen attention, speech, and memory. In turn, counseling can improve the relationship between the patient and care provider and improve treatment compliance. On the other hand, drugs can interfere with the long-term resolution of psychological problems because they relieve the immediate symptoms and reduce the patient's motivation to confront the underlying problems. Furthermore, they may produce psychological dependence or intensify a patient's perceptions of being ill. Thus, there are complex considerations surrounding the use of therapeutic drugs in a counseling context.

Mental health professionals are likely to encounter clients who use drugs nonmedically, and must make decisions about the extent to which this drug use contributes to the presenting problems. Recreational drug use is very common, especially among people with high levels of life stress, adjustment difficulties, and life transitions, who are most likely to seek counseling. Therefore, the counselor should always include a thorough assessment of the level of drug use to determine whether the use is in itself a source of problems, whether it contributes to other existing problems, and whether it might interfere with the counseling process.

*Emma Childs and Harriet de Wit*

*Authors' Note:* Supported by DA02812.

**See also** Attention Deficit/Hyperactivity Disorder (v1); Depression (v2); Medication Adherence (v1); Panic Disorders (v2); Physical Health (v2); Prescription Privileges (v1); Psychological Well-Being, Dimensions of (v2); Substance Abuse and Dependence (v2)

## Further Readings

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed., Text rev.). Washington, DC: Author.

- Brunton, L. L. (Ed.), Lazo, J. S., & Parker, K. L. (Assoc. Eds.). (2006). *Goodman & Gilman's The pharmacological basis of therapeutics* (11th ed.). New York: McGraw-Hill.
- Gorman, J. M. (2003). Treating generalized anxiety disorder. *Journal of Clinical Psychiatry*, 64(Suppl 2), 24–29.
- Hollon, S. D., Jarrett, R. B., Nierenberg, A. A., Thase, M. E., Trivedi, M., & Rush, A. J. (2005). Psychotherapy and medication in the treatment of adult and geriatric depression: Which monotherapy or combined treatment? *Journal of Clinical Psychiatry*, 66(4), 455–468.
- Huang, B., Dawson, D. A., Stinson, F. S., Hasin, D. S., Ruan, W. J., Saha, T. D., et al. (2006). Prevalence, correlates, and comorbidity of nonmedical prescription drug use and drug use disorders in the United States: Results of the National Epidemiologic Survey on Alcohol and Related Conditions. *Journal of Clinical Psychiatry*, 67(7), 1062–1073.
- Lader, M. H., & Bond, A. J. (1998). Interaction of pharmacological and psychological treatments of anxiety. *British Journal of Psychiatry Supplement*, 34, 42–48.
- Luft, B., & Taylor, D. (2006). A review of atypical antipsychotic drugs versus conventional medication in schizophrenia. *Expert Opinion on Pharmacotherapy*, 7(13), 1739–1748.
- Rang, H. P., Dale, M. M., & Ritter, J. M. (Eds.). (2006). *Pharmacology* (4th ed.). Philadelphia: Churchill Livingstone.
- Slatkoff, J., & Greenfield, B. (2006). Pharmacological treatment of attention-deficit/hyperactivity disorder in adults. *Expert Opinion on Investigational Drugs*, 15(6), 649–667.
- Stanton, M. D. (2004). Getting reluctant substance abusers to engage in treatment/self-help: A review of outcomes and clinical options. *Journal of Marital and Family Therapy*, 30(2), 165–182.

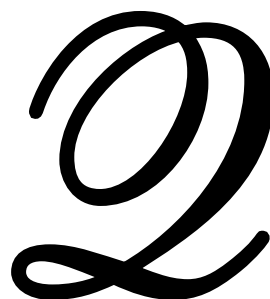
## PSYCHOTHERAPY, OUTCOMES OF

**See** OUTCOMES OF COUNSELING  
AND PSYCHOTHERAPY









---

## QUALITY OF LIFE

---

Quality of life (QOL) is a concept that has been considered vital to counseling and psychotherapy services since the profession began. Clients seek counseling services to improve their QOL, and so QOL is of critical importance to both process and outcome in therapy. Although more than 20,000 articles referencing QOL appeared in the psychological literature between 1980 and 1994, a consensus definition of QOL remains elusive. The concept is often assumed to be self-explanatory, but it is used in varying ways by different authors and professions.

The World Health Organization first defined QOL as multifaceted, consisting of total well-being in social, physical, and mental functioning. Medical definitions of QOL, derived from this early work, emphasize the capability for a full and active life by patients with physical illness; in other words, the individuals' ability to live fully without restrictions on their everyday activities.

Recent works in psychology have added additional key observations. First, since *quality* denotes excellence, *quality of life* at its most basic reflects the degree to which an individual *experiences excellence* in the major domains of his or her life. Second, QOL involves more than physical comfort and the absence of pathology. QOL represents a degree of excellence in which an individual's personal experience and functioning are excellent in social, psychological, cognitive, and physical ways. Positive psychology distinguishes between the "pleasant" (enjoyable) life and the "meaningful" (engaged) life, and it suggests that the highest degree of QOL is gained from a life

*fully engaged* in sustaining meaningful activities. This latter reasoning dates to Aristotle's definition of happiness (often paraphrased by John F. Kennedy) as "full use of one's faculties along lines of excellence."

QOL exists on a continuum that ranges from the lowest to the highest degrees of subjective experience and excellence in life. QOL can be reliably measured via self-report; hundreds of scales have been developed to measure aspects of QOL. Each measure typically selects specific dimensions of QOL that involve emotional, physical, or cognitive functioning. Subjective estimates of QOL may also be made related to a specific client group or "referral reason" (e.g., QOL in pediatric, medical, or oncological care). Qualitative assessment procedures (most often in the form of an interview) also have been developed.

Multiple subdisciplines of psychology, counseling, and medicine use the construct of QOL in three common ways: (1) as a construct denoting overall well-being, (2) as a factor for assessing a person's satisfaction with his or her life situation (even during serious or chronic illness), and (3) as an outcome variable for evaluating the effectiveness of counseling and therapy efforts to improve a person's life. Quantifying and refining the concept of QOL will further enhance practitioners' ability to evaluate therapeutic interventions, and, by focusing clients' attention on what is right with their lives, these efforts may be therapeutic in and of themselves.

*Janet F. Gillespie*

*See also* Client Attitudes and Behaviors (v2); Counseling Process/Outcome (v2); Csikszentmihalyi, Mihaly (v2);



Happiness/Hardiness (v2); Hope (v2); Leisure (v2); Optimism and Pessimism (v2); Physical Health (v2); Positive Psychology (v2); Psychological Well-Being, Dimensions of (v2); Seligman, Martin E. P. (v2)

### **Further Readings**

Gladis, M. M., Gosch, E. A., Dishuk, N. M., & Crits-Christoph, P. (1999). Quality of life: Expanding the scope

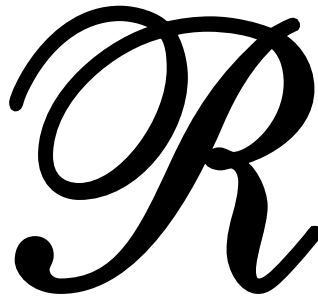
of clinical significance. *Journal of Consulting and Clinical Psychology*, 67, 320–331.

Keyes, C. L. M., & Magyar-Moe, J. L. (2003). The measurement and utility of adult subjective well-being. In S. J. Lopez & C. R. Snyder (Eds.), *Positive psychological assessment: A handbook of models and measures* (pp. 411–425).

Washington, DC: American Psychological Association.

Koot, H. M., & Wallander, J. L. (2001). *Quality of life in children and adolescents: Concepts, methods, and findings*. London: Brunner-Routledge.





---

## **RATIONAL EMOTIVE BEHAVIOR THERAPY**

---

Albert Ellis first demonstrated and introduced his innovative rational-emotive therapy (RET) in 1957. In 1993, Ellis revised and expanded the scope of his theory, creating rational emotive behavior therapy (REBT). REBT resulted from Ellis's response to the frustration he experienced as a psychoanalyst when his patients were not improving using traditional psychoanalytic techniques. Ellis found that patients seemed to improve more rapidly when he was more active and direct in his methods. The perceived lack of efficacy of psychoanalytic treatment caused Ellis to return to his philosophical roots in Greek, Roman, and ancient Asian philosophy and seek a more effective form of therapy. These philosophies laid the foundation for REBT, which states that people are disturbed not by things, but by their views of those things.

Ellis focused on people's cognitions as the sources of their psychological distress and believed there were two basic biological tendencies in how humans think. The first is that humans have a biological tendency to think irrationally and in a dysfunctional manner. This is based on humans' predisposition to think "crookedly," and is supported by the observation that irrational thinking is so prevalent despite the individuals' attempts to think rationally. The second biological tendency is that humans also tend to work toward changing their dysfunctional thinking and acting. Humans have the ability to recognize when their irrational thoughts are causing a disturbance, the ability to see

that a change can be made to alter the irrational thinking, and the ability to actively work toward changing the irrational thoughts through cognitive, emotive, and behavioral methods. REBT works with that ability in order to help individuals identify and change their irrational belief systems to more rational ones. Overall, the image of the person in REBT is one of optimism. REBT has a basic proposition that people have goals, desires, and purposes in life that generally can be described as striving for happiness, a long life, self-actualization, success, approval, and comfort. A healthy person sees these goals and desires as options, not absolute givens that must occur.

Understanding this therapeutic approach can be best explained by going through the ABCs of REBT. An Activating Event or Activating Experience (A) is something that happens to a person. For example, a student receives a bad grade on a paper. People typically assume the Activating Event causes the emotional or behavioral Consequence (C) (perhaps the student's feeling of being a complete failure and withdrawing from the class, in this example). However, the Consequence is not a direct result of the Activating Event, but rather a result of the Belief (B) system the person has about the Activating Event. For example, if the Belief about getting a good grade on a paper is that it would be pleasant and rewarding to get such a good grade, but not mandatory, the resulting Consequence could be disappointment or frustration when receiving the bad grade and perhaps a resolve to do better in the future. However, if the person's Belief is "I must get a good grade because anything less than perfect means that I am stupid and will never succeed in life," then



the Consequence would be despair and depression when the bad grade was returned. Therefore, it is not the Activating Event that results in the Consequence, but the Belief, which is based on biological or genetic predisposition, constitutional history, prior interpersonal and social learning, and predisposed and acquired habit patterns.

As mentioned earlier, just as humans have a natural propensity to be rational and straight thinking, they also have the propensity to be “crooked-thinking” creatures. Irrational beliefs differ from rational beliefs in two distinct ways. First, they are absolute or dogmatic and are expressed through rigid forms of “must,” “should,” “ought,” and “have to.” Second, irrational beliefs lead to negative emotions that interfere with the achievement of goals. REBT posits that the irrational beliefs are centered on the human tendency to make demanding and commanding statements about what *should* and *must* happen in life and that these things *absolutely* and *necessarily* must occur to obtain the desired result.

Subsequently, Ellis identified four basic forms of irrational beliefs: (1) “musturbatory” statements—believing that something or someone *should*, *ought*, or *must* be different from the way it actually does exist; (2) “awfulizing”—believing that something is *awful*, *terrible* or *horrible* when it is this way; (3) “I-can’t-stand-it-itis”—believing that one *can’t bear*, *stand*, or *tolerate* this person or thing and this person or thing should not be this way; and (4) “damnation”—believing that people have made or keep making horrible errors and because they should not act in this manner, they deserve nothing good in this life and should be forever labeled as rotten people. REBT holds that most of the irrational beliefs originate from musturbatory beliefs. Ellis has detailed 12 of the most common and frequently seen “musts” in therapy. These include all-or-nothing thinking, jumping to conclusions and negative nonsequiturs, fortune-telling, focusing on the negative, disqualifying the positive, allness and neverness, minimization, emotional reasoning, labeling and overgeneralization, personalizing, phonyism, and perfectionism.

The consequences of these and similar musturbatory statements often bring people to seek counseling. Irrational thoughts result in dysfunctional emotions and behaviors and inhibit people from living rational and effective lives. It becomes the job of the REBT therapist to work with clients and assess their ABCs of a specific belief system or systems and identify ways

in which the clients can alter those beliefs to achieve consequences that are more rational.

## Counseling Techniques

The counselor working from an REBT perspective takes an active role in identifying the client’s irrational thoughts and challenging those thoughts so that the client can differentiate between rational and irrational belief systems and choose beliefs that are more rational. This happens in the Disputing (D) component of REBT counseling. There are three aspects of this process of determining and correcting the irrational belief. The first is to debate any irrational belief. Debating can be done by asking questions such as “What evidence supports your thought?” and “In which way does it have any truth or falseness?” The primary goal of debating is to take clients’ shaky hypotheses about the world around them and actively and vigorously dispute their irrational beliefs until they are surrendered or revised. The second goal is to discriminate between musts (irrational beliefs) and preferences (rational beliefs). For example, a person has the ability to discriminate that waiting in line can be a hassle, but not a horror. Additionally, a person can argue that getting a bad grade is unfortunate, but not unbearable. The final component is to define the irrational statements being used. In the example used earlier, the irrational thought could be defined as “I always write bad papers and I am going to get a failing grade on this paper, too.” By defining the irrational thought, the client can begin to redefine the overgeneralized statement, which could become “Although I may have written a bad paper in the past, this does not mean I will always write bad papers.” Thus, in debating, discriminating, and defining the irrational thought, clients can begin the process of redirecting and restructuring their cognitive thought processes.

Once the ABCD aspects have been sufficiently covered, the individual is ready for the end result of acquiring a new Effect (E) or philosophy that replaces the old irrational belief. For example, the client might realize that, “Yes, I have written bad papers in the past and my earlier irrational attitude toward papers could be self-defeating and undesirable. I accept the fact that I am not perfect, but will work hard to produce a quality paper. If I were to again get a poor grade, however, this would be an unfortunate occurrence rather than a catastrophic event.” It should be noted that just learning the ABCs and going through D and E once is



not enough to permanently remove irrational beliefs. REBT theory states that by nature individuals are irrational beings, thus it is their natural tendency to think irrationally. It is only by actively, forcibly, repeatedly, and continually doing the ABCDEs, that rational beliefs will be maintained.

Therapy is an educational process that often includes the use of out-of-session or homework assignments. Clients are taught how to use REBT beyond therapy sessions, so that when they leave the therapist's office, they will be equipped to debate, discriminate, and define their irrational thoughts and to create their own new effective behavior or philosophy. The therapist helps to educate clients through pamphlets, books, attending lectures and workshops, and listening to tapes. One of the most important techniques used in REBT is in vivo assignments. This technique consists of homework assignments in which clients perform specific tasks outside of therapy and monitor their cognitions during the homework assignment. For example, homework assignments may consist of techniques that increase their frustration tolerance by encouraging them to remain in uncomfortable situations, antiprocrastination exercises, and skill-training exercises. Antiprocrastination exercises encourage clients to start tasks earlier rather than later, which disputes the need for comfort in the current moment. Finally, skill-training exercises provide the client with needed skills, such as assertion or increased social skills. Through these techniques, clients are able to receive positive reinforcements for their rational behavior and corrective assignments to extinguish irrational behavior. The use of REBT techniques provides the therapist with a wide array of options when counseling an individual. These techniques not only are used to help a client in the here and now, but also equip the client to address dysfunctional beliefs in the future.

### Healthy Personality

If musturbatory beliefs are the foundation of a dysfunctional person, then the absence of musturbatory beliefs constitutes a healthy person. REBT recognizes that humans have goals, wishes, desires, and wants. If these desires remain nonabsolute and do not escalate to grandiose dogmas or demands, then an individual will remain less psychologically disturbed. Since life is unpredictable and difficult, however, people will experience healthy negative emotions such as sadness, regret, disappointment, and annoyance

when their desires are not met. These negative emotions are thought to be healthy because they help people remove obstacles to attain the goal and to make constructive adjustments when their desires are not met.

In comparison to the absolutist irrational beliefs, the rational beliefs consist of rating or evaluating badness, tolerance, and acceptance. Rating or evaluating badness acknowledges that a thwarted desire is bad. The badness, however, is not rated as catastrophic or awful. Tolerance is the polar opposite of low frustration tolerance or "I-can't-stand-it-itis." Here the rational person will accept that an undesirable thing has happened, rate the event according to its badness, attempt to change the undesirable event, or accept that the event can't be changed and actively pursue other goals. Acceptance is the alternative to the irrational damnation. Through rational acceptance, a person realizes that humans are fallible creatures who will make mistakes and accepts that humans live in a complex world where there are things that are outside of their control.

There are two types of strategies in REBT: general and elegant. General REBT is synonymous with cognitive-behavioral therapy, whereas elegant REBT is unique in many different aspects. The major goal of elegant REBT is to encourage clients to make a profound philosophic change in the areas of ego disturbance and discomfort disturbance. This involves helping clients give up their irrational musturbatory processes and replace them with rational, nonabsolute thinking. Elegant REBT also helps clients pursue long-range basic goals by helping them fully accept who they are and how to tolerate unchangeable and uncomfortable life conditions (i.e., develop a healthy personality). Therapists using elegant REBT strive to help clients obtain the skills necessary to prevent irrational beliefs in the future. When it is evident that a client is not able to make a philosophical change, either with a specific behavior or in general, the therapist will often switch to using general REBT. The therapist using general REBT will apply methods to effect behaviorally based change.

*David Dahlbeck and Suzanne H. Lease*

*See also* Behavior Therapy (v2); Cognitive-Behavioral Therapy and Techniques (v2); Cognitive Therapy (v2); Ellis, Albert (v2); Homework Assignments (v2); Integrative/Eclectic Therapy (v2); Psychoeducation (v2); Therapist Techniques/Behaviors (v2)



### Further Readings

- Bernard, M. E., & DiGiuseppe, R. (1989). Rational-emotive therapy today. In M. E. Bernard & R. DiGiuseppe (Eds.), *Inside rational-emotive therapy: A critical appraisal of the theory and therapy of Albert Ellis* (pp. 1–7). San Diego, CA: Academic Press.
- Dryden, W., & Ellis, A. (1987). Rational-emotive therapy (RET). In W. Dryden & W. L. Golden (Eds.), *Cognitive-behavioral approaches to psychotherapy* (pp. 129–168). New York: Hemisphere.
- Ellis, A. (1973). *Humanistic psychotherapy: The rational-emotive approach*. New York: McGraw-Hill.
- Ellis, A., & Dryden, W. (1997). *The practice of rational emotive behavior therapy* (2nd ed.). New York: Springer.
- Ellis, A., & Grieger, R. (1977). *Handbook of rational-emotive therapy*. New York: Springer.
- Prochaska, J. O., & Norcross, J. C. (1999). *Systems of psychotherapy: A transtheoretical analysis* (4th ed.). Pacific Grove, CA: Brooks/Cole.

---

## REFRAMING

---

Reframing is a technique used by counselors to shift a client's view of a particular problem, event, or person. It is based on the assumption that when clients are able to view a situation from another perspective, opportunities for finding alternative, acceptable solutions to their problems increase. The effectiveness of reframes in therapy is documented in both clinical outcomes and empirical research.

A reframe differs from an interpretation in that interpretations are associated with a basis in reality or truth. In a reframe, the therapist attempts to shift how a client views a problem as a method for moving toward change rather than replacing a faulty belief with a different, but accurate, view. The therapist's utilizing a reframe helps the client move from a linear view of a problem to a systemic and circular view. It provides a context for clients and therapists to work together toward promoting change.

### Using Reframes in Counseling

There are two core elements to the successful application of reframes in psychotherapy. Because people often associate bad intentions with inappropriate behavior, reframing that changes the manner in which a problem is perceived can change a person's

attributions and meaning of the behavior. Presenting the problem in a positive context (for example, the behavior helps the couple bond) rather than a negative one (the behavior is an indication of a lack of trust) is the first element in reframing. This is known as a positive connotation.

A second core element in reframing is moving from an individual to a systemic framework. Often when couples or families come to counseling, one person is viewed as the individual with the problem. This individual has already been targeted by the family as the one who needs to change; however, unless all family members (including the individual's partner) can view the problem from a systemic stance where members acknowledge their contributions to the maintenance of the problem, therapy will not be effective.

Movement from an individual to a systemic framework is accomplished through systemic and/or bilateral reframes. Systemic reframes are those where one statement captures the dynamics of both partners in the relationship and is positive. For example, a systemic reframe for a couple who constantly argue might be to remark how much passion and care is evident between the members of the couple, as most couples who do not care about each other do not fight. Bilateral reframes are two or more statements that reframe each individual's behavior. Both statements are commonly, but not necessarily, used in combination with a paradoxical intervention. An example of this is when a therapist congratulates one partner for resisting the other partner's attempts to move toward a more intimate relationship, as intimacy can be frightening. The other partner also is congratulated, then, for supporting his or her partner's attempts to avoid intimacy.

Reframing appears to be a simple technique, but is actually quite difficult to implement properly. Therapists should give attention to differentiating between an interpretation (a supposed statement of truth) and a reframe. Supervision should be sought when the therapist is in doubt.

*Gerald R. Weeks and Katherine M. Hertlein*

*See also* Meaning, Creation of (v2); Paradoxical Interventions (v2); Positive Psychology (v2); Therapist Interpretation (v2); Therapist Techniques/Behaviors (v2)

### Further Readings

- Weeks, G. R., & Treat, S. R. (2001). *Couples in treatment* (2nd ed.). Philadelphia: Brunner-Routledge.



---

## REHABILITATION COUNSELING

---

Rehabilitation counseling is a process that is designed to assist people with disabilities in accomplishing their goals and in achieving independence and full participation in all aspects of community life. Rehabilitation counseling is also a recognized counseling profession, with a long history and established professional credentialing procedures. It is variously conceptualized as a specialty within counseling, as a specialty within rehabilitation, and as a separate profession.

The historical roots of rehabilitation counseling date back to the early 1900s. During World War I, many military personnel returned home with disabilities, and rehabilitation programs were established to assist them in returning to productive civilian roles. The Soldier Rehabilitation Act (Public Law 65–178) was enacted in 1918. Simultaneously, efforts were under way in several different states to assist workers who had been injured in industrial accidents in returning to work, the roots of contemporary worker's compensation programs. Finally, the Smith-Fess Act of 1920 (Public Law 66–236) established a vocational rehabilitation program for civilians with disabilities. All of these initiatives evolved into the extensive network of government, private-nonprofit, and private-for-profit agencies and programs to assist people with disabilities. Rehabilitation counseling plays a central role within these agencies and programs, providing assessment, counseling, and coordination of rehabilitation services.

### Definitions of Rehabilitation Counseling

As is true with other professions and specialties, a variety of definitions of rehabilitation counseling have been advanced by individual scholars and practitioners and by professional organizations. An official definition of rehabilitation counseling is provided by the Commission on Rehabilitation Counselor Certification (CRCC), the national credentialing body for rehabilitation counselors, in their “scope of practice statement”:

Rehabilitation counseling is a systematic process which assists persons with physical, mental, developmental, cognitive, and emotional disabilities to achieve their personal, career, and independent living goals in the most integrated setting possible through

the application of the counseling process. The counseling process involves communication, goal setting, and beneficial growth or change through self-advocacy, psychological, vocational, social, and behavioral interventions.

This official definition emphasizes that rehabilitation counseling focuses specifically on the needs of people with all different types of disabilities; that counseling is central to the process; and that integrated settings are emphasized in the pursuit of career and independent living goals.

### Rehabilitation and Disability

#### *Rehabilitation*

Rehabilitation counseling is a part of the broader overall rehabilitation process. Medical dictionaries define rehabilitation as restoration or return to function following illness or injury. Rehabilitation is further defined as a process to facilitate independence and a return to full participation in life activities following the occurrence of disability, including employment as a core life activity. This definition is clearly encompassed within the official CRCC definition of rehabilitation counseling. When injury or illness occurs, acute care interventions are pursued to treat, manage, and stabilize the resulting medical condition. However, long-term consequences of illnesses and injuries, including disabilities, will sometimes remain after all available treatments have been pursued, and rehabilitation interventions may then be required to facilitate maximum function, full participation in life activities, and high quality of life. In addition to those disabilities that occur later in life, some occur at birth or during the early developmental years. In these cases, the same principles of assisting individuals in achieving independence, full participation, and quality of life apply. A variety of professions participate in rehabilitation programming, including physical, occupational, speech and language, and recreation therapy, rehabilitation psychology, social work, and rehabilitation counseling.

To illustrate the rehabilitation process, a spinal cord injury may occur through a variety of events, such as a motor vehicle crash, a fall, a diving accident, or a gunshot wound, resulting in paralysis below the level of the injury. An individual who sustains a spinal cord injury will often be taken to a trauma center and



will initially be treated through medical interventions to manage the acute condition and any complications that may result, and also to limit long-term adverse consequences. After the medical condition is stabilized, the individual will often be transferred to a rehabilitation unit within the hospital, where a variety of disciplines will assist the individual in recovering function and dealing with the limitations that will remain in the long term. The individual will learn new ways to perform tasks, for example, moving from place to place using a wheelchair, driving a car through the use of hand controls, and performing basic living tasks, such as eating and grooming. Many aspects of the life of the individual, as well as the lives of family and friends, will be affected. For example, the individual may no longer be able to work in the same occupation that had been a primary source of family income and personal identity. In some instances, it may be possible to help an employer identify accommodations that will make it possible for the individual to again perform the job. In other instances, the individual may need assistance in making new plans for the future. Every aspect of life may be affected, and rehabilitation professionals can participate in assisting the individual in recovering function, identifying and implementing accommodations, planning for the future, and maximizing independence and quality of life.

Rehabilitation services are provided in a variety of agencies and programs, and rehabilitation counseling is a part of the programming in many of these settings. Government programs providing rehabilitation services include agencies at the federal level (e.g., the Department of Veterans Affairs, where rehabilitation counseling is practiced in both the Veterans Benefits Administration, which coordinates disability and rehabilitation benefits, and in the Veterans Health Administration, which includes the Veterans Industries/Compensated Work Therapy Program that provides rehabilitation services to veterans with disabilities); the state level (the State-Federal Vocational Rehabilitation agencies, which exist in all states and jurisdictions in the United States, along with separate agencies for people with blindness and low vision in a number of states); and the county and city levels (e.g., local government agencies providing rehabilitation and long-term support services for people with developmental disabilities and with severe and persistent mental illness).

Many private agencies and programs also provide rehabilitation services, both nonprofit and for-profit.

Private-nonprofit programs include independent living centers (ILCs), rehabilitation facilities (e.g., Goodwill Industries), hospitals (e.g., physical medicine and rehabilitation units in university and community hospitals), disability organizations (e.g., state and local offices of the Epilepsy Foundation and United Cerebral Palsy), and a variety of community agencies providing rehabilitation and long-term support for people with disabilities (e.g., mental health, supported employment, and supported living programs). Private-for-profit programs often serve people with work or personal injuries covered by workers' compensation, automobile, and other insurance policies. These programs are sometimes a part of national and international insurance companies that provide workers' compensation or long-term disability coverage. Some are freestanding companies and private practices that may operate in one location or in many locations nationwide, and others are disability management programs that are a part of large business and industrial organizations. These programs facilitate the prevention of illness and injury and assist workers who have sustained disabilities in their attempts to return to work.

## ***Disability***

Since individuals with disabilities are the focus of the rehabilitation counseling process, it is important to define *disability*. However, different definitions of disability are advocated by different professional groups, and also by groups representing people with disabilities themselves. In addition, disability is defined by laws and government regulations, often in different and sometimes conflicting ways. These laws can have a dramatic impact on opportunities and protections provided to individuals with disabilities. For example, legal definitions of disability determine whether children are eligible for special education services in elementary and secondary schools; whether college students are eligible for accommodations, such as extended time on examinations and special services to facilitate their education; and whether adults are eligible for vocational rehabilitation services, including financial assistance with education and training in colleges and universities, technical colleges, and other types of training programs. In addition, legal definitions determine eligibility for disability benefits, such as Social Security Disability Insurance (SSDI) and Supplemental Security Income



(SSI) benefits, or for legal protections in employment and housing.

The term *disability* is sometimes used to refer to a variety of medical or related conditions (e.g., spinal cord injury, brain injury, schizophrenia, epilepsy, cerebral palsy, or diabetes), and *impairment* is sometimes used as an alternative to the term *disability* to express this meaning. In contrast, other definitions are based on the functional limitations associated with physical, cognitive, or psychiatric impairments that affect the performance of various tasks or functions (e.g., mobility, communication, self-care, self-direction, interpersonal skills, work tolerance, or work skills) or limit the fulfillment of major roles or life activities (e.g., employment and independent living). Other terms, such as *impediment* and *handicap*, are sometimes used as alternatives to disability to express this meaning. For example, for purposes of determining eligibility for SSDI or SSI benefits, disability is defined in terms of medical impairments that result in an inability to work in any “substantial and gainful activity.” In determining eligibility for services provided through the State-Federal Vocational Rehabilitation Program, disability is defined as a physical or mental impairment that results in a substantial impediment to employment. In identifying individuals who are provided legal protection under the Americans with Disabilities Act (ADA) of 1990, disability is defined as an impairment that substantially limits one or more major life activities, such as self-care, performance of manual tasks, walking, seeing, hearing, breathing, sitting, standing, lifting, reaching, learning, and/or working.

The most contemporary definitions recognize the importance of the physical, social, and cultural environment in defining disability. The environment is viewed as a primary source of barriers, stereotypes, and discrimination, which play central roles in the disabling consequences of physical, cognitive, and psychiatric impairments. Such definitions have been incorporated into ecological models of disability and rehabilitation counseling practice, which focus on interactions between individuals and their environments. Consistent with ecological models, rehabilitation counseling is not limited to traditional counseling interventions that focus on the individual. Rather, other types of interventions, such as advocacy, are also included, focusing on environmental factors contributing to disability and the interactions between the individual and environmental factors.

The variety of types of disabilities is extensive, with many different physical, cognitive, and psychiatric conditions, illnesses, and injuries. Examples include sensory disorders (e.g., blindness and low vision, deafness and hearing loss); developmental disabilities (e.g., cognitive disabilities, autism, epilepsy, brain injuries occurring during the developmental years); mental illness (e.g., schizophrenia, affective disorders, personality disorders); substance abuse and addiction disorders; injuries (e.g., spinal cord injuries, traumatic brain injuries, burns, amputations, carpal tunnel syndrome, chronic pain due to low back and other injuries); and a variety of other illnesses and conditions (e.g., stroke, cardiovascular disease, cancer, HIV/AIDS, respiratory disorders, multiple sclerosis, muscular dystrophy, rheumatoid arthritis, diabetes, chronic renal failure).

## Rehabilitation Counseling Practice

### *Guiding Principles*

Many of the guiding principles, philosophies, and values underlying the practice of rehabilitation counseling are shared by counseling in general, as well as by other helping professions. The belief in the worth and dignity of all people, including people with disabilities, is particularly important. Following from the belief in the worth of all people, rehabilitation counseling practice is dedicated to facilitating full access to opportunities for participation in all aspects of community life and to the pursuit of individually determined goals, consistent with the opportunities available to others in society. Following from the belief in the dignity of all people, rehabilitation counseling attempts to empower people with disabilities in achieving control over their own lives and the opportunities and goals that they choose to pursue. Consistent with this value is an emphasis on informed choice in rehabilitation counseling practice, viewing people with disabilities as equal collaborators in the rehabilitation counseling process and assisting them in obtaining and processing the information that they need to make their own decisions regarding services, interventions, and goals.

Also similar to counseling in general, rehabilitation counseling has a long tradition of going beyond limitations and problems to focus on the strengths of individuals with disabilities and helping them to build on those strengths in overcoming the difficulties that they



face in accomplishing their goals and living high-quality lives. In addition, the ecological perspective in rehabilitation counseling advocates a focus not only on the individual but also on environmental contexts, in assessing difficulties brought to rehabilitation counseling and in the planning of goals, services, and interventions.

Another value held in contemporary rehabilitation counseling practice, as specified in the CRCC definition of rehabilitation counseling, is the importance of pursuing “personal, career, and independent living goals in the most integrated settings possible.” Historically, career and independent living goals for people with disabilities, particularly for those with significant cognitive disabilities and severe and persistent mental illness, were often focused on segregated settings. Large numbers of people with disabilities were congregated in large work environments, such as sheltered workshops, and in large living environments, such as skilled nursing facilities, community-based residential facilities, halfway houses, and group homes. Contemporary practice emphasizes the pursuit of employment goals in regular work environments in business and industry, where individuals with disabilities will be integrated with the regular workforce, with necessary supports provided to facilitate success. Similarly, integrated living environments would be exemplified by one or two people with disabilities living in a regular community apartment building or complex, together with nondisabled people, with necessary supports provided.

### ***Rehabilitation Counseling Process***

The rehabilitation counseling process is generally consistent with the counseling process in general. The process is collaborative, with rehabilitation counselors and individuals with disabilities jointly assessing and identifying needs; establishing personal, career, and independent living goals; identifying barriers to accomplishing those goals; identifying needed services and interventions to overcome the barriers and accomplish the goals; organizing those services and interventions into a service plan; and implementing and evaluating the progress and success of the plan. Individuals with disabilities often seek rehabilitation counseling at times of change or crisis, such as the onset of a disability, changes in condition or functioning associated with disability, or times of transition (e.g., discharge from a hospital, completion of

high school and moving on to adult and community life, struggles with the demands of an education or training program, the illness or death of a caretaker, or termination from a job). At times of crisis, assistance will often be required through rehabilitation counseling in processing those changes and their implications, identifying and accessing community resources, and finding new ways to meet needs, which may precede the establishment and pursuit of personal, career, and independent living goals.

As in counseling in general, in rehabilitation counseling the emphasis is on the counseling relationship and developing a strong working alliance between rehabilitation counselors and individuals with disabilities. As is also true in counseling in general, eclectic approaches to counseling are common, with counselors drawing from a number of different counseling theories and techniques in their practice. Because of the emphasis on facilitating career, independent living, and life decisions, trait-and-factor theories and concepts are often applied. Given their emphasis on helping people build on strengths, cognitive-behavioral theories and practices can be beneficial in guiding people to develop skills for coping with difficulties and become masters of their own destinies to greater degrees.

Given the complexity of needs that is often associated with disabilities, the involvement of many different professionals, programs, and services is often required and, as a result, service coordination and case management are often critical components of the rehabilitation counseling process. In addition, given the common focus on career goals, important components of the process are often job development and placement and the facilitation of independent job-seeking efforts on the part of individuals served.

Some functions and tasks are unique or are emphasized to a greater degree in rehabilitation counseling practice than in counseling in general. Given the prominence of ecological perspectives, and the belief that problems related to disability reside in large part in the physical and social environments in which people with disabilities live and work, advocacy is emphasized. This includes both advocating for people with disabilities and assisting them in their efforts at self-advocacy. Related to advocacy, rehabilitation counselors may be called upon to consult with business, industry, and other organizations in facilitating accessibility and accommodating the needs of people with disabilities, including the identification of assistive



technology that may be used. In addition, rehabilitation counselors may be called upon to assist in legal proceedings, such as workers' compensation, personal injury, and divorce cases, to assess the impact of disability on earning potential so that appropriate compensation can be determined. Similarly, in life care planning, rehabilitation counselors may be called upon to assess the life-long service needs of individuals with disabilities, along with the costs of obtaining those services, in order to determine appropriate insurance settlements following the onset of a disability.

### **Professional Aspects of Rehabilitation Counseling**

Different points of view have long existed regarding the relation of rehabilitation counseling to other counseling and rehabilitation disciplines. Rehabilitation counseling has been conceptualized as a specialty within counseling, as a specialty within rehabilitation, and as a distinct and separate profession. The different points of view have resulted in multiple professional associations in rehabilitation counseling. Consistent with the view of rehabilitation counseling as a counseling specialty, the American Rehabilitation Counseling Association (ARCA) is a division of the American Counseling Association (ACA), along with other counseling specialties, such as employment, mental health, school, marriage and family, addiction, and offender counseling. Consistent with the view of rehabilitation counseling as a specialty within rehabilitation, the Rehabilitation Counselors and Educators Association (RCEA) is a division of the National Rehabilitation Association (NRA), along with other specialties in vocational evaluation, work adjustment, job placement, and independent living. Consistent with the view of rehabilitation counseling as a separate profession, the National Rehabilitation Counseling Association (NRCA) exists as a separate professional association, with no affiliation with a parent group, and some would consider the rehabilitation specialties represented within NRA to be specialties within rehabilitation counseling per se, focusing on particular rehabilitation counseling functions.

Rehabilitation counseling has been a pioneer in the movement toward the credentialing of practitioners, developing an accreditation mechanism for master's degree programs in rehabilitation counseling through the Council on Rehabilitation Education (CORE) and a national Certified Rehabilitation Counselor (CRC) credential through CRCC. Both mechanisms were

established in the mid-1970s, preceding by a number of years the comparable accrediting processes for general counseling through the Council for Accreditation of Counseling and Related Educational Programs (CACREP) and the National Board for Certified Counselors (NBCC).

Rehabilitation counselors are included in the licensing provisions for general counselors in many states, and a few states have separate credentials for rehabilitation counselors and related professionals, including the Licensed Rehabilitation Counselor (LRC) credential in Louisiana and New Jersey and the Qualified Rehabilitation Consultant (QRC) credential in Minnesota. Ethical standards specific to rehabilitation counseling practice were first developed and adopted by NRCA in 1972, which evolved into the current Code of Professional Ethics for Rehabilitation Counselors. The master's degree is generally considered to be the professional practice degree in rehabilitation counseling. In addition, a smaller number of universities offer programs to prepare rehabilitation counseling professionals at the doctoral degree level. Graduates of doctoral programs often enter academic positions in universities in the training of rehabilitation counselors and related professionals, in addition to positions in research, administration, supervision, and clinical practice, both within and outside of universities.

Knowledge domains specified by CRCC for inclusion in the CRC examination represent an official position regarding the competencies that are important to the practice of rehabilitation counseling. Some of the domains are shared with counseling in general, while others reflect the specialized services provided in rehabilitation settings and the unique needs of people with disabilities. Examples of more rehabilitation-specific knowledge subdomains are indicated in parentheses, following the more general domains in the following listings. Counseling is central to practice, including individual counseling, career counseling and assessment (e.g., interpretation of assessment results for rehabilitation planning, transferable work skills analysis, assistive technology), mental health counseling, and group and family counseling. Other rehabilitation counseling interventions include case and caseload management, job development and placement services (i.e., vocational implications of functional limitations associated with disabilities), and vocational consultation and employer services (i.e., employer practices that affect the employment or



return to work of individuals with disabilities, job analysis, job modification, and restructuring techniques).

Domains are also specified regarding the rehabilitation and human services systems, including rehabilitation services and resources (e.g., community resources and services for rehabilitation planning, school to work transition for students with disabilities, and Social Security programs, benefits, and disincentives affecting return to work); foundations, ethics, and professional issues (e.g., ethical standards for rehabilitation counselors and legislation affecting individuals with disabilities); and healthcare and disability systems. Finally, remaining domains relate to knowledge of disabilities and of the people typically served by rehabilitation programs, including the medical, functional, and environmental implications of disabilities and psychosocial and cultural issues.

Among the different counseling interventions, individual counseling is most commonly practiced by rehabilitation counselors but, depending on the specific settings in which rehabilitation counselors practice, group counseling may also be frequently used, along with family counseling. Career counseling is commonly practiced in many rehabilitation settings, because of the central importance of work and career for individuals with disabilities and the impact that disability can have on career direction and employment. In addition, personal issues, coping and adaptation to disability, and consideration of life decisions and plans are often the focus of rehabilitation counseling practice.

*Norman L. Berven*

**See also** Americans with Disabilities Act (v1); Chronic Illness (v1); Counseling, Definition of (v1); Empowerment (v3); Impairment (v1); Life Transitions (v2); Personal and Career Counseling (v4); Persons With Disabilities (v4); Physical Health (v2); Quality of Life (v2); Therapy Process, Individual (v2); Traumatic Brain Injury and Rehabilitation (v1)

### Further Readings

- Bolton, B. F. (Ed.). (2001). *Handbook of measurement and evaluation in rehabilitation* (3rd ed.). Gaithersburg, MD: Aspen.
- Chan, F., Berven, N. L., & Thomas, K. R. (Eds.). (2004). *Counseling theories and techniques for rehabilitation and health*. New York: Springer.
- Chan, F., Leahy, M. J., & Saunders, J. L. (Eds.). (2005). *Case management for rehabilitation health professionals* (2nd ed., Vols. 1 & 2). Osage Beach, MO: Aspen Professional Services.
- Commission on Rehabilitation Counselor Certification. (2001). *Code of professional ethics for rehabilitation counselors*. Rolling Meadows, IL: Author.
- Commission on Rehabilitation Counselor Certification. (n.d.). *Scope of practice for rehabilitation counseling*. Rolling Meadows, IL: Author.
- Falvo, D. R. (2005). *Medical and psychosocial aspects of chronic illness and disability* (3rd ed.). Sudbury, MA: Jones & Bartlett.
- Frank, R. G., & Elliott, T. R. (Eds.). (2000). *Handbook of rehabilitation psychology*. Washington, DC: American Psychological Association.
- Parker, R. M., & Szymanski, E. M. (Eds.). (2005). *Rehabilitation counseling: Basics and beyond* (4th ed.). Austin, TX: Pro-Ed.
- Power, P. W. (2006). *A guide to vocational assessment* (4th ed.). Austin, TX: Pro-Ed.
- Riggart, T. F., & Maki, D. R. (2004). *Handbook of rehabilitation counseling*. New York: Springer.
- Roessler, R. T., & Rubin, S. E. (2006). *Case management and rehabilitation counseling* (4th ed.). Austin, TX: Pro-Ed.
- Rubin, S. E., & Roessler, R. T. (2001). *Foundations of the vocational rehabilitation process* (5th ed.). Austin, TX: Pro-Ed.
- Smart, J. (2001). *Disability, society, and the individual*. Austin, TX: Pro-Ed.
- Szymanski, E. M., & Parker, R. M. (Eds.). (2003). *Work and disability: Issues and strategies in career development and job placement* (2nd ed.). Austin, TX: Pro-Ed.
- Vash, C. L., & Crewe, N. M. (2004). *Psychology of disability* (2nd ed.). New York: Springer.
- Weed, R. O., & Field, T. M. (2001). *The rehabilitation consultant's handbook* (3rd ed.). Athens, GA: Elliott & Fitzpatrick.
- Zaretsky, H. H., Richter, E. F., III, & Eisenberg, M. G. (Eds.). (2005). *Medical aspects of disability* (3rd ed.). New York: Springer.

---

## RELATIONSHIPS WITH CLIENTS

---

The therapeutic relationship is central to counselors' work with clients. The therapeutic relationship is the association, rapport, and connection between a counselor and client. The establishment of the therapeutic relationship begins with the joining process, wherein



the counselor and client get to know each other and clarify the need and purpose for counseling. The therapeutic relationship includes such things as unconditional regard for the client, placing the needs of the client first, engaging the client in a positive and collaborative manner, understanding the client and his or her context as it pertains to the presenting problem, mutually agreeing upon treatment goals and interventions, and empowering the client. In essence, the therapeutic relationship is the interaction, connection, and process between counselor and client in efforts to bring about the desired results in therapy.

Understanding the roles that a counselor plays and that the counselor may simultaneously engage in two or more of those roles is central to understanding the concept of *dual* or *multiple relationships* (the terms are used interchangeably). Counseling professionals function in a variety of professional roles, corresponding with their education, training, and experience. These include the roles of therapist, supervisor, researcher, employer, consultant, professional association officer, or expert witness. Simultaneously, therapists are functioning in other roles related to the personal, social, and business aspects of their lives (e.g., family member, friend, religious organization member, social acquaintance, sexual partner, business partner). A multiple relationship is defined as a situation in which the therapist functions in roles associated with a professional relationship with a client and also assumes another definitive and intended role that is not inconsequential or the result of a chance encounter. The multiple relationships may be concurrent or consecutive.

The concept of boundaries is critical to the discussion and understanding of multiple relationships. A professional boundary is conceptualized as a frame or limit that demarcates what is included or excluded from the therapeutic relationship. This includes the structure and content of therapy, as well as the professional responsibilities and behaviors that appropriately help clients. Critical areas relevant to boundary issues include time, place, space, money, gifts, services, clothing, language, self-disclosure, and physical contact. Meeting clients outside of the standard location for sessions or exchanging gifts with clients are examples of potential boundary violations.

Related to the construct of boundaries is the power a person has to influence another person or events. Power has the potential to be both helpful and harmful to those involved. This is particularly the case when there is unequal power between the parties

involved and when one person has the ability to impose his or her will over others. Factors that contribute to power differences include such things as role, sex, education, and socioeconomic status. Therapists are considered to have greater power than clients in the therapeutic relationship. Therapists' professional power is derived from four sources: societal ascription, expert knowledge, client expectations, and personal power. For example, in society, therapists occupy a position of authority and respect based on the work that they do and the potential influence that they have on people. When people (e.g., clients) come to them, the expectation is that therapists are experts within the field and that they have the knowledge and ability to help clients with the problems or challenges they face. Through the licensing process, society grants professionals the right to use their knowledge and power to benefit others.

### **Rationale for Avoiding Multiple Relationships**

The inherent power differential in the therapeutic relationship raises the concern that professionals could use their power and authority to take advantage of client vulnerability and exploit clients for their personal gain. Knowledge of the potential for exploitive relationships has led to the prohibition of harmful multiple relationships by professional associations, therapists, licensing boards, ethics committees, and educators. The prohibition derives from the belief that engaging in additional relationships puts the therapeutic relationship and client at risk; that conflicting roles and boundary violations could precipitate impaired therapist judgment and exploitation of the client.

### **Boundaries**

In her book about boundary violations in professional relationships, Marilyn R. Peterson described the roles of professionals and asserted that contemporary counseling professionals function as secular shamans. Intrinsic to the shaman perspective is that shamans act in the best of interest of those they help. Building upon this perspective, Peterson elaborated that society sets counseling professionals apart, elevating them to privileged positions of power and allowing them to influence and manage people's lives. Because of this position of power and influence, it becomes even more critical that professionals respect the boundaries



of their relationship with clients and not violate the trust and confidence bestowed upon them. This responsibility requires that professionals exercise restraint and vigilance to make sure that the client's best interests come before their own. If therapists are acting in the client's best interests, then they will exercise self-restraint and avoid situations that might tempt them to abandon the needs of the client and further their own interests.

Because trust in and vulnerability to the therapist and appropriate distance between therapist and client are inherent to the therapeutic process, many experts on ethics in the counseling profession advocate for therapists maintaining strict boundaries with clients. Clear boundaries are viewed as essential in therapy, and deviation from those boundaries presents a potential threat to the therapeutic process. Those who advocate for clear boundaries also consider crossing boundaries as a potential precursor to harming the client, varying in severity from harm to exploitation or even sexual relationships with clients.

Another concept discussed in the multiple relationship literature is that of the slippery slope. The term *slippery slope* refers to the notion that failure to adhere to rigid standards will gradually lead to relationships that are exploitative and harmful to the client. This process is thought to occur when one boundary is crossed without a clear damaging result, making it easier to cross future boundaries. The acceptance of the notion of a slippery slope has led to the generally accepted caution to avoid it by avoiding boundary violations or multiple relationships with clients. In the cautionary stance of risk management, therapists are admonished to avoid certain behaviors or practices because they might be misinterpreted and questioned by licensing board, ethics committees, and courts.

### **Problematic Aspects of Multiple Relationships**

In the seminal article on what makes dual relationships so problematic, Karen S. Kitchener used role theory to explain the difficulties that arise in dual relationships when one person is involved, simultaneously or sequentially, with role categories that conflict or compete. She proposed that it is the conflicting or competing roles that become problematic and identified three specific guidelines for differentiating between dual relationships that have a high versus a low probability of leading to difficulty. The first guideline addresses

the incompatibility of the expectations associated with multiple roles (e.g., therapist and friend). When role expectations are incompatible or compete, there is often confusion about how one should behave. When these expectations are unclear or conflict, there is greater potential for feelings of frustration, confusion, and anger, which in turn could lead to actions that could be harmful. The second guideline addresses the conflicting obligations associated with the roles (protecting the client's welfare when functioning as a therapist, but reducing the client's autonomy when giving advice as a friend). The problem in confusing these roles is that there may be confusion as to the underlying intentions. The final guideline addresses the power differential and notes as that differential increases, the potential for exploitation also increases. In the face of large power differences, clients may not be able to determine if they are being harmed.

### **Unavoidable Multiple Relationships**

Another aspect of multiple relationships that makes them so problematic is that they are sometimes unavoidable. Avoiding multiple relationships is particularly difficult for therapists who practice in small, rural communities; in the military; and in definite communities with minority populations; or who are clergy and/or work in religious settings.

Unlike clinicians practicing in large urban areas where they are able to maintain anonymity, those working in rural and small communities face unique challenges. The literature related to rural and small communities reveals three characteristics that practitioners face: impact of greater distances and population scarcity, living and working in smaller communities with their formal and informal social and political units, and the multiple levels of personal and professional relationships.

For those living in rural areas, there is typically a greater physical distance between communities. As a result, members of these small communities are interdependent so that necessary services can be provided within the community. It is possible that the only choice for shopping will be a clients' store, or that the therapist's children will attend the same school or become friends with clients or clients' children. Part of the difficulty is the fact that rural therapists have limited options for referring clients to other service providers. Additionally, the longer a therapist resides in the community, the more interaction the therapist



has with community members, and the more difficult it becomes to separate professional and personal relationships. In rural communities, there is a cultural and social expectation of overlapping relationships and that “everybody knows everybody.”

For therapists who are members of small communities and/or minority groups, it may be difficult to avoid multiple relationships. Clients frequently choose therapists because they are a part of a shared community and are expected to be more sensitive to the clients’ issues. Small, shared communities include not only therapists from minority ethnic backgrounds but also gay and lesbian therapists. The ethical dilemma of being known and setting personal boundaries within these small communities can be especially complex and daunting for these therapists. All therapists, and particularly those within small communities, need to make sure that their social, emotional, and sexual needs are met through relationships with friends, colleagues, family, partners, or others and not through relationships with clients. It is important that therapists prepare for these unavoidable multiple relationships by increasing their awareness of their own needs, establishing their own guideline or model for managing unavoidable multiple relationships, having competent colleagues with whom to consult, and having outlets for personal fulfillment and satisfaction outside of the therapeutic setting. It is also essential that therapists who navigate unavoidable multiple relationships have frank and clear discussions with clients about how they will manage the complexities of the multiple relationships, including potential conflicts and how those conflicts will be addressed and resolved.

### **Sexual Relationships With Clients and Their Impact**

Sexual relationships with clients are the most extreme form of multiple relationships. The American Psychological Association (APA) Code of Ethics and Standards of Practice clearly prohibits therapists from having sexual relationships with their current clients. Relationships with former clients (after a 2-year time period of no therapeutic contact) are not considered unethical, but are strongly discouraged. As a result of the ethical and legal prohibitions, therapists’ sexual involvement with current clients is rare. Depending on the survey, the frequency of therapist-reported sexual contact between therapist and client ranges from 0% to 3% for female therapists and from 3.8% to

13.7% for male therapists. There is little information pertaining to client reports of the frequency of sexual contact between therapist and client. The literature has shown that a sexual relationship between therapist and client is harmful to the client. This harm ranges from affecting the client’s emotional, social, and sexual adjustment, to negative feelings about the experience, a negative impact on his or her personality, and a negative impact on the client’s sexual relationship with his or her primary partner.

In describing the negative effects of therapist–client sexual involvement, Kenneth S. Pope reported that it commonly results in a distinct clinical syndrome, which he termed the *therapist-patient sex syndrome*. This syndrome has symptoms similar to those seen in sexual abuse, child abuse, posttraumatic stress disorder, battered spouse syndrome, and rape response syndrome. Just like in these other syndromes, in therapist-patient sex syndrome the appearance of adverse effects may be delayed. The 10 aspects identified as characteristic of this syndrome are ambivalence; feelings of guilt; a sense of emptiness and isolation; sexual confusion; impaired ability to trust; identity, boundary, and role confusion; emotional lability; suppressed rage; increased suicidal risk; and cognitive dysfunction. These adverse effects, and the severity of most of them, attest to the harm clients experience when their therapists are sexually involved with them.

### **Argument for Nonsexual Multiple Relationships**

In addition to the fact that some multiple relationships are unavoidable, some therapists argue that the avoidance of nonsexual multiple relationships is, in fact, detrimental to clinical work with clients. Those in favor of multiple relationships emphasize the distinction between a boundary violation and a boundary crossing. A *boundary violation* is a departure from clinical practice that places the client or therapeutic process at risk. Boundary violations refer to actions on the part of the therapist that are harmful, exploitative, and in direct conflict with the preservation of the clients’ dignity and the integrity of the therapeutic process. Examples of boundary violations are sexual and financial exploitation of the clients. *Boundary crossing* is a nonpejorative term that indicates a departure from traditional therapeutic settings or constraints. Examples of boundary crossings are making home visits to a bedridden sick client; taking a plane



ride with a client who has a fear of flying; attending a client's wedding, child's bar mitzvah, or other functions; or conducting therapy while walking on a trail with a person who requests it and seems to benefit from it. Not all boundary crossings are harmful, and therefore not all are violations. In addition to encouraging the distinction between boundary violations and boundary crossings, proponents of multiple relationships argue that rigid boundaries are contrary to being clinically helpful to clients.

The rationale for engaging in benign boundary crossing is based on research on the importance of rapport and warmth to the effectiveness of therapy. Proponents of this position describe boundary crossings as being a means for increasing familiarity, understanding, and connection and thereby increasing the likelihood of success for the clinical work. They further argue that the maintenance of rigid boundaries between therapists and patients in many small, close-knit communities is unrealistic and impossible. They cite the social norms within these communities of flexible and permeable boundaries and mutuality as requiring less rigid boundaries between professionals and their clients and argue that imposing such rigid boundaries on these communities is countertherapeutic.

Proponents of this view do not dismiss the importance of the power differential in the relationship, but suggest that power has become interchangeably associated with exploitation and harm in the ethics literature. They assert that it is not the power differential or multiple relationship that is problematic, but rather the therapists' propensity to abuse their power for selfish gain. Supporters of multiple relationships also argue that using the power differential as a rationale to avoid multiple relationships is insulting and dismissive of the clients' power and ability to navigate relationships and make decisions for themselves.

### **Guidelines for Decision Making With Multiple Relationships**

Sexual relationships with clients are clearly defined as unethical and harmful to clients. Although there is little research regarding the effects or benefits of nonsexual multiple relationships with clients, the generally accepted stance in the field is that therapists should exercise caution in developing additional relationships with clients. While professional codes of ethics provide general guidelines, they do not provide clear and specific direction for every situation that may arise for

therapists. It is up to the individual therapists to assess and evaluate clinical situations and choose behavior that they believe is the most ethical, legal, and beneficial to the client. This is part of the therapists' professional responsibility. To this end, it is important that therapists either adopt an existing ethical decision-making model or formulate or adapt one of their own.

Building upon existing ethical decision-making models and K.S. Kitchener's guidelines regarding role theory and relationships, Michael C. Gottlieb developed a model for avoiding exploitive multiple relationships. Gottlieb's model is based on three critical dimensions of the ethical decision-making process: power, duration of the relationship, and clarity of termination. *Power* refers to the amount of power the therapist has in relation to the client. *Duration of the relationship* has to do with the time involved and is related to power in that power increases over time. Power is low when the relationship is brief, but increases as relationship continues. *Clarity of termination* refers to the client's perspective of how long the professional relationship will continue. Gottlieb encouraged therapists to evaluate each of these dimensions from the client's perspective, determine the risk of being perceived as exploitive, and then determine if they want to proceed with the additional relationship. If a therapist does choose to pursue another relationship in addition to the therapeutic relationship, the therapist should consult with a colleague and discuss it thoroughly with the client. The therapist should review the entire ethical decision-making process and the potential risks and/or adverse consequences so that, if the client chooses to engage in the additional relationship, it is done with informed consent.

### **The Responsibility of the Therapist**

Therapists are expected to be responsible professionals and monitor themselves when it comes to multiple relationships. They must be aware of themselves (integrity, competence) and keep any of their personal issues or self-serving behaviors in check. They do this by making sure that they are appropriately connected to significant others, family, friends, and colleagues, and that their needs are being met through these interactions rather than through relationships with clients. When therapists find themselves vulnerable and at risk, they should seek appropriate support and guidance through consultation with colleagues, supervision, or personal therapy. This is critical to avoiding



multiple relationships, but even more important in those instances when a therapist is already involved in an overlapping or multiple relationship. It is also essential that the therapist is self-aware so as to keep self-interest in check and to keep clients' interests at the forefront. This self-monitoring is also critical in the area of boundaries in order to avoid boundary crossings that continue down the slippery slope to boundary violations. By engaging in careful self-awareness, therapists recognize multiple relationship issues and ethical dilemmas, use ethical decision-making models to plan for and facilitate ethical practice, and behave in ways that are in the best interest of clients.

Colleen M. Peterson

**See also** Code of Ethics and Standards of Practice (v2); Counseling Process/Outcome (v2); Ethical Codes (v1); Ethical Decision Making (v1); Ethical Dilemmas (v1); Expectations About Therapy (v2); Impairment (v1); Rural Practice, Challenges of (v1); Working Alliance (v2)

### Further Readings

- Anderson, S. K., & Kitchener, K. S. (1996). Nonromantic, nonsexual posttherapy relationships between psychologists and former clients: An exploratory study of critical incidents. *Professional Psychology: Research and Practice, 27*, 59–66.
- Brownlee, K. (1996). The ethics of non-sexual dual relationships: A dilemma for the rural mental health professional. *Community Mental Health Journal, 32*, 497–503.
- Catalano, S. (1997). The challenges of clinical practice in small or rural communities: Case studies in managing dual relationships in and outside of therapy. *Journal of Contemporary Psychotherapy, 27*, 23–35.
- Gottlieb, M. C. (1993). Avoiding exploitive dual relationships: A decision-making model. *Psychotherapy, 30*, 41–48.
- Gutheil, T. G., & Gabbard, G. O. (1993). The concept of boundaries in clinical practice: Theoretical and risk management dimensions. *American Journal of Psychiatry, 150*, 188–196.
- Herlihy, B. (1992). Dual relationships in perspective. In B. Herlihy & G. Corey (Eds.), *Dual relationships in counseling* (pp. 3–18). Alexandria, VA: American Association for Counseling and Development.
- Kitchener, K. S. (1988). Dual role relationships: What makes them so problematic? *Journal of Counseling and Development, 67*, 217–221.
- Peterson, M. R. (1992). *At personal risk: Boundary violations in professional-client relationships*. New York: Norton.
- Pope, K. S. (1989). Therapist-patient sex syndrome: A guide to assessing damage. In G. O. Gabbard (Ed.), *Sexual exploitation in professional relationships* (pp. 39–55). Washington, DC: American Psychiatric Press.
- Schank, J. A., & Skovholt, T. M. (1997). Dual-relationship dilemmas of rural and small-community psychologists. *Professional Psychology: Research and Practice, 28*, 44–49.
- Smith, D., & Fitzpatrick, M. (1995). Patient-therapist boundary issues: An integrative review of theory and research. *Professional Psychology: Research and Practice, 26*, 499–506.
- Strasburger, L. H., Jorgenson, L., & Sutherland, P. (1992). The prevention of psychotherapist sexual misconduct: Avoiding the slippery slope. *American Journal of Psychotherapy, 46*(4), 544–555.
- Zur, O., & Lazarus, A. A. (2002). Six arguments against dual relationships and their rebuttals. In O. Zur & A. A. Lazarus (Eds.), *Dual relationships and psychotherapy*. New York: Springer.

---

## RESILIENCE

---

Resilience, or resiliency, is the ability to survive, and thrive from, stressful experiences while building up protective skills to manage future hardship. Psychological resilience involves *cognitive, emotional, social, and physical* skills. Researchers have identified many factors that facilitate resilience and healthy adaptation to negative events and threats. For example, strong interpersonal social skills foster subsequent positive and prosocial behavior and relationships. Strong interpersonal skills help buffer stress and encourage support from others. Emotional intelligence (EI) is another trait or skill that buffers stressors and builds resilience. Emotional intelligence skills include self-awareness, other-awareness, modulation of emotions, identifying emotions in others, and responding appropriately and effectively in a positive manner. Cognitive skills that build resiliency include learning how to identify and dispute negative thinking, using critical thinking strategies in order to make more effective and accurate appraisals of negative events, thinking optimistically and having a sense of control and management over hardship, and reframing thoughts or ideas into proactive ones. In the physical realm,



demonstrating prosocial behavior that encourages and facilitates personal development, through giving, sharing, and helping others, builds resilience.

Although there has been some disagreement in the definitions of resilience across cultures, researchers agree that certain skills and strengths acquired in childhood help build resilience. Strong social skills and relationships in youth help buffer stress. Those who are involved in extracurricular activities like sports or music seem to have strong interpersonal skills that boost confidence and maturity. Involvement in activities also increases contact with others that facilitates solid support systems. The ability to interact and have rewarding relationships with peers and adults using effective communication and demonstrating appropriate personal boundaries builds self-esteem. The ability to problem solve is an active demonstration of resiliency. The ability to manage one's own emotions and assess the emotional response of others is paramount in developing and maintaining resilience.

Environmental factors related to resilience include higher socioeconomic level, levels where caregivers are not overly stressed and focused on financial security. Stability in schools and an educational environment where creativity and talent are nurtured and respected are additional factors in cultivating resiliency.

Other factors that foster resiliency are stable healthy families that encourage healthy developmental outcomes in children and consistent parenting that promotes autonomy, cooperation, independence, competence, and self-regulation with appropriate boundaries. Temperament is also related to resilience. Children are born with certain traits that endure over time and are modified and shaped by environment. A "good" fit between parents and children is crucial to bonding and subsequent development.

Resilience develops over time and is not considered a trait. Research on resilience has included terms like *adaptive coping*, *emotional coping*, *psychological resilience*, *learned optimism*, *hardiness*, *thriving*, and *flourishing*. These terms are used somewhat interchangeably.

### History of the Study of Resilience

Norman Garmezy first coined the term *resiliency* when he began studying adults with schizophrenia in the 1940s. His work led him to discover factors that buffer individuals from psychopathology. In the

1970s, he focused on identifying risk factors and developing resiliency strategies. The heightened interest in resilience research has occurred as a result of more at-risk youth being identified for serious lifelong problems, and the concomitant desire to identify factors that would reduce or prevent the occurrence of these problems. A widely used assessment for identifying resilience, The Denver Developmental Screening Test, was developed by William K. Frankenburg in the 1960s. Scientists continue to discover strengths and factors leading to resilience.

When scientists Emmy Werner, Michael Rutter, and Garmezy discovered that more than 30% of those living in at-risk conditions were surviving and thriving, despite severe hardship, they committed to discovering what strengths provided such protection. Circumstances associated with an at-risk designation include, but are not limited to, poverty, despair, lower socioeconomic levels, instability in schools, poor interpersonal skills, pessimism, limited access to health care, poor critical thinking skills, poor mental and/or physical health, antisocial behavior, unstable families, no belief in God or a higher power, inconsistent parenting, and a lack of warmth and love.

### Development of Resilience

Scientists across disciplines have begun to recognize many common factors that are associated with psychological and emotional resilience. Numerous longitudinal studies have assessed what factors contributed to resilience over time. One category of factors includes infant bonding and attachment style. Attachment styles set the stage for values, attitudes, and basic skills that are integral to the development of resilience. Attachment styles begin to develop in early childhood and are refined through adulthood. Therefore, scientists have concluded that parents are a major influence on the development of resilience, through modeling; support; teaching self-reliance and interpersonal skills; setting appropriate limits; showing love and facilitating healthy attachment and bonding; and demonstrating and teaching moral values, problem-solving skills, and self-control. An environment where emotional warmth is demonstrated is integral to the development of resilience.

Traits, like temperament, and environmental characteristics play a role as well, but seem to be lesser influences in the development of resilience. In addition to the factors related to the development of resilience in



children, researchers are identifying resilient qualities in middle-age and older adults. Adults who experience crises fare best when they are socially integrated and able to share their feelings with friends and peers, use their strengths to cope with daily activities, and seek professional help when needed. Those who maintain resilience take action when crises occur, while seeing adversity as part of life. They feel competent to solve problems, nurture and care for themselves to stay healthy, manage their emotions, and have a realistic sense of hardship. Resilient individuals find meaning in adversity; this meaning-making tends to facilitate personal growth and a renewed sense of and gratitude for life. Adults who can look to the future and not focus on the past seem to fare best.

With the psychosocial stressors in the last decade, including the natural disasters around the world, economic downturn, and international strife, researchers have been especially interested in promoting factors that help individuals thrive and flourish, rather than just survive. Resilience is being tested and studied across all domains and cultures. Researchers have learned that resilience is developed over time by experiencing conditions of environmental protective factors and/or developing skills, cognitive awareness, and strategies that facilitate resilience. In childhood, skills and strategies for coping are learned, and over time, developed, enhanced, and internalized. In adulthood, resilience factors are embedded in the personality and become part of the constellation of competencies individuals use to cope with life's adversities.

### **Clinical Applications of Teaching Resilience**

The field of psychology is moving toward a prevention model, including education that teaches what qualities, skills, and strategies promote and maintain resilience and subsequent well-being. Researchers have identified many factors that promote resilience, and educational institutions are beginning to institute resilience-enhancing programs to students. School settings are a natural environment for cultivating qualities related to resilience. Children spend 7 to 10 hours per day in school, and thus, have many opportunities in that setting to build strategies and skills for success. Protective factors that lead to resilience and coping can be taught from kindergarten through high school. Research demonstrates that a framework for developing resilience should include helping children avoid risk exposure, minimizing

consequences from risk exposure, fostering self-reliance and esteem by teaching children how to reframe negative thinking, and providing opportunities for personal growth. Policy in schools must meet the demands of a diverse population and help children find their strengths instead of trying to manage negative behavior. The fostering of factors associated with resiliency must be part of the learning environment. Schools are vital to helping youth to be resilient.

Parents and communities have roles to play in this educational process. Parents, teachers, and caregivers can promote solid emotional, cognitive, behavioral, and social skills in youth. The shift from identifying risk factors to identifying resilience factors is the focus of contemporary research. Chris B. Rush, president of the Resiliency Institute, created a model for resiliency, *The Seven Keys to Resiliency*, which helps teach and foster skills that help youth develop into healthy and productive citizens. The American Psychological Association (APA) has adopted and embraced his model, and Martin Seligman, past president of the APA, has been conducting research on resiliency factors since the 1960s. Seligman and colleagues conduct the Penn Resiliency Program (PRP) to help children build strong cognitive skills for coping with adversity.

Sybil Wolin and Steve Wolin are also primary researchers in resiliency studies. The Search Institute has been at the forefront of research for more than 20 years. There are many educational programs around the world teaching resiliency skills and strategies, with more in development.

The research demonstrates that resiliency skills are best learned and internalized during youth, however, current researchers are studying how adults can learn to change their thinking and manage their emotions and behavior to develop resilience. Psychologists and other trained mental health professionals have the ability to teach adults how to recognize and capitalize on their strengths rather than just addressing their weaknesses. Since all people have the capacity for resilience, it is reasonable that clinicians can help those who feel a sense of hopelessness regarding their situations to find and develop their strengths. In her pioneering work over the last 30 years, Emmy Werner has demonstrated how Native Hawaiians have overcome adversity and thrived, despite overwhelming odds. The results of many long-term studies are positive for those who grow up in at-risk environments.

Schools, parents, and communities at large can play a big part in the development of resilience. The



community must commit to working together with parents, educators, and other institutions to cultivate an attitude toward identifying and fostering strengths that lead to the development of resilience. Since resilience is developed over time, optimal conditions of environmental protective factors, cognitive awareness, and strategies that facilitate resilience can set the stage for optimal development. Researchers will continue to identify what factors constitute resilience. Parents, communities, and schools are starting to work together in helping children thrive, not merely survive, when adversity strikes. Although there is no one factor that determines who will develop resilience, the research clearly demonstrates that all human beings have the potential to develop their strengths.

*Dora Finamore*

**See also** Cancer Management (v1); Coping (v2); Disasters, Impact on Children (v1); Happiness/Hardiness (v2); Hope (v2); Optimism and Pessimism (v2); Positive Psychology (v2); Rehabilitation Counseling (v2); School Counseling (v1); Self-Esteem (v2); Stress (v2); Stress Management (v2)

### Further Readings

- Dubow, E. F., & Luster, T. (1990). Adjustment of children born to teenage mothers: The contribution of risk and protective factors. *Journal of Marriage and the Family*, 52, 393–404.
- Garnezy, N. (1985). Stress-resistant children: The search for protective factors. In J. E. Stevenson (Ed.), *Recent research in developmental psychopathology* (Book supplement to the *Journal of Child Psychology and Psychiatry* No. 4, pp. 213–233). Oxford, UK: Pergamon Press.
- Grothberg, E. H. (1997). The International Resilience Project: Findings from the research and the effectiveness of interventions. In *Psychology and education in the 21st century: Proceedings of the 54th Annual Convention of the International Council of Psychologists* (pp. 118–128). Edmonton, Alberta, Canada: IC Press.
- Masten, A. S., & Coatsworth, J. D. (1998). The development of competence in favorable and unfavorable environments: Lessons from research on successful children. *American Psychologist*, 53, 205–220.
- Masten, A. S., Hubbard, J. J., Gest, S. D., Tellegen, A., Garnezy, N., & Ramirez, M. (1999). Competence in the context of adversity: Pathways to resilience and maladaptation from childhood to late adolescence. *Development and Psychopathology*, 11(1), 143–169.
- Neill, J. (2006). *Resilience*. Retrieved September 1, 2006, from <http://www.wilderdom.com/psychology/resilience/PsychologicalResilience.html>
- Werner, E., & Smith, R. S. (1982). *Vulnerable but invincible: A longitudinal study of resilient children and youth*. New York: McGraw-Hill.
- Werner, E. E., & Smith, R. S. (1992). *Overcoming the odds: High risk children from birth to adulthood*. Ithaca, NY: Cornell University Press.
- Winfield, L. F. (1994). *NCREL monograph: Developing resilience in urban youth*. Retrieved September 1, 2006, from <http://www.ncrel.org/sdrs/areas/issues/educatrs/leadrsdp/le0win.htm>

---

## ROGERS, CARL R. (1902–1987)

---

Carl Ransom Rogers developed a robust humanistic psychological theory and therapy that established him as a preeminent exponent of and eloquent spokesperson for psychology's third force (humanism). In doing so he transformed the ways in which the counseling process is conceptualized and conducted. He embarked upon an ambitious experimental campaign to subject his theoretical and therapeutic ideas to empirical scrutiny and testing. He also sought to apply his humanistic philosophy to other substantive areas of inquiry (e.g., education and international relations). Most contemporary counseling psychologists acknowledge the central importance of the core conditions in therapeutic change. Many of Rogers's ideas about the counseling process, once considered revolutionary, now influence or have been integrated into today's practice of counseling throughout the world. His seminal ideas have vastly enriched and expanded our vision about personality functioning and change and will continue to fruitfully influence and affect counselors and clients for countless generations to come.

### Education and Career

Rogers obtained his B.A. in 1924 from the University of Wisconsin, and his M.A. in 1928 and Ph.D. in 1931 from Columbia University. He served as a psychologist at the Rochester Guidance Center (1928–1939), professor of psychology at the Ohio State University (1940–1945), professor of psychology and Executive Secretary of the Counseling Center of the University of Chicago (1945–1957), and professor of psychology



and psychiatry at the University of Wisconsin (1957–1963). He concluded his career with appointments at the Western Behavioral Sciences Institute from 1964 to 1968 and the Center for the Studies of the Person from 1968 to 1987. He received a Distinguished Scientific Award in 1956 and Distinguished Professional Contribution Award in 1972 from the American Psychological Association.

### Contribution

Rogers's most enduring contribution to counseling was his *client-centered* (also referred to as *person-centered*) approach. To best understand his system, three areas require attention: (1) the client-centered view of disturbance, (2) the therapeutic conditions of personality change, and (3) the process of therapeutic change.

#### ***The Client-Centered View of Disturbance***

Clients who come for counseling experience some type of disequilibrium. This is the product of conflict, tension, and distress, which result from dishonesty with self. At its most fundamental level, Rogers viewed disturbance as originating in an individual's losing trust in his or her "self." As this occurs, individuals begin to distort, deny, or inauthenticate their own experience of the world, and over time to separate increasingly from that fully, freshly felt experiencing of self and the world. Rogers used the term *incongruence* to capture this idea of the discrepancy between one's self and one's experience. As incongruities emerge, increase further in magnitude, and become incorporated into everyday functioning, the individual operates more on a basis of "what I should be" or "who I must be" than on a basis of "who I am."

Rogers's belief in humanity was eminently positive, optimistic, and proactive. He believed that each person possesses an inherent tendency to fully develop his or her capacities, a process Rogers termed *self-actualization*. Though life experiences can derail this tendency, this "great upward striving" still calls to us. Clients may express this in myriad ways: "Something doesn't feel right," "I don't believe that I'm being true to myself," "I really think I'm selling myself short," "I don't like it when I do that." Clients experience that something is wrong (e.g., conflict, tension, or distress), they sense that this involves a compromise of self (e.g., incongruity, discrepancy, or dishonesty), and they wish for a better adjustment

(actualization). The antidote for these disturbances lies in reconnecting clients with their authentic selves; reestablishing the process of their listening to, valuing, and trusting their innermost selves; and setting them on the path to becoming fully functioning individuals.

#### ***The Therapeutic Conditions of Personality Change***

For Rogers, the key question in the therapeutic relationship was: How can the counselor provide a relationship that the client can use for personal growth? That question expressed Rogers's heartfelt conviction that the counselor provides a helping, facilitative relationship that has the potential to liberate clients from their incongruous, unactualizing way of being. When that helping, facilitative relationship is provided, clients will *use* it to help themselves grow. Clients are capable of personal growth in a counseling relationship characterized by three core conditions: empathic understanding, unconditional positive regard, and genuineness.

*Empathic understanding* is often defined by the phrase "walk a mile in my shoes." Rogers advocated that counselors (metaphorically) crawl into the skin of their clients, to see as they see, to think as they think, and to feel as they feel. By profoundly understanding their clients, communicating that understanding, and facilitating further and deeper exploration, counselors open the way for clients to begin listening to and understanding themselves. For Rogers, being empathic was the core facilitative condition that freed clients to use the counseling relationship to grow.

*Unconditional positive regard* (also referred to as *nonpossessive warmth*, *respect*, *liking*, *acceptance*, and *prizing*) is an appreciation of clients for who they are. It also involves a positive respect for and acceptance of the client's immediate experiencing. In the words of Thomas Harris's popular 1969 book, *I'm OK—You're OK*, positive regard involves genuinely feeling and communicating to clients that they are "OK."

*Genuineness* (also referred to as *realness*, *congruence*, and *transparency*) entails honestly being yourself in the counseling relationship. The counselor puts up no front or façade. Genuineness involves honesty, expressed with sensitivity, compassion, and appropriateness. Although genuineness is difficult to define concretely, when present in a counseling interview, its



salience is incontrovertible, its presence palpable, and its power miraculous.

### ***The Process of Therapeutic Change***

Rogers's conception of the therapeutic change process has been likened to peeling an onion—taking off one layer at a time. The therapeutic change process cannot be rushed. Therapeutic change takes time. Each client's needs must be considered and respected, and a program of change must be charted accordingly. Clients should be allowed to proceed at the pace that promotes optimal growth and learning. Generally, personal growth involves the development of the self from more general and undifferentiated to more specific and differentiated; from blocked to unblocked; from less open to more open; from more distant to more immediate; from less responsible to more responsible; and from compromised function to full function.

Rogers conceived of the therapeutic process as involving seven stages. Clients in the first stage refuse to acknowledge that a problem exists and are unwilling to talk about anything other than external generalities. This is typical of involuntary clients. In stage two, clients perceive problems to be of external origin and fail to recognize their own personal contribution. A limited acceptance of their feelings and some freer self-expression occurs in stage three. In the next stage clients become more present focused, further accept and own their feelings, and begin to evidence some self-responsibility; self-acceptance and self-responsibility are further enhanced in stage five. The clients' internal communications are clear, their perceptions of their experiences are sharp, and their focus is present oriented in the penultimate stage. The final stage of counseling is characterized by the highest levels of immediacy and openness to experience, and by the emergence of self-acceptance and self-responsibility.

*C. Edward Watkins, Jr.*

**See also** Client Attitudes and Behaviors (v2); Counseling Process/Outcome (v2); Counseling Theories and Therapies (v2); Facilitative Conditions (v2); Humanistic Approaches (v2); Individual Therapy (v2); Therapy Process, Individual (v2)

### **Further Readings**

Rogers, C. R. (1942). *Counseling and psychotherapy*. Boston: Houghton Mifflin.

Rogers, C. R. (1951). *Client-centered therapy*. Boston: Houghton Mifflin.

Rogers, C. R. (1957). The necessary and sufficient conditions of therapeutic personality change. *Journal of Consulting Psychology*, 21, 95–103.

Rogers, C. R. (1959). A theory of therapy, personality and interpersonal relationships as developed in the client-centered framework. In S. Koch (Ed.), *Psychology: A study of science: Vol. 3. Formulations of the person and the social context* (pp. 184–256). New York: McGraw-Hill.

Rogers, C. R. (1961). *On becoming a person*. Boston: Houghton Mifflin.

Rogers, C. R. (1970). *Carl Rogers on encounter groups*. New York: Harper & Row.

Rogers, C. R. (1972). *Becoming partners: Marriage and its alternatives*. New York: Delacorte Press.

Rogers, C. R. (1980). *A way of being*. Boston: Houghton Mifflin.

---

## **RYAN, RICHARD M.**

---

**See** DECI, EDWARD L., AND RYAN, RICHARD M.

---

## **RYFF, CAROL D. (1950– )**

---

Carol D. Ryff is Director of the Institute on Aging and Professor of Psychology at the University of Wisconsin-Madison. She received her doctoral degree in 1978 from The Pennsylvania State University in Human Development and is a fellow of the American Psychological Association's Adult Development and Aging division (APA Division 20) and the Gerontological Society of America. Her research centers on the study of psychological well-being, an area in which she has developed multidimensional assessment scales that have been translated to more than 25 different languages and are used in research across diverse scientific fields. Investigations by Ryff and her colleagues have addressed how psychological well-being varies by age, gender, socioeconomic status, ethnic/minority status, and cultural context as well as by the experiences, challenges, and transitions individuals confront as they age. Whether psychological well-being is protective of good physical health is also one of Ryff's major interests and the source of her ongoing longitudinal investigations linking



positive psychosocial factors to a wide array of biomarkers (neuroendocrine, immune, cardiovascular) as well as to neural circuitry. A guiding theme in much of this inquiry is human resilience—that is, how some individuals are able to maintain, or regain, their well-being in the face of significant life challenge and what neurobiological, psychological, and social factors underlie this capacity.

Ryff's model of psychological well-being, encompassing six dimensions, has been instrumental in developing a well-being enhancing psychotherapeutic strategy, called *well-being therapy*. This therapeutic approach has been validated in several randomized controlled studies. Impairments in environmental mastery, autonomy, personal growth, interpersonal relationships, goal in life, and self-acceptance, the six dimensions of well-being, are frequently observed in clinical practice. Another important area of application is concerned with the process of recovery. Ryff's work has yielded seminal implication for counseling and clinical psychology, psychiatry, and psychosomatic medicine all over the world.

Ryff has written more than 120 publications in the research areas described above, and she currently directs the Midlife in the United States (MIDUS) longitudinal study, which is based on a large national

sample of Americans, including twins. Funded by a \$26 million grant from the National Institute on Aging, MIDUS II has become a major forum for studying health in aging as an integrated biopsychosocial process.

*Giovanni Fava*

**See also** Adult Development (v1); Adults in Transition (v4); Aging (v1); Life Transitions (v2); Physical Health (v2); Psychological Well-Being, Dimensions of (v2); Resilience (v2)

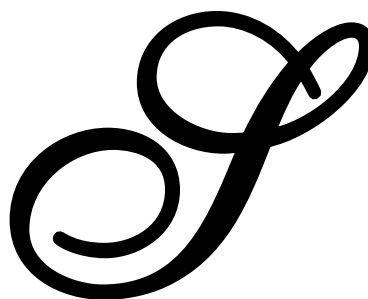
### Further Readings

- Ryff, C. D., Love, G. D., Urry, H. L., Muller, D., Rosenkranz, M. A., Friedman, E., et al. (2006). Psychological well-being and ill-being: Do they have distinct or mirrored biological correlates? *Psychotherapy and Psychosomatics*, 75, 85–95.
- Ryff, C. D., & Singer, B. (1996). Psychological well-being: Meaning, measurement, and implications for psychotherapy research. *Psychotherapy and Psychosomatics*, 65, 14–23.
- Singer, B., & Ryff, C. D. (2001). *New horizons in health: An integrative approach*. Washington, DC: National Academy Press.









---

## SCHIZOPHRENIA, ADULT

---

*Schizophrenia*, derived from the Greek for “severed mind,” refers to a mental disorder characterized by the fragmentation of mental functioning and a split between thinking and feeling. This entry discusses the definitions of the concept; the epidemiology and prevalence; and the course, causes, and functional assessment of schizophrenia. Then, this entry addresses rehabilitation, evidence-based practice, policy issues, and recovery.

### Definitions

The origin of the concept of “schizophrenia” is usually attributed to the German psychiatrist Emil Kraepelin. Kraepelin first used the term *dementia praecox*, or “premature dementia,” to distinguish it from other psychotic illnesses. In the early 20th century, the Swiss psychiatrist, Eugen Bleuler, argued that the term *dementia* is misleading because dementia suggests an irreversible progressive brain disease. Bleuler stated that the most salient characteristic of the disorder is not its onset nor its course, but the particular nature of its expression in cognitive functioning. He proposed the term *schizophrenia* to suggest the fragmentation of mental functioning and a split between thinking and feeling. Bleuler also argued that there is extensive variability among individuals who had obtained this label, suggesting that there is a group of similar but distinct disorders. He made the new name plural, *the schizophrenias*. Although the term *schizophrenia* is used in contemporary

diagnostic systems, the diagnostic criteria and subtypes found in the *Diagnostic and Statistical Manual (DSM)* are largely those of Kraepelin.

*DSM* diagnosis of schizophrenia requires the presence of at least two types of psychotic symptoms, including hallucinations, delusions, irregular affect, and confusion or disorientation. Delusions alone are sufficient if they are “bizarre” (i.e., they could not possibly be true, as when a person believes he or she is dead). Symptoms must be present for at least 6 months, unless suppressed by treatment, and must be accompanied by impairment in personal and social functioning. The diagnosis may be elaborated by the assignment of subtypes, based on the specific quality of the symptoms and the course of the disorder.

Historically, the concept of schizophrenia, and of psychiatric diagnosis in general, has been criticized as not being grounded in theory. Furthermore, in contrast with medical diagnoses, psychiatric diagnoses do not identify the cause of the illness. Typically, two opinions in the contemporary psychiatry and psychopathology communities emerge when describing schizophrenia. The first is a traditional view that schizophrenia is a unitary disease much like Kraepelin originally described. The second view is that schizophrenia is a generic category for a variety of specific disorders that have little in common other than periods of psychosis. This ambiguity is reflected in the existence of a related diagnosis, *schizoaffective disorder*, in which characteristics of schizophrenia co-occur with characteristics of affective disorders, primarily bipolar disorder or depression. Even when diagnosed rigorously with the criteria provided by the *DSM*, people receiving the diagnosis of schizophrenia



comprise a very heterogeneous group with respect to age of onset, symptoms and other behavioral expressions of illness, degree of functional disability and other characteristics. There is no clinical picture that is unique to or always present in “schizophrenia.”

For these reasons, the term *schizophrenia* has limited utility in clinical treatment, social policy, or mental health administration. This has stimulated widespread use of the more inclusive term *serious mental illness* (SMI), which captures schizophrenia’s essential features, including a chronic course and severe functional disability.

Symptoms that are associated with schizophrenia can be separated into positive, negative, and disorganized symptoms. Sensory experiences, thoughts, and behaviors that are present but not typically found in people without the illness (e.g., hallucinations, delusions, and bizarre behavior) are called positive symptoms. Negative symptoms are so named because they refer to an absence or reduction of thoughts, feelings, and behaviors (e.g., reductions in communication, inability to feel pleasure (anhedonia), psychomotor retardation, apathy, and blunted affect). Negative symptoms are sometimes subdivided into primary and secondary symptoms. Primary negative symptoms are a direct expression of the disorder, while secondary symptoms are indirect consequences, such as depression consequent to loss of functioning, or side effects of medication (e.g., sedation). Finally, disorganized symptoms refer to a fragmentation of experience or behavior (e.g., disorientation, incoherent speech, purposeless motor activity). Although the most salient characteristics of schizophrenia tend to be positive or disorganized symptoms, negative symptoms account for a significant degree of morbidity associated with the disorder. Similarly, one of the most important insights about schizophrenia in recent decades has been that the disabilities associated with schizophrenia stem at least as much from the inability to perform activities of routine daily living as from symptoms.

### Epidemiology and Prevalence

Schizophrenia occurs in 1% to 1.5% of the population. This rate is approximately the same across cultures. The meaning of this estimate is questionable, however, due to its reliance on the traditional diagnostic system. About 3% of the general population meet the more inclusive criteria for serious mental illness

(SMI). The economic burden of SMI (e.g., cost of treatment, supportive social services, loss of productivity) is comparable to that of heart disease or cancer.

### Course

The onset of schizophrenia typically occurs around adolescence. While the majority of individuals undergo a prodromal phase that involves a slow and gradual development of symptoms, onset can also be abrupt. Many factors can influence the onset and course of the disorder, including stress, genetics, environmental factors, gender, and culture. The course is usually episodic, meaning there are periods of more pronounced psychosis interspersed with periods of relatively intact functioning. However, people who meet diagnostic criteria are highly heterogeneous with respect to the frequency, duration, and severity of episodes. In some individuals, the episodes are so frequent, severe, and/or prolonged that the psychosis appears to be continuous.

Contrary to the common belief that persons afflicted with the disorder are doomed to interminable incapacity, many actually recover. Bleuler’s opposition to Kraepelin’s view of dementia praecox was based in part on his observation that approximately one third of people diagnosed with schizophrenia recover. Systematic research suggests that people recover at even higher rates, with up to two thirds recovering or significantly improving.

### Causes

There is no single pathogen in the origins of schizophrenia. An array of factors interacts to produce the wide variability associated with the disorder. Environmental factors, especially stress, are thought to interact with a diversity of genetic, neuroanatomical, neurophysiological, neuropsychological, and behavioral *vulnerabilities* to produce the disorder. These interactions are understood to exert their influence over the span of childhood and adolescent development.

Genetic factors appear to play an important role; having a first-degree relative with schizophrenia increases a child’s risk of eventually being diagnosed with the disorder from 1.5% to approximately 10%. An identical twin with the diagnosis increases the risk for the other twin to about 50%. Pregnancy complications, abnormal fetal development, and/or birth complications are also related to an increased



rate in developing schizophrenia. Theories about the mechanisms of genetic causes range from vulnerability to prenatal viral infection to abnormal distribution of specific neurotransmitter receptors.

Many studies have found structural abnormalities in the frontal lobes, temporal lobes, and basal ganglia. These studies support the theory that schizophrenia involves a widespread disturbance in cognitive coordination and its underlying neural basis. These findings may account for the wide range of cognitive deficits associated with schizophrenia. Neurodevelopmental studies reveal common neuromotor abnormalities in infancy and early childhood in individuals who develop schizophrenia in adolescence or adulthood.

Environmental factors such as poor nutrition, exposure to chemicals, viral disease, trauma, and psychosocial stressors may also result in an increased risk for the disorder. Possible links between environmental events and structural brain abnormalities include *developmental neurodysplasia* and *cortisol*. Neurodysplasia is a relatively subtle disruption of brain development. The second trimester of gestation appears to be an especially vulnerable time for neurodysplasia to be induced through genetic abnormalities, viral infection, and toxic levels of cortisol or physical injury. Cortisol is a hormone secreted when a person is under stress. High levels of cortisol may produce neural cell death in brain areas associated with schizophrenia. Additionally, high cortisol levels in a pregnant woman may affect brain development in the fetus.

At the neurophysiological level, schizophrenia is generally understood as an episodic dysregulation of brain activity, possibly as a consequence of neuroanatomical abnormalities. The neurophysiological dysregulation is primarily mediated by the neurotransmitter dopamine. Pharmacological agents used to treat psychosis all affect the dopamine system, but there are intricate interactions between dopamine and other neurotransmitter systems, especially those mediated by serotonin. Newer pharmacological agents tend to have multiple actions across neurotransmitter systems.

Psychosocial influences can serve as environmental vulnerabilities that may exacerbate the disorder and further decrease functioning (e.g., family difficulties, poor interpersonal relationships, lack of social supports). Progression of the disorder can also be influenced by institutionalization and assumption of a “mental patient” social role. This highly dynamic accumulation

of environmental and behavioral vulnerabilities, interacting with biological vulnerabilities, determines the lifelong course of the disorder.

## Functional Assessment

Functional assessment is an individualized approach used in the assessment and treatment of individuals with SMI. Since the 1960s, functional assessment has become a very important clinical tool. Strengths and liabilities are evaluated on a continuum that includes neurobiological, cognitive, behavioral, and social-environmental levels of functioning. The most molecular levels of functioning include the impact of neurophysiological abnormalities. The intermediate levels include cognitive abilities (e.g., problem solving, self-monitoring, ability to make social inferences). The most molar levels of functioning extend to the person’s environment, and include family functioning, cultural attitudes about mental illness, and implications of public policy on service provision for individuals and families affected by SMI. The functional approach recognizes human beings as complex integrated systems, while affording a comprehensive picture of a client’s level of functioning, regardless of diagnosis. Most importantly, functional assessment informs *case formulation*, a comprehensive approach to understanding and treating the whole person.

## Psychiatric Rehabilitation

Psychiatric rehabilitation is an integrated approach that combines functional assessment, psychosocial interventions, and biomedical treatment. Over the past three decades, psychiatric rehabilitation has gradually gained favor over “medical model” approaches limited to drug treatment and social support. Psychiatric rehabilitation typically combines multiple assessments and interventions (e.g., rehabilitation counseling, social skills training, wellness or illness management, cognitive therapy). The person undergoing treatment is a key collaborator in this process. Rehabilitation focuses on the reduction of disability while promoting more effective adaptation to the individual’s environment by using specific interventions to improve coping and behavioral abilities. This approach assumes that community adaptation consists of three factors: the characteristics of the individual, the community’s requirements for adequate functioning, and the supportiveness of the environment. Each



of these three areas is a focus of assessment and treatment. Rehabilitation composed of comprehensive services combined with assessment and interventions that are individually tailored to clients' needs has consistently resulted in a significant improvement in functioning. Psychiatric rehabilitation provides a promising approach to helping people in institutional settings achieve the abilities necessary to live in the community.

### Evidence-Based Practice

Recently, the concept of evidence-based practice (EBP) has become a major focus of attention in health care, within and outside of mental health care. Treatment of schizophrenia is no exception. However, definitions of what constitutes "evidence-based practice" range from specific treatments tested in randomized controlled trials to broader combinations of empirical evidence, clinician experience, and systematic consideration of client values and desires. EBP principles can be straightforwardly applied to the specific modalities of psychiatric rehabilitation (e.g., pharmacotherapy, social skills training, and supported employment). It is less clear how evidence-based practice can be applied to the holistic, individualized approach of psychiatric rehabilitation. There is a pervasive tendency for mental health policy to adopt a "one size fits all" presumption about service needs despite the fact that people with SMI comprise a heterogeneous group with vastly diverse individual needs. Similarly, as recovery progresses, it is expected that different types of services will be optimal at different times throughout a person's life. The near future will probably see extensive adaptation of evidence-based practice principles to the complexities of SMI and psychiatric rehabilitation.

### Contemporary Policy Issues

Treatment and other services for SMI have undergone major structural changes over the past half century. Deinstitutionalization in the 1960s resulted in a change from an institution-based to a community-based mental health system. Unfortunately, many gaps and inconsistencies occurred in the community mental health system. Only the people who had a sufficient level of functioning and skill were able to remain in the community. Due to the unforeseen

service gaps created by this shift, many people became "lost" within the community service system. People not engaged through traditional outpatient services were soon engaged by the criminal justice system, returned to the hospital, or became "revolving door" consumers of emergency services.

Movement toward a community system continues, and has brought into question the need for long-term inpatient services. Numerous states have closed or are in the process of closing state hospitals and developing community-based services. Unfortunately, some of these closures have been premature due to a lack of planning and supports needed to support the transition. Consequently, increases in homelessness, a disproportionate presence of people with SMI in the correctional system, and personal tragedies have occurred due to ill-considered risk factors. No state has completely eliminated its need for longer-term institutional services, although the number of people served in such settings has been dramatically reduced. The mission of the remaining services is changing, from providing permanent domicile to returning people to the community.

### Recovery

The *recovery movement* is a social movement energized primarily by people with SMI, often known as "consumers" or "survivors" of mental health services. The movement has historical origins in the early 20th century, but has become most influential in national mental health policy over the past decade. Since the 1970s the recovery movement has been associated with psychiatric rehabilitation, to the degree that psychiatric rehabilitation has been characterized as "the technology of recovery." No comprehensive definition of *recovery* exists, but all definitions advocate as a goal that the client will gain autonomy and independence. This contrasts with the traditional "medical model" goals of controlling symptoms and preventing relapse or hospitalization. The recovery concept provides a sense of hopefulness to people with SMI, with the idea that their diagnosis is not a terminal condition but rather one of possibility. It holds that people are more than their diagnosis, and counters the stigmatization that they are somehow the cause of their disabilities. The concept emphasizes that people with SMI must have a voice in their treatment and rehabilitation, and a sense of responsibility, instead of being passive recipients of services. The recovery movement gained a



national forum in the United States in the 1999 Surgeon General's Report on Mental Health, and more recently in the report of the 2003 President's New Freedom Commission on Mental Health.

The report of the president's commission calls for a national effort to strengthen the evidence base for rehabilitation and recovery methods, and to accelerate their dissemination. However, all aspects of research and treatment development have been vigorously criticized as lacking sufficient client participation. As with psychiatric rehabilitation research in general, the research that supports recovery would benefit from more systematic inclusion of clients' perceptions of and experiences in actual treatment and other services.

Robert W. Johnson, Nancy H. Liu,  
Ashley Wynne, and William D. Spaulding

**See also** Clinical Presenting Issues (v2); Dementia (v2); *Diagnostic and Statistical Manual of Mental Disorders (DSM)* (v2); Evidence-Based Treatments (v2); Functional Behavioral Assessment (v1); Personality Assessment (v2); Personality Disorders (v2); Psychopathology, Assessment of (v2)

### Further Readings

- American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed., Text rev.). Washington, DC: Author.
- President's New Freedom Commission on Mental Health. (2004). *Report to the president*. Retrieved from <http://www.mentalhealthcommission.gov/reports/reports.htm>
- Silverstein, S. M., Spaulding, W. D., & Meditto, A. A. (2006). *Schizophrenia*. Cambridge, MA: Hogrefe & Huber.
- Spaulding, W., Sullivan, M., & Poland, J. (2003). *Treatment and rehabilitation for severe mental illness*. New York: Guilford Press.
- Spaulding, W. D. (Ed.). (1999). *New directions for mental health services: Vol. 84. The state hospital in the 21st century* (pp. 35–46). San Francisco: Jossey-Bass.
- Substance Abuse and Mental Health Services Administration (SAMHSA). (2004). *Evidence-based practices: Shaping mental health services toward recovery*. Retrieved from <http://mentalhealth.samhsa.gov/cmhs/communitysupport/toolkits>
- U.S. Public Health Service. (1999). *Mental health: A report of the surgeon general*. Retrieved from <http://www.surgeongeneral.gov/library/mentalhealth>

## SECONDARY TRAUMA

Secondary trauma is the emotional spread of the effect of trauma symptoms as a result of close and extended contact with traumatized individuals. Generally, the traumatized person has close and extended contact with others, such as family members, friends, or mental health professionals. These individuals are at risk of experiencing psychological distress through direct exposure to the traumatized person. Symptoms of secondary trauma are similar to those of posttraumatic stress disorder (PTSD), but are less severe. Symptoms of secondary trauma include having unwanted thoughts or images about the trauma incident, persistent avoidance of places or activities related to the traumatic incident, detachment from others, and increased arousal indicated by sleep disturbances, irritability, concentration difficulties, or being overly vigilant.

The term *secondary trauma* has been used to encompass both vicarious trauma and compassion fatigue. *Vicarious trauma*, like secondary trauma, refers to the experiencing of trauma symptoms caused by close association with a traumatized person. *Compassion fatigue*, on the other hand, refers to the acquisition and development of symptoms by mental health professionals who are engaged in a therapeutic relationship with traumatized individuals.

### Vicarious Trauma

Secondary trauma symptoms have been found in individuals who live with a traumatized family member, were raised by parents who were traumatized, or grew up with parents who were traumatized war veterans. Children of Holocaust survivors have been shown to acquire secondary trauma symptoms via intergenerational transmission; that is, the emotional and behavioral symptoms exhibited by family member(s) of one generation have been found to pass on to those of the next generation. Individuals in relationships with traumatized persons are also likely to acquire trauma reactions. It was found that when one partner reported a history of childhood physical or sexual abuse, the other partner reported significant symptoms of psychological distress. Research thus suggests that being in a family with someone who has been traumatized puts one at risk of developing vicarious trauma.

There are two hypotheses as to how exposure to a traumatized family member leads a person to acquire



and experience vicarious trauma. The first suggests that the emotional bond between family members is the avenue through which the traumatized person's symptoms are transmitted to others in the family. Underlying a caring relationship is sympathy and empathy. Empathy is similar to sympathy, but goes beyond sympathy in that empathy involves vicariously experiencing the thoughts, feelings, and experience of another. It is not surprising that individuals are vulnerable to acquiring and experiencing vicarious trauma from a family member, since being in the same family implies close and regular contact. In addition, family systems are usually one of the primary social support networks that individuals turn to for support and caring in times of difficulties and distress. Family members are likely to want to know what happened during the traumatic incident, how the traumatized person has been negatively affected, and what behavioral and emotional symptoms have developed. By virtue of being emotionally connected, a family member may feel the pain of the traumatized person to the extent of experiencing similar trauma symptoms.

Another hypothesis is that being exposed to a traumatized person can cause a family member to formulate beliefs about him- or herself, others, or the world in general that predisposes the family member to acquire and experience secondary trauma symptoms. For example, in incidents in which individuals are brought up by parents who have been traumatized by war or other atrocities, they may view the world as an unjust and unsafe place in which catastrophic and uncontrollable events can suddenly occur. These are similar beliefs often held by traumatized individuals that perpetuate trauma-related symptomology.

### Compassion Fatigue

Working with individuals in a therapeutic relationship can be fulfilling and rewarding, as the therapist facilitates healing and recovery in clients who suffer from the psychological aftermath of having experienced a traumatic incident. However, being in such a helping role sometimes causes emotional pain due to direct exposure to the client's traumatic material. Compassion fatigue is therefore an occupational hazard of being in the role of providing therapeutic help. Research has found that many sexual assault trauma counselors develop intrusive and unwanted images similar to those of their clients. Other research has indicated that female psychotherapists who work with large numbers of

sexual abuse cases, or have seen a high number of sexual abuse survivors over the course of their careers, are more likely to develop and experience trauma symptoms than those who see fewer sexual abuse cases.

As to how or why psychotherapists who work with traumatized clients are vulnerable to develop symptoms of compassion fatigue, the first explanation, which involves empathy, is similar to the one mentioned for vicarious traumatization. Empathy is a major resource for psychotherapists in helping the traumatized, given its centrality in comprehending the experience and perspectives of clients. Empathy is indispensable in establishing rapport in a therapeutic relationship, assessing presenting problems, and formulating a treatment approach. While empathizing with a traumatized client helps the therapist to understand the client's experience of being traumatized, the process may traumatize the therapist. Another reason why working with traumatized individuals can cause impairment in therapists is that exposure to clients' trauma may provoke or reactivate unresolved issues from therapists' own trauma histories.

### Compassion Fatigue Versus Burnout

Compassion fatigue is not to be confused with burnout. While these are both occupational hazards of being a psychotherapist, they are different from each other. Burnout is a process that begins gradually and gets worse over time. The literature on burnout supports the notion that the process is set in motion by gradual exposure to job strain, loss of idealism, a lack of sense of accomplishment, and accumulation of intensive contact with clients, particularly those whose problems are perceived as chronic, acute, complex, and require skills beyond what the therapist possesses. The causes and mechanisms leading to symptoms of compassion fatigue, as mentioned above, are quite different from those leading to burnout. Secondary trauma symptoms (STS) precipitated by compassion fatigue can emerge suddenly without warning. STS can happen to a psychotherapist at any point of his or her career. Additionally, STS also has a faster recovery rate than burnout.

### Assessing Secondary Trauma

Despite the importance of studying secondary trauma, given its major impact on family members, close friends, and psychotherapists, there are few psychometrically



sound instruments to assess this type of traumatization. Most of the existing instruments are designed for specific populations, such as mental health workers or children of Vietnam veterans who were diagnosed with PTSD. Another problem is that existing measures often lack reliable cutoff scores to facilitate clinical decision making. In some cases, both limitations are present. The Secondary Trauma Scale (STS) was developed to address these limitations. When the 18-item secondary trauma scale was administered to a university-age sample (along with other instruments to measure anxiety, depression, and symptoms of intrusiveness, avoidance, and dissociation), initial results indicated that higher scores on the scale were associated with emotional distress and intrusive and avoidance symptoms.

In summary, because most individuals turn to their existing social support networks in times of crises or distress, clinical attention should also be extended to those who provide care and support to those traumatized directly, such as family members. Given that compassion fatigue is a natural by-product of working with and caring for traumatized individuals, it should be recognized as the cost of caring for mental health professionals and addressed openly in training programs to prepare them to cope with these issues in the future. Secondary exposure to trauma may cause helpers to inflict additional pain on their clients, lose objectivity, or suffer negative impact on their own well-being. Treating and preventing such occupational hazards is important for sustaining helpers' longevity and effectiveness. Given the impact of secondary trauma, more research attention should be directed at validating psychometric instruments to measure the severity of secondary trauma in order to facilitate appropriate intervention and treatment.

Macy M. Lai

*See also* Caregiver Burden (v1); Caregiving (v1); Cognitive-Behavioral Therapy and Techniques (v2); Disasters, Impact on Children (v1); Posttraumatic Stress Disorder (v2); Transference and Countertransference (v2)

## Further Readings

- Brady, J. L., Guy, J. D. Poelstra, P. L., & Brokaw, B. F. (1999). Vicarious traumatization, spirituality, and treatment of sexual abuse survivors: A national survey of women psychotherapists. *Professional Psychology: Research and Practice*, 30, 368–393.
- Catherall, D. R. (1992). *Back from the brink: A family guide to overcoming traumatic stress*. New York: Bantam Books.
- Figley, C. R. (1995). Compassion fatigue: Toward a new understanding of the costs of caring. In H. Stamm (Ed.), *Secondary traumatic stress: Self-care issues for clinicians, researchers, and educators*. Lutherville, MD: Sidran Press.
- Ghahamanlou, M. A., & Brodbeck, C. (2000). Predictors of secondary trauma in sexual assault trauma counselors. *International Journal of Emergency Mental Health*, 1, 229–240.
- Motta, R. W., Chirichella, D. M., Maus, M. K., & Lombardo, M. T. (2004). Assessing secondary trauma. *Behavior Therapist*, 27, 54–57.
- Motta, R. W., Kefer, J. M., Hertz, M. D. & Hafeez, S. (1999). Initial evaluation of the Secondary Trauma Questionnaire. *Psychological Reports*, 85, 997–1002.
- Nelson, B. S., & Wampler, K. S. (2000). Systemic effects of trauma in clinic couples: An exploratory study of secondary trauma resulting from childhood abuse. *Journal of Marital and Family Therapy*, 26, 171–184.

---

## SELF-DISCLOSURE

---

Self-disclosure refers to the verbal disclosure of personally sensitive information by client or counselor, and may involve disclosure about actions, thoughts, or feelings.

The necessity of client self-disclosure in counseling has a long tradition, beginning with Sigmund Freud, who asserted that clients should disclose everything that comes to mind. This expectation persists to the current day. Practitioners who follow a range of counseling approaches agree that counseling would not be successful without client self-disclosure, for healing occurs through the discussion of personally sensitive content and the resolution of concerns related to that content. This belief in the healing potential of disclosure is not universally supported, however, for some counselors believe that clients' views of themselves suffer when they reveal shameful material.

Client self-disclosure has been the focus of extensive research, beginning with the work of Sidney Jourard, who investigated what information clients reveal, and to whom. The research evidence demonstrates that most clients reveal intensely personal material, and their disclosures focus on aspects of themselves or their parents that they dislike.



Nevertheless, half of all clients keep secrets from their counselor, often about sexual concerns, relationship problems, or a sense of failure. Both sexes disclose equally and in similar areas, and the longer clients are in counseling and the stronger they experience the counseling relationship, the more they disclose.

Although client self-disclosure is largely seen as necessary for successful counseling, counselor self-disclosure is viewed as a controversial, but potentially powerful, intervention. Some of this controversy reflects the different theoretical approaches to counseling.

Counselors following a psychodynamic approach limit their use of self-disclosure, believing that a neutral, abstinent, and anonymous counselor is necessary for resolving client transference. Humanistically and existentially oriented counselors evince stronger support for self-disclosure, viewing it as a way for counselors to demonstrate their genuineness and positive regard, show the counselor as human, and reassure clients that their concerns are normal. Counselors who follow behavioral, cognitive, or cognitive-behavioral approaches view self-disclosure positively when it is intended to model client self-disclosure. Feminist counselors assert that disclosures are helpful because they equalize power in the counseling relationship and allow clients to make informed decisions about whether to work with a counselor. Finally, those who follow a multicultural approach support self-disclosure as a means of earning clients' trust, especially when working with clients from different sociocultural backgrounds.

Research regarding counselor self-disclosure has examined the frequency of and reasons for self-disclosures, and their immediate and longer-term effects. Regardless of theoretical orientation, counselors disclose infrequently and their disclosures focus mostly on professional background. Their goals are to give information to clients, reassure clients that their experiences are normal, model appropriate self-disclosure, and strengthen the counseling relationship. Counselors avoid disclosure when doing so would meet their own needs or shift the focus from clients. Nonclients (e.g., undergraduates) view counselor self-disclosure positively and like counselors who self-disclose neither too much nor too little. Clients perceive counselor self-disclosure as helpful with regard to immediate outcome, but the longer-term effects are unclear.

Sarah Knox

**See also** Clinical Presenting Issues (v2); Cognitive-Behavioral Therapy and Techniques (v2); Communication

(v3); Facilitative Conditions (v2); Humanistic Approaches (v2); Psychoanalysis and Psychodynamic Approaches to Therapy (v2); Transference and Countertransference (v2); Working Alliance (v2)

### Further Readings

- Farber, B. A. (2003). Patient self-disclosure: A review of the research. *Journal of Clinical Psychology/In Session*, 59, 589–600.
- Hill, C. E., & Knox, S. (2002). Self-disclosure. In J. C. Norcross (Ed.), *Psychotherapy relationships that work: Therapist contributions and responsiveness to patients* (pp. 255–265). Oxford, UK: Oxford University Press.
- Jourard, S. M. (1971). *Self-disclosure: An experimental analysis of the transparent self*. New York: Wiley.

---

## SELF-EFFICACY/ PERCEIVED COMPETENCE

---

First developed in 1977, self-efficacy is an important component of Albert Bandura's social cognitive theory. Self-efficacy refers to people's judgments of their ability to perform necessary behaviors to produce desired outcomes in specific situations. These judgments are highly context specific and tend to influence which activities people will attempt, how much effort they will put into the activities, how long they will persist at them, and their emotional responses while involved in the activities. For example, adolescents who feel more efficacious about their writing abilities than their math skills will be more likely to (a) take writing classes and avoid math classes, (b) exert more effort in their writing classes than math classes, (c) experience more anxiety in math than writing classes, and (d) persist longer in writing than math classes when they encounter difficulties.

### Dimensions of Self-Efficacy

Self-efficacy beliefs vary on three dimensions: magnitude, strength, and generality, although the strength dimension is employed most widely in self-efficacy measures. Nonetheless, all three dimensions have potentially important implications for performance. The magnitude dimension encompasses the number of steps, or level of task difficulty, people consider themselves capable of performing. Some people limit



themselves to attempting only simple tasks while others attempt the most difficult and complex tasks. For example, a person trying to lose weight may feel efficacious to abstain from eating sweets when there are no sweets present. However, that person may feel less efficacious to pass up the dessert cart at a restaurant.

Efficacy beliefs also vary in strength. People with weak efficacy beliefs are easily discouraged by obstacles and setbacks, while people with strong efficacy beliefs persevere despite disconfirming experiences. For example, two people wanting to abstain from sweets may feel they can pass up the dessert cart at a restaurant, but one may hold this belief with more certainty.

Finally, efficacy beliefs vary in generality. Self-efficacy beliefs in one behavioral or situational domain may generalize to other behaviors or situations depending on the extent to which those behaviors and situations require similar skills. For example, the person able to pass up the dessert cart may also feel efficacious in passing by a bakery without walking in.

### Sources of Self-Efficacy

A strong sense of efficacy can be developed in four ways: mastery experiences, vicarious learning experiences, social persuasion, and physical and emotional states.

#### **Mastery Experiences**

Mastery experiences are personal experiences that give people a sense of accomplishment and a feeling of mastery. By managing challenges through successive achievable steps, people develop a sense of mastery. Mastery experiences are the most effective way to develop a strong sense of efficacy because they offer the most authentic evidence that one can do what it takes to succeed. Success experiences help build self-efficacy, while failures undermine it. For example, using the weight loss example, a person who has lost weight in the past is more likely to have higher self-efficacy in this area than someone who has not been able to lose weight previously. Success experiences need to be at least somewhat challenging in order to develop a strong sense of efficacy. Easy successes can lead to expectations of quick results, which may lead people to become easily discouraged when faced with obstacles or setbacks. Overcoming obstacles through perseverance teaches people that success often requires sustained effort, which, in turn, creates

resilient self-efficacy beliefs. Once people develop a strong sense of efficacy, they persevere when facing difficult tasks, work harder to overcome obstacles, and rebound quickly from setbacks. The negative impact of occasional failures is diminished.

The effects of failure on efficacy beliefs depend in part on when they occur. If failures occur before a resilient sense of efficacy is established, they will undermine self-efficacy. The person will be less likely to do what it takes to overcome obstacles and rebound from setbacks. However, if a resilient sense of efficacy has already been established, the person will work hard to overcome obstacles and rebound easily from setbacks, thus increasing self-efficacy even more.

#### **Vicarious Experiences**

Mastery experiences are not the sole source for developing a strong sense of efficacy. Vicarious experiences through social modeling are another way to develop self-efficacy. If people see others similar to themselves succeed through persistent effort, they may come to believe they, too, can succeed in similar activities. The impact vicarious experiences have on self-efficacy depends on how similar to the model people perceive themselves to be. The greater the perceived similarity, the more impact the model's successes and failures will have on a person's self-efficacy beliefs. People seek models proficient in the skills and abilities they wish to acquire. Competent social models may help increase efficacy by teaching skills and strategies for managing the demands of the environment. For example, let's say that the person who wants to lose weight has a friend who has lost weight. If that friend has a similar build, eating habits, or lifestyle, the person may feel more efficacious in his or her own ability to lose weight.

Social models also provide a gauge by which people judge themselves. Many times adequacy in specific areas is gauged in relation to the performance of similar others. This is called *social comparison* and is a primary factor in the self-appraisal of abilities. For example, an art student who compares himself to other art students rather than to Picasso or his 3-year-old nephew will more likely develop an accurate sense of efficacy on artistic tasks. Comparing one's artistic talents to Picasso will undermine efficacy beliefs, while using one's 3-year-old nephew as a model will lead to unrealistically high self-efficacy beliefs. Such social comparison information can have far-ranging consequences on the types of activities people choose to



pursue and on their feelings of efficacy regarding those pursuits.

### ***Social Persuasion***

The third source for developing a strong sense of efficacy is social persuasion. People can lead others, through suggestion, into believing they have the ability to do what is necessary to accomplish a certain outcome. While social persuasion is not as effective as mastery or vicarious experiences, often people can be verbally persuaded that they possess the ability to master certain activities. People who are persuaded in this manner are more likely to sustain effort and try harder when faced with obstacles. People who want to effectively persuade others should arrange situations and events in ways that promote success and avoid placing people prematurely in situations where they might fail. The strength of social persuasion depends on factors such as the perceived expertness, trustworthiness, and attractiveness of the persuasive source.

### ***Physical and Emotional States***

The final source for developing a strong sense of efficacy is to reduce stress and depression while increasing physical stamina. People use their physical and emotional states to judge their capabilities. An elevated mood can enhance self-efficacy, while a negative mood may diminish it. People tend to associate stress, tension, and other unpleasant physiological signs with poor performance and perceived incompetence. In activities requiring strength and stamina, feelings of fatigue and pain cause self-efficacy beliefs to decrease. How an emotion is perceived and interpreted is more important than the level of intensity. People with a strong sense of efficacy are more likely to view their state of emotional arousal as energizing, while people with a weak sense of efficacy will view their state of emotional arousal as debilitating.

## **Mediating Processes**

Self-efficacy beliefs regulate human functioning through four major types of processes: cognitive, motivational, affective, and selective.

### ***Cognitive Processes***

A key purpose of thought is to enable people to visualize possible outcomes of different courses of

action. It allows people to exercise control over activities that are important to them. Most courses of action are first preceded by thoughts. These thoughts become guides for action when developing skills. Self-efficacy beliefs influence thoughts in ways that can either bolster or impair performance. People's self-efficacy beliefs influence how they visualize future events and approach potential situations. Self-efficacy and visualization are bidirectional. High self-efficacy beliefs foster positive visualizations and positive visualizations strengthen self-efficacy beliefs. People with high self-efficacy beliefs in a specific domain display greater cognitive resourcefulness, more flexibility, and an ability to manage their environment in that domain. They set higher goals for themselves and have a stronger commitment to those goals. People with high self-efficacy visualize themselves navigating those situations successfully. These positive visualizations enhance subsequent performance. People with low self-efficacy in a specific domain are more likely to visualize failure scenarios in that domain. They tend to dwell on personal deficiencies and what is likely to go wrong. This undermines motivation.

### ***Motivational Processes***

According to Bandura, there are three different forms of cognitive motivators, each with a corresponding theory. The motivators are causal attributions, outcome expectancies, and cognized goals. The corresponding theories are attribution theory, expectancy-value theory, and goal theory. In attribution theory, causal attributions of performance affect motivation. Attributions are the explanations people give for behaviors or events. Efficacy beliefs influence these causal attributions. People with low self-efficacy attribute their failures or setbacks to low ability, while people with high self-efficacy attribute failures or setbacks to too little effort or ineffective strategies. People with high self-efficacy believe that success is a matter of more effort or better strategies.

In expectancy-value theory, people are motivated by the outcomes they expect to achieve through specific courses of action. The strength of the motivation is based on two factors: the expectation that a specific action will produce a specific outcome and the attractiveness of that outcome. The more people expect that their behavior will secure a specific outcome and the more highly valued the outcome, the greater their motivation will be to perform the activity.



Goal theory suggests that explicit, challenging goals based on personal standards enhance motivation. Motivation based on these personal standards involves comparisons between people's adopted personal standards and their perceived performance. In order to evaluate how they are doing, people set personal standards and judge how well they are performing against those standards. Self-efficacy beliefs play a key role in this form of motivation. Often, people choose goals based on their self-efficacy beliefs. How efficacious people feel will influence what challenges they choose to undertake, how much effort they will expend, and how long they will persevere in the pursuit of their goals.

### ***Affective Processes***

Self-efficacy is an important component to the self-regulation of emotional states. Efficacy beliefs affect the nature and intensity of emotional experience through a person's ability to control thought, action, and affect. Efficacy beliefs influence where people place their attention and whether situations will be construed as benign or distressing. People's belief in their ability to cope affects how much stress, anxiety, or depression they will feel. People with high coping efficacy behave in ways that make difficult situations more manageable. According to Bandura, often the distress people feel results from failures to control upsetting thoughts. People with strong coping efficacy are more able to control such thoughts.

### ***Selection Processes***

By selecting their environments, people have a choice in what they become. Choices are influenced by self-efficacy beliefs. Self-efficacy beliefs influence the types of activities and environments people choose to become involved in, as well as the environments they actually produce. People shape their lives by choosing environments that encourage certain capabilities and lifestyles and avoid activities and environments they believe to exceed their capabilities.

## **Self-Efficacy and Mental Health**

Three major types of self-efficacy have been identified: task-specific self-efficacy, self-regulatory efficacy, and coping efficacy. Task-specific self-efficacy refers to people's beliefs in their ability to perform the specific tasks required to succeed within a given domain.

Self-regulatory efficacy is defined as people's perceived ability to guide and motivate themselves to perform self-enhancing behaviors. Coping efficacy refers to people's beliefs in their ability to deal with particular obstacles. Research shows that coping efficacy is significantly related to mental health.

### ***Coping Efficacy, Stress, and Anxiety***

Individuals encounter stressors on a daily basis. These daily stressors have been found to be important indicators of psychological distress. People's beliefs in their ability to regulate their functioning, exercise control over their environment, and manage the stressors in their lives affect their psychological well-being. Strong coping efficacy has been shown to reduce stress reactions. People are less likely to feel stress when they believe they can handle the task or situation. Researchers have found that when people have low coping efficacy, their distress significantly increases when faced with stressors. However, if people's perceived coping efficacy is strengthened, they will display less stress and physiological arousal when faced with the same stressors. Perceived self-efficacy is also related to people's approach to coping with stressful situations. People with high coping efficacy are motivated to change the harsh environment and stressful situation. Through increasing or maintaining their coping efforts, they alter stressful situations into more benign ones, thus alleviating their stress.

Anxiety is a psychological problem that is often a result of stress. Anxiety is aroused when people feel they are unable to cope, either cognitively or behaviorally, with potential threats. Bandura argued that low coping efficacy beliefs regarding difficult circumstances cause anxiety and avoidant behaviors. People who believe they can control their environment and cope with the potential threats are less likely to feel anxious. People with low coping efficacy tend to view potentially threatening events as unmanageable, perceive situations as fraught with dangers, and exaggerate the severity of potential threats. They become distressed and experience high levels of anxiety. People tend to avoid situations that cause them anxiety or potential anxiety.

### ***Self-Efficacy, Coping Efficacy, and Depression***

Perceived self-efficacy plays an important role in depression. Three types of self-efficacy beliefs



influence depression. First, people may feel unable to perform at a level that would bring them personal satisfaction. Second, people may feel incapable of developing meaningful relationships with others. Third, people may feel unable to control depressive thoughts. According to Bandura, there is a relationship among self-efficacy expectations, outcome expectations, outcome value, and depression. If people believe that a highly valued outcome is obtainable through specific behaviors, but believe they are not capable of performing those behaviors, depression and self-devaluation may occur.

Bandura and his colleagues have found that perceived academic self-efficacy and social self-efficacy, which address two important aspects of adolescents' lives, affect adolescents' depression both directly and indirectly. Perceived academic and social self-efficacy affect depression directly via their influences on adolescents' mood and emotional states. Perceived academic self-efficacy has an indirect effect on depression via its impact on adolescents' engagement in behaviors that lead to academic achievement. A strong sense of academic efficacy also affects depression by decreasing adolescents' academic stressors and promoting motivation and confidence in their abilities. High social self-efficacy reduces adolescents' vulnerability to depression by promoting supportive relationships with peers. Furthermore, perceived academic self-efficacy and social efficacy can be buffers to prevent adolescents from risky activities, such as delinquency and substance abuse, by reducing their risk of depression, promoting academic achievement, and developing peer support. It is also important to note that the relationship between self-efficacy and depression is not limited to adolescents or young adults. Among senior citizens, self-efficacy has been found to significantly predict depression, beyond what could be predicted by demographics, income, or health.

### ***Coping Efficacy and Life Transitions***

Perceived coping efficacy serves as a regulatory function in the transitions of life. It is especially important during the transition process from adolescence to adulthood, which can be full of stress, challenge, and risk. Adolescents with high coping efficacy tend to cope with the transition well. They pursue activities that build competencies and resist peer pressure to engage in risky behaviors.

Coping efficacy can also promote mental health later in life. Seniors with high coping efficacy beliefs are more likely to adapt readily to the challenges of aging. They engage themselves and their environment to facilitate the transition process by improving and maintaining physical health, improving social skills, and enhancing cognitive functioning.

### ***Coping Efficacy and Trauma***

Each year millions of people experience traumatic life events such as natural disasters, sexual or physical assaults, or the death of a loved one. Even long after the trauma, people may show signs of stress by experiencing recurrent nightmares, flashbacks of the event, and sleep disturbances. Research has shown that people's beliefs in their ability to exercise some control over their personal functioning and environment after the event have an impact on their posttraumatic recovery. Traumatic events alone are not enough to cause stress or disorder. People's appraisal of the event substantially contributes to the emotional well-being following it. People with high self-efficacy in their ability to control their environment and recover from traumatic events tend to experience less distress and make efforts to effect changes in their lives.

### ***Implications***

It has been shown that high coping efficacy can reduce people's vulnerability to stress and depression, enhance their resiliency to adversity, and improve their mental health. Thus, increasing coping efficacy can be a focus of intervention for counselors. The first task for counselors is to assess their clients' perceived coping efficacy through questions about the clients' beliefs in their competence in behaviors related to coping with stressful events. When counselors find that clients unrealistically underestimate their capabilities, counselors may focus on the causes of these perceptions by exploring clients' culture, family background, and previous experiences. Thus, in the assessment stage, counselors try to help clients identify areas of vulnerability and explore areas of behavior where they feel an inability to cope with stress.

In addition to informal assessments or discussions with clients, counselors can use developed instruments to assess clients' self-efficacy. Since self-efficacy is not a global trait, but an individual's belief related to distinct behavioral domains, there is no single measure



of self-efficacy that can be used across different contexts. Self-efficacy measures have been developed for various domains. Self-efficacy instruments in the career domain have been developed to assess clients' efficacy about their decision-making abilities (e.g., career decision making self-efficacy) and activities involved in specific career fields (e.g., mathematics self-efficacy) as well as career fields themselves (e.g., engineering self-efficacy). In addition, self-efficacy scales have been developed to assess social efficacy, coping efficacy, and a variety of other domain-specific tasks (e.g., computer, weight loss, and smoking cessation self-efficacy beliefs).

Once the counselor and client decide on a domain of behavior in which to strengthen self-efficacy, it can be beneficial to the client's psychological adjustment and well-being to move to an intervention stage. In this stage, counselors help clients build higher levels of self-efficacy. It is helpful to use the four sources of self-efficacy—mastery experiences, vicarious experiences, social persuasion, and physical and emotional states—as a framework for this stage.

Counselors can help clients recall and process previous successful experiences as a way of motivating clients to face future challenges. In addition to helping clients explore their previous successful experiences, counselors can also focus on facilitating future achievement. Counselors can help clients make plans and strategies to achieve their goals. They can help clients break down difficult tasks, behaviors, or goals into smaller, more easily manageable steps. They can provide relevant resources, if necessary, to help clients gain success experiences.

Counselors can help clients increase their self-efficacy by the use of vicarious experience. Counselors can help clients find social models in their environment by helping them identify people who have succeeded in the behavioral domains where the client lacks self-efficacy. The more similar to the model the client feels in terms of gender, ethnic group, and background, the more influence the model will likely have on the client. Models can be family members, friends, or even people from the media.

The third source of efficacy is social persuasion. Counselors can strengthen clients' self-efficacy by expressing their belief in the clients' capabilities, encouraging them, and reinforcing their efforts. In addition to the encouragement and support that is vital to clients' progress, counselors can also help clients set realistic goals, discuss possible barriers to achieve

the goals, help clients find ways to cope with and overcome these barriers, and attribute success experiences to growing competency rather than to such other factors as good luck and tasks that are too easy. It should be noted that the role of the counselor is not just to convey positive appraisals, but rather to realistically boost clients' self-efficacy, and to help clients improve their coping skills.

Finally, as mentioned earlier, people tend to depend on their physical and emotional states to judge their capabilities. They may interpret their emotional arousal as a sign of poor performance. Therefore, counselors can help clients increase self-efficacy by teaching them techniques to reduce stress and emotional arousal. Some of these techniques include anxiety management, relaxation training, and teaching clients more adaptive self-talk. Counselors can help clients become aware of their negative self-talk, and teach them ways to stop their self-defeating thinking patterns and replace the patterns with task-focused cognition.

Selena Tramayne, Xiaoyan Fan,  
and Steven D. Brown

*See also* Bandura, Albert (v2); Coping (v2); Depression (v2); Locus of Control (v3); Panic Disorders (v2); Personality Theories, Social Cognitive (v2); Resilience (v2); Self-Esteem (v2); Self-Esteem, Assessment of (v2); Social Cognitive Career Theory (v4); Stress Management (v2)

### Further Readings

- Bandura, A. (1977). Self-efficacy: Toward a unifying theory of behavioral change. *Psychological Review*, 84, 191–215.
- Bandura, A. (1988). Self-efficacy conception of anxiety. *Anxiety Research*, 1, 77–98.
- Bandura, A. (1989). Human agency in social cognitive theory. *American Psychologist*, 44, 1175–1184.
- Bandura, A. (1997). *Self-efficacy: The exercise of control*. New York: Freeman.
- Bandura, A. (1998). Personal and collective efficacy in human adaptation and change. In J. G. Adair, D. Belanger, & K. L. Dion (Eds.), *Advances in psychological science* (Vol. 1, pp. 51–71). Hove, UK: Psychology Press/Erlbaum (UK) Taylor & Francis.
- Bandura, A. (1999). Social cognitive theory of personality. In L. A. Pervin & O. P. John (Eds.), *Handbook of personality: Theory and research* (pp. 154–196). New York: Guilford Press.
- Bandura, A., Cioffi, D., Taylor, C. B., & Brouillard, M. E. (1988). Perceived self-efficacy in coping with cognitive



- stressors and opioid activation. *Journal of Personality and Social Psychology*, 55, 479–488.
- Bandura, A., Pastorelli, C., Barbaranelli, C., & Caprara, G. V. (1999). Self-efficacy pathways to childhood depression. *Journal of Personality and Social Psychology*, 76, 258–269.
- Benight, C. C., & Bandura, A. (2004). Social cognitive theory of posttraumatic recovery: The role of perceived self-efficacy. *Behavioral Research and Therapy*, 42, 1129–1148.
- Betz, N. E. (1992). Counseling uses of career self-efficacy theory. *Career Development Quarterly*, 41, 22–27.
- Betz, N. E. (2004). Contributions of self-efficacy theory to career counseling: A personal perspective. *Career Development Quarterly*, 52, 340–353.
- Blazer, D. G. (2002). Self-efficacy and depression in late life: A primary prevention proposal. *Aging and Mental Health*, 6, 315–324.
- Caprara, G. V., Scabini, E., Barbaranelli, C., Pasorelli, C., Regalia, C., & Bandura, A. (1998). Impact of adolescents' perceived self-regulatory efficacy on familial communication and antisocial conduct. *European Psychologist*, 3, 125–132.
- Maddux, J. E. (Ed.). (1995). *Self-efficacy, adaptation, and adjustment: Theory, research and application*. New York: Plenum Press.

---

## SELF-ESTEEM

---

Self-esteem is generally considered to be how individuals evaluate their self-worth and competence. This evaluation can be positive or negative. Having a positive sense of self or good self-esteem is linked to many positive behaviors, such as achievement, initiation, motivation, and good mental health. Not all researchers and clinicians, however, approach the study of the self or self-esteem in the same way, and this lack of consensus has led to the many measures that are available for trying to ascertain the level of self-esteem of individuals.

In the next sections of this entry the various ways of thinking about the self and self-esteem will be reviewed. There will be a brief history of self-esteem and a discussion of how to define *self-esteem* (and related terms). Finally, the issue of how to measure self-esteem and various measures that are currently being used to study self-esteem will be reviewed.

### A Historical Overview

The first glimpses of theoretical differences in explaining the self system can be seen beginning with the

mind-body debates of the Greek philosophers, Socrates, Plato, and Aristotle. These philosophers all theorized about where the “essence of a person” (the self) resided, in the soul or in the mind. Centuries later these early quests to understand the body and soul influenced other philosophers and scientists to examine what constitutes an individual’s “self-identity.” One of the most influential of these philosopher-scientists to discuss the self-concept in depth was William James in his 1890 book *The Principles of Psychology*. James is credited as the first psychologist to develop a theory of self-concept. It is his theoretical structure of self-concept that laid the groundwork for all of the other theories that have since been posited about this construct.

James incorporated his ideas of self into the concepts of “I” and “me.” The “I” is the subjective self and the “me” is the objective self. The “I” is the essence of the self or what constitutes one’s personal identity. It cannot be observed directly and, according to James, can only be discovered through reflection. The “me” is the combination of all things that are objectively known about the self; that is, those things that incorporate one’s material self, family, and friends and one’s social self. Unlike the “I,” the “me” can be observed and empirically examined.

There are three elements of the Jamesian “me”: the material “me,” the spiritual “me,” and the social “me.” According to James’s theory, these elements are ordered in a hierarchical structure with the material self at the bottom, the spiritual self at the top, and a combination of material and social elements in the middle. Self-evaluations then, according to Jamesian theory, are the reflection of how individuals weight the subjective importance of these different characteristics of the “me.” The importance placed on these characteristics becomes the standard that objective information is referenced against and dictates what is considered to be a success or a failure.

This overview of James’s theory regarding self-concept is only a brief summary of a very critical piece of work that has affected self-concept research throughout history, including contemporary times. Indeed, symbolic interactionists Charles Cooley and George Herbert Mead were influenced by the Jamesian concept of the “social self” when developing their theories on the impact of socialization. Cooley’s concept of the “looking-glass self,” for example, posits that individuals can only know themselves through the reactions and social interactions of others. Mead also considered social interactions



important to the development of the self but, like James, acknowledged a core self that is modified by these interactions. Other psychological paradigms as diverse as psychoanalytic and behaviorist theory were affected by James's framework of self-concept. Sigmund Freud and his followers, like James and Mead, believed that individuals were influenced by the way others view them or feel about them. They, however, added the idea that the self-concept exists at birth and is modified by childhood interaction with family members, especially the mother.

In contrast to the psychoanalytic theorists, behaviorists do not believe that individuals have an innate self. Instead, behaviorists such as John Watson and B. F. Skinner believed that individuals are the sum of all of their experiences, which are modified by positive and negative reinforcement from the environment. Individuals, therefore, interact with their environment and, through various forms of reinforcement, learn what is beneficial to their survival and continue those behaviors. By understanding these behaviors and social contingencies, individuals can begin to understand how they are different from others, and derive a sense of self. Therefore, self-development, according to behaviorism, occurs as individuals become active in creating an environment that is positively reinforcing to them.

These theoretical paradigms were not the only ones affected by the Jamesian structure of the self. Over the course of the last 3 decades, the research has moved away from the view that learning is affected by the environment only. Learning is now viewed as an interaction of cognitive processes and reinforcement from the environment. The area of self-concept research has followed the lead of the field. It is clear that the concept of self is part of the cognitive structure of a person. When individuals think of themselves, they have a mental representation of themselves. When they interact with others, they derive information from these encounters and modify how they view themselves and how they view others. In this way, individuals are processing information from their environment and either modifying existing thoughts or ideas or adding new ones. This information processing during important interactions is what is considered social cognition. Most of the theories from the literature today are based on some concept of social cognition.

The problem that social cognition addresses is whether individuals are accessing information about the self when answering questions or responding to statements that seek to gather information about either

self-concept or self-esteem. Thus, when attempting to gain any information from measures where individuals report on their own thoughts and feelings (self-report), the researcher assumes that some aspect of memory is being incorporated in the response. In general it is believed that information about this self is held in long-term memory. Some researchers, however, believe that the only way to answer questions related to self is to have this information assessable in short-term memory. Cognitive researchers make the argument that information on emotions, plans, and evaluations are generally held in short-term memory and, therefore, should be accessible during self-report assessments. They base their research on a general information-processing model that emphasizes the retrieval of information from the short-term memory.

## Definitional Issues

Self-definitions can be classified into uni- and multi-dimensional definitions. Early definitions of *self-concept* emphasized a general or overall self-concept that influenced individuals' reactions or behaviors over all situations. For example, people with a high sense of self-worth will deal more competently with all life events than will those who have a low sense of self-worth.

Since the 1980s, however, there has been a general shift away from these unidimensional definitions toward a more multidimensional view. The multidimensional definitions emphasize that individuals view themselves differently across situations. One may have a good self-concept of his or her reading abilities but not have one involving his or her math abilities. Hence, the behavior would be different depending on whether a person was dealing with a reading or math situation.

The dimensionality distinction is not the only one that has affected research on the self. A more difficult distinction to make when defining the self is whether it is evaluative or descriptive. Some researchers see this distinction as the difference between self-esteem and self-concept. Self-esteem, for example, is viewed as the degree of liking or satisfaction with the self (e.g., "I am a good person"). Self-concept, on the other hand, is more descriptive and can be evaluative (as in "I love math") or nonevaluative (as in "I am a boy"). Unfortunately, the difference between these two constructs is often just semantic. Individuals can describe themselves as both descriptive and evaluative at the



same time (e.g., “I am smart because I like to read”). It is important when defining the self to be explicit about which element of the self is being studied, the descriptive or the evaluative. Too many researchers are not making these distinctions and, therefore, are claiming to study the self-concept or descriptive self when they are actually gathering information on the evaluative self. Some of the confusion in these terms comes from the historical study of the self where philosophers and researchers tried to understand the nature of the self and its evaluative component, self-esteem.

### Methodological Issues

Classically, the way to measure the self and self-esteem is through some type of self-report methodology. Generally, self-report methodologies can be categorized as either reactive or spontaneous. The most often used as well as the more popular of these two methodologies is the reactive self-report. This type of self-report is characterized by a closed-ended response format that uses a Likert-type scale representing differing dimensions. In general, participants in a study are asked to react to questions or dimensions derived by the researcher and then to locate themselves on the scale provided. This type of methodology is usually easy to use, often creates little interaction between the participants and the researcher, and creates data that can easily be manipulated quantitatively. The majority of self-concept measures used in current research are considered reactive.

The spontaneous approach allows the participant rather than the researcher to create the dimensions that are examined. This approach is often labeled “open-ended” because participants are allowed to answer in unconstrained ways. In this approach, participants generally answer a vague question such as “Who are you?” without any constraints as to how long they answer or how much they answer. In some situations boundaries are established for the amount of time or numbers of answers that are given. The spontaneous approach, generally, is more difficult to score and summarize than is the reactive and usually involves a great deal of interaction between the participant and the researcher.

The decision of what type of methodology to use is dependent on what type of process the researcher is attempting to examine, descriptive or evaluative. Some researchers believe that these two processes tap into different aspects of the self. Hence, by using only

evaluative measures, important information about the construct of the self is lost. Thus, it is important to understand which aspect of the self is being studied, and this is an important distinction to keep in mind when deciding on what type of methodology to use when examining self. Other issues that are also important to the measurement decision are discussed below.

Even though self-report is not the only methodology used for gathering information on children and adults, it is often the most used in the literature and consistent with theoretical concepts on how to retrieve information about the self. There are inherent problems, however, in dealing with this type of methodology. Issues such as how accessible this information is in the memory when being asked these questions, the situations or contexts a person is in when answering these questions, and other individual or developmental differences that might influence how one answers questions about the self are important factors to consider.

The accessibility of the self refers to the cognitive processes involved in how information about the self is distributed and processed through the memory and how easily it is retrieved when queries regarding the self are made. Due to the reliance on memory in examining the self, there are inherent biases such as self-deception that occur when trying to access this information.

In general, because obtaining information about the self involves cognitive processes that have to be accessed and organized, researchers who study the self need to be aware of the biases that can occur in self-reports. In general, information that is easily accessible, that involves information about the self that is attended to on a regular basis, and that agrees with standard norms is more likely to be reported than information that does not meet these criteria.

The second area of concern in using self-reports involves the contextual, situational, and cultural factors that influence how individuals respond to questions about the self. If individuals are asked questions about the self when they are at work then they are more likely to discuss themselves in terms that define them in that environment. Information about the self can also be affected by the emotional state (good or bad moods) of an individual, how individuals want to be perceived by the researchers (self-presentation), and the culture of the individuals. The view that context, situation, and cultural factors influence the self is highly consistent with the symbolic interactionist ideas that were posited by Cooley and Mead. When



studying the self, it is important to understand the environmental and cultural norms that may be affecting the responses that individuals give to questions regarding the self. These factors may be contributing to the actual development of self-esteem or may be biasing the responses that are given.

## Self-Esteem Measures

Almost everyone will be given some form of a self-esteem measure at some point in their life. Self-esteem plays a central role in our understanding of human behavior, and it is important that care is taken in choosing the right instrument for measuring this characteristic. The following section examines a representative sample of self-esteem measures that are widely used and readily available.

Perhaps the most famous and widely used unidimensional measure is the Rosenberg Self-Esteem Scale that was developed to study adolescents but is now used across the whole age range. The Rosenberg is a 10-item scale that asks individuals to rate themselves using four categories (*strongly agree* to *strongly disagree*) on a series of questions regarding their sense of self-worth or confidence (e.g., “I feel that I’m a person of worth, at least on an equal plane with others”). This scale has been widely used in all areas of psychology, is easy to administer, and can be adapted to be used with children as well as adults. It is considered a highly reliable and valid measure of self-esteem. The measure is especially useful for getting a global sense of how a person feels about him- or herself and is a good predictor of other measures of mental health such as depression and anxiety. It is not a good predictor of more specific domains like academic ability or body image.

Another widely used unidimensional measure is the Coopersmith Self-Esteem Inventory. This inventory was developed for use with children but now is used with both children and adults. The inventory assesses subjects’ general attitudes toward themselves and in comparison to significant others in their lives. This scale contains around 50 items (even though this has been adapted across time) and individuals rate these items as being *like me* or *not like me*. The Coopersmith has good reliability and validity. Like the Rosenberg, this scale has been used effectively to ascertain a global sense of self-worth but not in predicting more specific domains of self-evaluations.

Overall, unidimensional scales are appropriate and useful for gathering information on the general

mental health of individuals. These scales were developed and based on assumptions that global self-esteem can be predicted across domains and be influential even to specific evaluations of domains such as achievement. However, psychological research has found that this is not the case, and a more multidimensional scale needs to be used when examining specific domains of functioning (e.g., achievement or sports).

As with the unidimensional scales, the multidimensional scales that are mostly widely used originated with work with children and adolescents and were adapted for use with other older and younger populations. These scales assume that individuals evaluate themselves differently across important areas of their lives. For example, they may evaluate themselves negatively on academics but positively on physical activities. The most noted of these scales is the Harter Self-Perception Profiles, which were originally designed for children but have been adapted and validated for adolescents, college students, adults, the elderly, and learning disabled students. In general, this measure assesses domains of cognitive, social, and physical perceived competence as well as general feelings of self-worth. The domains measured and numbers of items vary by the form that is used, but in general the scale contains 28 items. Each item consists of two paired alternative statements regarding the domains that are being measured (e.g., “I am good at reading” or “I am not good at reading”). Individuals are instructed to pick one of these items and rate it using response categories range from *really true for me* or *sort of true for me*. These measures have good reliability and have been validated across multiple studies.

The Self-Description Questionnaires created by Herbert Marsh and colleagues is similar to the Harter scales in that multiple dimensions are examined and the scales have been found to be reliable and valid for use with individuals ranging from childhood into adulthood. The dimensions vary across the age range, but in general scores can be obtained on individuals’ self-evaluation of academic ability, physical ability, physical appearance, relations with same and opposite sex peers, relations with parents, religion/spirituality, honesty, emotional stability, and general self-worth. Depending on the age of the respondent, the measure varies from 64 to 134 items regarding ability (e.g., “I am good at running”) that are rated from as *definitely false* to *definitely true*. The scaling varies from 5-point scales for the youngest children to 8-point scales for adolescents and adults.



These scales are just a small example of what is available for examining self-esteem. They were chosen because they have been used across multiple populations, and due to their popularity, there is information on how reliable and valid these measures are for use with various groups in the population. However, a simple search of the literature in self-esteem will uncover many more scales that are available for examining various aspects of self-esteem. Care should be taken in ascertaining that these measures are appropriate for use with various populations and have been shown to measure what they purport to measure. It is important for researchers and clinicians to use measures that are specific to the type of issue they want to understand, whether it be a global sense of self-worth or more specific evaluations of competencies across a wide spectrum of behaviors.

### Future Directions

Over the course of time the theoretical paradigms involving the self have taken their structure from the early works of William James and have built upon each other to form the contemporary theories that today are based on cognitive processing of aspects of the self. However, debate about what constitutes the self continues. Historically, the idea that social interactions play an important role in the development of the self has had strong support, but the exact nature of what constitutes the self remains vague. What is generally agreed upon, however, is that understanding the self involves understanding the separation of the descriptive and evaluative self. This distinction has a direct impact on the methodology that is used to gather information on the self.

The methodological issues are an especially difficult problem for research on the self. Even though the research history on self and the self-concept is vast, there are still many such issues on how to best measure this phenomenon. It is clear that the self develops across time and also changes (perhaps frequently) during that time, and thus measures that can examine this development are important but are difficult to find and confounded by the abilities of each age group. Many of these issues can be resolved by paying strict attention to the research methodology and psychometrics involved in obtaining information from self-report methodologies. Others, however, are more complicated and involve the theory and definitional differences in those who study the self and related constructs.

The problems of measuring a construct like self-esteem are inherent in all studies that try and examine and predict elements of the personality. Some researchers assume that phenomena that occur at the cognitive level will be manifested by behaviors that can be observed and measured. Others feel that behaviors should not be used to measure personality traits because we are unable to determine what cognitive processes might be affecting that trait. They argue that constructs like self-esteem should not be studied because there is no clear way to measure them or even know if you are measuring the right thing. Most people, however, can name many situations where they have observed behaviors of children, friends, and family members and suspected that these behaviors emanate from some activity involving their self-esteem. Therefore, there are observable behaviors that can be directly attributable to how people conceive of themselves.

As the majority of the theories suggest, individuals develop their self and self-concept through social interaction. There may be some innate cognitive process that is modified by social interaction or just social interaction, but either way people display behaviors and express opinions about who they are, from a very young age. For this reason it is important that psychologists be able to study and measure this phenomenon. Future work needs to address the issues of theory, definition, and methodology that have remained unresolved across the centuries. A consensus on these issues will lead to better measurement and a better understanding of how self-esteem influences the mental health and behavior of individuals.

*Pamela E. Davis-Kean*

**See also** Cognitive Therapy (v2); Locus of Control (v3); Personality Theories, Social Cognitive (v2); Psychological Well-Being, Dimensions of (v2); Self-Efficacy/Perceived Competence (v2); Self-Esteem, Assessment of (v2)

### Further Readings

- Baumeister, R. F. (Ed.). (1993). *Self-esteem: The puzzle of low self-regard*. New York: Plenum Press.
- Blascovich, J., & Tomaka, J. (1991). Measures of self-esteem. In J. P. Robinson, P. R. Shaver, & L. S. Wrightsman (Eds.), *Measures of personality and social psychological attitudes* (Vol. 1). San Diego, CA: Academic Press.



- Davis-Kean, P. E., & Sandler, H. M. (2001). A meta-analysis for preschool self-concept measures: A framework for future measures. *Child Development*, 72(3), 887–906.
- Harter, S. (1983). Developmental perspectives on the self-system. In P. H. Musser (Ed.), *Handbook of child psychology* (4th ed., Vol. 4, pp. 275–385). New York: Wiley.
- Hattie, J. (1992). *Self-concept*. Hillsdale, NJ: Lawrence Erlbaum.
- James, W. (1950). *The principles of psychology* (2nd ed., Vols. 1 & 2). New York: Dover. (Original work published 1890)
- Wylie, R. C. (1989). *Measures of self-concept*. Lincoln: University of Nebraska Press.

---

## SELF-ESTEEM, ASSESSMENT OF

---

Self-esteem is one of the most widely studied variables in the social and behavioral sciences. A vast literature spanning many disciplines has shown that high self-esteem promotes behaviors, goals, and coping mechanisms that facilitate success in school, work, and relationships. High self-esteem impedes mental and physical health problems, delinquency, substance abuse, and antisocial behavior. Given its importance, it is not surprising that researchers have developed a diverse array of scales and procedures to assess self-esteem.

This entry discusses the issues involved in assessing self-esteem and provides an overview of the leading self-esteem measures used by psychologists. The entry begins by explaining what psychologists mean by the construct of self-esteem. Next it provides an overview of the most commonly used measures of self-esteem. The entry ends by briefly addressing several broader questions that bear on the interpretation of self-esteem measures and their use in research and applied contexts, including, Is self-esteem a stable trait or a transient state? How large a concern is socially desirable responding? Can self-esteem be assessed in young children? Does self-esteem vary as a function of age, gender, social class, and ethnicity? How does self-esteem differ from other aspects of personality, such as narcissism and neuroticism?

### Conceptualizing Self-Esteem

Self-esteem is generally conceptualized in terms of phenomenological experience. At the turn of the 20th

century, William James defined *self-esteem* as the degree to which people perceive their accomplishments as consistent with their goals and aspirations. In the mid-1980s, Morris Rosenberg extended this definition by adding that self-esteem involves feelings of self-acceptance, self-liking, and self-respect. These definitions have been applied to both global and domain-specific self-esteem. Global self-esteem refers to an individual's overall evaluation of him- or herself. Domain-specific self-evaluations focus on a specific facet of the self, such as physical appearance or academic competence.

The conceptualization of self-esteem as a phenomenological construct is inextricably linked to its measurement. If people subjectively experience themselves as competent, likable, and valued, then they necessarily have high self-esteem, regardless of their actual level of competence and likableness. Given this conceptualization, it is not surprising that self-esteem is most commonly assessed via self-report scales.

### Commonly Used Measures of Self-Esteem

The measurement of self-esteem is a long-standing issue in psychology, dating back to James's seminal writings on the self in 1890. Over the years, researchers have proposed a wide range of self-esteem measures. In addition to numerous self-report scales, there are "experience sampling" measures, pictorial and puppet measures for children, measures based on observer and peer ratings, self-ideal discrepancy measures, measures based on preferences for the letters in one's name, and reaction time measures such as the Implicit Association Test (IAT). The vast majority of researchers rely on face-valid self-report scales (i.e., scales in which what is being assessed is obvious); therefore, this section focuses on several of the most widely used self-report scales. However, measures of implicit self-esteem are increasing in popularity, so this section also reviews the most commonly used implicit measure, the IAT. This section ends by discussing the degree to which different self-esteem scales and measures are correlated with each other (i.e., convergent validity).

### Self-Report Scales

The most commonly used self-report scale is the Rosenberg Self-Esteem Scale, followed by the Coopersmith Self-Esteem Inventory, the Harter



Self-Perception Profile, and the Marsh Self-Description Questionnaire. The Rosenberg scale assesses global self-esteem. The other three measures assess global and domain-specific self-evaluations, but in some research contexts, only the global self-esteem subscales are used.

*Rosenberg Self-Esteem Scale (RSE).* In work with adults, the RSE is by far the most widely used measure of self-esteem, and it has received more psychometric analysis and empirical validation than any other self-esteem measure. The RSE is made up of 10 face-valid items, 5 positively worded and 5 negatively worded. Most researchers use a 4-, 5-, or 7-point Likert scale with the end points labeled *strongly disagree* to *strongly agree*. Several researchers have adapted or shortened the RSE. Most recently, a single-item version (SISE) was developed and validated for use when time is limited. The SISE asks the participant to rate the statement “I have high self-esteem” using a 5-point Likert scale.

*Coopersmith Self-Esteem Inventory (SEI).* The SEI was developed to assess multiple self-concept domains in children. The original SEI assessed four domains (peers, parents, school, and personal interests) and included 50 items that were rated as being unlike me or like me. Coopersmith later created a modified version based on the best 25 items. The SEI is primarily used with children, but an adult scale is also available.

*Self-Perception Profile (SPP).* The SPP was developed to assess multiple domains of self-concept and includes a separate global self-concept subscale. The original SPP was developed for children, but it has been adapted for use with adolescents, college students, and adults. Therefore, the SPP has the advantage of allowing cross-age comparisons.

The SPP presents two statements and asks the participant to choose the one that is most self-descriptive, and then rate it as *a lot like me* or *a little like me*. These responses are coded into a 4-point scale. The scale for young children (with preschool to first grade and boy and girl versions available) is administered individually in pictorial format, eliminating the need for reading skills. However, no global subscale is available for young children because it has been argued that children under 8 cannot communicate feelings of global self-worth. The other scales use the same format as the scale for young children, except pictures are not used. All scales assess multiple dimensions, but some of the dimensions vary to ensure that they are age appropriate.

*Self-Descriptive Questionnaire (SDQ).* The SDQ was developed to assess domain-specific self-evaluations across age groups and includes a separate global subscale. The SDQ is longer than most other self-concept scales and it has separate forms for children (76 5-point Likert items), for adolescents (102 6-point Likert items), and for college students and adults (136 8-point Likert items). If cross-age comparisons are desired, these scales can be adapted to use the same response format. All scales assess multiple dimensions, but some of the dimensions vary to ensure they are age appropriate.

### ***The Implicit Association Test (IAT)***

The self-report scales described above may not tap true, deep-seated feelings about the self because they are face-valid. Therefore, participants might base their answers on what they believe the scale administrator wants to hear or what they believe is most socially desirable. To address this concern, researchers have developed measures of implicit self-esteem (i.e., aspects of self-evaluation that are assumed to be automatic, overlearned, and operative outside of conscious awareness). Such measures are believed to avoid the need for direct self-evaluation that occurs when individuals are asked to complete a self-report measure of self-esteem.

One of the most commonly used measures of implicit self-esteem, the IAT, uses a computerized reaction time procedure to assess the degree to which individuals associate the self with positive versus negative concepts. The IAT self-esteem score is based on the difference between the time it takes an individual to respond to positive items linked with the self versus negative items linked with the self. A person with high implicit self-esteem will link positive items with the self faster than negative items (i.e., they have an implicit representation of the self as positive). Because the task requires the individual to respond extremely quickly, the associations assessed through this procedure are assumed to be automatic and unconscious. If the IAT is administered along with a self-report measure of self-esteem, the IAT should be administered first to avoid carryover effects.

### ***Correlations Between Measures***

Different self-report measures of self-esteem tend to be moderately to strongly correlated with each other ( $r$ s = .40 to .70). Substantially lower correlations



are found between self-esteem measures based on different assessment methods. Correlations between self and observer/informant reports of self-esteem generally range from the .20s to the .40s. Correlations between self-report scales and implicit measures of self-esteem are generally weak to nonexistent; that is, an individual's self-reported level of self-esteem has virtually no relation to measurements of his or her implicit level of self-esteem. Researchers are currently debating whether this lack of convergence reflects problems with the validity of the implicit measures or the fact that explicit and implicit self-esteem are psychologically distinct constructs and therefore should not be empirically related. Findings such as this raise a number of broader issues regarding the use of self-esteem measures in research and real-world contexts. Some of these issues are addressed in the following section.

### **Broader Issues**

#### ***Is Self-Esteem a Stable Trait or a Transient State?***

Researchers who study the correlates and consequences of self-esteem generally assume it is a stable trait that predicts future behavior. The research literature provides ample support for this claim. Although self-esteem levels can be temporarily elevated or depressed in everyday life and through laboratory manipulations, numerous longitudinal studies have documented the stability of self-esteem across years and even decades of life. Test-retest correlations for self-esteem are comparable to those found for more basic dimensions of personality, such as extraversion, conscientiousness, and neuroticism. At the same time, the stability of self-esteem is far from perfect, even after taking into account the attenuating effects of measurement error (i.e., scale unreliability). Thus, self-esteem, like more basic personality traits, continues to change throughout the life span.

#### ***Is Socially Desirable Responding a Concern?***

An important question is whether individuals with high self-esteem truly believe the highly desirable picture they paint of themselves, or if they are intentionally hiding their personality flaws and inflating their

virtues. A related question is whether they are in fact responding honestly (i.e., basing their responses on conscious self-beliefs), but lack insight into their deep-seated, unconscious feelings. These two forms of social desirability—intentional self-presentation (or impression management) and self-deception—have been examined in relation to self-esteem.

Self-esteem is generally not associated with the impression management facet of social desirability, but it is associated with self-deception. Thus, high self-esteem individuals generally do not attempt to manipulate their responses to portray themselves in a positive light to others. However, they may be prone to self-deception because they are unaware of self-doubts about their competence, attractiveness, and likableness. Whether or not this poses a problem in the measurement of self-esteem depends on one's conceptualization of self-esteem. If self-esteem is defined in terms of conscious experience, then the fact that conscious self-evaluations may not reflect unconscious feelings and beliefs does not pose a problem for the assessment of self-esteem. However, if unconscious feelings and beliefs are assumed to be central to self-esteem, then implicit measures might be more valid and useful than explicit measures.

#### ***Is Self-Esteem Distinct From Related Personality Constructs?***

Self-esteem is empirically related to several basic dimensions of personality. High self-esteem individuals tend to score high on the traits Extraversion, Conscientiousness, Agreeableness, and Openness to Experience, and low on Neuroticism. Despite this empirical overlap, self-esteem often predicts important life outcomes over and above these basic personality dimensions.

A more complex issue is the relation between self-esteem and narcissism. Measures of self-esteem and measures of narcissism tend to be moderately correlated. However, theories of narcissism suggest that this overlap is not valid, but rather reflects a tendency for narcissistic individuals to have inflated self-esteem as a way of defending against unconscious feelings of inadequacy. From this perspective, self-esteem measures are contaminated by narcissism, because narcissistic individuals attain higher scores than is warranted by their true level of self-esteem. To correct for this problem, some



researchers have conducted statistical analyses to empirically distinguish individuals whose self-esteem is inflated by narcissism from those who have genuinely high self-esteem. In many prediction contexts, the removal of narcissistic tendencies from measures of self-esteem actually increases the predictive validity of self-esteem and can even reverse the direction of self-esteem effects.

### **Assessing Self-Esteem in Young Children**

Despite some divergence of opinion, most researchers believe that self-report, pictorial, or puppet-based measures of global self-esteem are valid for children as young as age 5 or 6, and virtually all researchers believe that global self-esteem scales are valid for children age 8 and older.

### **Differences in Self-Esteem as a Function of Age, Sex, Social Class, and Ethnicity**

Self-esteem tends to be high in childhood, drops during adolescence (particularly for girls), increases gradually throughout adulthood, and then declines sharply in old age. Despite these changes in average levels, individuals tend to maintain their relative ordering: Individuals who have relatively high (or low) self-esteem at one point in time tend to have relatively high (or low) self-esteem years later. Nevertheless, this rank-order stability is somewhat lower during childhood and old age than during adulthood.

On average, men's self-esteem scores tend to be about one third of a standard deviation higher than women's self-esteem scores. This gender difference emerges during adolescence and holds across most of the life span. Socioeconomic status is very weakly related to self-esteem levels; wealthy individuals have only slightly higher self-esteem than working class individuals. In the United States, African Americans and Caucasians tend to report the highest levels of self-esteem, followed by Latinos/as and then Asian Americans.

A voluminous body of research suggests that self-report measures of self-esteem are useful tools in psychological assessment—they are reliable, valid in a wide range of populations, and predict important real-world outcomes. In short, if the goal is to discover whether individuals consciously experience positive self-regard, it may be possible, as the eminent

psychologist Gordon Allport suggested, to simply ask them.

*Richard W. Robins, Kali H. Trzesniewski,  
and Roberta A. Schriber*

**See also** Locus of Control (v3); Personality Assessment (v2); Psychological Well-Being, Dimensions of (v2); Psychometric Properties (v2); Quantitative Methodologies (v1); Self-Esteem (v2)

### **Further Readings**

- Baumeister, R. F., Campbell, J. D., Krueger, J. I., & Vohs, K. E. (2003). Does high self-esteem cause better performance, interpersonal success, happiness, or healthier lifestyles? *Psychological Science in the Public Interest*, 4, 1–44.
- Blascovich, J., & Tomaka, J. (1991). Measures of self-esteem. In J. P. Robinson, P. R. Shaver, & L. S. Wrightsman (Eds.), *Measures of personality and social psychological attitudes* (pp. 115–160). San Diego, CA: Academic Press.
- Byrne, B. M. (1996). *Measuring self-concept across the lifespan*. Washington, DC: American Psychological Association.
- Harter, S. (1999). *The construction of the self*. New York: Guilford Press.
- James, W. (1890). *The principles of psychology*. Cambridge, MA: Harvard University Press.
- Robins, R. W., Hendin, H. M., & Trzesniewski, K. H. (2001). Measuring global self-esteem: Construct validation of a single-item measure and the Rosenberg Self-Esteem scale. *Personality and Social Psychology Bulletin*, 27, 151–161.
- Trzesniewski, K. H., Donnellan, M. B., Caspi, A., Moffitt, T. E., Robins, R. W., & Poulton, R. (2006). Adolescent low self-esteem is a risk factor for adult poor health, criminal behavior, and limited economic prospects. *Developmental Psychology*, 42, 381–390.

---

## **SELF-HELP GROUPS**

---

Self-help groups consist of individuals who share the same problem or concern. Group members provide emotional support to one another, learn ways to cope, discover strategies for improving their condition, and help others while helping themselves. Self-help groups, also referred to as *support groups* or *mutual help groups*, are cost-free, voluntary groups that have no limit as to how long a person can attend. Self-help



groups rely on the experiential knowledge of members, as everyone has valuable contributions based on their unique experiences. Self-help groups encourage personal responsibility and self-care, with most self-help groups having one or more of the following three basic functions: (1) providing social support for members so that they can overcome life-disrupting problems through mutual support and assistance; (2) providing education about the problem or concern the group addresses, often through presentations from health and mental health professionals and materials obtained at group meetings; (3) providing advocacy for bringing about social and/or personal change to improve conditions for those who face the same issue or problem.

While the most widely recognized self-help group is Alcoholics Anonymous, there are groups available for nearly every concern and problem. Self-help groups are available for addictions; physical illness and health; parenting, family, and youth; disability; grief and bereavement; mental illness and health; emotional, physical, and sexual abuse; widowhood; divorce; and pregnancy, childbirth, and fertility concerns.

Research estimates that more than 25 million Americans have been involved in self-help groups at some point during their lives and as many as 10 million have attended a group in the previous year. As self-help groups have gained popularity, they have increasingly come to be recognized as an emerging social movement. Over the past half century, self-help groups have become a prominent component of healthcare systems across the world. Yet, because of their grassroots nature, the growth of self-help groups has primarily been through word of mouth. The growth of self-help groups can likely be attributed to a number of reasons, including greater recognition of the unique benefits self-help groups, growing acceptance and use of alternative therapies and approaches across the United States, and limited access to health and mental health professional services.

A growing body of research and literature suggests that self-help groups are an effective and efficient complement to traditional health and human services. The benefits of self-help groups are well documented in these studies. The benefits include improved patient/client outcome, greater social and emotional support, and higher levels of personal satisfaction. Additional benefits include a better understanding of the disease or concern leading to better decision making; lower unnecessary dependence on the healthcare system; and improved access to health care.

A number of reasons have been offered suggesting why self-help groups work for those who attend. These reasons include:

- *Instant identity.* Recognizing that there are others who face the same situation or problem
- *Empowerment.* Being able to meet the challenges and concerns using their own strengths and abilities
- *Mutual self-disclosure.* Sharing with one another about their experiences
- *Helper-therapy principle.* Growing stronger through the process of helping others
- *Social role models.* Noticing that others who have experienced the same situation, issue, or problem are in a better position and able to cope
- *Shared ideology.* Creating a new understanding of the situation, issue, or problem based on shared experiences

Self-help groups have increasingly come to be viewed as dynamic and complex social groups. While the 12 steps of Alcoholics Anonymous continue to be the most widely recognized model, self-help groups are growing in their diversity, with differences in their structure, mission, and focus. Many self-help groups meet in churches, hospitals, or individual members' homes, with little external support or prescribed structure. Other groups have developed into nationally recognized nonprofits with sophisticated structures and political power (e.g., National Alliance for the Mentally Ill). Similar to other community-based programs and services, most self-help groups do not simply exist without outside factors contributing to their development. Previous research has found that many self-help groups have some type of formal relationship with either national self-help organizations, local agencies, and/or professionals in their community.

### **Professional Involvement in Self-Help Groups**

Health and human service professionals are increasingly aware of and involved in assisting self-help groups. The extent of professional involvement in self-help groups ranges from groups with no involvement to those that have a professional actively involved in group meetings. Many professionals, particularly counselors, have supported the self-help group movement. The ideas and principals of self-help groups are consistent with those of counseling, including a strength-based approach, recognition of participants'



experiences, and empowering others. At the same time, the dilemma faced by counselors is the extent to which they should be involved in self-help groups, and in particular how they can support people starting self-help groups. Professional therapists, counselors, and health and human service professionals can support self-help groups in a number of ways as described below.

### ***Referrals to Self-Help Groups***

Self-help groups' primary needs are public awareness and new members. Health and human service professionals are "gatekeepers" to many individuals who could benefit from participation in a self-help group.

### ***Forming a Core Group of Leaders***

One of the most important roles a counselor can play is to encourage the development of shared leadership in new self-help groups. When someone expresses interest in starting a group, counselors might suggest finding others who would be interested in helping. Several people contributing to the development of a group creates shared responsibility for the group and clarifies its purpose. One of the tenets of self-help groups is shared leadership, which has also been found to predict successful groups. Perhaps most importantly, the organizational tasks of the group are no longer the responsibility of one individual, thus decreasing the potential of the leader's experiencing frustration and burnout.

### ***Setting Realistic Expectations***

Group founders are motivated to start groups because they want to help others and believe that self-help groups provide the type of help that is needed. Yet, starting a group also involves a number of organizational tasks. Potentially, there is incongruence between founders' expectations for starting a group and the reality. Counselors are in a position to help founders recognize that starting a group involves both help giving and receiving, as well as organizational aspects. In many cases, it takes up to 6 months for a group to form and have regular group meetings. Counselors can help founders to have more realistic expectations as the group develops.

### ***Assisting With Organizational Tasks***

Several discussions prior to group meetings can be useful to clarify hopes, purpose, and format.

Counselors' skills match nicely with helping facilitate these meetings without becoming the group leader. Regular discussions regarding the direction of the group can also be useful, as members have an opportunity to express their opinions about group topics, speakers, and structure.

A second organizational task identified by self-help group founders was finding adequate meeting locations. Counselors often are knowledgeable about accessible, cost-free meeting locations. With a limited amount of effort, counselors can suggest to founders a number of meeting locations, allowing them to decide which would fit their needs.

### ***Connecting With Groups and the Local Community***

Counselors are very knowledgeable about community resources. Self-help groups represent another resource for counselors' clients and patients. By maintaining information about self-help groups, counselors can help new groups by referring clients and patients.

Strong relationships with community organizations and professional gatekeepers can help newly developing groups receive much-needed referrals from other sources. Counselors are particularly well suited for helping group founders make these connections due to their knowledge of local social services, organizations, and professionals.

Self-help groups are a useful complement to the services of health and mental health professionals, providing participants with opportunities to learn, grow, and help others. These groups are effective in improving the outcomes of participants, especially considering that they are free.

*Scott Wituk and Greg Meissen*

**See also** Alcoholics Anonymous (v1); Community-Based Health Promotion (v1); Empowerment (v3); Group Therapy (v2); Help-Seeking Behavior (v3); Individual Therapy (v2); Interpersonal Learning and Interpersonal Feedback (v2); Social Support (v2)

### ***Further Readings***

- Kessler, R. C., Mickelson, K. D., & Zhao, S. (1997). Patterns and correlates of self-help group membership in the United States. *Social Policy*, 27(3), 27–46.
- Kyrouz, E. M., Humphreys, K., & Loomis, C. (2002). A review of research on the effectiveness of self-help mutual aid groups. In B. J. White & E. J. Madara (Eds.),



- American self-help clearinghouse self-help group sourcebook* (7th ed., pp. 71–85). Cedar Knolls, NJ: American Self-Help Group Clearinghouse.
- Powell, T. J. (1990). Differences between national self-help organizations and local self-help groups: Implication for members and professionals. In T. J. Powell (Ed.), *Working with self-help*. Silver Springs, MD: NASW Press.
- Schubert, M. A., & Borkman, T. J. (1991). An organizational typology for self-help groups. *American Journal of Community Psychology*, 19, 769–787.
- Shepherd, M., Shoenberg, M., Slavich, S., Wituk, S., Warren, M., & Meissen, G. (1999). The continuum of professional involvement in self-help groups. *Journal of Community Psychology*, 27, 39–53.
- White, B. J., & Madara, E. J. (1998). *The self-help sourcebook*. Denville, NJ: Northwest Covenant Medical Center.
- Wituk, S., Shepherd, M., Warren, M., & Meissen, G. (2002). Key ingredients contributing to the survival of self-help groups. *American Journal of Community Psychology*, 30, 349–366.

## SELIGMAN, MARTIN E. P. (1942– )

Martin Elias Peter Seligman was born August 12, 1942, in Albany, New York. As an undergraduate, he majored in philosophy at Princeton University, and he took his Ph.D. in psychology at the University of Pennsylvania under the supervision of Richard Solomon. Except for sabbatical leaves and a brief stint teaching at Cornell University, Seligman has spent his professorial career at the University of Pennsylvania, where he is professor of psychology. He is best known for his work on learned helplessness, depression, optimism, and positive psychology.

In the 1960s and early 1970s, Seligman and fellow University of Pennsylvania graduate students discovered and investigated the phenomenon of *learned helplessness*. Animals exposed to uncontrollable aversive events later showed striking deficits in different situations; that is, they behaved helplessly. Seligman interpreted this phenomenon in cognitive terms, at the time a radical approach. He proposed that an animal that learned in one situation that its responses were independent of outcomes generalized an expectation of response-outcome independence (i.e., helplessness) to other situations. He demonstrated the same phenomenon among people, and proposed that the basic learned helplessness phenomenon might serve as a laboratory model for reactive depression.

By the late 1970s, laboratory data suggested that the learned helplessness model did not fully account for the range of responses that people showed in response to uncontrollable events. Seligman and colleagues reformulated the theory to incorporate the causal attributions made by people for the original uncontrollable events. People's interpretations of why the events occurred determined whether deficits did or did not follow. "Pessimistic" attributions—those to stable, global, and internal causes—produce long-lasting and pervasive deficits accompanied by a loss of self-esteem.

In the 1980s, Seligman applied the basic findings about learned helplessness and his attribution reformulation to guide investigations of the treatment and prevention of depression. Seligman and his colleagues demonstrated that cognitive therapy for depression works in part because it changes an individual's pessimistic explanatory style, turning it in a more optimistic direction. This led to the development of a prevention program in which young people at risk for depression are taught cognitive problem-solving skills and to dispute pessimistic causal explanations. This intervention effectively prevents subsequent depression.

In the early 1990s, Seligman reframed his work on pessimism (and the negative outcomes under its sway) to focus on optimism (and positive outcomes). Seligman later dubbed this emphasis *positive psychology*. The underlying tenet is that psychology should be as concerned with discovering how to lead a positive, healthy, fulfilling life as it is with discovering how to remedy the disorders that trouble so many individuals. In just a few years, positive psychology has grown from a provocative label to a burgeoning field. Positive psychology promises to be a literal science of mental health, not simply a science of mental illness negated. Seligman's most lasting contribution may prove to be his reinstitution of the psychological good life as a legitimate topic for scientific investigation and theory-guided encouragement.

*Christopher Peterson*

**See also** Depression (v2); Internalizing Problems of Childhood (v1); Learned Helplessness (v3); Optimism and Pessimism (v2); Positive Psychology (v2)

### Further Readings

- Seligman, M. E. P. (1991). *Learned optimism*. New York: Knopf.
- Seligman, M. E. P. (2002). *Authentic happiness*. New York: Free Press.



## Web Sites

Martin E. P. Seligman: <http://www.psych.upenn.edu/~seligman/>

---

## SKINNER, B. F. (1904–1990)

---

Having made contributions that were as profound as they were practical, Burrhus Frederic (B. F.) Skinner was one of the most eminent psychologists of the 20th century. Born on March 20, 1904, in Susquehanna, Pennsylvania, he developed an early penchant for inventing and experimenting, was a keen observer of biology and behavior, and read Francis Bacon. With an emerging intellectual independence, he entered Hamilton College in 1922 as an English major, but he bristled at its social conventions and institutional constraints. Encouraged by Robert Frost, he began a career as a writer, but writing failed him in that it didn't make a difference in Progressive, modernist America.

While he was writing, though, he was reading. Bertrand Russell was praising John B. Watson's behaviorism and Sinclair Lewis was extolling life in science. The latter resonated with what Skinner had read in biology at Hamilton: Jacques Loeb's insistence that experimentation was the foundation of knowledge. When Skinner sought advice about psychology, his professors directed him to Ivan P. Pavlov and Harvard University. After deciding on Harvard, he continued to read. Pavlov was demonstrating the importance of experimental control, H. G. Wells was promoting science over the humanities for understanding behavior, and Watson was promoting behaviorism in ways that appealed to Skinner's growing iconoclasm.

### The Shaping of a Behaviorist

Skinner arrived at Harvard in 1928 and found a psychology department more aligned with structuralist theories of mind than a science of behavior. He turned to William J. Crozier's Department of General Physiology, which engaged Loeb's science. With support from his colleague, Fred S. Keller, Skinner began several lines of research to demonstrate the lawfulness of behavior on which the environment acted—reflex behavior (e.g., food elicits salivation in dogs). This was Pavlov's science. What emerged, though, were new apparatus (e.g., the Skinner box) and a preparation that

revealed the lawfulness in behavior that acted on the environment—instrumental behavior (e.g., bar pressing by rats is reinforced by food). This science in which cause was unmediated functional relations, influenced by Ernst Mach, would be Skinner's science.

Skinner received his Ph.D. in 1931, but remained at Harvard on fellowships, where he distinguished between respondent and operant behavior, and conducted research on the latter. He was influenced by Percy W. Bridgman, who taught him about operationalizing his terms, and by reading Charles S. Peirce, who inclined him toward hard-nosed philosophical pragmatism (e.g., truth as successful working). Skinner moved to the University of Minnesota as an instructor in 1936 and, that fall, married Yvonne (Eve) Blue from Flossmoor, Illinois. Their first child, Julie, was born in 1938, the same year he published *The Behavior of Organisms*. This seminal account of his experimental analysis of behavior is among his most important contributions to psychology and was the foundation of a new discipline—behavior analysis.

### Style and Content of Science

In Skinner's style of science, knowledge was based on description, prediction, and experimental control. Experimental control was established through the discovery and demonstration of functional relations between independent and dependent variables. The discovery and demonstration of these relations were the process and product of within-individual experimental analysis. Irreducible functional relations were science's basic principles. And theory was their systematic integration. Skinner uniquely extended this style to behavior as a subject matter in its own right. The content of his science was the principles of operant behavior. In 1938, these included conditioning and extinction, primary and secondary reinforcement and punishment, response differentiation and induction, stimulus control and generalization, and motivating operations. These principles remain fundamental in psychology.

### Extensions and Applications

From the beginning, Skinner saw that science could be extended beyond the basic principles to interpret everyday behavior and applied to behavior of societal importance. His first interpretation concerned verbal behavior, which resulted in 1957 in what he considered his most important book—*Verbal*



*Behavior*. This work was later applied to communication training for children with autism. At Minnesota, he extended his research to behavioral genetics and conducted seminal research in behavioral pharmacology. He also engineered behavior, training a rat to pull a chain that released a marble the rat then dropped down a tube to produce food. This demonstrated the practical effectiveness of reinforcement, simulated symbolic behavior, and was a microcosm of a token economy. During World War II, he engaged in military research, training pigeons to guide simulated bombs to precise destinations. This inspired his students, Keller and Marian Breland, to apply his science to commercial animal training.

In the 1940s, Skinner turned to human behavior. He invented a “baby tender” (i.e., a raised, enclosed, mobile space for playing and sleeping, with a full front window and shade, air filter, heating and humidity controls, and a roll of sheets for the bedding) for Eve and their second child, Deborah (b. 1944), to make infant care easier and enhance his daughter’s well-being. Although it was a contribution to domestic engineering, Skinner conducted no experiments with it. He also wrote a novel, *Walden Two*, in which he described a community’s use of his science to improve its cultural practices (e.g., childrearing, education, labor, and environmental stewardship). The book was not intended to be a blueprint for particular practices, however, because Skinner believed that communities should take an empirical approach to discovering effective, acceptable practices. Experimentation was constant; practices were contingent.

In 1945, Skinner moved to Indiana University as a full professor and chairperson of the psychology department. By then, he had formulated a philosophy of his science—radical behaviorism: Psychology referred to behavioral functioning, both public and private, and nothing more. In addition, he criticized theories of human behavior based in folk psychology, not science; social sciences that established facts, not functional relations between them; and applied psychology that focused on correlations instead of experimentation.

### A Matter of Consequences

Skinner returned to Harvard in 1948 and established a pigeon laboratory. His pigeon research resulted in his 1957 compendium with Charles Ferster, *Schedules of Reinforcement*. He published *Science and Human Behavior* in 1953, which provided interpretations of

individual behavior (e.g., self-control and thinking), social interactions (e.g., aggression), and cultural practices (e.g., education and government), and described how to change them. This work provided a foundation for applications in behavior therapy and applied behavior analysis.

In the early 1950s, Skinner began two lines of research with collaborators that extended his science to education and psychiatric patients. Skinner invented teaching machines, created programmed instruction, and described classroom applications, which resulted in his 1968 book, *The Technology of Teaching*. He critiqued psychoanalysis and suggested how his science could be integrated with biological approaches to psychopathology. He also addressed ethical issues in the control of human behavior. In a debate with Carl Rogers, for instance, he argued that values do not mediate behavior—they specify reinforcers; that choice was not free—it was lawful; and that the fear of control was impeding science-based applications. These issues engaged Skinner throughout the 1960s, and resulted in his controversial 1970 book, *Beyond Freedom and Dignity*, which made him a public intellectual.

Skinner retired from Harvard as a professor emeritus in 1974, the same year he published *About Behaviorism*, an overview of his system. He remained active, however. He integrated his science with biology; conducted simulation research on cognition; addressed utopian and philosophical implications of his science; and wrote about language and consciousness. He also offered advice about intellectual self-management in a 1983 book with M. E. Vaughan, *Enjoy Old Age*; contended with ethical issues in the use of punishment; criticized psychology’s mediational theories of mind; and addressed international conflict and peace.

Skinner died of leukemia on August 18, 1990, just after receiving the last of his many awards—the American Psychological Association’s first award for a Lifetime Contribution to Psychology. His contributions were unique. His philosophy of science came from science, not philosophy. His science was grounded in experimental control, not predictions from theory. His extensions took science beyond the basic principles and his interpretations were based on and constrained by those principles. His applications were demonstrations of experimental control in solving societal problems. These applications, in turn, strengthened the validity of his philosophy, science,



extensions, and interpretations. Skinner was a systematic psychologist.

*Edward K. Morris*

*See also* Bandura, Albert (v2); Behavior Therapy (v2); Dialectical Behavior Therapy (v2); Personality Disorders (v2); Personality Theories, Behavioral (v2); Positivist Paradigm (v2); Psychoeducation (v2); Rogers, Carl R. (v2)

### Further Readings

- Bjork, D. W. (1993). *B. F. Skinner: A life*. New York: Basic Books.
- Ferster, C. B., & Skinner, B. F. (1957). *Schedules of reinforcement*. New York: Appleton-Century-Crofts.
- Skinner, B. F. (1938). *The behavior of organisms: An experimental analysis*. New York: Appleton-Century.
- Skinner, B. F. (1948). *Walden two*. New York: Macmillan.
- Skinner, B. F. (1953). *Science and human behavior*. New York: Macmillan.
- Skinner, B. F. (1957). *Verbal behavior*. New York: Appleton-Century-Crofts.
- Skinner, B. F. (1968). *The technology of teaching*. New York: Appleton-Century-Crofts.
- Skinner, B. F. (1971). *Beyond freedom and dignity*. New York: Knopf.
- Skinner, B. F. (1974). *About behaviorism*. New York: Knopf.
- Skinner, B. F. (1999). *Cumulative record* (definitive ed.; V. G. Lates & A. C. Catania, Eds.). Cambridge, MA: B. F. Skinner Foundation.
- Skinner, B. F., & Vaughan, M. E. (1983). *Enjoy old age: A program of self management*. New York: Norton.

---

## SOCIAL SUPPORT

---

Social support has been one of the most widely examined constructs in social science research since the 1970s, although the concept originated over a century ago. *Social support* is defined as those social interactions or relationships that provide individuals with actual assistance or that embed individuals within a social system believed to provide love, caring, or a sense of attachment to a valued social groups or dyad. Social support can provide a conduit to resources beyond those otherwise available to the individual. Studies have illustrated how people's relationships with others affect both psychological and physical health. The vast majority of social support research focuses on

the positive aspects of the phenomenon, but the sometimes harmful effects of social support have been examined also. The positive attributes of social support include better mental and physical health outcomes both in times of stress and when stress is not occurring.

Social support aids individuals in many different kinds of stress situations and across cultures. Social support is beneficial to those exposed to organizational stressors, those exposed to high levels of hassles, and those exposed to more major stressors. Even following exposure to traumatic stress, social support has been found to be beneficial both at the time of the trauma and years later. Social support has a positive effect in virtually every culture in which it has been examined, including both individualistic and more collectivist cultures. Women tend to be more likely to be the purveyors of social support, but both men and women derive benefit from social support. The positive influence of social support is found in children, adolescents, adults, and older individuals.

Social support operates by providing a sense of belonging and attachment and by offering the provision of other resources that aid and support individuals. It is important that this support be congruent with the characteristics of the individual and situation. Social support does not exist in isolation, but typically is found in individuals with high self-esteem, self-efficacy, and optimism. Social undermining may occur, even in otherwise positive social relationships, and its negative impact can overshadow the positive influence of social support. Social support processes occur on individual, familial, and community levels and these processes determine the effect of social support.

### Conceptual Frameworks of Social Support

Several frameworks have been offered to conceptualize the influence of social support. For example, the stress-buffering hypothesis predicts that social support will buffer, or protect, individuals from the negative effects of stress. Research investigating this hypothesis has found that when stress is high and social support is strong, social support protects against negative mental and physical health outcomes. Conversely, social support does not act as a buffer when stress levels are low.

A second framework is the direct or main effect model of social support. This model posits that social support has a positive effect on health and well-being



that is independent of the level of stress. Research on social integration has supported this model. Specifically, individuals who are more socially integrated, or have a larger number of social roles, tend to experience less psychological distress and better physical health than individuals who are less socially integrated or have fewer social roles. Furthermore, individuals who reported stronger social integration also show slower onset and faster recovery from physical disease than those who are less socially integrated. These results reveal potent effects of social support and confirm its direct, positive influence.

### **Mechanisms by Which Social Support Exerts Its Influence**

More recent research has examined the mechanisms that explain the relation between social support and better mental and physical health. Specifically, the models of attachment, ecological congruence, and conservation of resource (COR) theories sought to explain the mediating and moderating factors that influence the relation between social support and positive health outcomes.

*Attachment theory* refers to the way that human beings form strong emotional bonds with selected others. This strong connection provides a way to understand personality development, emotional distress, and psychopathology. Attachment theorists contend that although attachment characterizes relationships from birth to death, attachment behavior is often most evident during the early childhood phase of life. Attachment patterns emerge in early childhood and develop in relation to the caregiver. People then adopt these patterns (e.g., being secure, being insecure, being dependent) in their relations with others in their life (e.g., their spouse, their own children, friends).

The importance of attachments is both biological and psychological. Positive attachments confer positive self-regard, a sense of value, and the sense that others will be there in times of crisis. This model suggests that social support may operate through sustaining this vital sense of attachment to others. The lack of positive attachment patterns in childhood creates obstacles to obtaining social support as a resource through the life cycle. Therefore, those who do not form a secure attachment in childhood may be less likely to benefit from or obtain social support as adults.

The identification of social support as an essential resource in the process of stress resistance was detailed

in several models that emphasized the construct of resource fit or ecological congruence. The ecological congruence model proposes that social support interacts with other resources to foster or inhibit stress resistance. By viewing the ecological context as critical in the relation between social support and stress, the specific conditions under which social support exhibits its beneficial and erosive effects became evident. Specifically, social support influences coping behaviors and recovery processes as a function of the individual's characteristics, the context in which the individual resides, the time since the event, and the situational demands.

The fit of social support to individuals' needs is partly a function of the unique characteristics of the individual and partly a product of common values shared by individuals of common social systems (e.g., such as those found in families, subcultures, and shared cultures). This means that in order for a resource to be advantageous, it must meet the individual's specific needs and inherent situational demands. Furthermore, the model proposes that a lack of fit of resources with situational demands and cultural values may further exacerbate the individual's distress level.

Conservation of resource (COR) theory has also been used to explain the influence of social support. COR theory posits that people are driven to build and maintain resources. Given this innate drive, the perceived or actual loss of resources, or the failure to gain resources after investment is threatening to them. Four categories of resources are outlined: (1) object resources (e.g., house, car), (2) personal resources (e.g., self-efficacy, self-esteem), (3) energy resources (e.g., time invested in studying for a test), and (4) condition resources (e.g., social skillfulness, family relationships, a good marriage). Resources are interdependent and typically travel in "caravans." For example, as people accumulate education (an energy resource), they also increase their self-esteem (a personal resource) and their income, which would stabilize their ability to maintain a car and a home (object resources). Resources are also seen as dynamic, changing entities rather than as static and ever-present. Therefore, resources can easily be used up and must be replaced. In addition, resources can be invested to sustain other resources, thereby garnering additional resources or strengthening resource reserves. In some cases, resources of one category can even be substituted for resources of another category.

COR theory suggests that social support is a key resource both because it conveys a sense of



attachment and because it provides people with access to resources beyond their personal purview. Social support as a condition resource is additionally important because this act of receiving social support may also build further resources. For example, individuals who can use social support to their own advantage will also benefit from increases in other important personal resources such as self-esteem and self-efficacy. These other personal resources will then travel in the resource caravan and can be used to garner and maintain resource reserves.

COR theory also suggests that resources and resource demands are interrelated on the individual, familial, and community levels. This implies that reciprocity of social support may lead either to building resources beyond the individual or to an additional form of stress and resource depletion. Often, individuals with the greatest need of social support live in communities where others are also in great need of social support. Not only must these individuals satisfactorily obtain the beneficial effects of social support when they are under stress, but they must also be prepared to offer reciprocal benefits to others in need. In this way, individuals may end up needing to provide social support at the same time that they desperately need to conserve their resources. Providing social support to others when the individuals are themselves in need of support or using all their resource reserves may have negative effects on both the individual and the social system.

### Negative Impact of Social Support and Social Undermining

The finding that social support has far-reaching beneficial effects was so enthusiastically received that the negative aspects of social interactions and their role in the traumatic stress process were neglected. When psychologists reconceptualized social interactions as a multifaceted construct consisting of both positive and negative aspects, however, they became aware that although social support is beneficial, simultaneous social undermining can occur. Social undermining is less common in sustained personal relationships, but when it occurs its effects are severe and often outweigh the influence of positive interactions.

Intentional negative aspects of social interactions, termed *social undermining*, *social negativity* or *social conflict*, are defined as those behaviors that are deliberate, negative actions directed toward the individual. Social undermining includes displays of negative

affect and negative evaluation of the person, arguments, fights, and blame. Also, some perceived supporters may be expected to provide positive support, yet they provide support that is harmful or detrimental by lacing it with demands, violations of privacy, expressions of frustration and disappointment, or criticisms of individuals' choices. They may openly express blame and other negative affect regarding individuals' experiences. Often supporters may encourage a negative choice in an attempt to alleviate their own stressors. These aspects erode the ameliorative effects provided by the positive, supportive interactions that individuals have experienced.

In addition, some acts that are intended as supportive may be unintentionally negative. The attempted support may be perceived as negative based on a mix of individual and social-contextual factors. A negative perception of support may arise from the provision of unwanted support, a sense of burden that the support cannot be reciprocated or repaid, or a feeling of helplessness or diminished self-esteem because of feeling weak and incapable. Furthermore, if the relationship has been historically negative, the motivation for the support may be perceived as a further act of undermining. When well-intentioned support is provided beyond the point that it is needed, supporters may be perceived as constraining and oppressive and the support becomes unhelpful. Finally, a supporter who provides too much support may cause individuals to feel incapable of assisting themselves in the stress-resistance process.

*Susaye S. Rattigan, Lisa C. Walt,  
Kristen H. Walter, and Stevan E. Hobfoll*

**See also** Attachment Theory (v4); Community-Based Health Promotion (v1); Developmental Counseling and Therapy (v2); Ego Strength (v2); Group Therapy (v2); Happiness/Hardiness (v2); Hope (v2); Interpersonal Learning and Interpersonal Feedback (v2); Optimism and Pessimism (v2); Positive Psychology (v2); Self-Esteem (v2); Self-Help Groups (v2); Stress (v2)

### Further Readings

- Blau, P. M. (1998). *Exchange: Power in social life*. New Brunswick, NJ: Transaction.
- Bowlby, J. (1969). *Attachment and loss: Vol. 1. Attachment*. Harmondsworth, UK: Penguin.
- Cohen, S., & McKay, G. (1984). Social support, stress and the buffering hypothesis: Atheoretical analysis. In A. Baum, S. E. Taylor, & J. Singer (Eds.), *Handbook*



- of psychology and health (Vol. 4). Hillsdale, NJ: Lawrence Erlbaum.
- Duck, S., & Silver, R. C. (Eds.). (1990). *Personal relationships and social support*. London: Sage.
- Hobfoll, S. E. (1988). *The ecology of stress*. New York: Hemisphere.
- Hobfoll, S. E. (1998). *Stress, culture and community: The psychology and philosophy of stress*. New York: Plenum Press.
- Pierce, G. R., Lakey, B., Sarason, I. G., & Sarason, B. R. (Eds.). (1997). *Sourcebook of social support and personality*. New York: Plenum Press.
- Sarason, B., Sarason, I., & Pierce, G. (1990). *Social support: An interactional view*. New York: Wiley.
- Schumm, J., Vranceanu, A., & Hobfoll, S. (2004). The ties that bind: Resource caravans and losses among traumatized families. In D. R. Catherall (Ed.), *Handbook of stress, trauma, and the family*. New York: Brunner-Routledge.

---

## SOCRATIC METHOD

---

The Socratic Method can be a useful tool for many forms of psychological treatment and can be incorporated into many schools of counseling and psychotherapy. Named after the famous philosopher Socrates, who lived in ancient Greece (469–399 B.C.) and who sought the answers to major philosophical questions through dialogue, the Socratic Method often refers to a reliance on questions to guide the flow of a dialogue in a somewhat predetermined manner. However, it is best to view the Socratic Method as consisting of the following key components: systematic questioning, inductive reasoning, universal definitions, disavowal of knowledge, self-improvement, and promoting virtue.

*Systematic questioning* refers to the use of a series of questions to explore a topic in detail. Questions can follow a variety of grammatical formats, but all seek to push the client to explore ideas, opinions, and beliefs from a new vantage point. Most questions are designed to promote independent thinking and rational problem solving. Clients are encouraged to approach difficult situations, explore different alternatives, and anticipate the consequences of various response alternatives. Systematic questioning can facilitate a process of self-guided discovery for the client.

*Inductive reasoning* involves the search for general answers, often based on a review of specific events.

Inductive reasoning can include the use of analogies to extend current knowledge through comparisons with similar phenomena. In addition, inductive reasoning can explore various causal factors in order to identify the true underlying cause of an event.

*Universal definitions* refer to general answers that apply to all cases across all time. Socrates sought the meaning of major issues, such as beauty, goodness, or courage. As related to counseling and psychotherapy, universal definitions can provide a basis for broad issues in treatment. The therapy dialogue can explore the meaning of various behavior labels (e.g., an “aggressive” child), evaluative standards (e.g., a “good” marriage), and abstract qualities (e.g., “true friendship”). In session, therapists and clients can discuss general definitions, specific examples, and potential limitations of current views. Limited or misguided definitions are confronted, refuted, and replaced with more useful terminology.

The concept *disavowal of knowledge* captures Socrates’ awareness of his own limitations, often referred to as *Socratic ignorance*. In a similar way, it is useful for therapists to recognize that their therapeutic skill and professional knowledge resides in the field of psychology and counseling. The client remains the expert on his or her own life, friends, and subjective experiences. When therapist and client both respect the limits of their knowledge, therapy is more likely to involve a true collaborative exploration.

The *self-improvement* component provides a basic framework for the Socratic Method. Clients are gently encouraged to gain more knowledge about self and others, accept their strengths and limitations, and learn to regulate their desires and emotions. Self-regulation relies on logic and reason in order to maintain control over more primitive desires.

*Promoting virtue* is a central goal of the Socratic Method. Socrates explored general issues related to the five cardinal virtues: wisdom, courage, justice, moderation, and piety. In a similar manner, it can be useful for therapists to move beyond the specifics of habit control and symptom reduction, and instead focus on cultivating long-lasting qualities inside the client. By promoting virtuous behavior in clients, a therapist can strive for generalized and lasting changes that help to reduce symptoms and promote prosocial behavior.

The Socratic Method has applications in psychotherapy sessions, classroom discussions, and clinical supervision. When used appropriately, the Socratic Method can enhance the collaborative exploration that



provides a strong foundation for effective psychological treatment.

*James C. Overholser*

*See also* Clinical Interview as an Assessment Technique (v2); Cognitive Therapy (v2); Communication (v3); Depression (v2); Dialectical Behavior Therapy (v2); Individual Therapy (v2); Narrative Therapy (v2); Therapist Techniques/Behaviors (v2)

### Further Readings

- Overholser, J. C. (1993). Elements of the Socratic method: I. Systematic questioning. *Psychotherapy, 30*, 67–74.
- Overholser, J. C. (1994). Elements of the Socratic method: III. Universal definitions. *Psychotherapy, 31*, 286–293.
- Overholser, J. C. (1999). Elements of the Socratic method: VI. Promoting virtue in everyday life. *Psychotherapy, 36*, 137–145.

## SOLUTION-FOCUSED BRIEF THERAPY

Solution-focused brief therapy (SFBT), also called *solution-focused therapy* or *solution-building practice therapy*, was developed by Steven de Shazer, Insoo Kim Berg, and their colleagues. As the name suggests, SFBT is future-focused and goal-directed, and focuses on solutions rather than on the problems that brought clients to seek therapy.

De Shazar, Berg, and their collaborators established the Brief Family Therapy Center (BFTC) in 1978 in Milwaukee, Wisconsin, as a training and research institution.

The entire solution-focused approach was developed inductively in the inner-city outpatient mental health service setting associated with the BFTC, in which clients were accepted without previous screening. The developers of SFBT spent hundreds of hours observing therapy sessions over the course of several years, carefully noting the therapists' questions, behaviors, and emotions that occurred during the session and how the various activities of the therapists affected the clients and the therapeutic outcome of the sessions. Questions and activities related to clients' report of progress were preserved and incorporated into the SFBT approach. The developers of SFBT were also strongly influenced by Milton Erickson's use of language and metaphor and the work at the

Mental Research Institute in California focusing on communication patterns in families of people diagnosed with schizophrenia.

Since that early development, SFBT has become an important school of brief therapy. It has become a major influence in such diverse fields as business, social policy, education, criminal justice services, child welfare, and domestic violence offenders treatment. Described as a practical, goal-driven model, a hallmark of SFBT is its emphasis on clear, concise, realistic goal negotiations. The SFBT approach assumes that all clients have some knowledge of what would make their life better, even though they may need some (at times, considerable) help in describing the details of their better life. SFBT also assumes that everyone who seeks help already possesses at least the minimal skills necessary to create solutions.

### Key Concepts and Tools

All therapy is a form of specialized conversations. With SFBT, the conversations are directed toward developing and achieving the client's vision of solutions. The following techniques and questions help clarify those solutions and the means of achieving them.

#### Looking for Previous Solutions

Solution-focused (SF) therapists have learned that most people have previously solved many problems and probably have some ideas of how to solve the current problem. To help clients see these potential solutions they may ask, "Are there times when this has been less of a problem?" or "What did you (or others) do that was helpful?"

#### Looking for Exceptions

Even when a client does not have a previous solution that can be repeated, most have recent examples of exceptions to their problem. These are times when a problem could occur, but does not. The difference between a previous solution and an exception is small, but significant. A previous solution is something that the clients have tried on their own that has worked, but that they later discontinued. An exception is something that happens instead of the problem, often spontaneously and without conscious intention. SF therapists may help clients identify these exceptions by asking, "What is different about the times when this is less of a problem?"



### ***Focusing on Present and Future Rather Than the Past***

The questions asked by SF therapists are usually focused on the present or on the future. This reflects the basic belief that problems are best solved by focusing on what is already working, and how clients would like their life to be, rather than focusing on the past and the origin of problems. For example, they may ask, “What will you be doing in the next week that would indicate to you that you are continuing to make progress?”

### ***Giving Compliments***

Compliments are another essential part of SFBT. Validating what clients are already doing well, and acknowledging how difficult their problems are encourages clients to change while giving the message that the therapist has been listening (i.e., understands) and cares. Compliments in therapy sessions can help to punctuate what the client is doing that is working. In SF therapy, compliments are often conveyed in the form of appreciatively toned questions of “How did you do that?” that invite the client to self-compliment by virtue of answering the question.

### ***Inviting the Clients to Do More of What Is Working***

Once SF therapists have created a positive frame via compliments and then discovered some previous solutions and exceptions to the problem, they gently invite the client to do more of what has previously worked, or to try changes they have brought up which they would like to try—frequently called “an experiment.”

### ***Asking the Miracle Question***

This unusual sounding tool is powerful in generating the first small steps of “solution states” by helping clients to describe small, realistic, and doable steps they can take as soon as the next day. The miracle question developed out of desperation with a suicidal woman with an alcoholic husband and four “wild” children who gave her nothing but grief. She was desperate for a solution, but thought that she might need a “miracle” to get her life in order. Since the development of this technique, the miracle question (MQ) has been tested numerous times in many different cultures. The most recent version is as follows:

*Therapist:* I am going to ask you a rather strange question . . . that requires some imagination on your part . . . do you have a good imagination?

*Client:* I think so, I will try my best.

*Therapist:* Good. The strange question is this: After we talk, you go home (go back to work), and you still have lots of work to do yet for the rest of today (list usual tasks here). And it is time to go to bed . . . and everybody in your household is sound asleep and the house is very quiet . . . and in the middle of the night, there is a miracle and the problem that brought you to talk to me about is all solved. But because this happens when you are sleeping, you have no idea that there was a miracle and the problems is solved . . . so when you are slowly coming out of your sound sleep . . . what would be the first small sign that will make you wonder . . . there must’ve been a miracle . . . the problem is all gone! How would you discover this?

*Client:* I suppose I will feel like getting up and facing the day, instead of wanting to cover my head under the blanket and just hide there.

*Therapist:* Suppose you do, get up and face the day, what would be the small thing you would do that you didn’t do this morning?

*Client:* I suppose I will say good morning to my kids in a cheerful voice, instead of screaming at them like I do now.

*Therapist:* What would your children do in response to your cheerful “good morning”?

*Client:* They will be surprised at first to hear me talk to them in a cheerful voice, and then they will calm down, be relaxed. God, it’s been a long time since that happened.

*Therapist:* So, what would you do then that you did not do this morning?

*Client:* I will crack a joke and put them in a better mood.



These small steps become the building block of an entirely different kind of day as clients may begin to implement some of the behavioral changes they just envisioned. This is the longest question asked in SFBT and it has a hypnotic quality to it. Most clients visibly change in their demeanor and some even break out in smiles as they describe their solutions. The next step is to identify the most recent times when the client has had small pieces of miracles (called exceptions) and get them to repeat these forgotten experiences.

### **Asking Scaling Questions**

Scaling questions (SQ) can be used when there is not enough time to use the MQ. Scaling questions are useful in helping clients assess their situations, track their progress, or evaluate how others might rate them on a scale of 0 to 10. It is used in many ways, including with children and clients who are not verbal or who have impaired verbal skills. One can ask about clients' motivation, hopefulness, depression, and confidence, and the progress they made, or a host of other topics that can be used to track their performance and what might be the next small steps.

The couple in the following example sought help to decide whether their marriage could survive or they should get divorced. They reported they have fought for 10 years of their 20 years of marriage and they could not fight anymore.

*Therapist:* Since you two know your marriage better than anybody does, suppose I ask you this way. On a scale of 1 to 10, where 10 stands for you have every confidence that this marriage will make it and 1 stands for the opposite, that we might just as well walk away right now and it's not going to work. What number would you give your marriage? (After a pause, the husband speaks first.)

*Husband:* I would give it a 7. (The wife flinches as she hears this.)

*Therapist:* (To the wife) What about you? What number would you give it?

*Wife:* (She thinks about it a long time) I would say I am at 1.1.

*Therapist:* (Surprised) So, what makes it a 1.1?

*Wife:* I guess it's because we are both here tonight.

### **Asking Coping Questions**

These questions are a powerful reminder that all clients engage in many useful things even in times of overwhelming difficulties. Even in the midst of despair, many clients do manage to get out of bed, get dressed, feed their children, and do many other things that require major effort. The question "How do you do it?" is an empowering question that opens up a different way of looking at client's resiliency and determination.

### **Research Findings**

Even though it is an inductively developed model, from its earliest beginnings, there has been consistent interest in assessing SFBT's effectiveness. Given the clinical philosophy behind the SFBT approach, it is not surprising that the initial research efforts relied primarily on client self-reports. Since then, an increasing number of studies have been generated, many with randomized comparison groups, such as that of Lotta Lindfors and Dan Magnusson who studied the effects of SFBT on the prison recidivism in Hageby Prison in Stockholm, Sweden. Their randomized study compared clients who received an average of five SFBT sessions and those who received their usual available services. Clients were followed at 12 and 16 months after discharge from prison. The SFBT group consistently did better than the control group.

A number of researchers have reviewed studies conducted in a variety of settings and geographical locations, with a range of clients. Based on the reviews of these outcome studies, Wallace J. Gingerich and Sheri Eisengrat concluded that the studies offered preliminary support that the SFBT approach could be beneficial to clients. However, more microanalysis research into the co-construction process in solution-focused conversation is needed to develop additional understanding of how clients change through participating in these conversations.

*Yvonne Mary Dolan*

*See also* Brief Therapy (v2); Constructivist Career Counseling (v4); Constructivist Theory (v2); Counseling Process/Outcome (v2); Counseling Theories and Therapies (v2);



Couple and Marital Counseling (v1); Family Counseling (v1); Therapist Techniques/Behaviors (v2)

### Further Readings

- Berg, I. K., & de Shazer, S. (1993). Making numbers talk: Language in therapy. In S. Friedman (Ed.), *The new language of change: Constructive collaboration in psychotherapy*. New York: Guilford Press.
- Berg, I. K., & Dolan, Y. (2001). *Tales of solution: A collection of hope inspiring stories*. New York: Norton.
- De Jong, P., & Berg, I. K. (2007). *Interviewing for solutions* (3rd ed.). Pacific Grove, CA: Brooks/Cole.
- De Shazer, S. (1984). The death of resistance. *Family Process*, 23, 79–93.
- De Shazer, S., Dolan, Y., Korman, H., Trepper, T. S., McCollom, E., & Berg, I. K. (2007). *More than miracles: The state of the art of solution-focused brief therapy*. Binghamton, NY: Haworth Press.
- Gingerich, W., & Eisengrat, S. (2000). Solution-focused brief therapy: A review of the outcome research. *Family Process*, 39, 477–498.
- Lindfors, L., & Magnusson, D. (1997). Solution-focused therapy in prison. *Contemporary Family Therapy: An International Journal*, 19, 89–103.
- McGee, D., Del Vinto, A., & Bavelas, J. (2005). An interactional model of questions as therapeutic interventions. *Journal of Marital and Family Therapy*, 31, 371–384.

---

## SPIRITUALITY/RELIGION

---

Traditionally, the word *spirituality* has been used for concepts and experiences that either are religious or are analogous to it. More recently, there has been controversy concerning the meaning and application of the term *spirituality* as it is differentiated from *religion* and *religiosity*. Inasmuch as the largest body of research relevant to issues in counseling and religion has concentrated on what can be defined as “religion and mental health,” this entry begins in that context and then addresses other understandings of spirituality.

The relation between religion and mental health can be divided into two separate, but related issues: the influence of religion on mental health and the place of religion in the counseling session.

### The Influence of Religion on Mental Health

For centuries, some of the most brilliant minds in the world’s cultures pondered the nature of the human condition in the context of religion. In general, these individuals took religion as a given, and presumed that the best life was that which conformed to the dictates of the religion with which the individual identified. Religion was generally presumed to be required for the good ordering of society, its function being to promote virtue and condemn vice, at least for the masses. When psychology began to emerge as a distinct discipline at the midpoint of the 19th century and sever its ties with philosophy, there was a general reconsideration of religion and its relation to human welfare. This process continued into the twentieth century, and a number of the founding fathers of the fledgling field of psychology essentially rejected religion out of hand (e.g., Sigmund Freud, John B. Watson, B. F. Skinner) as a remnant of unsophisticated and superstitious thinking.

As the specialties of clinical and counseling psychology developed after World War II and were influenced by behavioral and psychoanalytic theories, psychology continued with the presumption that religion was the vestige of an earlier, irrational mentality, and that it was detrimental to optimal functioning. Items with religious content were included in the first edition of the Minnesota Multiphasic Personality Inventory (MMPI) because therapists had heard such phrases from their clients, and associated them with their clients’ disorders. Positive correlations between the Marlowe-Crown Social Desirability scale and measures of religiousness were taken as evidence that religious individuals had a strong “approval motive” and thus their answers on other measures were suspect. Albert Ellis, one of the most prominent therapists of the second half of the 20th century, promoted rational-emotive therapy (RET), which took for granted that religion was irrational and thus a detriment to mental health.

Over time, evidence grew that the presumption of a general negative impact of religion on mental health was untenable. A large-scale factor analysis of the MMPI discovered that its religion-related items loaded on a factor orthogonal to those measuring disorders. These items were removed from the MMPI-2. Other research found that religious and nonreligious



individuals differed in their response patterns to certain items on the Social Desirability Scale. When these items were removed, there was no correlation between the remaining items on the Social Desirability Scale and measures of religiosity.

The 1990s saw continuing research on religion-related topics, as well as impressive meta-analytic reviews of the area supporting a positive view of religion. Harold Koenig, Michael McCullough, and David Larson's *Handbook of Religion and Health* is among the best sources for summary data on research on religion and mental health. They found that across a wide range of disorders—depression (118 findings surveyed), suicide (114 findings), anxiety disorders (80 findings), schizophrenia and other psychoses (22 findings), alcohol and drug use (99 findings), delinquency (41 findings), marital instability (42 studies)—religiousness was associated with lower rates of risk in the majority of cases.

Koenig and colleagues were careful to note nuances:

- Depression is more common among Jews and unbelievers than among Christians and Protestants.
- Depression and anxiety display a stronger negative relation to activity in a religious community than simple religious belief. They also have a stronger negative relation with intrinsic (religion as an end to itself) rather than extrinsic (religion as source of social support and networking) orientations toward religion.
- There is no clear linkage between any particular denomination and suicide, although rates are lower among conservative Protestants and Muslims, and generally lower among the religiously committed.
- There are no prospective studies involving religiousness and schizophrenia, so causal statements are largely unwarranted.
- In contrast, there is evidence that early religious involvement in youth may be protective factor against later delinquency.
- Religious homogamy (both spouses being of the same religious background) may be a factor in the negative relation between religiousness and marital instability.

Thus, far from supporting the view that religion is somehow pathogenic, the empirical evidence is that religion may be an influence for reducing the likelihood for a variety of disorders. However, it is neither ethical nor practical to try to inculcate religion into all clients to make their lives better.

## Religion in the Counseling Session

As noted earlier, Ellis considered religion irrational and therefore essentially antithetical to the therapeutic process. Others, however, were engaged in a body of theory and research that would integrate the involvement of religious principles in the therapeutic process. An increasing number of researchers studied aspects of religion (e.g., religious coping, forgiveness) and their roles in clients' lives. In 2000, the American Psychological Association (APA) prominently featured works on integrating religion/spirituality and psychology in its publications catalogue and, later that same year, Ellis himself published an article admitting that even conservative religion can have positive mental health influences. Currently, both the American Counseling Association (ACA) and APA acknowledge religion as a form of diversity that requires the same level of attention as gender, racial/ethnic background, and sexual orientation.

How should such issues be addressed in the counseling session? Several sources addressing the integration of religious beliefs and therapy recommend the taking of a religious/spiritual history of the client. The following questions might be asked: "Has religion or spirituality played a major force in your development?" "Were you raised within any religious tradition?" "How would you describe yourself now?" Regardless of the answers to these questions, they may provide insights that will be profitable in ways that are not immediately evident.

Two aspects of therapy with the religious client are most important. The first are the "cultural" aspects of religious affiliation. Clients from denominations with strict behavioral constraints (e.g., Mormons, Seventh-Day Adventists) can sometimes be provoked to terminate therapy prematurely when presented with seemingly innocuous questions (e.g., "Would you like a cup of coffee?"). Similarly, the intense degree of religious involvement in more conservative denominations, or for the more conservative members of some of the main denominations, may seem aberrant to the uninformed therapist when in fact they simply reflect a standard level of commitment in that context. Clinical psychologists, who have been shown in surveys to be far less likely to be actively involved in religious settings than the general population, need to be trained, as a part of their competence in cultural diversity, in the cultures and practices of various religious traditions.



The second aspect of religion that brings unique characteristics to counseling and therapy is religious coping. This is the great strength of religion-accommodative therapy. It joins the insights of psychology to those of theology and religion. If both therapist and client find it acceptable, strategies of invoking God, Jesus, a beloved saint, or an honored ancestor to be present while imaging a traumatic event; engaging in prayer at the beginning or end of a given session; or contacting a minister of the person's denomination to suggest a form of religious practice that may be effective for that individual may be employed. Any of these actions can have profound, unique effects in the therapeutic setting.

Of course, not all forms of religious coping are good. Kenneth Pargament and his colleagues noted that one characteristic of negative religious coping could be evidenced by a change or "reappraisal" of long-held religious understandings. For example, a change by a client from a traditional image of a loving God to one who actively punishes wrongdoing, and is punishing the client specifically, is associated with greater depression.

## Spirituality

Traditionally, the term *spirituality* has had two primary meanings. One was to describe the way in which one is religious, as in Eastern versus Western spirituality or Franciscan versus Jesuit spirituality. The second was to describe the heights of human experience, after the manner of Abraham Maslow's "peak experiences."

More recently, however, spirituality has become quite popular in the psychological literature. Spirituality first became a *Psychological Abstracts* keyword in 1988. Between then and the end of 2005, some 2,470 entries were classified with that keyword, nearly as many as those that have been associated with Religion (2,621). Of course, these numbers reflect cross-listings; fewer than half of the Spirituality entries (1,212) are related only to that keyword; without also being cross-listed with some more traditional, religion-related keyword (the name of a specific denomination, religion, or religiosity or specific religious practices). Thus, much recent usage of the word *spirituality* has been to focus attention on the unique, personal, experiential characteristics of religiousness. Often this is defined as an individual's personal experiences of and relationship to the divine, which may or may not be specifically framed within a particular religious institution or tradition.

Although spirituality and religion do overlap, there is an ongoing interest in the counseling field in a spirituality that is largely disconnected from religion. Rheta L. Steen, Dennis W. Engels, and W. Tom Thewett III quote the Association for Spiritual, Ethical, and Religious Values in Counseling (ASERVIC)—publisher of the journal *Counseling and Values*, a forum for much of the current discussion of the function of spirituality in counseling—as having defined *spirituality* in the following way:

Spirit may be defined as the animating life force, represented by such images as breath, wind, vigor, and courage. Spirituality is the drawing out and infusion of spirit in one's life . . . a capacity and tendency that is innate and unique to all persons. [It] moves the individual toward knowledge, love, meaning, peace, hope, transcendence, connectedness, compassion, wellness, and wholeness. Spirituality includes one's capacity for creativity, growth, and the development of a value system. [It includes] experiences, beliefs, and practices. Spirituality is approached from a variety of perspectives, including psychospiritual, religious, and transpersonal. While . . . usually expressed through culture, it both precedes and transcends culture. (p. 109)

Most striking about this definition is the near complete absence of any reference to religion. In a similar vein, the writings of Daniel Helminiak seek to disengage spirituality from religion, asserting that spirituality is innate in the human condition and has no necessary connection to concepts of God or the supernatural, and that such connections are almost invariably prescriptive (linked to religious doctrine and privileging certain perspectives). An approach like Helminiak's is a minority view, and there is thus relatively little research connecting it to therapeutic outcomes, given the lack of clear operational definitions. Furthermore, the common concatenation of the terms *religion* and *spirituality* threatens to further confuse matters, as spirituality becomes associated with both traditional religious practices and measures and less traditional "scientific" (to use Helminiak's term) understanding.

On the positive side, the broadening of the understanding of the human condition to include not only problems in living but also struggles with more overarching issues concerning knowledge, love, meaning, peace, hope, transcendence, connectedness, compassion, wellness, and wholeness is certainly an



advance for the practice of counseling. Ethical standards for counselors increasingly mandate that counselors be open to such spiritual concerns when they are raised by their clients, be aware of them as diversity issues, and be willing to refer their clients if they don't feel prepared to deal with the type of spirituality that the clients presents. The *Diagnostic and Statistical Manual, Fourth Edition, Text Revision (DSM-IV-TR)* defines such circumstances under the V-code 62.89 as "distressing experiences that involve loss or questioning of faith . . . conversion to a new faith, or questioning of spiritual values that may not necessarily be related to an organized church or religious institution" (p. 741). The acceptance of such issues into the therapeutic process can only ultimately result in enriching the definitions of health and wholeness.

### Current Literature

The current literature suggests that (a) there is strong evidence that employing both the cultural and spiritual aspects of traditional religious frameworks can strengthen a therapist's understanding and the effectiveness of his or her clients; (b) knowledge of the client's religious background, as well as knowledge of religious coping styles, can inform the therapist both of possible additional coping mechanisms available and of potentially maladaptive uses of religious concepts; and (c) there is as yet no significant body of evidence for the healing power of a "spiritual, but not religious" approach. Although advocates claim that religious beliefs confer psychological benefits and critics argue that some aspects of religious doctrine are psychologically harmful, there is little convincing evidence to substantiate these beliefs when religion, per se, is distinguished from behaviors justified on the basis of religious beliefs.

Michael J. Donahue

**See also** Coping (v2); Espiritismo (v3); Forgiveness (v2); Jung, Carl (v2); Religion/Religious Belief Systems (v3); Spirituality (v3); Spirituality and Career Development (v4)

### Further Readings

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed., Text rev.). Washington, DC: Author.

- Ellis, A. (2000). Can rational emotive behavior therapy (REBT) be effectively used with people who have devout beliefs in God and religion? *Professional Psychology: Research and Practice*, 31, 29–33.
- Helminiak, D. A. (1996). A scientific spirituality: The interface of psychology and theology. *The International Journal for the Psychology of Religion*, 6, 1–19.
- Hill, P. C., & Hood, R. W., Jr. (1999). *Measures of religiosity*. Birmingham, AL: Religious Education Press.
- Koenig, H. G. (Ed.). (1998). *Handbook of religion and mental health*. San Diego, CA: Academic Press.
- Koenig, H. G., McCullough, M. E., & Larson, D. B. (2001). *Handbook of religion and health*. New York: Oxford University Press.
- Paloutzian, R. F., & Park, C. L. (Eds.). (2006). *Handbook of the psychology of religion and spirituality*. New York: Guilford Press.
- Pargament, K. I. (1997). *The psychology of religion and coping*. New York: Guilford Press.
- Richards, P. S., & Bergin, A. (Eds.). (2000). *Handbook of psychotherapy and religious diversity*. Washington, DC: American Psychological Association.
- Richards, P. S., & Bergin, A. (Eds.). (2004). *Casebook for a spiritual strategy in counseling and psychotherapy*. Washington, DC: American Psychological Association.
- Shafranske, E. P. (Ed.). (1996). *Religion and the clinical practice of psychology*. Washington, DC: American Psychological Association.
- Steen, R. L., Engels, D., & Thweatt, W. T., III (2006). Ethical aspects of spirituality in counseling. *Counseling and Values*, 50, 108–118.

## STRESS

Stress is an unpleasant state of emotional arousal that people experience in situations that they perceive as dangerous or threatening. It is accompanied by physiological, behavioral, and cognitive changes. Although stress signals danger and thus has a protective function, the experience of chronic stress is a causative factor in physical illness as well as poor life adjustment and psychiatric disturbance.

Individuals differ in their propensity to experience stress and in their ability to cope effectively. Effective coping ultimately involves effective problem solving although emotion-focused strategies are useful in the short term and in uncontrollable situations. When stress and poor coping are experienced chronically, the resultant physiological changes may contribute to the onset



of disease. Sustained stress and poor coping may also produce psychopathological reactions that have been termed *anxiety disorders*. The workplace is a source of stress for many individuals. Intervention programs have been developed to help anticipate and prevent occupational stress, to deal with ongoing workplace stressors, and to address the aftermath of workplace stress.

### Physiological Changes

Walter Cannon, one of the first people to study the stress response, coined the term *flight-or-fight* to describe the body's activation as it prepares to confront or retreat from a stressor. Both responses require an alert, rapidly aroused individual, poised for action. Although the flight-or-fight system may have been adaptive in the ancient past when people dealt mostly with physical stressors, it is less effective in contemporary society where people often face threats to self-esteem that are not amenable to direct action. Continual activation of the flight-or-fight system via arousal of the sympathetic nervous system and secretion of stress hormones is thought to account for many health problems, such as chronic pain disorders and cardiovascular disease.

Another stress pioneer, Hans Selye, observed that medical patients with different illnesses often shared symptoms such as muscle weakness and weight loss. He theorized that these responses might all be part of a generalized pattern of physiological response to stress that occurred irrespective of the nature of the stressor. His three-stage model of the stress response (the general adaptation syndrome) consisted of an initial stage of generalized arousal (alarm stage), followed by the body's attempt to adapt to and resist the stressor (resistance stage). If the stressor persists over a long period of time, the resources of the chronically overtaxed body are exhausted and the resulting physiological damage leaves the body vulnerable to disease and even death (stage of exhaustion). Recent research indicates that many of the damaging effects of chronic stress are due to cortisol, a hormone that is secreted by the adrenal gland via activation of the hypothalamic-pituitary-adrenal axis during stress arousal.

### Behavioral Changes

No single behavior has emerged as a reliable indicant of stress. Stress is often reflected in changes in outward behavior such as tremors, heavy breathing, nail

biting, teeth clenching and grinding, speech disturbances, and avoidance behaviors. However, these behaviors may reflect boredom or other emotional states. Psychologist Paul Ekman has noted that one way people commonly express strong emotions is through facial expressions. He concluded that when a person confronts a stressor and experiences extreme fear the facial features that become most distinctive are the eyebrows (raised and drawn together), eyes (open, lower lids tensed), and the lips (stretched back).

### Cognitive Changes

Richard Lazarus and Susan Folkman have developed the most influential model of the cognitive changes that occur during the stress process. Lazarus and Folkman emphasize that the stress process begins with a conscious appraisal of threat in the environment. This initial assessment or *primary appraisal* of an event may involve anticipated threats, ongoing stressors, or past occurrences that are producing negative self-evaluations. *Secondary appraisal* involves assessment of the resources individuals have at their disposal to deal with threatening circumstances. These appraisals can change rapidly and affect a person's decision regarding how to cope with the situation.

The cognitive appraisal model provides a useful description of the processes involved in responding to the kinds of stressors most people confront daily. However, some stress reactions do not involve sustained conscious activity. When confronted with life-threatening stimuli (e.g., an attacking snake), "crude" sensory information is rapidly passed by the thalamus (a sensory way station in the brain) to the amygdala, a structure in the brain that prompts people to take immediate defensive action to insure their survival (e.g., fighting, fleeing, freezing) and "ask questions later."

### Stressors

Stressors—those circumstances that induce stress responses—are classified into three general categories: catastrophic events, major life changes, and daily hassles. A catastrophe is a sudden disaster or other life-threatening event that strains individuals' coping capabilities to their limits. Exposure to such traumatic events may have enduring negative consequences, as indicated by the incidence of posttraumatic stress disorder in the wake of war trauma, sexual assault, and natural disasters.



Major life changes include serious illness, breakup of a marital relationship, job loss, imprisonment, or death of a close family member. Even events that are planned and generally considered to be desirable (e.g., marriage, voluntary retirement, or the birth of a child) require readjustments that can be stressful. Death of a spouse and divorce were rated as the most disruptive major events, according to a survey conducted in 1967. Although the relative ranking of stressors has changed somewhat, as seen in surveys conducted in 1978 and 1994, death of a spouse and divorce, along with death of a close family member, have continued to be rated as the most stressful life events.

Daily hassles, sometimes termed *chronic background stressors*, refer to seemingly minor annoyances associated with everyday living. Examples include troublesome neighbors, inconsiderate smokers, having to care for a pet, commuting to work daily in heavy traffic, and living and working in a noisy environment. These events may pose only minor inconveniences taken alone, but they can cause significant levels of stress when experienced repetitively. Cumulative exposure to daily hassles is associated with illness to a greater degree than exposure to major life events.

### Stress and Personality

There is considerable evidence that some individuals are stress prone (i.e., more likely to respond with high levels of stress to any given situation). People who score higher on measures of trait anxiety, such as the trait anxiety scale of the State-Trait Anxiety Inventory, have been found to consistently experience higher levels of stress (or state anxiety) when exposed to situations involving threat to self-esteem or threat of failure than persons who score lower on those measures. However, fears of specific situations that are not social or evaluative in nature—especially those that have a strong physical threat component—are not related to trait anxiety. Individuals who have a strong fear of snakes or spiders or of going to the dentist are not necessarily *generally* fearful people, and they usually function well in social situations. Specific fears or phobias usually stem from aversive experiences people have had with that particular situation. Proneness to fear-specific situations is best measured by specific-fear inventories such as the Dental Anxiety Scale.

Although some people find the prospect of encountering circumstances involving some element of physical threat to be particularly stressful, other individuals

(labeled “sensation seekers”) actively seek out risky and dangerous situations. Sensation seekers are not the opposite of chronically anxious individuals, and sensation seeking is unrelated to general trait anxiety. Despite the fact that sensation-seeking activities are often life threatening, sensation-seeking behavior is influenced by a genetic predisposition. Furthermore, this seemingly fearless, heroic behavior is encouraged by others and is likely perpetuated via the more frequent sexual activity that is characteristic of those who score high on this trait.

### Coping With Stress

Coping is the process of managing the demands imposed on a person during stressful encounters. When using problem-focused coping behaviors, people attempt to diminish their stress level by actively dealing with the situation that is inducing the stress. People’s problem-focused strategies include confrontation, making a plan of action, and getting advice from someone who can help them do something concrete about the problem they are facing. Emotion-focused coping strategies involve trying to directly moderate the unpleasant emotions that accompany stress without necessarily attending to the stressor that is inducing those emotions. Common emotion-focused strategies include denial, escape-avoidance, turning to religion, acceptance, and positive reappraisal. Sometimes people seek support from others for strictly emotional reasons (to get sympathy or as a way to express their feelings) without seeking anything concrete from the encounter.

Accurate reality testing is considered the hallmark of mental health, and effective problem-focused coping is a prime contributor to a sense of self-worth or self-efficacy. Nevertheless, emotion-focused coping is useful as a short-term strategy and as a way of managing seemingly uncontrollable situations. In marital counseling, for example, teaching emotion-focused strategies such as acceptance and detaching from problems using humor is important to set the stage for the introduction of more active problem-solving approaches.

The stress appraisal and coping process is dynamic and transactional. People are continually reappraising situations, and for those perceived as threatening they are constantly considering different potential coping strategies. Complex events such as interpersonal relationships include multiple stressors, and people are often dealing with multiple events simultaneously. How a person deals with each encounter is influenced



by other ongoing events, by his or her knowledge of past successes and unsatisfactory outcomes, and by the coping strategies he or she used in those instances.

### ***Traits Associated With Effective Coping***

It is important to distinguish between coping and coping outcomes. The latter refer to the effectiveness of coping strategies. Several related personality traits (relatively stable behavioral dispositions) have been associated with the ability to cope more effectively. These traits include (a) hardiness, which is characterized by the view that life experiences are controllable and that change is a positive rather than an aversive event; (b) an internal locus of control orientation, which is characterized by the belief in personal control over events and one's ability to directly influence important outcomes through one's behavior, and (c) optimism, which is characterized by the general expectancy that good things will happen. In contrast to pessimists, who believe that negative events will persist, optimists view bad experiences as temporary setbacks. Optimism has been found to be associated with the effective use of problem-focused coping and the ability to adapt successfully to stressful events such as coronary-artery bypass surgery. Optimists deal better with negative information that challenges their positive beliefs and make better use of the information to solve problems than pessimists.

## **Stress and Psychopathology**

There is no clear dividing line between normal stress reactions and those that are maladaptive and indicative of psychopathology. Nevertheless, some cardinal features of maladaptive stress reactions are known. Maladaptive stress reactions appear to be overdetermined and out of proportion to the actual degree of danger confronting the individual. They are sustained over an extended period of time, resulting in continued stress arousal, preoccupation with thoughts of failure, and a sense of loss of control that is often independent of ongoing life events. The individual's behavior is characterized by "anxious apprehension," in which attention turns inward and problem solving becomes increasingly ineffective.

Psychopathological reactions characterized by anxiety and poor ability to cope with stress have been termed *anxiety disorders*. Anxiety disorders include:

- generalized anxiety disorder (chronic anxiety with worries about family, money, work, and illness)
- simple phobia (persistent fear of specific objects such as animals and heights)
- social phobia (fear of being in situations where there is the prospect of being watched and evaluated)
- panic disorder (recurrent, unexpected panic attacks)
- obsessive-compulsive disorder (persistent thoughts that are viewed as uncontrollable accompanied by repetitive behaviors designed to ward off those anxiety-inducing thoughts)
- posttraumatic stress disorder (exposure to a traumatic stressor outside of the usual range of human experience followed by recurrent reexperiencing of the event, avoidance of thoughts associated with it, and arousal symptoms such as sleeping disturbances and anger outbursts)

Most of these disorders are treated effectively with behavioral stress management techniques, sometimes in combination with antianxiety medication.

## **Stress and the Workplace**

Occupational stress is a serious and increasing problem in the United States. For most people their work is not only a source of income but also an important source of self-esteem and status. Frustrating and unsatisfying job conditions produce personal distress and have also been associated with inefficient job performance, increased employee theft, accidents, absenteeism, and substance abuse. Another increasingly common reaction to job stress is violent behavior directed against those whom the worker deems responsible for his or her problems.

The recent rise in occupational stress has been attributed in part to the increased numbers of people employed in service industry work. These occupations are said to produce burnout and are associated with an unusually high incidence of violence. Other factors are corporate restructuring and the uncertainty produced by it, and social and technological changes that have rendered previously desirable skills unmarketable. General causes of occupational stress include physically unpleasant working conditions, an inability to form satisfying interpersonal relationships on the job, sexual harassment, role ambiguity, and role conflict.

Among the most important variables contributing to job stressfulness are the extent to which a job is perceived as demanding and the flexibility the worker



has to make decisions and do what is necessary to get the job done. The most stressful job is one that makes high demands but gives the worker little decision latitude. Jobs with those characteristics often produce debilitating stress symptoms.

There is some evidence that women are more likely than men to experience stressors related to sexual harassment and pay inequity. Age appears to bear a curvilinear relationship to job stress, with people in their 20s and 30s reporting lower levels of occupational contentment than younger or older workers. Individuals characterized by extreme competitiveness, time urgency, difficulty in controlling their impatience, and difficulty expressing their hostility in acceptable ways (i.e., the type A personality) are physiologically overresponsive to stress, more prone to develop cardiovascular disease, and a greater source of stress for others in the work setting.

Worksite stress-management interventions include preventive interventions, programs designed to deal with ongoing stressors, and programs addressing the aftermath of workplace stress. Examples of preventive interventions programs are those designed to ease the transition into the work environment by helping workers prepare for and anticipate job stressors, and selection and placement procedures to avoid mismatching individuals and jobs. Interventions for ongoing stress include in-house fitness or wellness programs that include relaxation and exercise classes and health promotion activities such as dietary control and cardiovascular fitness. In some work settings (e.g., police, fire, emergency medical services), the incidence of traumatic events is sufficiently high that critical-incident stress debriefing teams are available to help workers deal with the aftermath of work stress. These teams provide a setting for trauma victims to interact, exchange information, and provide mutual support.

*Stephen M. Auerbach*

**See also** Acculturative Stress (v3); Coping (v2); Critical Incident Stress Debriefing (v2); Life Transitions (v2); Normative Issues (v2); Occupational Stress (v1); Panic Disorders (v2); Posttraumatic Stress Disorder (v2); Stress Management (v2); Stress-Related Disorders (v1); Work Stress (v4)

## Further Readings

Auerbach, S. M., & Gramling, S. E. (1998). *Stress management: Psychological foundations*. Upper Saddle River, NJ: Prentice Hall.

- Barlow, D. H. (2004). *Anxiety and its disorders: The nature and treatment of anxiety and panic* (2nd ed.). New York: Guilford Press.
- Lazarus, R. S., & Folkman, S. (1984). *Stress, appraisal, and coping*. New York: Springer.
- McEwen, B. S., & Lasley, E. N. (2002). *The end of stress as we know it*. Washington, DC: Joseph Henry Press.
- Sapolsky, R. M. (1998). *Why zebras don't get ulcers: An updated guide to stress, stress-related diseases, and coping*. New York: Freeman.

---

## STRESS MANAGEMENT

---

Hans Selye first introduced the concept of stress in 1926. In his early work, Selye defined *stress* as a bodily response to overuse or damage. Modern definitions view stress as a response to internal or external factors that are perceived as threatening. Refinements in this field have led to the use of two terms: *stressor*, the stimulus that causes stress, and *stress*, the reaction or response of the individual to the stressor.

Stressors tend to fall into two categories: biological and psychosocial. Biological (or biogenic) stressors have properties that elicit a physiological response. They cause chemical or electrical stimulation in the body that causes the body to react with arousal. Biogenic stressors bypass cognitive processes and include substances like caffeine, nicotine, and stimulant drugs.

Psychosocial stressors are real or imaginary events that, because of a person's interpretations, cause the body to respond with the stress response. Richard Lazarus first described the importance of cognition in the stress process with the term *cognitive appraisal*. Cognitive appraisal is the idea that the interpretation individuals assign to an event determines whether it is stressful or not. If the cognitive appraisal is that the stimulus is a threat, the stress response will be activated. Psychosocial stressors may be psychological (worries or fears) or social (relationships, racism, or sexism).

Once a stimulus is appraised as a stressor, a complex set of processes occurs in the body. It was labeled the *general adaptation syndrome* (GAS) by Selye and consists of a series of three stages. George Everly, Jr. described the GAS as "the missing link" that explains how stress causes physical dysfunction. When facing a stressor, the body prepares itself for action. Evolutionarily useful, the alarm phase is commonly known as *flight-or-fight*. In this phase, the sympathetic



nervous system is aroused. Stress symptoms like rapid heartbeat, perspiration, increased blood pressure, dilation of pupils, and difficulties swallowing are signs that the body is responding to a stressor.

If the threat or stressor continues, the individual enters the resistance phase. During this phase, the body works to reestablish homeostasis and repair any physical damage that occurred during the alarm stage. If the stressor continues and homeostasis cannot be achieved, the body will eventually enter the exhaustion phase in which physical breakdown occurs. During this phase, the individual is vulnerable to opportunistic disease and damage to target organs in the cardiovascular, gastrointestinal, and immune systems. The alarm and resistance phases are repeated many times over the life span. In fact, some individuals experience this type of activation and return to homeostasis on an almost daily basis. The damage that occurs with the exhaustion phase is significant and may not be able to be repaired.

### Coping

Coping is an individual's response to the stressor. The ability to cope can greatly mitigate the impact of a stressor. Coping is defined as any attempt to manage a stressor and can be adaptive or maladaptive. Relaxation, imagery, and meditation are examples of adaptive coping while abusing drugs and alcohol are maladaptive means of coping. When coping is successful, the individual returns to homeostasis and no physiological damage occurs. When coping is unsuccessful, the stressor continues to cause arousal in the individual and eventually causes physical harm.

### Managing Stress

Everly developed a multidimensional model of managing stress that targeted each part of the stress response (see Figure 1). Intervention can occur at the level of the stressor, during the appraisal process, at the point at which neurological systems are triggered, or at the physiological level. At each of these points, several interventions can occur that enable individuals to manage their response to stress and return to homeostasis.

#### ***Managing Stress Through Environmental Engineering***

Stress may first be reduced at the level of the stressor. D. A. Girando and Everly labeled intervention at

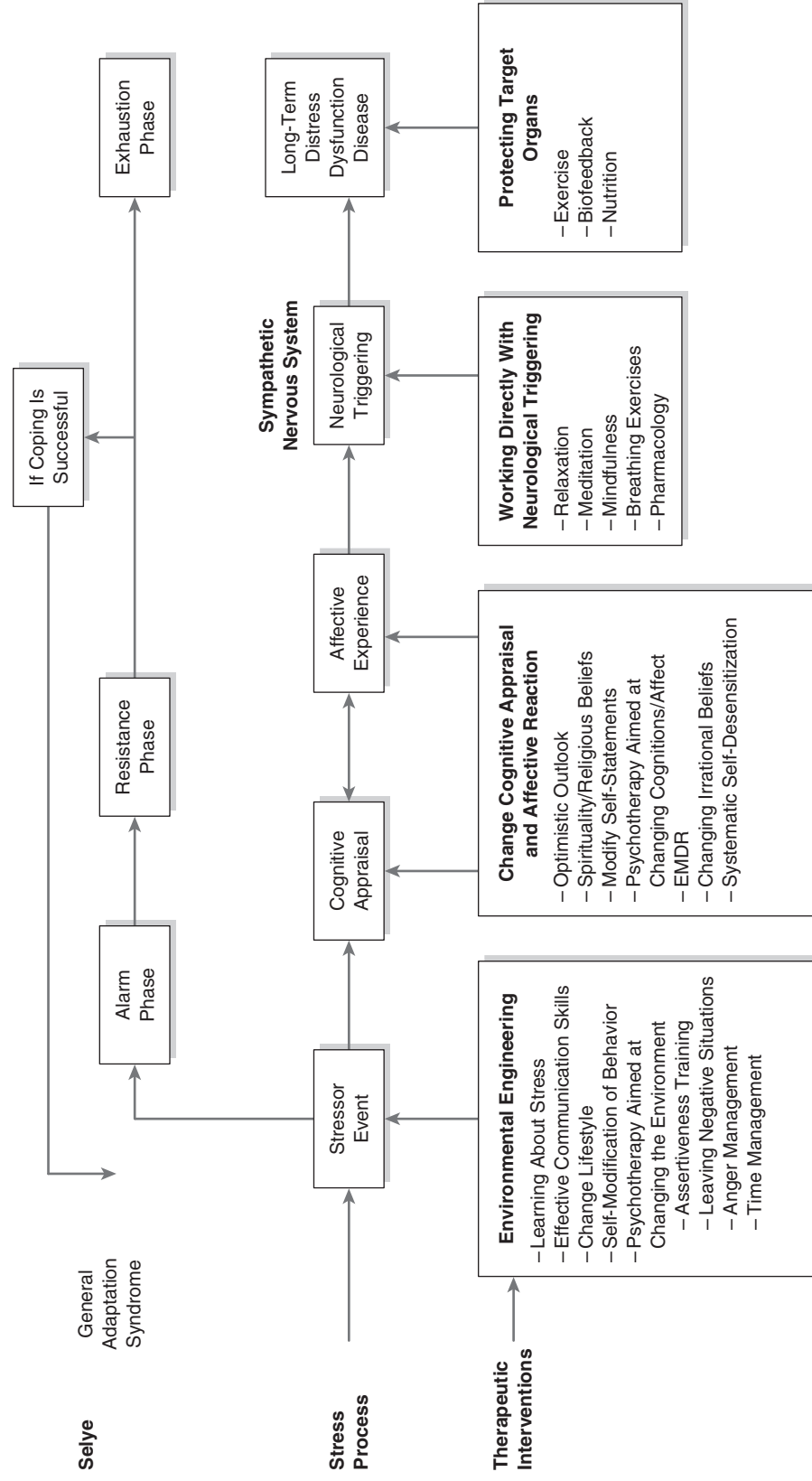
this level *environmental engineering*. Environmental engineering involves changing the external and internal environment so that exposure to the stressor does not occur. Forms of environmental engineering range from ergonomic aids (a more functional keyboard) to simple changes in the environment (closing one's door while working) to more drastic measures (changing careers to develop a less stressful lifestyle). In some cases, knowledge about the stressors in an environment helps people make changes so that the environment is less stressful. For example, knowing that a NASCAR race will be loud causes many spectators to bring earplugs, changing the level of the stressor (the noise) that they experience.

Self-modification of behavior is another way to change the environment and reduce interaction with stressors. Behavior modification involves recognizing and defining a target behavior, assessing its frequency, developing a plan to modify the behavior, reinforcing the change, and evaluating the plan for effectiveness. Through this process, individuals can change behaviors that cause them stress.

Planning and time management are interventions that change the environment. Planning involves thinking about the future, and it can be narrow (planning the day) or broad (planning a career). Time management may help in coping with current or future stressors as the individual works to develop goals, priorities, and schedules. Both methods involve identifying and preparing for stressors.

Psychotherapy functions as an intervention at several places in the model. In environmental engineering, psychotherapy may involve communication skills, assertiveness training, or anger management. Understanding nonverbal communication and being able to reflect, paraphrase, and summarize can change an individual's interpersonal environment drastically. In assertiveness training, individuals learn to speak their thoughts in order to communicate their inner perceptions more clearly. Anger management courses generally consist of helping individuals recognize their problems with anger and developing more effective ways to express negative feelings. Environment changing therapy may be as simple (or complex) as individuals working with a therapist who enables them to remove themselves from stressors. In some cases, leaving a stressful job or abusive marriage is the only way to reduce exposure to a stressor. In these cases, intense individual or group therapy may be the most useful intervention





**Figure 1** Stress intervention points

Source: Adapted from Everly, G. S., Jr. (1989). *A clinical guide to the treatment of the human stress response*. The Plenum series on stress and coping. New York: Plenum Press. Used with kind permission of Springer Science and Business Media.



for changing the environment and managing exposure to stressors.

### ***Managing Stress Through Changing Cognitive Appraisals and Emotional Interpretations***

Another point of intervention occurs when an individual makes a cognitive appraisal or emotional interpretation of an event. Several cognitive styles have been found to be helpful in managing stress. Individuals with an optimistic outlook on life have been found to have greater longevity, remain in their jobs longer, and have superior immune system functioning when compared to individuals with more pessimistic outlooks. Martin Seligman defined *optimistic style* as a hopeful view of the world that enhances well-being and fights depression. For many individuals, a more optimistic style may be learned and/or practiced through psychotherapy and coaching.

Although psychologists have long ignored religious life and spirituality, a spiritual life may aid in managing stress by providing a filter through which appraisals are made. Organized religion may provide forgiveness, fellowship, social support, and hope for the future. Regardless of the spiritual tradition, security may be obtained through attachment to a higher power. Like an optimistic outlook, spirituality has been shown to provide a positive foundation from which stressors can be appraised.

Salvatore R. Maddi's transformational coping helps individuals reinterpret stressors as opportunities, which can be appraised positively. In this type of coping, an individual works to develop a different perspective and views stressors as opportunities for growth. As individuals change their perspective, they feel more in control, thereby changing their appraisal to a less stress-provoking stance. Transformational coping can occur individually or with the help of a therapist.

Modifying internal conversation can be an important form of changing a cognitive appraisal of events. As delineated by Albert Ellis, overgeneralizations, catastrophizing, black and white thinking, and blaming are modes of unproductive thought that can cause almost any situation to become a stressor. In working with self-statements that cause stress, individuals must first become aware of their negative self-statements and begin to challenge these statements when they occur. Writing negative thoughts and developing positive challenges to them can help manage stress at the level

of cognitive appraisal. For example, instead of thinking, "I'm so stupid! I'll never figure this out!" a student might think, "Math isn't my thing, but with some extra tutoring, I can grasp this concept." The goal is to replace negative self-appraisal with more effective and rational thinking. In this way, the cognitive appraisal and the ensuing emotions are changed at the point at which they occur and the stress process is halted.

Another form of stress management that helps individuals change their appraisals is Francine Shapiro's eye movement desensitization and reprocessing (EMDR). EMDR is a behavioral treatment developed to help individuals overcome traumatic events. Traumatic events often have cognitive appraisals and strong affect that accompany them, leading to extreme amounts of stress. EMDR works through changing cognitive self-statements, awareness of emotional and physical states, and bilateral brain stimulation to revise an individual's cognitive appraisals of an event and calm the affective reaction.

Systematic desensitization can also change cognitive and affective appraisal. Traditionally practiced by behavior therapists, systematic desensitization helps individuals decrease anxiety from stressors by developing a hierarchy of anxiety-provoking events and practicing alternating relaxation with anxiety. In essence, the client relaxes while imagining increasingly anxiety-provoking material. Alternating relaxation with the stressor provides an opportunity to practice managing negative emotions and controlling anxiety. As an individual relaxes while thinking about the stressor, his or her appraisal of the stressor is changed.

### ***Managing Stress by Calming Neurological Triggering***

The third intervention point occurs when a stressor has triggered the sympathetic nervous system. If the individual perceives a threat, this system will become activated in defense of the body and psyche resulting in the classic physiological distress symptoms. Helpful interventions at this level are those that directly affect arousal and enhance the relaxation response by making changes at a neurological level. Over time, use of the relaxation response protects the individual from the disease and psychological dysfunction incurred in Selye's exhaustion phase. Relaxation, meditation, mindfulness, breathing exercises, and pharmacology are interventions that act at the point of neurological arousal and are effective in calming the sympathetic nervous system.



Probably the best known of all stress management techniques is progressive muscle relaxation (PMR). First described by Edmund Jacobson in 1938, PMR combats stress by producing physiological responses that are incompatible with stress. In PMR, individuals are taught to relax the major muscles of the body by alternately tensing and relaxing muscle groups. This process produces a state of physiological calm. Because the body cannot be activated and relaxed at the same time, PMR is particularly effective at reducing the neurological arousal that occurs when faced with a stressor. Another approach is to focus on breathing while progressively relaxing each muscle group without tensing. After sequentially relaxing each muscle group, the individual experiences less tension and can achieve a state of deep relaxation. PMR is a skill that can be learned with practice. Many individuals find that they can monitor their tension levels and reduce them at will. This has the effect of intervening in the stress response process by decreasing neurological activation.

While relaxation works to inhibit stress by quieting the body, meditation works by quieting the mind. Meditation is the practice of narrowing one's attentional focus to breathing or a single thought (a mantra) with the goal of lowering mental activity. There are many types of meditation, but the best known is transcendental meditation (TM). In TM, the meditator focuses on the mantra for 15 or 20 minutes. Other types of meditation are centering prayer and meditative walking. Meditation has been shown to slow metabolism; decrease breathing rate, heart rate, and blood pressure; increase immune activity; and improve reaction time and memory.

In a related way, mindfulness meditation helps individuals manage stress by focusing on thoughts and narrowing attention to notice each thought that enters their consciousness. Mindfulness can be defined as nonjudgmentally paying close attention to present experience. Jon Kabat-Zinn developed *mindfulness based stress reduction* (MBSR) for use with chronically ill patients. Essentially, MBSR teaches mindfulness meditation techniques to be used every day. The goal of the program is to help individuals manage the stress and pain of disease by becoming aware of their automatic/habitual thoughts without judging them, allowing for the possibility that these feelings can pass and reality can be reframed.

Deep breathing is another form of stress management that works to decrease neurological triggering.

Sometimes called brief relaxation, breathing relaxation consists of taking several deep slow breaths. Deep breathing may help individuals make an immediate association with relaxation while providing relief at a physiological level. It has been found to help manage pain and may also be helpful in preparing for stressors like making a speech.

A final form of neurological intervention can be found in psychopharmacology. There are a number of psychoactive drugs on the market (benzodiazepines, antidepressants, and sedatives) that can be very effective for calming neurological reactions and emotional distress that accompany exposure to extreme stressors. At the same time, many of these drugs are addictive and can lead to greater problems and distress when used long term. Each of these medications should be taken under the supervision of a psychiatrist or medical practitioner. Pharmaceutical intervention for stress management should be used for short periods of time and only for extreme distress.

### ***Managing Stress to Protect Organs and Systems***

A fourth point of intervention is the use of stress management techniques to protect organs and systems that would be damaged by exposure to long-term stress. Research shows that chronic stress has negative effects on a variety of bodily systems and organs. Biofeedback, exercise, and proper nutrition are interventions that protect against the chronic effects of stress.

Biofeedback enables individuals to manage their responses to stressors by learning to control their autonomic nervous system. Specifically, biofeedback involves electrical monitoring of muscle contractions (electromyograph EMG), brain waves (electroencephalograph, EEC), sweating (galvanic skin response, or GSR), or heat monitoring of skin to increase awareness of the functioning of one's autonomic nervous system. Electric or thermal monitors provide information regarding nervous system arousal. As individuals experience autonomic nervous system arousal (muscle tension, increased heart or brain waves, sweating), a system of tones or lights alerts them to the increase in arousal. They practice relaxing and are given "feedback" through the tones or lights that they are becoming more relaxed. Biofeedback, especially when combined with cognitive methods described previously, can be effective for learning how to relax deeply. The goal of biofeedback is control



of physiological functioning. At the same time, this method provides empowerment for clients who experience the ability to control their autonomic nervous system and manage their stress reactions. Biofeedback has been used to manage chronic headaches, musculoskeletal pain, fibromyalgia, premenstrual syndrome, and menopausal symptoms. The limitations of biofeedback are that it requires specialized equipment and a skilled instructor.

Conventional wisdom suggests that exercise is a positive intervention for managing the emotional and physiological effects of stress and helping the body heal, recover, and prepare for stressors. Several hypotheses exist to explain the effectiveness of exercise. These include familiarity with physiological arousal due to exercise causes appraisals of arousal to be less threatening, increases in self-efficacy, diversion of attention from stressors, and biochemical and/or physiological changes that occur because of exercise. Although the mechanisms are not completely clear, research strongly suggests that individuals who exercise have an increased sense of well-being and reduction in tension. Studies have also shown the positive effects of exercise on systems like the cardiovascular system, which are most likely to be harmed by chronic stress. Thus, exercise can have the threefold benefit of strengthening underlying systems while reducing physiological arousal and changing the individual's appraisal of a stressor.

Nutrition plays an increasing role in managing a number of medical conditions and its impact in the area of stress management is important. Donald Morse and Robert Pollack have argued that nutrition can be a physiological stressor if an unhealthy diet is eaten. They also have argued that a poor diet and lack of nutrition can lead to a vicious cycle in which psychological stressors lead to unhealthy eating, which, in turn, becomes a physiological stressor that affects psychological and physiological health. Morse and Pollack have suggested that a healthy diet can aid in stress management by protecting physiological systems, repairing damage done by chronic stress, and causing less psychological reactions to stressors.

Mary J. Schwendener-Holt

*See also* Cognitive-Behavioral Therapy and Techniques (v2); Coping (v2); Critical Incident Stress Debriefing (v2); Eye Movement Desensitization and Reprocessing (v1); Physical Health (v2); Resilience (v2); Spirituality/Religion (v2); Stress (v2)

### Further Readings

- Bernstein, D. A., & Borkovec, T. D. (1973). *Progressive relaxation training: A manual for the helping professions*. Champaign, IL: Research Press.
- Eliot, R. S. (1995). *From stress to strength: How to lighten your load and save your life*. New York: Bantam Books.
- Everly, G. S., Jr. (1989). *A clinical guide to the treatment of the human stress response*. The Plenum series on stress and coping. New York: Plenum Press.
- Girdano, D. A., & Everly, G. S., Jr. (1979). *Controlling stress and tension: A holistic approach*. Englewood Cliffs, NJ: Prentice Hall.
- Humphrey, J. H. (2003). *Stress education for college students*. New York: Novinka Books.
- Kabat-Zinn, J. (2005). *Coming to our senses: Healing ourselves and the world through mindfulness*. New York: Hyperion.
- Lazarus, R. S., & Folkman, S. (1984). *Stress, appraisal and coping*. New York: Springer.
- Morese, D. R., & Pollack, R. L. (1988). *Nutrition, stress and aging*. New York: AMS Press.
- Pelletier, K. R., (1992). *Mind as healer, mind as slayer: A holistic approach to preventing stress disorders*. New York: Delta/Seymour Lawrence.
- Quick, J. C., Quick, J. D., Nelson, D. L., & Hurrell, J. J., Jr., (1997). *Preventive stress management in organizations*. Washington, DC: American Psychological Association.
- Seligman, M. E. P. (1990). *Learned optimism*. New York: Knopf.
- Selye, H. (1976). *The stress of life* (Rev. ed.). New York: McGraw-Hill.

---

## STRONG, STANLEY R. (1939– )

---

Stanley R. Strong is an influential counseling psychologist who characterized his life and career as devoted to the construction and evaluation of hypothetical models of underlying realities. Born in 1939 in Butte, Montana, Strong completed his bachelor's degree at the University of Montana and his Ph.D. at the University of Minnesota in 1966. Influenced by a number of professors and visiting scholars at Minnesota (e.g., Lloyd Lofquist, Kurt Lewin, Karl Weick, Elliot Aronson, Leon Festinger, and Marvin Dunnette), he came to view counseling as a social organization. From the onset, Strong alternated between disenchantment and attraction to the specialty of counseling psychology. This resulted in a short period of employment as an industrial psychologist



followed by an appointment as a professor of counseling psychology, a later appointment in student affairs administration, and it culminated in teaching assignments in both counseling and social psychology.

Strong spent significant periods of his career working in the Office of Student Life Studies at Minnesota, initially with Ralph Berdie; as a faculty member in the Psychology Department at Minnesota; at the University of Nebraska–Lincoln with Dave Dixon and Chuck Claiborn; and for 20 years at Virginia Commonwealth University (until his retirement in 2000) with Donald Kiesler and Everett Worthington. These positions provided opportunities for productive collaborations with colleagues and students.

Strong's application of research findings and theoretical models from social psychology to the discipline of counseling psychology exerted a profound influence on the subsequent development of the profession. During the early 1960s, the training of counseling psychologists heavily emphasized interventions based on trait and factor psychology and skill development in empathic understanding, unconditional positive regard, and congruence. As a consequence, classroom instruction frequently was devoted to the discussion of whether a counselor should influence a client. These discussions often were lengthy, heated, and lacked resolution. Strong's 1968 article on counseling as an interpersonal influence process, and his subsequent research on interpersonal influence, provided closure for this debate. By the end of the decade, Strong's application of social psychology theory and research to the counseling process had begun the evolution of counseling psychology into the applied psychological science that exists today.

Strong's earliest and most productive collaboration was with Lyle Schmidt, while both were at Minnesota. Building on Strong's seminal paper "Counseling: An Interpersonal Influence Process," they conducted a series of analogue studies that energized research in counseling psychology, both conceptually and methodologically. These early studies demonstrated the importance of the client's perceptions of the counselor's expertness, interpersonal attractiveness, and trustworthiness in the influence process. Today, nearly 40 years later, these dimensions are accepted as foundational to the therapeutic relationship; important contributions to the *common factors* documented to underlie the effectiveness of different approaches to psychotherapy.

Strong and Schmidt also demonstrated that these variables could be studied in a laboratory counseling analogue setting. These studies, although open to retrospective criticism, served to stimulate derivative research that refined and enhanced psychologists' understanding of the counseling process.

Strong's influence has been magnified many times over because of his generative influence on colleagues and students. Influenced and trained by Strong, some of the most influential and productive scholars of the past three decades have continued to advance research on social influence, social power, and evolving explanatory models, including Dave Dixon, Fred Lopez, Cathy Wambach, Jim Lichtenberg, Don Dell, Marty Heesacker, Chuck Claiborn, Puncky Heppner, and Tony Tinsley.

Strong's social influence model has been cited as one of the primary theories that have shaped the development of counseling psychology. Furthermore, the empirical research stimulated by his model is documented as one of the most influential systematic investigations of the counseling process.

Strong periodically shifted his research focus, cycling between the context of discovery and the context of verification, as he attempted to understand the change process in counseling. His attempts to understand the anomalies found in research results led him to incorporate principles and constructs from other theories. Many of these shifts paralleled changes taking place in social psychology. From his early applications of Heider's *dissonance theory* to counseling, he extended his research to the application of attribution theory to influence in counseling. His efforts to integrate communication systems, impression management, social influence, and attribution research and theory were summarized in *Change Through Interaction* (1982), a book he coauthored with Chuck Claiborn. His later efforts incorporated concepts from paradoxical interventions, Leary's interpersonal classification scheme, and social constructivism. A recipient of the Leona Tyler Award from division 17 of the American Psychological Association, his award address explicated his social constructivist, volitional position.

While a Fulbright fellow in England, Strong made a commitment to the Christian faith. At various periods of his life, he wrote extensively on counseling from a Christian-value perspective.

Strong's energy was also reflected in avocational interests. He restored a total of nine houses, including



an antebellum home in historic Richmond, Virginia. He studied architectural history and was involved in design and computer-assisted drawing.

Stan Strong believed strongly in the free will of men, that people have the ability to change. This belief led to a career committed to the scholarly examination of how people make changes and how counselors can assist this process. His contribution to counseling psychology over more than a 30-year period leaves a lasting legacy. To the question—Should a counselor influence a client?—Strong's legacy provides this answer: A counselor can't help it, and in fact, should harness the power of that influence and maximize it for the client's benefit.

David N. Dixon

*See also* Counseling Process/Outcome (v2); Counseling Skills Training (v2); Expectations About Therapy (v2); Facilitative Conditions (v2); Heppner, Puncky Paul (v2); Meaning, Creation of (v2); Taxonomy of Helpful Impacts (v2); Tinsley, Howard E. A. (v4); Wampold, Bruce E. (v2)

### Further Readings

- Heesacker, M. (2000). Counseling psychology: Theories. In A. E. Kazdin (Sr. Ed.), *Encyclopedia of psychology* (Vol. 2, pp. 320–324). Washington, DC: American Psychological Association/Oxford University Press.
- Kivlighan, D. M. (2000). Counseling process and outcome. In A. E. Kazdin (Sr. Ed.), *Encyclopedia of psychology* (Vol. 2, pp. 312–316). Washington, DC: American Psychological Association/Oxford University Press.
- Strong, S. R. (1968). Counseling: An interpersonal influence process. *Journal of Counseling Psychology*, 15, 215–224.
- Strong, S. R. (1970). Causal attribution in counseling and psychotherapy. *Journal of Counseling Psychology*, 17, 388–399.
- Strong, S. R. (1971). Experimental laboratory research in counseling. *Journal of Counseling Psychology*, 18, 106–110.
- Strong, S. R. (1991). Theory-driven science and naïve empiricism in counseling psychology. *Journal of Counseling Psychology*, 38, 204–210.
- Strong, S. R., & Claiborn, C. D. (1982). *Change through interaction*. New York: Wiley.
- Strong, S., Yoder, B., & Corcoran, J. (1995). Counseling: A social process for constructing personal powers. *The Counseling Psychologist*, 23, 374–384.
- Wampold, B. E., & White, T. B. (1985). Research themes in counseling psychology: A cluster analysis of citations. *Journal of Counseling Psychology*, 32, 123–126.

## SUBSTANCE ABUSE AND DEPENDENCE

Substance abuse and dependence are complex problems that are often encountered in a counseling practice. Substance abuse and dependence have been defined as disorders that affect the mind, the body, and the spirit. This entry summarizes the background, definitions of the clinical problem, levels of care and counseling modalities, components of counseling and clinical approaches, and future of counseling for substance abuse.

### Background

Counseling for alcohol and drug problems can be distinguished from exploratory psychotherapy in its direct focus on attaining abstinence and problem solving around situations that can trigger a relapse or impede recovery. Historically, substance abuse counseling has been the preferred approach in community treatment programs in residential and outpatient settings. In addition, in most treatment settings, the emphasis on a disease model of alcoholism or addiction leads to a counseling approach rather than psychotherapy. Individuals with alcoholism or drug dependence tend to benefit from guidance, assistance with recovery-oriented decision making, and support for their capacity to cope with stressful events that can lead to relapse.

### Key Terms and Concepts

Many terms are used to describe alcoholism and other substance related disorders. Some use *substance misuse* as a general term for the unhealthy or harmful use of substances. Substance misuse can include use of alcohol or other drugs with negative consequences to individuals' social, psychological, and physical well-being.

*Substance abuse*, the most widely used term, has both general and specific meanings. In general usage, *substance abuse* is the catch-all term that is used in governmental department titles and federal grant programs to describe programs and services dealing with illicit drug use and alcohol misuse or abuse. More precisely, the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR)* divides substance misuse into two main classifications: substance abuse and substance dependence. *Substance*



*abuse* is a diagnosis having four criteria, at least one of which must be met within a 12-month period: (1) recurrent substance use resulting in a failure to fulfill major role obligations at work, school, or home; (2) recurrent use in situations in which it is physically hazardous such as driving an automobile; (3) recurrent substance-related legal problems; and (4) continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of substances. In addition, individuals cannot have ever met the criteria for substance dependence for the particular class of substances.

*Substance dependence* is a more serious problem related to substance use. The term *chemical dependency* is often used to mean substance dependence and is used more often than *substance dependence* in Alcoholics Anonymous-oriented programs. Others use the term *addiction* or *addictive disease* to describe substance dependence, although addiction can include compulsive behaviors other than substance use, as in sexual addiction or gambling addiction.

Individuals diagnosed with substance dependence must meet at least three of the following *DSM-IV-TR* criteria within a 12-month period: (1) tolerance as defined by either increased use for the desired effect or diminished effect from the same amount; (2) withdrawal when the substance is abruptly stopped or the individual uses the substance to stave off withdrawal symptoms; (3) often taking the substance in larger amounts or for longer periods than intended; (4) desire to reduce use or failed effort to reduce use; (5) spending excessive time procuring the substance; (6) giving up social, occupational, or recreational activities because of substance use; and (7) continuing to use the substance in spite of negative emotional or physical consequences.

*Recovery* is a process undertaken by individuals who are working on their substance-related problems. Many counseling programs actively promote recovery activities such as participating in Alcoholics Anonymous (AA) or other self-help programs. Most of these recovery activities are called 12-Step programs because they are built around the 12 steps of AA, and many programs also use the 12-step framework for counseling.

### Levels of Care and Counseling Modalities

Counseling has been the mainstay of substance abuse treatment across all modalities of care, including residential, intensive outpatient, and outpatient care. However, substance related problems are not treated

in just one type of counseling setting. Instead, based on the assessment, individuals with substance-related problems may receive services in very intensive settings, such as residential treatment or intensive outpatient settings, or they may be seen in less intensive outpatient counseling offices. For individuals with substance dependence who cannot achieve detoxification on their own, the treatment episode may well begin with an inpatient stay in a hospital or in a nonmedical, residential detoxification program. Once detoxified, clients may be referred either to a residential programs or to other less intensive settings. The continuum of treatment is often described in terms of levels of care, and the American Society of Addiction Medicine has outlined levels with defined physical and psychosocial problems tied to different treatment intensities. Levels of care are also often defined as modalities of care because they describe different types of treatment setting. Counseling is typically a part of the treatment approach at every level of care.

### Inpatient and Detoxification

During detoxification in either a hospital or a non-medical program, counseling generally has the primary goal of helping clients make the transition into an intensive, focused treatment, and recovery program. Medical detoxification programs use medications to provide a stepwise reduction in the use of intoxicating substances. For example, if the client has been using central nervous system depressants such as alcohol or tranquilizers, the detoxification will include the use of a similar medication in incrementally decreased amounts until the person is drug free. Likewise, clients on opiates may receive methadone in incrementally decreased amounts until withdrawal symptoms are expected to be very mild and unlikely to lead to a return to illicit opiates to blunt withdrawal effects. Nonmedical detoxification programs do not use any psychoactive substance to ease the individual toward a drug-free status. A calm environment and mild foods and drink are offered to create a reduced stimulus setting for withdrawal. During detoxification, clients generally lack the cognitive clarity needed to address the range of problems that will arise in changing their substance use patterns. At this phase, the goal is simply to stay on track with abstinence from any nonprescribed intoxicating substance and to prepare for and enter a comprehensive treatment program. Counselors may work with clients undergoing detoxification as recovery coaches who encourage clients to follow through



with treatment, and as discharge planners who make arrangements for more sustained treatment.

### ***Residential***

After clients have successfully detoxified, they are often referred to residential treatment, which is a non-medical environment that typically offers intensive group and individual counseling services within a controlled, drug-free environment. Counseling in residential programs is often structured around 12-Step concepts. The counseling goals are threefold: (1) to support and strengthen client commitment to recovery; (2) to educate clients about the effects of substance use on the body, the mind, and brain, and on social, educational, vocational areas of life; and (3) to prepare clients for long-term aftercare counseling in outpatient settings. Residential treatment is usually thought of as the first major step in beginning treatment and recovery. Residential stays used to be very lengthy (6 to 18 months) and to rely on the therapeutic community which used other clients who were further along in recovery to provide supportive counseling. Current programs are typically 3 to 4 weeks in length and use professionally trained counselors as well as some counselors who have personal recovery experience with or without professional training.

### ***Intensive Outpatient Programs***

Sometimes used as an alternative to residential treatment, intensive outpatient programs (IOPs) offer a structured outpatient setting that is in between the confines of residential and the open-ended quality of weekly outpatient counseling visits. IOPs include 3 to 5 days of group and individual counseling and participation in 12-Step self-help groups for 3 to 5 hours each day. Clients receive an intensive regimen of counseling that either builds on residential counseling experiences or is the first substantial treatment after detoxification. The individual counseling sessions address the relation of clients' substance-related problems to specific situational problems such as relationship problems (e.g., divorce or difficulty with children and parenting), employment problems, or personal experiences (e.g., emotional, physical, or sexual abuse). Group counseling addresses ways to maintain recovery-oriented behavior (i.e., remaining abstinent and watching for signs or triggers for relapse). In other words, the group counseling tends to address the common characteristics of addiction, substance abuse, or dependence, while

individual counseling shows how specific personal issues relate to the addiction or substance use problem. Both forms of counseling are essential components of a comprehensive IOP program.

### ***Outpatient***

Outpatient counseling is the least intensive form of treatment for substance use problems. Outpatient usually includes mostly individual counseling, but it can also include group counseling. The focus of individual counseling is the same as in IOPs (i.e., how personal life issues relate to substance use problems). Outpatient groups focus mostly on the common characteristics of substance use problems. Outpatient counselors usually encourage clients to use 12-Step self-help programs (e.g., Alcoholics Anonymous or Narcotics Anonymous) in addition to counseling as a way of supporting their recovery processes. Outpatient counseling may also include the use of couples or family counseling.

### ***Couples or Family Counseling***

While not a separate level of care, family or couples counseling is distinctly different from other outpatient counseling approaches. The focus of couples or family counseling is centered on the whole family relationship and how it can contribute to substance use or recovery. The family members are seen as playing roles that can support or hinder recovery. Counseling approaches are aimed at engaging all members of the family in recovery because, to some extent, the entire family is affected by the problem and needs to make changes to promote the substance using member's recovery. Family counseling may be used when any member of the family is the substance user—the husband, wife, grandparent, adolescent child, partner, or another person who lives in the home and is "like family."

The premise of family approaches is that all members have roughly equal power and control (albeit sometimes tacit or indirect control) within the family. For that reason, couples and family counseling approaches are not indicated when the family has a violent or abusive member. When there is an abusive parent or partner, there is no power equilibrium and victims of abuse are not in a position to initiate change without threat to their safety. Hence, family or couples counseling for alcohol or drug problems is used only after violence has been ruled out by a thorough and competent assessment. Partner violence is typically seen either as situational or as a version of terrorism



where there is a pattern of intimidation, coercion, and control. Cases involving milder forms of situational violence can sometimes be treated in couples counseling. However, cases of more persistent violence are not candidates for couples counseling.

### ***Opiate Replacement Programs***

There are some substance dependent clients who cannot achieve or maintain abstinence and whose repeated treatment attempts have failed. Two governmentally sanctioned alternative medical treatments exist for those clients whose dependence pattern involves opiates such as heroin, morphine, codeine, or the many prescription opiate pain killers: methadone and buprenorphine. The latter is often used in combination with an opiate antagonist to block the effects of any additional opiates that clients might use in addition to buprenorphine. Both of these medications are opiate substitutes that stave off withdrawal symptoms and block the effects of additional opiates. Counseling is a federal requirement for all licensed opiate replacement programs, and the counseling usually focuses on improving clients' abilities to seek and maintain gainful employment, complete their education (that may have been neglected due to a drug user lifestyle), and abandon a life of crime.

## **Components of Counseling in Substance Abuse Settings**

### ***Screening***

Counseling begins with screening to identify clients having a substance use problem. The Alcohol Use Disorders Identification Test (AUDIT), the Drug Abuse Screening Test (DAST), the Michigan Alcoholism Screening Test (MAST), and the CAGE (the acronym comes from first letters in key words in the questions) have all been used in counseling settings to screen for potential substance use problems. For clients who are identified as possibly having substance use problems, an assessment is the next step.

### ***Assessment***

An assessment determines the scope and severity of substance-related problems. The assessment also guides the development of a counseling plan with clients. Assessment includes obtaining information

about the specific substances being used, frequency of use, quantity of use, social context of use, route of administration (smoked, oral, or injected), age of first use and age of beginning regular use, and clients' level of motivation or readiness for change. Counselors can use any of a number of standardized and validated instruments to guide the assessment process, but most assessments use semistructured interviews that draw questions from standardized instruments. Counselors may feel too constrained by lengthy questionnaires that make it difficult to remain client centered.

Generally, counseling assessment of substance use is more effective when substance use questions are delayed until there is a level of trust or rapport established between the counselor and client. Self-reports of substance use can be unreliable in the absence of trust and a beginning working alliance. The assessment must be thorough, however, because the more indirect approaches give clients too much room for denying problematic use. A direct, matter-of-fact, but kindly approach is most effective. Unless directly asked about specific substance use behaviors, clients may avoid bringing them up, thus misleading the focus of a counseling plan.

### ***Assessing Motivation for Change***

Counselors also need to assess clients' motivation for change. Since the introduction of the *transtheoretical stages of change* model, substance abuse treatment has been attentive to clients' level of interest in personal change rather than simply trying to make all clients accept the standard treatment package. This model identified five stages in the change process: (1) *precontemplation*: the individual has not yet begun to think about having a problem associated with substance use; (2) *contemplation*: the individual has begun to think about the problem and may have a distant intention to look into help; (3) *preparation*: the individual has begun a specific behavioral plan for change; (4) *action*: the point at which changes are now under way; and (5) *maintenance*: the person sustains the gains made during the action phase. The transtheoretical model is widely used in the substance abuse treatment field, regardless of the theoretical orientation underlying the treatment approach. For example, 12-Step-oriented programs make use of it as do cognitive-behaviorally oriented programs. It has the simplicity of offering a way to think about clients' preparedness for counseling and the degree to which



they are open to being challenged about their problem behaviors. The 32-item University of Rhode Island Change Assessment (URICA) is widely used to assess the client's stage of change.

### ***Assessing Problems Related to Substance Use***

A wide range of psychosocial problems co-occur with substance use problems. The most likely co-occurring conditions are (1) mood disorders, (2) anxiety disorders, (3) posttraumatic stress disorders, (4) antisocial and borderline personality disorders, (5) partner and/or parental abuse, and (6) eating disorders. Other problems related to substance use may include housing, child removal/custody, legal problems, crime victimization, and social problems. Counselors initially screen for these conditions and then assess the ones that are positive for screening. Counseling approaches for assessing co-occurring disorders may follow *DSM-IV-TR* criteria or may involve assessment instruments. The difficulty with using instruments is that they can add considerable structure and length to a counseling assessment session since so many disorders can co-occur. For example, depressed substance abuse clients may also have posttraumatic stress disorder or another anxiety disorder and they may also have a personality disorder. In current practice, competent substance abuse assessment also addresses all the likely co-occurring conditions. Once the assessment is complete, counselors must decide which problems the intervention(s) should target. Current practice following the assessment of the most immediate threat to well-being also involves counseling on all conditions simultaneously, an approach called *integrated treatment*, rather than treating one condition (what used to be called the *underlying* condition) followed by treating the other.

### **Counseling Practices and Approaches**

There are many approaches to counseling individuals with substance use problems, which range from open-ended, client-centered to very structured, curriculum-based approaches. Increasingly, public policies call for the use of evidence-based practices. However, the application of these practices is limited by numerous problems in "translating" research into real-life situations. First, there is only very limited evidence from clinical trials to support the benefits of one approach

versus any others. Second, research studies are usually careful in selecting subjects with only one disorder to test their interventions while in real-life practice, most clients have at least one other co-occurring condition. Third, there are many different cultures among clients in real-life practice, and research studies typically have limited cultural representation among their subjects. Thus, while there is considerable interest in using evidence-based practices, there are numerous limitations to the implementation of these practices.

### ***Recovery Dynamics***

Most substance abuse treatment centers (particularly residential programs) use a form of counseling that is derived from the AA, NA, or another 12-Step self-help recovery philosophy. Recovery Dynamics is a more formalized treatment program that takes the 12-Step ideas and turns them into phased treatment objectives. Every client in a recovery dynamics program is exposed to all the phases. Recovery Dynamics and other 12-Step approaches have had general treatment outcome support but have not been tested in clinical trials against other approaches.

### ***Cognitive-Behavioral Approaches***

Cognitive-behavioral approaches have been favored in treating substance abuse problems across many different modalities of treatment. Part of the reason is that cognitive approaches place an emphasis on the discovery of unrealistic or irrational beliefs and the replacement of those with rational decision making. Many irrational beliefs drive the compulsive use of substances and counseling can address those beliefs while laying the groundwork for more rational responses. Cognitive-behavioral approaches enjoy a high degree of empirical support for their efficacy in treating substance abuse and a wide range of co-occurring disorders.

### ***Motivational Interviewing and Motivationally Enhanced Treatment***

Motivational interviewing owes much to the client-centered Rogerian approaches of the 1960s and 1970s. It is a client-centered approach rather than a "program" of content that each client must experience. It places an emphasis on gradually inducing clients into treatment by recognizing their stage of



change and by not rushing into an immediate recovery plan. Motivational approaches highlight the importance of empathy, feedback to clients about their problems as perceived by the counselor, and enlistment of client decisions for change plans instead of “administered” interventions. The techniques of motivational interviewing were extended into the intervention phase in what came to be known as *motivationally enhanced treatment*. Motivational approaches have been used with all types of substance abuse clients, including adolescents, women suffering from violence victimization, and criminal justice clients. Motivational approaches have received research support in a variety of settings and with different populations.

### **Social Skills Building**

Another counseling approach emphasizes teaching clients the social skills that are necessary for recovery and living without dependence on alcohol or drugs. Social skills building approaches are designed to discover and address gaps in clients’ skill set. Hence, social skills approaches tend to be more compatible with strengths-based case management, an often-used adjunct to counseling for substance use problems. While case management is not necessarily a counseling activity, it is often used along with counseling to help clients carry through on counseling goals and attain community resources to support recovery. Social skills training has received research support as an effective approach for treating alcoholism and alcohol abuse.

## **Special Populations for Counseling**

### **Adolescents**

Adolescents require treatment approaches that differ from those used with adults. The standard AA, NA, 12-Step ideas have little acceptance in adolescent counseling settings. There are adaptations of self-help models; however, they have yet to gain empirical support. Adolescent counseling is most likely to involve family counseling and even the active engagement of at least one parent in the intervention. Adolescent substance abuse is seen as directly tied to family systems issues and thus successful treatment is seen as requiring the engagement of the entire family.

### **Women**

Women have lower rates of both substance abuse and dependence than men, but related co-occurring problems such as childhood or adult victimization and depression, PTSD, and anxiety are very common among women who develop serious substance-related problems. Some programs have found that up to 80% of their female clients report childhood or adult experiences of physical or sexual abuse and well over half will experience depression, anxiety, or posttraumatic stress disorder. Others may have personality disorders. Women in substance abuse counseling typically have other kinds of concerns such as pregnancy and health problems that are related to victimization. Their substance use and all these co-occurring problems require attention in counseling.

### **Criminal Justice Clients**

There is increasing need for substance abuse treatment both in prison and in probation and parole settings. For example, it has been estimated that 80% of men in prison were substance involved when they committed their crimes. In addition, drug courts (special court programs that provide close judicial supervision, case management, and treatment for drug-involved defendants) have increased in the United States and counseling is an integral part of the drug court approach. Counseling is provided as a direct service of the drug court in some jurisdictions and by contracting with counselors outside the court system in other jurisdictions. Cognitive-behavioral and 12-Step-oriented counseling approaches are frequently used with criminal justice involved substance abusers. Some programs also use a variation of cognitive-behavioral therapy that addresses criminal thinking more than irrational thinking. It examines criminal intent and automatic thoughts about stealing, harming others, or otherwise breaking the law. Counseling criminal justice-involved clients also means careful attention must be given to confidentiality issues, and that counselors may be required to release information about counseling compliance to the court or probation or parole officers.

### **Co-occurring Mental Disorders**

A large percentage of substance abusers in counseling have co-occurring mental disorders. After assessing for immediate treatment needs, an *integrated treatment* counseling approach is used with clients



who have co-occurring disorders because it addresses substance use and mental health simultaneously. The integrated approach avoids concerns about which disorder underlies the other or which is the more pressing. Nevertheless, an integrated treatment for co-occurring condition increases the counselor's burden dramatically. Counselors must be competent in dealing with a wide array of problems in order to address clients' needs. When the specialty needs exceed the competence of a counselor or program, the next best approach is a collaborative treatment in which clients receive services from multiple healthcare providers.

### **Cultural Competency in Counseling for Substance Use Problems**

Counseling for substance use problems is conducted among people from many different races and ethnicities. Counseling approaches need to be sensitive to these differences to address substance use problems effectively without creating resistance or perceived stigma. The "fit" between client and counselor may be heavily affected by cultural factors. This is all the more complicated in substance abuse counseling because of the added factor of stigma associated with substance use. The counseling profession, like other human services, has struggled with how to develop and train meaningful competencies without promulgating stereotypes that conflict with individual cases. National organizations have been developed to help formulate competencies and training programs. Competency generally involves counselors' recognition of their own culture as well as an appreciation of their clients' cultures as they may be shaped by race and ethnic factors. With substance use problems, counselors' own recovery experiences may add yet another consideration. Some clients want a counselor who has also been in recovery, while others do not regard this as important. Sensitivity to these factors as well as to race, gender, and ethnicity may be important in matching counselors and clients.

### **Future Directions and Trends**

Funding for substance abuse counseling perhaps peaked during the 1980s when private insurance included generous benefit packages for inpatient care. Now, funding is largely restricted to individual out-of-pocket or public funding. However, the need for counseling for substance abuse problems is unlikely to

abate. Brief interventions, some of which involved only one or two sessions, are being studied more closely than in the past. However, the complexity of problems presented by clients is also increasing and this complexity suggests more intensive interventions. The end result is that with the growing complexity of co-occurring conditions, counselors need to continually add to their basic skills to remain competent.

*Robert Walker and TK Logan*

**See also** Abuse (v2); Alcoholics Anonymous (v1); Cigarette Smoking (v1); Cognitive-Behavioral Therapy and Techniques (v2); *Diagnostic and Statistical Manual of Mental Disorders (DSM)* (v2); Group Therapy (v2); Individual Therapy (v2); Physical Health (v2); Problem-Solving Appraisal (v2); Psychopharmacology, Human Behavioral (v2); Rational Emotive Behavior Therapy (v2); Self-Help Groups (v2)

### **Further Readings**

- Lowinson, J. H., Ruiz, P., Millman, R. B., & Langrod, J. G. (2005). *Substance abuse: A comprehensive textbook* (4th ed.). Philadelphia: Lippincott, Williams & Wilkins.
- Miller, W. R., & Rollnick, S. (2002). *Motivational interviewing: Preparing people for change* (2nd ed.). New York: Guilford Press.
- Najavits, L. M. (2002). *Seeking safety: A treatment manual for PTSD and substance abuse*. New York: Guilford Press.

---

## **SUICIDE POTENTIAL**

---

Suicide is a serious public health issue both at the global level and in the United States. Globally, the World Health Organization indicates that there were 1,000,000 deaths by suicide in 2000, and projects that there will be 1.5 million suicide deaths in the year 2025. Additionally, the overall rate of suicide in the world has been steadily increasing since 1950. In the United States, according to the American Association of Suicidology, there were approximately 31,000 deaths by suicide in 2003 and, although there are no solid data identifying the actual number of suicide attempts, this organization estimates that there are at least 25 attempts for every suicide death.

Efforts to address the incidence and prevalence of suicide and suicidal behavior, while initially focused on developing standardized methods for prediction, have



focused more recently on the identification of suicide potential through the assessment of salient risk factors and clinical indicators of suicidality. This entry provides an overview of the identified suicide risk factors and characteristics that counselors need to be aware of in their clinical work with suicidal individuals.

### Treating the Potentially Suicidal Individual

Clinicians are urged to consider the issue of the interpersonal context of the assessment of suicide potential even before they complete the assessment of risk factors and potential indicators, as recent work in this area has suggested that suicidal clients often perceive the assessment process as impersonal and dehumanizing. Moreover, both theory and research suggest that the validity of assessment information is related to the quality of the interpersonal relationship from the client's perspective. Thus, clinicians working with suicidal individuals should acknowledge the importance of considering the assessment process from the client's point of view. Adherents to this perspective consider the suicidal individuals—not the counselor—as the experts in their suicidality. Additionally, suicidality is viewed as the central clinical problem in these models, as opposed to being addressed as a symptom of some underlying psychopathology. Regardless of the approach to the assessment of suicide potential (e.g., standardized assessment measures, clinical interview, or a combination), a greater focus on collaboration and a therapeutic assessment approach to suicide risk assessment will serve to increase the reliability and validity of information accrued through the process.

With the importance of the therapeutic relationship in mind as the backdrop for identifying information relevant to the assessment of suicidal potential, there are two different approaches for identifying risk factors and clinical indicators. The first approach is the top-down or clinician-focused model embedded in the Suicide Assessment Checklist (SAC) developed by James Rogers and his colleagues, and the second is the horizontal model reflected in the Collaborative Assessment and Management of Suicidality (CAMS) protocol developed by David A. Jobes and his colleagues.

### Suicide Assessment Checklist (SAC)

In this model, the clinician prompts for information and completes the assessment protocol from what is

typically an “expert” position. The SAC identifies a number of status and clinical variables that have been shown in the literature to be related to increased suicide potential. The status variables include the following:

- Previous psychiatric history (implying a psychiatric diagnosis)  
Diagnoses specifically linked to greater suicide potential include:
  - i. Depression
  - ii. Bipolar depression (especially with psychotic features)
  - iii. Anxiety disorders
  - iv. Schizophrenia
  - v. Post-Traumatic Stress Disorder
  - vi. Personality disorders (especially borderline personality disorder)
- Drug and alcohol use
- Prior suicide attempts
- Sex  
Males at higher risk
- Age  
Ages 15 to 35 and 65 and older at higher risk
- Suicide survivor status
- Marital status  
Divorced, separated, or widowed at higher risk
- Presence of a suicide plan including:
  - An identified method
  - Method access
- Making final plans
- The presence of a suicide note
- Dependent children in the home  
Serving as a protective factor

Similarly, clinical risk factors identified in the SAC model include the following:

- Worthlessness
- Hopelessness
- Social isolation
- Depression
- Impulsivity
- Hostility
- Intent to die
- Environmental stress
- Lack of a future time perspective

The SAC provides for a quantitative summary assessment of suicide risk based on the identification of



the status variables and ratings on the clinical risk factors. In general, higher scores are interpreted as indicating greater risk. However, the application of strict cutoff scores is discouraged, and clinicians are prompted to integrate the SAC information with their clinical experience in making final intervention decisions.

The SAC provides a structured approach for the assessment and documentation of factors related to increased suicide potential. However, there are a number of important clinical constructs that are not taken into account in this model. Neither does it specifically promote a strong working alliance. The following approach includes these additional clinical constructs while fostering a horizontal or collaborative interpersonal context.

### **Collaborative Assessment and Management of Suicidality (CAMS)**

The CAMS model integrates a variety of approaches in the process of assessing and intervening with suicidal clients including attention to the behavioral, cognitive, psychodynamic, humanistic, existential, and interpersonal aspects of the suicidal experience of the client. The CAMS protocol prompts the client, in collaboration with the counselor, to provide a self-assessment of the following constructs that have been shown to be related to increased suicide potential:

- Psychological pain
- Stress
- Agitation
- Hopelessness
- Self-hate
- Reasons for living
- Reasons for dying

Within the CAMS model, clients not only identify their level of distress on a variety of clinical variables, but also specify which aspects are the most troubling for them. Similarly, reasons for living and reasons for dying are rank ordered in terms of importance, leading to the development of targeted interventions. In addition to the risk factors identified in the SAC, the CAMS model also identifies the following four specific risk factors:

- Suicide rehearsal (i.e., practicing suicide-related behaviors)
- Relationship problems
- Legal problems
- Health problems

Currently, there is no research demonstrating the relative efficacy of these approaches. However, taken together, the status variables, risk factors, and clinical constructs incorporated in these two models provide a relatively comprehensive outline of the most salient indicators of suicide potential. Nonetheless, as important as familiarity with these factors is to accurately accessing the suicide potential of a client, it is equally important to understand the impact of the interpersonal context on the assessment process. Assessment and intervention are uniquely intertwined when responding to suicidal crises, and the quality of the information gathered in the process will be a function of the counselor's ability to engage the client collaboratively and on an existential level.

*James R. Rogers*

*See also* Bipolar Disorder (v2); Crisis Counseling (v2); Death and Dying (v1); Depression (v2); Panic Disorders (v2); Personality Disorders (v2); Posttraumatic Stress Disorder (v2); Schizophrenia, Adult (v2); Stress (v2); Substance Abuse and Dependence (v2); Suicide Postvention (v1)

### **Further Readings**

- Jobes, D. A., & Drozd, J. F. (2004). The CAMS approach to working with suicidal individuals. *Journal of Contemporary Psychotherapy*, 34, 73–85.
- Michel, K., Leenaars, A. A., Jobes, D. A., Orbach, I., Valach, L., Young, R. A., et al. (2001). *Meeting the suicidal person: New perspectives for the clinician*. Retrieved June 1, 2006, from <http://www.aeschiconference.unibe.ch/index.html>
- Rogers, J. R., Lewis, M. M., & Subich, L. M. (2002). Validity of the Suicide Assessment Checklist in an emergency crisis center. *Journal of Counseling and Development*, 80, 493–502.
- Westefeld, J. S., Range, L. M., Rogers, J. R., Maples, M. R., Bromley, J. L., & Alcorn, J. (2000). Suicide: An overview. *The Counseling Psychologist*, 28, 445–510.









---

## TAXONOMY OF HELPFUL IMPACTS

---

Psychologists have made systematic efforts to identify the relation of events that occur during therapy to the beneficial outcomes clients report. This critical topic is addressed by every theory of psychotherapy, and well over a thousand studies of the efficacy of therapeutic interventions have been published during the last seven decades. Recently, psychologists have undertaken systematic analyses of that evidence to identify the common factors that—regardless of therapeutic approach—account for much of the success of psychotherapy.

Robert Elliott analyzed data from 24 single-session interviews in 1985 and identified 86 helpful therapist responses that he clustered into eight types of helpful events. He further grouped these helpful events into two “superclusters.” Four helpful events formed the *task* supercluster because they involved direct work or progress on the client’s presenting problem. They are as follows:

*New perspective:* asking information-gathering questions to get clients to think about the effects of their behaviors

*Problem solution:* providing a detailed summary at the end of the session and suggesting strategies for clients to try before the next session

*Problem clarification:* asking questions at the beginning of the session to help clients clarify the nature of their problem

*Focusing awareness:* directing clients’ attention to some aspect of the problem to obtain information that is more detailed

The other helpful events formed the *interpersonal* supercluster because they referred to some form of helpful interpersonal contact. They are as follows:

*Understanding:* making a comment that illustrates an understanding of clients’ thoughts and feelings

*Client involvement:* proposing one possible course of action and encouraging clients to evaluate its feasibility for their personal situation

*Reassurance:* making a positive comment that encourages clients to believe they can deal with their problems effectively

*Personal contact:* revealing relevant personal information to seem more human to clients

Psychologists concerned primarily with group interventions have focused their efforts on the identification of in-therapy events that clients perceive as having a helpful therapeutic effect. Raymond J. Corsini and Bina Rosenberg identified mechanisms that account for beneficial change during group psychotherapy in an influential article that provided the initial foundation for research on this topic. Betty Berzon and her associates proposed a list of nine helpful therapeutic factors that Irvin D. Yalom expanded upon in his influential *The Theory and Practice of Group Psychotherapy*. Yalom suggested that 12 factors



were responsible for most of the therapeutic benefits of group psychotherapy: altruism, group cohesiveness, universality, interpersonal learning: input, interpersonal learning: output, guidance, catharsis, identification, family reenactment, self-understanding, instillation of hope, and existential factors.

Dennis M. Kivlighan, Karen D. Multon, and Brossart performed principal components analysis of critical incidents data to further refine and reduce the list of helpful impacts. Based on this research they developed the Group Counseling Helpful Impacts Scale for use in research on the relation between group leader behaviors and clients' perceptions of their helpful impact. This instrument measures four helpful impacts: Emotional Awareness—Insight, Relationship, Other Versus Self Focus, and Problem Definition—Change.

None of these taxonomies has stimulated much research, but the idea that some therapist interventions are more likely than others to stimulate beneficial changes in clients continues to be important to psychologists.

Howard E. A. Tinsley

**See also** Common Factors Model (v2); Counseling Process/Outcome (v2); Counseling Theories and Therapies (v2); Evidence-Based Treatments (v2); Facilitative Conditions (v2); Group Therapy (v2); Outcomes of Counseling and Psychotherapy (v2); Therapist Techniques/Behaviors (v2); Wampold, Bruce E. (v2)

### Further Readings

- Berzon, B., Pious, C., & Parsons, R. (1963). The therapeutic event in group psychotherapy: A study of subjective reports of group members. *Journal of Individual Psychology, 19*, 204–212.
- Corsini, R., & Rosenberg, B. (1955). Mechanisms of group psychotherapy: Process and dynamics. *Journal of Abnormal Social Psychology, 51*, 406–411.
- Elliott, R. (1985). Helpful and nonhelpful events in brief counseling interviews: An empirical taxonomy. *Journal of Counseling Psychology, 32*, 307–322.
- Kivlighan, D. M., Jr., Multon, K. D., & Brossart, D. F. (1996). Helpful impacts in group counseling: Development of a multidimensional rating system. *Journal of Counseling Psychology, 43*, 347–355.
- Wampold, B. E. (2001). *The great psychotherapy debate: Models, methods, and findings*. Hillsdale, NJ: Lawrence Erlbaum.

Yalom, I. D. (2005). *The theory and practice of group psychotherapy* (5th ed.). New York: Basic Books.

---

## TEST INTERPRETATION

---

One of psychology's most important and enduring contributions to civilization is the development of the psychological test. Psychologists have invented and refined psychometric procedures (i.e., tests) for assessing a breathtakingly wide array of constructs. Among the topics reviewed in this volume of the *Encyclopedia of Counseling*, for example, are the assessment of academic achievement, adaptive behavior, affect, counseling process, counseling outcome, depression, intelligence, language, memory, mental status, neuropsychological functioning, personality, problem solving, psychopathology, and self-esteem. Also reviewed are assessment procedures such as the use of clinical interviews and projective techniques. Psychologists are presently developing advanced technologies such as computer-assisted assessment, computer test interpretation, and item response theory.

Most counseling psychologists regard psychological assessment as an important activity regardless of their work setting or the type of clientele. A national survey of American Psychological Association members revealed that the work activities of counseling psychologists include collecting information about their clients (80.3%) and identifying and diagnosing their clients' problems (76.6%). More than 20% of their total professional time is devoted to assessment and diagnosis. Psychological tests are so critical to the work of psychologists that Rene V. Dawis and David Lubinski have described them as serving the same function as the microscope to microbiologists and the telescope to astronomers.

Assessment is not an end unto itself; the critical intent is to obtain information that will be useful in addressing the practical problems confronting the individual and society. However, the incremental utility of assessment has not been established and the belief in the value of assessment rests more on assumptions of utility than on empirically demonstrated benefits. Although studies have examined the efficacy and effectiveness of a variety of therapeutic approaches, scant empirical attention has been paid to the process of assessment.

Test interpretation, in particular, is one assessment procedure that has received relatively little scientific



scrutiny. This entry describes approaches to assessment and interpretation, explains how a skilled psychologist prepares for and delivers an interpretation, and summarizes the evidence pertaining to the effectiveness of test interpretation.

## Approaches to Assessment

### *Clinical Interview*

The assessment technique most widely used by counseling psychologists is the clinical interview. However, psychometric assessment procedures have numerous advantages over the interview. For example, therapists gain experience one client at a time, but tests provide information based on large numbers of people in the form of norm groups. Given the fallibility of human memory, therapists are likely to forget some cases and to give too much weight to memorable, but atypical, cases. The norm groups provided by tests are not overly influenced by unusual or graphic cases.

Administering a test to an individual can be thought of as analogous to conducting a standard interview. At the conclusion of the procedure, the test reports descriptive information (scores) having an approximately known level of reliability. In contrast, psychologists conduct semistandard interviews and obtain descriptive information having an unknown reliability. The test scores suggest inferences having an approximately known validity. In contrast, psychologists draw inferences that have less validity than the inferences drawn from the tests. Furthermore, supporters and critics repeatedly examine the reliability and validity of tests, while the reliability and validity of the interview, as an assessment device, is virtually never examined.

### *Clinical Versus Statistical Prediction*

The end goal of assessment is to obtain information that can be used to guide the important decisions psychologists and examinees must make. That means the information obtained from tests must be useful in predicting important real world phenomena. The issues that confront individuals and require predictions are as diverse as life itself: whether to get married or divorced, which course of study or job to pursue, whether an incarcerated individual should be permitted to rejoin the community, and what approach will most effectively treat the symptoms that interfere with an individual's ability to function in society. In

short, the usefulness of test scores lies in the real life criteria they can predict.

In 1954, Paul Meehl demonstrated that the inferences (i.e., predictions) trained therapists draw from psychological tests are not as accurate as those made using statistical algorithms. Well over 100 studies have been published demonstrating that statistical algorithms are usually more accurate than trained therapists in predicting people's future behavior.

The greater accuracy of statistical algorithms is attributable to several of the factors explained above (i.e., norm groups, reliability, and validity). An additional problem occurs when combining multiple pieces of information. Therapists have limited ability to determine the proper weight to give each factor, and they are likely to be influenced by irrelevant considerations. Statistical algorithms derive weights for each factor that lead to the most accurate predictions possible.

Despite overwhelming evidence that actuarial predictions are more accurate, the use of test information in clinical practice has remained virtually unchanged in the half century since the publication of Meehl's book. A challenge to psychology is to develop procedures for better integrating the results of assessment procedures into clinical practice. A careful examination of this issue is long overdue.

### *Computer Test Interpretation*

The development of computer programs capable of preparing test interpretations was pioneered in the area of vocational interest measurement three decades ago. Since that time the practice has expanded to include personality tests and tests used in making psychological diagnoses. Essentially, the computer program compares the test results to the normative data available for the test and determines the range within which the score falls (e.g., very low, average, slightly elevated). It then selects relevant descriptive phrases, sentences, and paragraphs from a library of interpretive materials and organizes these into a narrative summary. When completed, that summary can be displayed on a computer monitor and printed, as desired.

Some interpretations consist of little more than normative statements that indicate whether a score could be considered low, average, or high. For example, a statement such as, "Your score on the introversion scale is in the normal range when compared to the scores of other high school freshmen" provides a normative interpretation.



Interpretations that are more elaborate explain the meaning of the score. For example, the meaning of *introversion* could be explained using statements like the following:

Introversion refers to a predisposition to be concerned with your own thoughts and feelings. Contrary to what many think, introversion is not the same as shyness. Shyness involves an element of apprehension or anxiety that is not necessarily present in introverts. Although introverts may be less inclined to seek companionship, for some it is merely because they are energized by being alone.

Some test interpretation programs take the process a step further and suggest implications of the scores for future behavior:

People who obtain similar introversion scores tend to avoid conflict and unpleasantness. They may enjoy social interactions, but also find them draining and typically feel a need for time to recharge their batteries after social interactions. They may be especially uncomfortable in social interactions with the opposite sex. They form social relationships slowly and deliberately, but once formed those relationships tend to be highly stable.

Although computer-generated interpretations sound authoritative, their reliability and validity require careful scrutiny. However, the cost of evaluating these algorithms is high and most psychologists do not possess the resources necessary to undertake such an evaluation.

### ***Self-Interpreting Tests***

Another major innovation in the last half century is the self-administering, self-scoring, self-interpreting test. Personality inventories such as the Allport-Vernon-Lindzey Study of Values and vocational interest inventories such as John Holland's Self-Directed Search pioneered this approach. The practice is now widely used in assessing constructs of interest in vocational psychology, it has been incorporated into computer-based guidance programs such as SIGI, and it is enjoying increasing use in personality tests such as the Neuroticism, Extraversion, Openness Personality Inventory-Revised (NEO PI-R).

Psychologists were originally concerned about the possibility that examinees would make mistakes in

scoring their tests that would lead to inaccurate information. Early research revealed that some scoring problems did exist, but modifications of the tests have reduced these problems to an acceptable level. There have also been numerous expressions of concern that examinees will make serious mistakes in attempting to interpret these tests for themselves. Despite this, a review of the literature reveals only seven investigations in which the accuracy and effectiveness of self-interpretation was considered. Those studies generally revealed no differences among the modes of test interpretation, but the lack of scrutiny of this important test interpretation innovation is cause for caution and concern.

## **Preparing and Delivering a Test Interpretation**

### ***Preparing the Interpretation***

Expert test interpretation requires the integration of technical information about the test with an intimate understanding of the individual who has taken the test. This requires preparation. Despite extensive experience with the tests to be interpreted, conscientious psychologists review reference sources to refresh their memory of the nuances that are critical to insightful test interpretation. Furthermore, they realize that test scores must be interpreted in the context of the personality and life history of an individual. For example, a comment reflecting doubt or pessimism about the prospects for a happy life takes on different meanings when made by a young person whose parents just died in a automobile accident and one who is undergoing treatment for leukemia. Psychologists avoid interpreting test results in isolation, if possible.

### **Understanding the Assessment Results**

Psychologists' initial question when preparing a test interpretation is, "What do these test results mean?" The objective is to develop hypotheses that can be tested when discussing the results with the client. Test scores provide statistical summaries of statements the client made in responding to test items or evaluations of the client's performance on tasks required by the test. As such, psychologists may ask clients to explain some of their responses to the test during a subsequent interview.

Counselors give special attention to the meaning of information that appears to be contradictory. Resolving apparent contradictions is important and often requires



discussion with the examinee to arrive at a clear understanding. Low or socially undesirable scores can be threatening or embarrassing to clients and require careful consideration. Psychologists think carefully about how to discuss this information with the client.

Psychologists may use a *nomothetic* (norm-based) or an *idiographic* (individual-focused) approach to understanding the meaning of the test results. Nomothetic interpretations tend to be quantitative. They compare the scores of the individual to a relevant comparison group, as when a ninth-grade student's performance on a math test is compared to that of other ninth-grade students. Placing the results in a relevant context allows the psychologist to distinguish average or typical scores from various types of exceptional scores. Psychometric testing and other quantitative methods are consistent with a nomothetic approach to test interpretation.

Psychologists working with individuals are also interested in understanding the examinee as a unique individual without reference to others. The idiographic approach to test interpretation involves an exclusive focus on the individual. Case studies, informal interviews, unstructured observation, and other qualitative methods are more consistent with idiographic approaches. The assessment of vocational interests is one area in which idiographic approaches are common. Vocational psychologists typically want to know how an individual's interests and abilities compare to those of a reference group, but also how each interest and ability compares to the other interests and abilities of the person. For example, while it is useful to know that a person's interest in music is strong when compared to the interests of other people, it may be even more important to know that the person has even stronger interests in business, teaching, and military service.

### Integration of Results

Psychologists must integrate their understanding of the test results with the other available information. This information may include others' comments, work- or school-based performance indicators, additional assessment results, and family background or work history information. At a minimum, most psychologists will have information gained from the interviews conducted prior to selecting the assessments for the individual to take.

The first step is to evaluate the consistency of the information. Psychologists identify any inconsistencies

and attempt to determine why they occurred. Mistakes in administering the test can result from errors such as using the wrong form of the test, the wrong answer sheet, or failing to follow the directions properly. Mistakes in scoring the test can result from a simple mistake when evaluating the test responses, using the wrong scoring procedure, using the wrong norm group for converting the raw scores to standard scores, or making a mathematical mistake when calculating the standard scores. Skilled psychologists do not assume the test result is correct when it contradicts the other information that is available, nor do they automatically disregard test results that do not confirm their expectations. They investigate the inconsistency and attempt to resolve the paradox. Often, this involves discussing the seeming inconsistency with the examinee.

### Presentation Order

Once psychologists have a clear understanding of the test results, they consider the order in which to present the information. This involves adopting the client's frame of reference. Psychologists develop a tentative plan that is subject to revision during the test interpretation interview. For example, the examinee might ask about a particular set of results that are of special interest, or express an interest in discussing something different than the test results.

Psychologists often begin the interpretation with more concrete information (e.g., achievement test results) and then move to information that is more abstract (e.g., personality test results). When the psychologist is uncertain about the best order or believes the order is unimportant with this particular client, he or she may review the tests to be interpreted with the client and ask the client's preference.

Psychologists realize that the test interpretation must be guided, in part, by the emotional needs of the client. They consider whether the client is psychologically ready to think about the test results effectively, able to handle threatening information constructively, and whether this is the most important use of interview time at this point.

### Preparing the Client

Despite the fact that the therapist and client have jointly agreed on the tests to administer and the timing of the test interpretation, psychologists realize that it is still important to prepare the client for the interpretation.



Therapists give clients an opportunity to raise any issues they regard as important prior to discussing the test results. The therapist begins the test interpretation only after determining what will be the most effective use of the interview time.

Psychologists lead the interview into a discussion of the test results when it is clear the client is ready. Often they describe the test briefly so the client can associate the results with the test he or she took. This is more important when the client took more than one test or the time lapse between completing the test and interpreting the results is prolonged.

Psychologists also review with the client the types of information the test provides and the types of interpretations that are possible. For example, a score indicating an interest in a particular occupation does not mean the person has the ability to be successful in that occupation. Psychologists explain the norm group used to interpret the test; they may interpret the results in relation to several norm groups. Before beginning the test interpretation psychologists also take care to make sure the client understands the inexact nature of test scores and the limits on the precision with which inferences can be drawn. Often they reiterate this point periodically throughout the interpretation process.

## ***Delivering the Test Interpretation***

### **Client's Goals**

A given test score may have several possible interpretations. The most useful interpretation addresses the issues confronting the client and therapist. For example, a given score on an academic aptitude test could indicate the client's intellectual ability is probably adequate for completion of a B.A. in history, or that completing a master's degree in international relations would be quite difficult. Psychologists make the test interpretation personally meaningful by relating the results to the issues and decisions confronting the client.

### **Test Precision**

Many individuals believe that tests can provide precise answers to their questions. They often report test results—particularly flattering or socially desirable results—using precise scores or unqualified statements (e.g., “My IQ is 130” or “I am an altruistic extravert”). Psychologists avoid the use of technical terms such as the standard error of measurement, but they do explain

that a test score (e.g., an IQ of 130) actually indicates an approximate level (e.g., an IQ somewhere between 124 and 136). Likewise, when relating the test score to an external criterion psychologists explain that the test score actually predicts a range of possible outcomes. It is not always necessary or desirable to give examinees exact scores or detailed technical information. Psychologists view the purpose of the test interpretation as conveying meaningful information.

### **Defensive Reactions**

Interpreting low or potentially undesirable scores can be difficult. Psychologists do not scold, disapprove, moralize, or use pejorative labels when interpreting such scores, but they are sensitive to the possibility that examinees will impose these reactions upon themselves. Psychologists do not avoid these scores nor downplay their importance, but they do remind clients of the limited accuracy of these scores. They point out the implications of the scores and relate them to the decision the client must make. The objective is to get clients to discuss what this information means for them.

Examinees need accurate information about their weaknesses and areas needing improvement as well as information about their strengths. Low or negative scores can be useful in raising issues the client needs to address. Talking about these scores allows the examinee to acknowledge these areas and to develop realistic plans. At the same time, psychologists remain sensitive to the client's feelings about these scores and deal with those feelings in a sensitive and constructive manner.

### **Plain Language**

Psychologists avoid technical terms and explain test results in language the typical individual can understand. They also avoid the use of words such as *neurotic*, *maladjusted*, *masculinity* or *femininity*, and *intelligence* that are likely to arouse unfavorable connotations. Once a counseling relationship has been established, psychologists also identify and avoid the use of individually threatening terms.

### **Encouraging Feedback**

Psychologists interpret test results in a manner that allows and encourages client participation. They



accomplish this goal by using a statement such as, “How does that compare with what you expected (or think about yourself)?” “Does that seem right to you?” or “You seem to be disappointed with that score.”

Eliciting client feedback allows the psychologist to determine whether the client understands the information being presented, and it provides information about the clients’ attitudes and feelings toward the information. Instead of asking a direct question, the psychologist periodically may ask the client to summarize the information being presented. This helps create a therapist–client discussion rather than a psychologist monologue, and it allows the psychologist to determine whether the client understands the information. Furthermore, this gives the client an opportunity to organize and integrate the information and to express his or her feelings about the information.

Psychologists may also ask the client to speculate on the implications of the test results. This requires that the client organize the information presented, integrate it with his or her existing knowledge, and draw conclusions about the implications of the information for the decisions he or she must make.

As noted earlier, skilled psychologists take care to ask clients about any unusual responses they noted when reviewing the test responses. For example, the psychologist might say, “I noticed on one of the items you replied that you sometimes think about injuring yourself. Can you tell me more about that?” This leads to a discussion of an issue of direct concern to the client and psychologist.

### **Test Profiles**

Many tests provide graphical representations of test scores. Use of these visual aids helps clients better understand the test interpretation. Visual aids help clients clarify, simplify, and organize the test results. Clients typically appreciate a graphical depiction of their test results that they can take home. Many psychologists also encourage clients to take notes throughout the test interpretation.

One effective test interpretation strategy involves having clients rate themselves on the traits on which they are to be tested before they take the tests. The psychologist plots these self-estimates on a blank test profile and then during the test interpretation plots the actual test scores on the same profile. This shows the relation between the client’s self-estimates and actual test scores and leads to a useful discussion to any

discrepancies. Clients find it useful to take this profile home for further study.

### **Follow-Up**

The client’s assimilation of test information continues after the test interpretation interview. Psychologists continue to refer to the information in subsequent interviews and to review and reinforce the clients’ understanding of that information whenever necessary.

## **Research on Test Interpretation Outcomes**

### ***Purpose of Assessment***

It is not possible to evaluate the practical utility of assessment without specifying the purpose of the assessment procedure; however, psychologists have given this issue little attention. It appears that most practicing psychologists use assessment procedures for one of three purposes. One is to obtain information for making predictions. For example, therapists perform assessments to obtain information for use in deciding how to work effectively with their clients or for use in advising their clients about future courses of action. Psychologists also perform assessments to obtain descriptive information to help them better understand their clients. Prediction is inherent as a secondary objective in this purpose. Finally, assessment procedures are used as an intervention. For example, psychologists sometimes interpret test results to increase their clients’ sensitivity to important developmental issues. Evaluating the practical utility of assessment requires a case-by-case specification of the purpose of assessment, but this information is virtually never available.

In addition to the three general purposes specified above, psychologists may anticipate a variety of specific benefits. Several objectives are possible, including the following: learning factual information, changing attitudes or behaviors, and influencing future decisions. Unfortunately, the criteria typically used in past research on the utility of assessment are the recall of specific scores and changes in the accuracy of self-estimates. These criteria do not adequately represent the many potential benefits of testing.

### ***Effects of Test Interpretation***

Howard E. A. Tinsley and Serena Chu reviewed 65 research studies that examined test interpretation



outcomes. Most of the research focused on the interpretation of aptitude and ability tests. Virtually no research examined the interpretation of vocational interest tests or the use of tests in individual psychotherapy, couples counseling, family counseling, substance abuse counseling, or any of the many other specialty areas in which psychologists provide services. They found that few studies have been competently done or adequately reported, and that the research is fraught with methodological weaknesses (e.g., flawed criteria, use of an immediate follow-up, lack of random assignment, and lack of a control group). They concluded that there is no coherent body of evidence demonstrating the efficacy of test interpretation as an intervention.

They reported tenuous support for only three conclusions. First, the use of visual aids improves the effectiveness of test interpretation. Second, group test interpretations are as effective as individual test interpretations. Third, examinees prefer individual test interpretations to group test interpretations. Since individual interpretations are six times more costly than group interpretations, however, providing individual interpretations when group test interpretations are feasible does not appear to be justified.

## Conclusion

Adroit test interpretation requires that psychologists extract accurate information from their assessment procedures, draw accurate inferences from that information, and accurately convey the results to their clients in a manner they can understand. There is little evidence documenting the ability of counseling psychologists to satisfy these requirements. Furthermore, a convincing case has not yet been made for the practical utility of testing even when these requirements are met. Despite this, psychologists who are conscientious in their preparation of the test interpretation, who take care to prepare the client for the interpretation, and who are proficient at delivering the interpretation find that test interpretation provides a valuable adjunct to therapy.

Howard E. A. Tinsley

*See also* Achievement, Aptitude, and Ability Tests (v4); Assessment (v4); Clinical Interview as an Assessment Technique (v2); Computer-Assisted Testing (v2); Culture-Free Testing (v3); Language Difficulties, Clinical Assessment of (v2); Meehl, Paul E. (v2); Projective Techniques (v2); Psychometric Properties (v2);

Psychopathology, Assessment of (v2); Quantitative Methodologies (v1); Tinsley, Howard E. A. (v4); Translation and Adaptation of Psychological Tests (v1); Wechsler, David (v2); Weiss, David J. (v2)

## Further Readings

- Goldman, L. (1971). *Using tests in counseling* (2nd ed.). Santa Monica, CA: Appleton-Century-Crofts.
- Goldman, L. (1972). Tests and counseling: The marriage that failed. *Measurement and Evaluation in Guidance*, 4, 213–220.
- Hambleton, R. K., Robin, F., & Xing, D. (2000). Item response models for the analysis of educational and psychological test data. In H. E. A. Tinsley & S. D. Brown (Eds.), *Handbook of applied multivariate statistics and mathematical modeling* (pp. 553–581). San Diego, CA: Academic Press.
- Meehl, P. E. (1954). *Clinical versus statistical prediction: A theoretical analysis and a review of the evidence*. Northvale, NJ: Jason Aronson.
- Meehl, P. E. (1956). Wanted—a good cookbook. *American Psychologist*, 11, 262–272.
- Tinsley, H. E. A., & Bradley, R. W. (1986). Test interpretation. *Journal of Counseling & Development*, 64, 462–466.
- Tinsley, H. E. A., & Chu, S. (1999). Research on test and interest inventory interpretation outcomes. In M. L. Savickas & A. R. Spokane (Eds.), *Vocational interests: Meaning, measurement and counseling use* (pp. 257–276). Palo Alto, CA: Davies-Black.

---

## THERAPIST INTERPRETATION

---

A therapist interpretation is a technique that introduces the client to a new, theoretically based frame of reference. An interpretation goes beyond the explicit and observable client content and involves communicating an inferred component with the intention of adding new knowledge, understanding, or meaning.

## Psychodynamic Approaches

Interpretation is the central technique in psychoanalysis and in most psychodynamic therapies in which achieving insight and new understanding is considered therapeutic. In early psychoanalytic formulations, interpreting client free associations served the function of abreacting strangulated affect. Over time, modifications were made to psychoanalysis, but the centrality of



interpretation remained. In general, an *interpretation* refers to client content that is out of awareness, and it serves to make the unconscious material conscious. Within the psychodynamic therapies, interpretations are divided between transference and extratransference interpretations, with the former believed to be more potent. *Transference* is the enactment of the patient's intimate past relationships, which distort current relationships, especially with the therapist. Interpretation of this transference promotes client awareness and resolution of the conflictual relationships. Although there are various conceptualizations within the psychodynamic approaches, interpretations are believed to be most effective when used sparingly, focused on client material that is close to consciousness, and delivered at an appropriate time during the course of treatment. Research also supports tentatively delivered interpretations over those stated in directive, absolute terms. Greater progress results when therapists accurately focus on interpersonal aspects of client material (wishes toward others and their expected or actual responses) rather than simply focusing on feeling states (response of self).

### Interpretation in Nondynamic Therapies

Although therapist interpretation is a historically important intervention that is consistently judged as helpful by clients, therapists, and objective raters, it is also among the more controversial techniques. Opponents of interpretation are critical of its use, arguing that it reduces client autonomy and implies a therapist agenda. This position argues that the use of interpretation is a manifestation of the medical model and that the interpretive therapist assumes a position of expert. Correct timing, depth, and accuracy of interpretation are responsibilities of the therapist, and client readiness to accept an interpretation is judged by the therapist. In addition, interpretation targets unconscious material (such as defenses or transference), suggesting that the therapist "knows" before the client. Furthermore, interpretations are often external, explanatory, and causal, pointing out etiological underpinnings of current behaviors. This position is rejected on philosophical grounds by some schools of therapy.

### Future Directions

Therapist interpretation has been the focus of much research and debate within and across schools of

therapy. Some authors consider interpretation as a common element across therapies, but different therapeutic vocabularies make comparisons difficult. With the traditionally rigid boundaries between therapeutic modalities becoming increasingly permeable, and with the therapeutic relationship and client factors accounting for the majority of the outcome variance, techniques such as interpretation may be de-emphasized and balanced with a relational emphasis in psychodynamic schools of therapy. In other therapeutic schools, interpretations may become more tolerated if applied in a manner that de-emphasizes therapist expertness and accentuates client agency.

Nicola Gazzola

**See also** Clinical Interview as an Assessment Technique (v2); Defenses, Psychological (v2); Evidence-Based Treatments (v2); Free Association (v2); Narrative Therapy (v2); Projective Techniques (v2); Psychoanalysis and Psychodynamic Approaches to Therapy (v2); Therapist Techniques/Behaviors (v2); Transference and Countertransference (v2); Underdiagnosis/Overdiagnosis (v2)

### Further Readings

- Claiborn, C. D. (1982). Interpretation and change in counseling. *Journal of Counseling Psychology*, 26, 378–383.
- Clark, A. J. (1995). An examination of the technique of interpretation in counseling. *Journal of Counseling & Development*, 73, 483–490.
- Crits-Christoph, P., Barber, J. P., Baranackie, K., & Cooper, A. (1993). Assessing the therapists' interpretations. In N. E. Miller, L. Luborsky, J. P. Barber, & J. P. Docherty (Eds.), *Psychodynamic treatment research: A handbook for clinical practice* (pp. 361–386). New York: Basic Books.
- Hammer, E. F. (Ed.). (1968). *Use of interpretation in treatment: Technique and art*. New York: Grune & Stratton.

---

## THERAPIST TECHNIQUES/BEHAVIORS

---

While many theories of psychotherapy and counseling develop specific techniques to fit their assumptions and concepts, many techniques cut across theories. Furthermore, many mental health practitioners make use of different theoretical frameworks and



interventions at different times, and these practitioners sometimes combine techniques and interventions from a variety of sources.

Positive therapeutic outcomes depend upon components (often termed *common factors*) that are found in many theoretical orientations. Hence, no one form of therapy is clearly superior to all the others. Successful therapy requires the integration of a positive therapeutic relationship with a set of common factors or techniques. These common factors have been classified in a number of ways, but there is consensus regarding the critical importance of two factors, the presence of a facilitative therapeutic relationship and of positive expectations for success on the part of clients.

Nevertheless, the selection of specific techniques is still important to the individual therapist when designing and implementing a treatment plan to ameliorate problems involving the client's thoughts (cognitions), feelings (affect), or actions (behavior). Most therapists are trained in a wide variety of theoretical orientations and techniques and they have many options for interventions. Psychologists consider both the usefulness of the techniques at their disposal for addressing the client's concerns and their appropriateness in terms of the client's cultural background (e.g., race, ethnicity, gender, sexual orientation, and ability status). Ethical and legal requirements mandate that the psychologist maintain a current knowledge of the empirical literature pertaining to the overall efficacy of therapeutic techniques and the appropriateness of interventions for use with clients from specific cultural backgrounds.

This entry describes the most widely used therapeutic techniques. In this review these techniques have been classified as supportive or relationship-building techniques and confrontational techniques, including cognitive techniques, behavioral techniques, and experiential techniques. Although some techniques fit in more than one category, each technique has been assigned to its dominant category.

### Relationship-Building Techniques

Carl Rogers minimized the importance of techniques per se. Instead, he regarded unconditional positive regard (i.e., a nonjudgmental appreciation of the client's worth as a person), accurate empathy (i.e., understanding the client's feelings), and genuineness (i.e., being "who you are" instead of "acting a part") as therapist behaviors that are both necessary and sufficient for the development of a positive therapeutic relationship. Many theorists and researchers have specific techniques

for building a positive therapeutic relationship, and training strategies have been developed to teach doctoral trainees how to establish a facilitative relationship. At least 12% of the success of psychotherapy is determined by the quality of the therapeutic relationship.

### Reflection

Reflection is one way that therapists communicate accurate empathy to their clients. Reflection requires the therapist to identify the client's feelings and then respond to the client with words that communicate understanding and (sometimes) put the feelings into context. Common feelings expressed by clients include happiness, concern, depression, hurt, fear, anger, loneliness, confusion, guilt, shame, and inadequacy. Reflection mirrors the client's feelings without evaluating them or adding content. Reflecting the essence of the clients' experience allows clients to overcome distortions and denial, validates clients' feelings, and encourages both therapists and clients to focus on the affective or feeling part of clients' lives. Some therapists regard reflection as the most critical skill in counseling.

### Paraphrasing

Paraphrasing is another relationship-building skill that consists of the therapist repeating back to the client a usually shortened version of what the client said. Effective paraphrases are brief, natural, well timed, tentatively expressed, focused on important topics, and used in balance with other skills. Accurate paraphrasing communicates to the client the therapist's interest and that the therapist is paying close attention. It also provides a check on the accuracy of the therapist's understanding and an opportunity for the client to correct the therapist if the therapist has misunderstood.

### Minimal Encourages

Also called *minimal verbal responses*, these verbal equivalents of a head nod are small verbal expressions such as "uh-huh," "yes," and "mm-hmmm." These verbalizations create little interruption, communicate that the therapist is listening, and encourage the client to continue.

### Summarization

Summarization is used at various points during a therapy session, at the end of a session, and at the



termination of therapy to integrate the therapeutic work. Summarization may integrate a number of paraphrases that are connected by a broad theme to organize information and help the client see patterns. It also communicates that the therapist is interested and attentive, thereby building a positive therapeutic relationship. In addition, summarization can be used to reinforce client progress and plan for future directions in which therapy might proceed.

### ***Encouragement***

This technique provides a sense of support to clients and increases hope so clients begin to believe in themselves. Encouragement focuses on solutions and optimism. Useful therapist skills include focusing on strengths, communicating respect, increasing awareness of options and humor in difficult situations, and being enthusiastic. Encouragement has also been used in family therapy to focus on solutions and family strengths rather than weaknesses or problems.

### **Confrontation**

Successful psychotherapy requires the “therapeutic paradox” of supporting the client and communicating caring, while at the same time confronting the client’s blind spots, faulty logic, misperceptions, and problematic behaviors. Clients may enjoy counseling and feel valued but make little progress if the therapist focuses exclusively on support. Conversely, focusing on confrontation and giving insufficient attention to support and relationship building often results in the client leaving therapy. Effective therapy requires the development and maintenance of a delicate balance of support and confrontation.

Confrontations may be gentle and tentative or very direct and powerful. The type of confrontation used may vary by theoretical framework or the therapist’s personality. Nevertheless, all confrontations are intended to encourage cognitive or affective insights or behavior change. The interventions described in the remaining sections may be primarily confrontational or a combination of confrontational and supportive.

### ***Cognitive Techniques***

Many cognitive techniques can be traced back to Alfred Adler’s and Albert Ellis’s theoretical assumptions that most problems are caused by irrational beliefs or mistaken thoughts. Irrational beliefs are

exaggerations (i.e., an event is “awful,” or “catastrophic,” or “terrible”), whereas more rational beliefs are more moderate (i.e., an event is regrettable or unfortunate). Ellis postulated that the most effective change results from actively and directly disputing clients’ faulty thinking and teaching clients to dispute their flawed beliefs. This may include homework in which the client analyzes the activating event (A), the irrational belief (iB), and the emotional and behavioral consequences (C), then disputes (D) the irrational belief and substitutes a rational belief (rB). The therapist may ask questions (e.g., “What is your evidence?”) or give directives (e.g., “Stop ‘shoulding’ on yourself”). The goal is to make clients aware of their self-talk so they can change the internal dialogue and problematic self-talk and the resulting feelings and behavior. The therapist may also challenge the discrepancies between the clients’ words and behavior, thereby confronting the self-defeating behavior.

Other views assume that emotional disturbance is a result of early decisions a child makes based on problematic early learning. These decisions result in dysfunctional life scripts. Injunctions (e.g., don’t be important, don’t succeed, don’t be sane) that children learn impose limits on who they can be or what they can do that carry into adulthood. These are challenged to create a healthier, more positive life script. Other cognitive theorists may label irrational beliefs as dysfunctional thoughts, cognitive distortions, automatic thoughts, and cognitive schema. Many cognitive techniques have been developed to confront clients to create awareness and change.

### **Thought Stopping**

Thought stopping is used to stop intrusive, repetitive, self-defeating thoughts. When an unwanted thought comes to mind, the client is instructed to say “stop” either silently or out loud. A physical reminder such as snapping an elastic band on the wrist may also be incorporated. After repeated practice of accessing a thought and then stopping it during therapy sessions, the client is instructed to practice outside therapy.

### **Thought Scheduling**

An alternative technique is scheduling the intrusive thought for a particular time. For example, a client who is disturbed by intrusive thoughts of a former love may be taught to think, “I’ll save those thoughts for a particular time each day,” whenever the thoughts



arise. In this fashion, the clients learn they have control over their intrusive thoughts.

### **Catastrophizing**

In catastrophizing, the therapist asks the client to imagine the worst possible event, explore the consequences, and consider possible coping strategies. This intervention interrupts irrational thoughts that create distress and helps the client consider more logical and rational possibilities. Clients generally discover that the worst is not the catastrophe they imagined, and fears are relieved.

### **Gender Role Analysis**

Feminist therapy postulates that part of an individual's problems result from rigid gender role expectations that restrict the person's development. This technique entails analyzing the messages the client has received from multiple sources (e.g., family, school, religion, peers, and the media), discerning their impact, and deciding which messages work and which should be discarded. For example, a young man may realize that his difficulties in relationships are related to learning from his family and peers that men are not supposed to express tender emotions. He can choose to discard that gender role expectation and express more emotions.

### **Consciousness Raising**

Consciousness raising involves clients developing an awareness of the biases and discrimination they have suffered due to their social identities (e.g., race, ethnicity, gender, sexual orientation, and ability status). For example, a client of color may face particular problems based upon stereotypes originating in the dominant culture. Consciousness raising helps clients understand how the dominant culture has shaped their self view so that effective change can occur. Strong emotions often accompany consciousness raising, so it is both a cognitive and an experiential/emotional technique.

### **Bibliotherapy**

Bibliotherapy involves assigning clients written materials to read to help them learn about the problems that concern them. Bibliotherapy can help clients explore their thoughts and feelings about their concerns and gain new insights. It can also help them

realize they are not alone in their experiences and reactions. Bibliotherapy assignments are carefully chosen and clearly focused on client issues, and in one survey 96% of psychologists reported that they assigned reading self-help books to clients occasionally or more often.

### **Cognitive Restructuring**

Cognitive restructuring is another term for helping clients identify irrational beliefs and automatic negative interpretations. Logical questions are used to help clients consider alternative attributions for the behavior of others and to seek evidence for the original assumptions. For example, the assumption that a friend no longer likes the client because the friend was recently abrupt is only one explanation for the friend's behavior. An alternative explanation is that the friend was stressed and distracted.

### **Redecision**

This technique involves helping the client examine the faulty learning that lead to a faulty life script and rededicate on a new life script. For example, a client can decide that she has worth and will no longer always put her needs last. Her script will change to reflect her as a person of value.

### **Miracle Question**

The miracle question, sometimes called the *magic question*, asks the clients, if a miracle occurred that solved all of their problems, what would be different. This question emphasizes a problem-solving mindset, and it helps clients develop therapy goals.

### **Push-Button Technique**

The client is asked to think about and focus on a positive, pleasant experience and to note the feelings that result. This teaches clients that thoughts and feelings are connected. Clients learn that focusing on particular thoughts can create particular feelings and that they can use the "push button" to stop unwanted, negative feelings and create positive ones.

### **Behavioral Techniques**

Behavioral techniques focus on changing the client's behavior. Behavior therapies assume that maladaptive



behaviors are learned and therefore new, more functional behaviors can be learned to replace them. Principles of learning are emphasized. Behavior changes may be preceded by cognitive interventions that help the client decide what behavioral changes are desirable.

### **Counterconditioning/ Systematic Desensitization**

These strategies inhibit and countercondition anxiety. Systematic desensitization generally uses deep relaxation to inhibit anxiety. After teaching the client to relax, the therapist has the client imagine anxiety-provoking material that is paired with relaxation. Systematic desensitization is used to treat concerns such as phobias, fear of flying, test anxiety, and public speaking anxiety.

### **Assertiveness Training**

Practicing assertive behaviors to overcome social anxiety and passivity is another example of counterconditioning. Interpersonal difficulties such as fear of complaining about poor service, inability to speak up in group situations, and inability to say no to requests from others can be ameliorated by assertiveness training. During assertiveness training, clients learn the differences among passivity, assertiveness, and aggression. Then role-playing and feedback are used to teach them to express their needs and feelings honestly and directly in a constructive manner. They practice direct and effective verbal ways of responding to situations both in therapeutic settings and later, as anxiety decreases, in their real lives. Assertive behaviors are practiced in situations that will likely lead to success so that these successful experiences will reinforce their continued practice of assertive behavior.

### **Shaping**

In shaping, therapists reinforce behaviors that represent successive approximations of the agreed-upon goal. For example, if a woman who suffers from agoraphobia manages to leave her house and walk to the mailbox, the therapist would reinforce that behavior as getting her closer to being able to leave home. As she becomes comfortable with that behavior, however, the therapist might require that she walk around the block to be reinforced. In gradual steps, the therapist helps the client engage in behaviors that are closer and closer to the ultimate goal.

### **Social Skills Training**

Some clients are unable to display appropriate social behaviors because they have never learned or even witnessed them. In such cases, the first therapeutic task may be teaching new skills. This can be done using instruction, demonstration, practice, role-playing, and homework assignments. For example, a young man who is afraid to ask a woman for a date could first be taught ways to begin a conversation. Then he could role-play these techniques in imaginary situations during therapy sessions. At a later stage, he would try these behaviors in social situations and discuss his experiences with the therapist during therapy.

### **Modeling**

Therapists sometimes help clients learn new behaviors by modeling those behaviors or helping clients find appropriate role models outside the therapy or counseling sessions. For example, the therapist might act out the role of a job seeker in an interview during therapy to model job interview behavior for the client.

### **Shame-Attacking Exercise**

An important source of emotional disturbance is self-blame. Therapists sometimes attempt to reduce self-blame by assigning clients to behave in ways they consider shameful or humiliating. Clients generally discover during the course of the assignment that other people are not nearly as aware of them as they thought, and are much less critical or disapproving than anticipated. This discovery lessens their feelings of shame, thereby making it easier for them to discard self-consciousness and behave more freely.

### **Role-Playing**

Role-playing provides an opportunity for clients to try out new behaviors and expand their self-awareness. For example, a client may role-play a difficult conversation with a family member to rehearse an approach and learn about the emotional reactions stimulated by that approach.

### **"Acting as If"**

"Acting as if" is an Adlerian technique useful with clients who wish they had behaviors and feelings that they believe are not in their repertoire. Instead of trying to convince clients that they do possess these



characteristics, the therapist seems to agree with clients and therefore suggests they just “act as if” they are confident, outgoing, assertive, or whatever is lacking. Because the new behaviors are “acting” and not “real,” clients feel less threatened by trying the new behaviors. In a sense, this technique creates a self-fulfilling prophecy because clients adopt the behaviors as their own as they become more comfortable performing them.

### **“Spitting in the Soup”**

When the therapist challenges client behaviors in such a way that hidden motivation, denial, or rationalization are uncovered, it makes it difficult for the client to continue the behavior. For example, a therapist may confront a wife about her tendency to start arguments with her husband to avoid intimacy. The realization of the hidden or denied motivation makes it difficult to continue. In other words, the therapist explains the payoff for the behavior to the clients. Henceforth, clients can no longer engage in that behavior without realizing their ulterior motive. The behavior becomes less appealing, just as spitting in soup would make it unappetizing.

### **Catching Oneself**

Adlerian therapists use this technique to interrupt their clients’ bad habits and self-defeating behavior patterns. Clients may start by regretting something they have done regularly. At each occurrence, the therapist helps clients anticipate the behavior earlier until the clients learn to “catch themselves” before engaging in the undesirable behavior or habit. Catching oneself can be an important prerequisite for the thought stopping described earlier, because clients must be able to anticipate the onset of an unwanted thought in order to stop it.

### **Political Advocacy**

A tenet of feminist therapy is that “the personal is political.” Therefore, engaging in political advocacy can be empowering and healing for the client. Working for any social justice cause that has meaning for the client can be effective. For example, a woman who has been a victim of domestic violence may empower herself and cement the power of her survivor status by working for changes in laws related to spousal abuse.

### **Imagery**

Imagery involves visualizing in the imagination (as used in systematic desensitization mentioned earlier). Intrusive, unwanted images of traumatic events can be modified by changing the images of what happened. For example, an attacker can be visualized as smaller in size to reduce the client’s feeling of powerlessness. Imagery can be used to express or explore emotions that are difficult to communicate in words and can create a here-and-now troubling experience during the therapy session.

### **Experiential Techniques**

Experiential techniques are used to get clients more in touch emotionally with their authentic selves, which is the most real expression of all feelings and the willingness to live in the moment. Fritz Perls developed a number of specific experiential techniques but believed that any experiential intervention that emerges in the moment can be therapeutic. Interventions are limited only by the creativity of the therapist. Some of his interventions involved dialogues between personal polarities to create experiential understanding. Whenever an individual recognizes a particular aspect of self, its opposite is implicit. Perls postulated that individuals are a never-ending sequence of polarities or opposites that aim for integration.

### **Top Dog/Underdog**

The top dog represents a person’s conscience. The underdog is the part of the personality that goes along with the bullying demands of the top dog but also displays passive resistance. For example, if a client’s top dog demands that the underdog work an extra 2 hours every day to feel worthwhile, the underdog might appear to acquiesce to the top dog but sabotage the work by feeling sleepy and being unproductive. An experiential way to resolve the conflict between these two aspects of the personality is to create a dialogue between them.

### **Empty Chair**

This technique provides a classic way to create a dialogue between personal polarities or between the client and other people. The therapist arranges two chairs facing each other, then clients act out the



dialogue between the two people or the two parts of their personality by occupying each chair in turn and saying what that person or aspect of personality would say. This intervention allows clients to say all of the things to the empty chair that they have been unable to express to another person or to express the two sides of an internal conflict. This intervention provides a cathartic experience that allows for greater self-awareness and understanding.

### **Exaggerating Movement**

Another technique to uncover deeper emotion entails exaggerating a client's movement. For example, if a client is jiggling a foot, the therapist might ask the client to exaggerate the motion. Exaggerating the motion typically increases the underlying emotion. The therapist might even ask the client what the foot is saying.

### **Dream Work**

Perls postulated that each character and object in a dream represents some part of the client. Asking each character and object in the dream to speak illuminates the meaning of the dream.

### **Hot Seat**

Perls believed that confrontation is often necessary to help clients recognize their incongruities. By agreeing to work, the client enters the hot seat. Sometimes the therapist intentionally frustrates the client to liberate hidden feelings and experiences and release the authentic self. This creates a "safe emergency" in which the client is challenged to experience disturbing personal material in a safe environment.

### **Assuming Responsibility**

Experiential therapy requires clients to take personal responsibility. This technique requires clients to end every sentence with the statement "and I take responsibility for it." Furthermore, clients may be asked to change words such as *can't* to *won't* or *but* to *and*. For example, a client might be instructed to change the sentence "I can't remember friends' birthdays" to "I won't remember friends' birthdays." Such changes underscore the clients' responsibility for the behavior. Another responsibility technique requires

the client to change every question into the statement behind it. For example, a client asking many questions about the therapist's credentials may be anxious about beginning therapy.

### **Playing the Projection**

When a client complains about or is critical of another person, the therapist suggests that the client is really critical of the part of self that has the same characteristics. The client may be asked to try on and play that part. For example, a client who complains excessively about a friend's anger may be asked to role-play that anger. The client's disturbance at the friend's anger may be a projection of the client's discomfort with personal anger.

### **Reversals**

In reversals, clients are asked to act out the opposite of their usual behavior. This experience helps get clients in touch with the hidden polarities within. For example, a loud and boisterous client is asked to act out a quiet side.

### **May I Feed You a Sentence?**

If the therapist perceives that the client is close to experiencing something but it is not quite there in awareness, the therapist may ask permission to feed the client a sentence. The sentence expresses this hidden material so that the client can try it on to see if it fits. This technique requires deep and accurate empathy on the part of the therapist. While an interpretation would only lead to intellectual understanding, the goal here is experiential awareness.

### **Flooding**

Flooding is a technique used to treat fear. The client is presented fear-evoking stimuli continuously either in vivo or via imagery. Flooding assumes that eventually the client will discover that there is no basis for the fear—nothing awful happens. In vivo flooding might be used for concerns such as fear of flying or riding in elevators. Imagery could be used as an initial strategy to address fear of flying or for a fear that is difficult or dangerous to experience in vivo, such as fear of spiders or snakes. Flooding has been successfully used with obsessive-compulsive



disorders, agoraphobia, panic disorder, posttraumatic stress disorder, and other phobias.

## Conclusion

As stated at the beginning, therapists choose from a myriad of possible techniques depending on the personality and theoretical orientation of the therapist and the personality and concerns of the client. Research has demonstrated that therapeutic success is determined more by the common factors that create a strong and positive therapeutic alliance than any particular techniques. However, the use of particular techniques can make the therapy experience more comfortable for both the therapist and the client, depending on their personalities.

Roberta L. Nutt

**See also** Adlerian Therapy (v2); Behavior Therapy (v2); Cognitive Therapy (v2); Cognitive-Behavioral Therapy and Techniques (v2); Common Factors Model (v2); Counseling Process/Outcome (v2); Counseling Theories and Therapies (v2); Couple and Marital Counseling (v1); Family Counseling (v1); Feminist Therapy (v1); Homework Assignments (v2); Humanistic Approaches (v2); Individual Therapy (v2); Integrative/Eclectic Therapy (v2); Outcomes of Counseling and Psychotherapy (v2); Panic Disorders (v2); Problem-Solving Appraisal (v2); Rational Emotive Behavior Therapy (v2); Relationships With Clients (v2); Transactional Analysis (v2); Working Alliance (v2)

## Further Readings

- Cormier, L. S., & Cormier, W. H. (1998). *Intervention strategies for helpers: Fundamental skills and cognitive-behavioral interventions* (4th ed.). Pacific Grove, CA: Brooks/Cole.
- Dinkmeyer, D., Jr., & Sperry, L. (2000). *Counseling and psychotherapy: An integrated, individual psychology approach*. Upper Saddle River, NJ: Prentice Hall.
- Egan, G. (1994). *The skilled helper: A problem management to helping* (5th ed.). Pacific Grove, CA: Brooks/Cole.
- Ellis, A., & Grieger, R. (Eds.). (1986). *Handbook of rational-emotive therapy*. New York: Springer.
- Heron, J. (2001). *Helping the client: A creative practical guide*. London: Sage.
- Hill, C. (2004). *Helping skills: Facilitating, exploration, insight, and action* (2nd ed.). Washington, DC: American Psychological Association.
- Ivey, A. E., & Authier, J. (1978). *Microcounseling: Innovations in interviewing, counseling, psychotherapy, and psychoeducation*. Springfield, IL: Charles C Thomas.

- Ivey, A. E., & Pederson, P. B. (1993). *Culture-centered counseling and interviewing skills: A practical guide*. Westport, CT: Praeger.
- James, R. K., & Gilliland, B. E. (2003). *Theories and strategies in counseling and psychotherapy* (5th ed.). Boston: Allyn & Bacon.
- Meichenbaum, D. H. (1997). *Cognitive-behavioral modifications: An integrative approach*. New York: Plenum.
- Nelson-Jones, R. (2005). *Practical counselling & helping skills: Text and activities for the lifeskills counselling model* (5th ed.). London: Sage.
- Norcross, J. C. (Ed.). (2002). *Psychotherapy relationships that work*. New York: Oxford University Press.
- Norcross, J. C., & Goldfried, M. R. (Eds.). (2005). *Handbook of psychotherapy integration* (2nd ed.). New York: Oxford University Press.
- Okun, B. F. (2002). *Effective helping: Interviewing and counseling techniques* (6th ed.). Pacific Grove, CA: Brooks/Cole.
- Poorman, P. B. (2003). *Microskills and theoretical foundations for professional helpers*. Boston: Allyn & Bacon.
- Safran, J. D., & Muran, J. C. (2000). *Negotiating therapeutic alliances*. New York: Guilford Press.
- Skovholt, T. M., & Rivers, D. A. (2004). *Skills and strategies for the helping professions*. Denver, CO: Love.
- Tolan, J. (2003). *Skills in person-centered counselling and psychotherapy*. London: Sage.

---

## THERAPISTS

---

**See** COUNSELORS AND THERAPISTS

---

## THERAPY PROCESS, INDIVIDUAL

---

For decades, clinicians have been interested in understanding the within-session interactions and specific factors that influence dynamics in counseling and psychotherapy. This interest in what happens in therapy, namely, the *therapeutic process*, spans disciplines of psychology, psychiatry, and social work. However, the large number of psychotherapeutic approaches, the assumptions underlying what therapeutic process entails, and the complexity inherent in understanding how therapy works has made studying process a daunting task. The bulk of research on the therapy process occurred between the 1970s and 1990s. The earlier research focused on therapist variables and response modes by isolating single overt behaviors



and assessing significant moments or events within the context of particular theoretical models. By the 1990s, the recognition of the therapeutic process as complex, interdependent, and based in overt and covert behaviors led researchers to examine process within the context of theoretical integration and technical eclecticism. Process is currently seen to be embedded in common therapist–client factors.

### Therapy Process Defined

In order to understand what constitutes “process,” it is important to distinguish it from other related aspects of therapy, namely, input variables, extratherapy variables, and outcome variables. *Input variables* refer to therapist demographics, personality, expectations, and theoretical orientations, whereas *extratherapy variables* refer to personal or world events that clients experience outside the therapeutic interaction. *Outcome* refers to changes that occur as a result of the therapeutic process (e.g., client satisfaction). While outcome and process may overlap as in the case of client insight or the working alliance, process is concerned with the intra- and interpersonal actions and interactions embedded in patterns of relationships. Specifically, Clara E. Hill and Maureen M. Corbett defined *process* as the overt and covert thoughts, behaviors, and feelings within psychotherapy sessions that pertain to the therapist and the client and the interaction between the two.

### Initial Approaches to Understanding Process

Early attempts to understand process were focused on what therapists do in therapy. As early as the 1920s, Sigmund Freud, Earl F. Zinn, and Percival M. Symonds recorded analytic and nonanalytic interviews to enable content analysis of sessions. In 1938, Frank Robinson started the first process research program in Counseling Psychology at Ohio State University. Session recordings helped identify both overt and covert therapist and client behaviors in therapy (e.g., self-disclosure, self-talk), with focus on therapist patterns across clients (e.g., interpretation, empathy). Carl Rogers’s “nondirective therapy” continued to emphasize the therapist’s role, identifying specific therapist skills. Although Rogers was opposed to focusing on therapist behaviors, in 1957, Rogers’s necessary and sufficient conditions (i.e., empathy, genuineness, and positive regard) became the primary indicators of therapeutic change. The

focus on therapists’ role in the therapeutic process continued with Robert R. Carkhuff’s model that emphasized therapists’ skills as important in creating client change. However, he suggested that it was primarily the therapist that was doing something to create change. In 1984, Laura N. Rice and Leslie S. Greenberg suggested a need to examine clients’ roles in creating change. At this time, the focus shifted to clients’ behaviors and therapists’ behaviors were seen as contextual sources of influence (e.g., expertness, attractiveness).

There were several assumptions underlying the initial conceptualization of therapy process as therapist guided. The first assumption was that therapeutic process was theory driven, meaning that what happened in the therapy session was directly related to the therapist’s theoretical orientation. However, in 1936, Saul Rosenzweig noted the uniform efficacy of different psychotherapies and proposed that there were some common factors across therapeutic approaches that were central to the therapy process. Numerous researchers strongly endorsed the presence of common factors or ingredients that influenced positive outcomes. However, while studies advocated for common factors, a second assumption underlying process research was the notion of homogeneity of process, or the idea that process was similar across clients (e.g., specific therapist behaviors or interventions would result in particular client responses regardless of when they occur in therapy). Arguments against this assumption note that process is contextually bound and varies over time, across therapists and clients, and in different situations. Similarly, other research points out the inappropriateness of drawing conclusions on the direction of influence on therapy process by examining the amount or frequency of a particular behavior (e.g., that a particular client behavior would follow a particular therapist intervention). The general consensus was to shift from isolating variables (e.g., examining the mere occurrence of behaviors) to understanding the pattern of contextualized variables or factors that influence therapeutic process. Furthermore, in 1986, David E. Orlinsky and Kenneth E. Howard highlighted that the therapeutic process entails a “dialogue” or “exchange” between clients and therapists with behaviors being influenced by the interpersonal relationship. This resulted in the therapeutic process being seen as an interpersonal, mutually constructed social change process with some common factors influencing the therapy process. As a consequence, several models of therapy process evolved.



## Models of Therapy Process

The relevance of overt and covert therapist and client behaviors has influenced the development of process models proposed by authors such as Hill and Kevin O'Grady, Jack Martin, Orlinsky and Howard, and William Stiles. In particular, the belief that events or behaviors in therapy occur at different levels of awareness for both therapist and client, and that their individual construals of the event can define how the interactions proceed has significantly influenced what factors are thought to impact therapy process. This cyclical nature of the psychotherapy process suggests that a therapist conceptualizes the client's issue based in a theoretical formulation, and decides on an intervention that may be based in verbal or nonverbal response modes. The client reacts to the therapist's intervention based on his or her construal of the therapist's intentions. The therapist then reacts to the client's response and formulates the next intervention. This continuous cycle of therapist and client interaction is embedded in the relationship that evolves within this context. In keeping with this continuous interplay between therapist and client intentions, interventions, perceptions, and behaviors, several authors, such as Stiles, Orlinsky and Howard, Hill, and Bruce Wampold, have highlighted the notion of integrating specific common factors into the therapy process. Contemporary views of the therapy process suggest that while there may be specific therapist techniques or client tasks that differ across theories, the therapy process is pantheoretical, with some common interconnected factors across therapies that include specific contributions from therapists, specific contributions from clients, and some mutual relationship factors.

### ***Therapist Contribution to Process***

Upon entering the therapy room, therapists bring not only their professional training but also their personalities and interpersonal styles, based in their upbringing and culture. The idea that these unique therapist input variables would influence what happens in therapy is both intuitive and empirically supported. In fact, the therapist factors that may cause therapy to progress, stall, change course, or end are complex and interdependent. Research has focused specifically on two classes of such processes—those that can be observed by a person outside the therapy relationship (overt), and those that reflect internal experiences of the therapist (covert).

### **Therapist Overt Processes**

Therapeutic techniques include the particular methods or strategies employed by therapists within a session to facilitate beneficial change in a client. Techniques were originally conceptualized as belonging to specific theoretical camps (e.g., two-chair technique in Gestalt therapy), and allegiance to a particular theoretical orientation does influence therapists' choice of intervention. Endorsement of eclectic approaches to therapy, however, has made it quite typical for therapists to "borrow" techniques from various theoretical traditions to cater to treatment contexts and clients' needs. Furthermore, intensive studies of therapy process actually suggest significant commonality across techniques that are described with different terms.

Hill posited that therapists use certain techniques according to the evolution of the therapy process. Supportive and informational techniques predominate during initial contact with the client, while exploratory techniques are preferred as the relationship deepens. Therapists may turn to theory-specific techniques during the "core work" of therapy, and to termination techniques as therapy comes to a close.

Verbal response modes represent a special subgroup of techniques that have been investigated in relation to in-session and distal therapy process. Verbal response modes refer to the grammatical structure of what therapists say, independent from their content or the context in which they are said. Verbal responses include open or closed questions, direct guidance, confrontation (pointing out incongruence), approval, paraphrasing, interpretations, and therapist self-disclosure. Theoretical orientation has been noted as influencing therapists' choice of response mode (e.g., psychodynamic therapists use interpretation more often than behavioral therapists).

While certain response modes have been identified as particularly helpful in producing immediate outcomes, researchers have suggested that the combination of responses with other process variables may produce cumulative impacts on outcome. Specifically, the skill and manner in which interventions are delivered may critically influence how they are received by the client and subsequently impact therapy process.

Therapists' nonverbal behavior also influences what occurs in therapy. Nonverbal behavior conveys emotion and attitudes towards the self and others, adds other dimensions of meaning onto what is stated verbally, and reflects sociocultural rules about communication. Paralanguage (e.g., speech intensity and volume), facial



expressions, eye contact, posture, proxemics (use of physical space in the therapy room), and touch are all relevant means of communicating in therapy.

### Therapist Covert Processes

While overt processes provide some information about how therapists proceed in therapy, understanding what is going on internally for the therapist (e.g., how therapists' internal thoughts and feelings influence his or her verbal responses in session) may be equally or even more relevant to therapy process. Attention to covert dynamics is an important step in the evolution of therapy process research, and relevant areas of study include therapist intentions, self-talk or internal dialogue, and countertransference.

*Therapist Intentions.* Examining a therapist's reasons for using particular interventions is important to our understanding of therapy process. Some common therapist intentions acknowledge client needs. These include setting limits; assessing; providing support; educating/giving information; exploring cognitions, behaviors, and feelings; and restructuring. Other intentions may reflect the therapists' needs, such as defending oneself, alleviating anxiety, or feeling superior to the client. Importantly, Hill and her colleagues suggested that therapists' intentions may be better descriptors of interventions than what therapists actually say. Finally, while therapists' ability to articulate their intentions has been linked with outcome, therapists may not always be aware of their intentions, or they may have specific wishes that the client know, or not know, their intentions. All these factors can influence how intentions shape therapy process.

*Self-Talk.* Therapist self-talk refers to therapists' internal dialogue, or things they say to themselves during session. Self-talk is a common occurrence in therapy that can relate to both positive feelings (e.g., empathy, caring) and negative feelings (e.g., frustration, distraction), and may interfere with counselors' ability to provide effective counseling. Counselors who struggle with their reactions may display negative or incongruent behavior, avoid or suppress specific affect or issues, and become overfocused on an issue or the client. While the self-talk literature is still evolving, findings to date suggest it is a complex process that can have far-reaching implications for therapy process, and would benefit from continued examination.

*Countertransference.* Rooted in psychoanalytic literature, countertransference was traditionally referred to as the therapist's unconscious, countertherapeutic reactions to the client's transference. Other definitions have included *all* of the therapists' reactions to the client, including reactions to the client that reflect the therapist's unresolved conflicts. While theorists continue to disagree on an exact definition, most research focuses on the latter definition and considers countertransference to be pantheoretical and a potentially hindering factor to therapy process if left "untreated." Research has identified some factors associated with countertransference reactions, as well as how therapists react to countertransference (e.g., feeling bored or angry).

### Client Contribution to Process

In 1992, Michael Lambert noted that 40% of variance in outcome (e.g., client improvement) was related to client variables and extratherapeutic factors (factors outside the therapeutic relationship). The focus on clients assumes clients are active agents who more often than not intentionally seek out therapy, engage with the therapist, and become involved in the therapeutic process. While the therapist serves as a guide, it is the client who ultimately decides the extent to which change will be made. Several approaches have been taken to understand client behaviors. Research has examined behaviors that are either present or absent in the therapeutic session, topics that clients discuss in therapy, how clients experience therapy, how clients progress, how they assimilate different experiences, and clients' cognitive complexity. An overarching construct that subsumes these behaviors is client involvement in therapy. As with therapist contributions, the focus on client contributions to therapy process identifies both overt and covert client behaviors as active ingredients in therapy process.

### Client Overt Processes

Client overt processes can manifest in terms of client involvement and resistance. Client involvement refers to the extent to which clients are open to the therapeutic process, engaged and motivated within the session, and are actively immersed in the process. Involvement refers to clients' readiness for change through initiation of topics, exploration of presenting problems, participation in change-oriented activities, and expressed comfort in informing therapists of their



reactions and problems in therapy. Involvement can also be influenced by client expectations of therapy.

Conversely, depending on theoretical orientations, client resistance has been identified in different terms. For example, behaviorally, resistance has been identified in clients' complaining, self-blaming, disagreeing with therapist, pushing their own agenda, sidetracking, not responding, and defending others. Psychodynamically, it has been seen in the form of recollection of material and deflection of pain or affect.

### Client Covert Processes

Client covert processes, on the other hand, refer to reactions and feelings that are not readily observable. Clients contribute to therapy process through the reactions they have to therapist interventions. For example, client reactions can be positive (e.g., feeling understood, viewing interventions as helpful) or negative (e.g., feeling stuck or misunderstood). Subsumed under the negative reactions are hidden reactions or nondisclosures. These can manifest in the form of secrets about life experiences that clients do not share with their therapist. Research suggests that clients hide their negative reactions from their therapists due to their fear of retaliation, or deference to therapists' authority, or feeling unsafe in therapy. Clients also refrain from sharing their reactions because they may be dissatisfied with therapy, feel vulnerable, or feel that their therapists may not understand them or their emotions. Embarrassment or shame about specific issues may also prevent clients from sharing their thoughts. While therapists may not be able to assess nondisclosures, literature suggests that being tuned into clients' nonverbals during a session might shed some light in assessing nondisclosures.

Finally, one important contribution from psychoanalytic theory that influences the therapeutic process from the clients' end is transference. Freud defined transference as a client's mental representation of early interpersonal relationships that are often distortingly imposed onto the therapist. These representations often are idiosyncratic, may be positive, negative, or mixed, and can manifest differently for various clients and therapists. However, it is also believed that transference may reflect the interpersonal interaction between the therapist and the client.

### Interactions Between Therapists and Clients

To reiterate an old, but germane point, what happens in therapy is inherently interpersonal, and the ways

clients and therapists relate to each other impact what happens in therapy. The interactional dynamics between the therapist and client have been considered in light of relational control theory. This perspective draws attention not only to what is said, but also how therapists and clients determine the nature and timing of their communication in therapy. The interpersonal transactions between the therapist and client are developed, defined, and mutually constructed within the social system of the dyad. These transactions have been discussed in the literature as relationship control, relationship defining, or turn taking. The process of negotiating fit between clients' and therapists' transactional patterns can have important influences for therapy process. Thus, understanding the therapy process requires attention to the patterns of communication between the therapist and client, including how rules about dyad-specific communication are developed, how speaking turns are defined and occur, who initiates shifts in topics, and how clients may internalize the therapeutic relationship.

### Therapeutic Alliance

Increasing evidence suggests that the strength of the therapeutic alliance, often used interchangeably with the terms *working alliance* and *helping alliance*, is the strongest and most reliable predictor of positive therapeutic change. Originating in psychoanalytic theory, Edward S. Bordin's quintessential conception of the working alliance emphasized mutually agreed-upon goals and tasks of therapy, and the reciprocal bond or emotional attachment between therapist and client. Research on the therapeutic bond posited three interpersonal subprocesses related to role and attachment functions in the therapy relationship: mutual collaboration on and pursuit of therapeutic objectives, interest and attention to one another, and reciprocal respect and emotional affirmation. The alliance currently reflects a pantheoretical concept that clinicians generally agree to be relevant within all therapeutic contexts. Attention has been paid to both therapist and client contributions to the therapeutic alliance.

### Therapist Contributions to the Alliance

Several therapist factors have been found to be related to stronger therapeutic alliances, including personal characteristics, comfort with close interpersonal relationships, low hostility, and sensitivity to cultural differences. Additionally, although not related to counseling competence, the therapist's level of professional



experience may suggest a greater likelihood of successfully engaging clients in the mutual construction of tasks and goals, which is strongly associated with effective outcomes. Finally, specific interventions, such as focusing on the here and now, focusing on non-verbal communication, defense mechanisms, interpersonal dynamics in the therapy relationship, and making accurate interpretations, are also associated with a stronger therapeutic alliance.

### **Client Contribution to the Alliance**

Clients' interpersonal strengths, such as friendliness, submissiveness, and social competence, and the quality of their past and current interpersonal relationships, have been found to be predictive of a stronger therapeutic alliance. Conversely, avoidant attachment styles and the extent to which clients cannot trust relationships early on are predictive of a weaker alliance. However, not all clients view the alliance in a similar manner. For instance, clients may perceive the alliance as collaborative, insight oriented, or nurturant. While both interpersonal characteristics and early attachment styles may influence the development of an alliance, further research is needed in this area.

### **Problems in the Alliance**

As a central feature of most therapies, the therapeutic alliance is prone to a number of problems as therapists and clients proceed in therapy, all of which contribute to fluctuations in the therapy process. Jeremy D. Safran and his colleagues, Peter Crocker, Shelly McMains, and Paul Murray, discussed "ruptures" in psychotherapy, referring to difficulties that develop due to defiant behavior. Bordin posited that the "rupture and repair" process of building and maintaining the alliance represented the real work of therapy, although other perspectives consider a solid alliance to be necessary in order for specific interventions to effect change. From the client's end, ruptures may manifest through overtly expressing negativity toward the therapist (such as challenging the therapist's competence), indirectly communicating hostility (i.e., showing up late to appointments), disagreeing over tasks or goals, avoidance behaviors, or nonresponsiveness to interventions. Mistakes or misunderstandings on the therapist's part may also result in impasses. Disagreements with tasks and goals of therapy, triangulations in relationships with significant

others, transference, therapist personal issues, level of client pathology, and/or therapist interventions (i.e., being too direct) may harm the alliance. Understanding the types of impasses, and client-therapist styles (e.g., hostile or supportive) can help improve our understanding of the therapeutic process as problems evolve in the alliance.

*Arpana G. Inman, Erin E. Howard,  
and Nicholas Ladany*

**See also** Career Counseling Process (v4); Client Attitudes and Behaviors (v2); Common Factors Model (v2); Counseling Process/Outcome (v2); Counselors and Therapists (v2); Hill, Clara E. (v2); Individual Therapy (v2); Outcomes of Counseling and Psychotherapy (v2); Relationships With Clients (v2); Transference and Countertransference (v2); Working Alliance (v2)

### **Further Readings**

- Bordin, E. (1979). The generalizability of the psychoanalytic concept of the working alliance. *Psychotherapy: Theory, Research and Practice*, 16, 252–260.
- Elliott, R., & James, R. (1989). Varieties of client experience in psychotherapy: An analysis of the literature. *Clinical Psychology Review*, 9, 443–467.
- Highlen, P., & Hill, C. (1984). Factors affecting client change in individual counseling: Current status and theoretical speculations. In S. D. Brown & R. W. Lent (Eds.), *Handbook of counseling psychology* (pp. 670–710). New York: Wiley.
- Hill, C. (1995). What are the mechanisms of change in the common factors? *Clinical Psychology: Science and Practice*, 12, 87–89.
- Hill, C., & Williams, E. (2000). The process of individual therapy. In S. D. Brown & R. W. Lent (Eds.), *Handbook of counseling psychology* (pp. 334–396). New York: Wiley.
- Horvath, A., & Symonds, B. (1991). Relation between working alliance and outcome psychotherapy: A meta-analysis. *Journal of Counseling Psychology*, 38, 139–149.
- Kiesler, D. (1966). Some myths of psychotherapy research and the search for a paradigm. *Psychological Bulletin*, 65, 110–136.
- Kolden, G. (1996). Change in early sessions of dynamic therapy: Universal processes and the generic model of psychotherapy. *Journal of Consulting and Clinical Psychology*, 64, 489–496.
- Lambert, M. (1992). Psychotherapy outcome research: Implications for integrative and eclectic therapists. In J. C. Norcross & M. R. Goldfried (Eds.), *Handbook of psychotherapy integration* (pp. 94–129). New York: Basic Books.



- Marmar, C. (1990). Psychotherapy process research: Progress, dilemmas, and future directions. *Journal of Consulting and Clinical Psychology*, 58, 265–272.
- Orlinksy, D., & Howard, K. (1986). The psychological interior of psychotherapy: Explorations with the therapy session reports. In L. S. Greenberg & W. M. Pinsof (Eds.), *The psychotherapeutic process: A research handbook* (pp. 477–501). New York: Guilford Press.
- Rice, L., & Greenberg, L. (Eds.). (1984). *Patterns of change*. New York: Guilford Press.
- Safran, J., Crocker, P., McMain, S., & Murray, P. (1990). Therapeutic alliance rupture as a therapy event for empirical investigation. *Psychotherapy: Theory, Research, Practice, Training*, 27, 154–165.
- Shoham-Salomon, V. (1990). Interrelating research processes of process research. *Journal of Consulting and Clinical Psychology*, 58, 295–303.
- Stiles, W. (1987). Some intentions are observable. *Journal of Counseling Psychology*, 34, 236–239.
- Wampold, B. (2001). *The great psychotherapy debate: Models, methods, and findings*. Mahwah, NJ: Lawrence Erlbaum.

---

## THURSTONE, LOUIS L. (1887–1955)

---

Louis L. Thurstone, who spent most of his career at the University of Chicago before founding a major psychometric lab at the University of North Carolina, made significant contributions to psychometrics, statistics, and the study of human intelligence during his long career. Thurstone developed methods for scaling psychological measures, assessing attitudes, and test theory, among many other influential contributions. In statistics, he is best known for the development of new factor analytic techniques to determine the number and nature of latent constructs within a set of observed variables.

These new statistical techniques allowed Thurstone to make his most enduring contribution to psychology: the *theory of primary mental abilities*, a model of human intelligence that challenged Charles Spearman's then-dominant paradigm of a unitary conception of intelligence. Spearman, using an earlier approach to factor analysis, found that scores on all mental tests (regardless of the domain or how it was tested) tend to load on one major factor. Spearman suggested that these disparate scores are fueled by a common metaphorical "pool" of mental energy. He named this pool the general factor, or *g*.

Thurstone argued that *g* was a statistical artifact resulting from the mathematical procedures used to study it. Using his new approach to factor analysis, Thurstone found that intelligent behavior does not arise from a general factor, but rather emerges from seven independent factors that he called *primary abilities*: word fluency, verbal comprehension, spatial visualization, number facility, associative memory, reasoning, and perceptual speed. Furthermore, when Thurstone analyzed mental test data from samples comprising people with similar overall IQ scores, he found that they had different profiles of primary mental abilities, further supporting his model and suggesting that his work had more clinical utility than Spearman's unitary theory.

However, when Thurstone administered his tests to an intellectually heterogeneous group of children, he failed to find that the seven primary abilities were entirely separate; rather, he found evidence of *g*. Thurstone managed an elegant mathematical solution that resolved these apparently contradictory results, and the final version of his theory was a compromise that accounted for the presence of both a general factor and the seven specific abilities. Thurstone's 1934 presidential address to the American Psychological Association provides a good overview of his work in the fields of statistics, intelligence, and psychometrics.

Although *g*-centric theories based on Spearman's work remain popular in the 21st century, Thurstone's theoretical and statistical work laid the groundwork for the development of well-regarded hierarchical theories of intelligence, such as those proposed by John Horn and Raymond Cattell, J. P. Guilford, and John Carroll. Thurstone's work also provided the theoretical and statistical foundations for many of the most highly respected tests of cognitive ability currently in use, including the Wechsler intelligence scales and the Armed Forces Vocational Aptitude Battery.

*Jonathan A. Plucker and Amber Esping*

**See also** Assessment (v4); Intelligence (v2); Intelligence Tests (v3); Psychometric Properties (v2); Quantitative Methodologies (v1)

### Further Readings

- Ruzgis, P. (1994). Thurstone, L.L. (1887–1955). In R. J. Sternberg (Ed.), *Encyclopedia of human intelligence* (pp. 1081–1084). New York: Macmillan.
- Thurstone, L. L. (1934). The vectors of mind. *Psychological Review*, 41, 1–32. Retrieved June 2, 2006, from <http://psychclassics.yorku.ca/Thurstone/>



Thurstone, L. L. (1938). *Primary mental abilities*. Chicago: University of Chicago Press.

Thurstone, L. L. (1952). L. L. Thurstone. In E. G. Boring, H. S. Langfeld, H. Werner, & R. M. Yerkes (Eds.), *A history of psychology in autobiography* (Vol. 4, pp. 295–321). Worcester, MA: Clark University Press.  
Retrieved June 2, 2006, from <http://www.unc.edu/depts/quantpsy/thurstone/llt.pdf>

---

## TRACEY, TERENCE J. G. (1952– )

---

Terence J. G. Tracey, an American counseling psychologist, is a leading researcher and theorist who has made important contributions to psychologists' understanding of vocational interests, vocational interest development, and the assessment of vocational interest structure. Tracey has also contributed significantly to psychologists' understanding of the counseling process from an interpersonal perspective, and to methodological approaches to counseling research.

### Academic Life

Tracey received his Ph.D. in counseling psychology from the University of Maryland in 1981. From 1981 to 1983 he taught and practiced as a counseling psychologist at the State University of New York at Buffalo. He joined the University of Illinois faculty in 1983, and served as the associate chair of the Department of Educational Psychology (1995–1997) and Chair and Training Director of the Division of Counseling Psychology (1988–1991, 1998–1999). Tracey joined the Arizona State University faculty in 1999. He served as associate editor of the *Journal of Counseling Psychology* from 1999 to 2005. He also serves on the editorial board of numerous academic journals spanning the counseling, clinical, vocational, and assessment areas. He has been awarded fellow status by the American Psychological Association (Divisions 7, 9, and 17), the American Psychological Society, and the American Association of Applied and Preventive Psychology.

### Research and Influence

Tracey's early research focused on the counseling process, client–therapist interactions, and interpersonal models of personality and psychotherapy.

Tracey examined interpersonal complementarity, or the fit of sequential interpersonal behaviors, between therapist and client. He proposed that a three-stage process of complementarity was indicative of successful therapy. He suggested that the most successful therapy outcomes are obtained when complementarity is initially high, dips to a low as therapy approaches the midpoint, and becomes high again as therapy moves toward its conclusion. Thus therapy dyads that did not follow the three-stage pattern would not result in a successful outcome. He suggested that change results from therapists altering their responses away from the historical responses established by clients, especially in the middle stages of therapy.

In the 1990s Tracey began a fruitful collaboration with James Rounds, focusing on John Holland's RIASEC (Realistic, Investigative, Artistic, Social, Enterprising, and Conventional) model of interests and the structure of vocational interests. Tracey and Rounds published the first extensive analyses of the structural elements of Holland's model. In this work they pioneered the use of multidimensional scaling and the randomization procedure to examine the underlying structure of interest data.

Extant models of interest structure such as Holland's RIASEC model were based on Anne Roe and Dale Predigers's recognition that occupations differed along two dimensions that reflected their involvement with *people* as opposed to *things*, and *data* as opposed to *ideas*. Tracey and Rounds argued that occupations also differed along a third dimension, *prestige*, and they proposed a spherical model that comprised eight interest types at the midlevel of prestige. The spherical model of interest structure has garnered strong empirical support internationally. Subsequently, Tracey developed the Personal Globe Inventory to measure the spherical model. Tracey's innovative analyses of circumplexity, including his use of the randomization procedure and multidimensional scaling analysis, has strengthened the empirical base of vocational psychology and enhanced the standing of counseling psychology research in the view of experimental psychology.

Maria U. A. Darcy

*See also* Counseling Process/Outcome (v2); Holland's Theory of Vocational Personalities and Work Environments (v4); Outcomes of Counseling and Psychotherapy (v2); Vocational Identity (v4); Roe's Theory of Personality Development and Career Choice (v4)



### Further Readings

- Tracey, T. J. G. (2002). Personal Globe Inventory: Measurement of the spherical model of interests and competence beliefs. [Monograph]. *Journal of Vocational Behaviour*, 60, 113–172.
- Tracey, T. J., Heck, E. J., & Lichtenberg, J. W. (1981). Role expectations and symmetrical/complementary therapeutic relationships. *Psychotherapy: Theory, Research and Practice*, 18, 338–344.
- Tracey, T. J., & Ray, P. B. (1984). The stages of successful time-limited counseling: An interactional examination. *Journal of Counseling Psychology*, 31, 13–27.
- Tracey, T. J. G., & Rounds, J. (1996). Spherical representation of vocational interests. *Journal of Vocational Behavior*, 48, 3–41.

## TRANSACTIONAL ANALYSIS

Transactional analysis (TA) is a therapeutic approach that emphasizes the ritualistic transactions of interactions and behaviors that occur between individuals. Developed by Eric Berne in the 1950s, TA focuses on social interaction, emotional well-being, and responsibility, involving life scripts that people develop based upon early childhood experiences. TA is an understandable, sophisticated structural analysis of thoughts, feelings, and behaviors.

### Brief History

Eric Berne, M.D., was born Eric Lennard Bernstein in Montreal, Canada, in 1910. He completed his education in 1935 at McGill University and his residency at Yale's Psychiatric Clinic. However, he experienced increasing frustration with the psychoanalytic approaches of the time. In response, he developed his own approach. In 1958, he published *Transactional Analysis: A New and Effective Method of Group Therapy*. He later published the popular best seller *Games People Play*, and numerous other books, manuscripts, and papers. Berne subsequently founded the International Transactional Analysis Association (ITAA), continuing as a psychotherapist and writer until his death in 1970.

### Basic Elements

TA is a psychosocial approach that uses a concept called *structural analysis* to understand the interactions

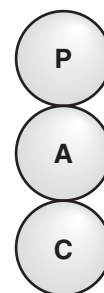
or *transactions* that occur between individuals. Berne's observations during group counseling sessions led to his identification of three ego states that coexist within personality: Parent, Adult, and Child. According to the theory, all three ego states exist within the individual. Even young children have an Adult and Parent ego state. Transactions occur between ego states.

### The Ego States

During Berne's early sessions, he noted that clients thought or behaved sometimes like children, sometimes like adults. Originally, he designated two ego states, the Child, named the *archaeopsyché*, and the Adult, named the *neopsyché*. Later, a third ego state was identified, that of the Parent, or *exteropsyché*. The Child denoted the creative, intuitive, and pleasure-seeking or sometimes rebellious nature of the person. The Adult formed the realistic, logical part of the person. The Parent was derived from introjection and identification with an individual's biological parents. Opinionated, judgmental and nurturing, often protective, the Parent completes the tripartite ego states that form personality: Parent (P), Adult (A), and Child (C) (see Figure 1).

The Parent state operates as a collection of prerecorded, judgmental rules for living. Like a tape playing in our heads, the Parent reminds us of the correct way to think, feel, or behave. It tells us how to react and how to live, right or wrong. When critical, as it often is, this state is known as the Critical Parent. When supportive, it is Nurturing.

The Adult state can be compared to a computer. Functioning in a factual, logical, and rational manner, the Adult faces facts and makes decisions. If the data are correct, the conclusion follows. If the facts are incorrect, the resultant answers are wrong. One of the key purposes of the Adult state is to provide a



**Figure 1** Parent, Adult, and Child ego states

Source: Adapted from Berne, E. (1964).



factually based appraisal of the effectiveness of behavior in the pursuit of goals. Contamination occurs when information from the Parent or Child state distorts the appraisal.

When in a Child state, individuals act like “the child they once were,” with the thoughts, feelings, and behaviors they once experienced. Individuals actually think, see, hear, and react as they may have as children. When the Child is thoughtful, imaginative, and creative, this is known as the Little Professor. When the Child is loving, hateful, or impulsive, this is the Natural Child. Guilt, shame and fearful states are identified in the Adapted Child. All three ego states—Parent, Adult, and Child—are important for healthy functioning; no single ego state should dominate the others.

### Transactions

Transactions are units of social interaction. They are communicative exchanges between people in both directions. Those exchanges originate in and are received by various ego states. When transactions are overt and pass to and from the same ego state (Adult to Adult, for example), these transactions are complementary, and communication flows. When they cross from one state to another (e.g., Adult to Child or Parent to Child), they become crossed and disrupt communication. Covert transactions are deceptive in nature and form the basis of games. Covert transactions also are ulterior in nature and occur when people say one thing and mean another.

### Strokes, Rituals, and Games People Play

Strokes are essential for survival. Positive strokes consist of praise, accolades, and commendation. They are verbal and nonverbal expressions of appreciation and value. Negative strokes are demeaning and judgmental. If people are to thrive as individuals, according to Berne, they need strokes. Just as transactions are units of exchange, strokes are units of interpersonal recognition. Counselors focus on this aspect of TA to assist people in the process of reversing unhealthy patterns of stroking.

There are five ways to get strokes: rituals, pastimes, intimacy, work, and games. Rituals are preset exchanges. Pastimes are common small talk. Intimacy and work, although challenging, are the most satisfying sources of strokes, whereas games are devious.

Undesirable or dysfunctional behavioral interactions earned the title of Games within TA. Games are defined by Berne as sets of often repetitious transactions with hidden or ulterior motives that result in predictable, well-defined outcomes.

Some games earned labels by Berne. These include *Ain't It Awful*, *I'm Only Trying to Help* and *Please Don't Kick Me*, among others. *If It Weren't for You* is often played out between couples so that one member of the couple can blame the other for not being able to achieve desired goals. *Why Don't You . . . Yes, But* (WDYB) is commonly found at social gatherings, committee meetings, and psychotherapy groups, where a problem is thrown out as “bait” and the offered solution results in a *Yes, But* response, making the transaction a game.

### Existential Life Positions and Life Scripts

Popularized by Thomas Harris, M.D., this aspect of TA notes that people are born OK, capable of change, and inherently healthy in human interaction. However, not everyone assumes an OK position. Founded on early and youthful social interactions, people may decide that “I’m OK, but you are not,” “You are OK and I am not,” or “You are not OK and neither am I.” The healthiest perspective is “I’m OK, you’re OK.” The early decisions may be self-limiting, but seemed to offer the best chance of survival at the time. These choices become a pattern resulting in a preconscious *life script* designed to reaffirm the life position. Some scripts are tragic, some banal, and others are healthy. Changing these self-limiting choices that form the life script is the goal of the psychotherapeutic process of TA. A common technique for doing so involves changing decisions made within the Child state (*redecisions*).

### The Therapeutic Milieu

TA educators or therapists are encouraged to focus on patterns of interaction, particularly seeking those transactions that are covert, those that cross-contaminate, or those that lead to delusion or self-limitation. Using symbols, *egograms* are constructed to illustrate the relative strength of ego states, and transactions are visually presented. Contracts are used as tools to resolve issues and educate clients. Scripts are analyzed. Permission to function in an Adult ego state is granted as a crucial device in overcoming unhealthy parental or child influences. Life scripts are outlined



with the intent of changing *self-limiting* patterns of thoughts, feelings, and behaviors.

In group TA settings, three stages are identified; *initial*, *working*, and *final*. In the initial stage, rapport is developed and contracts for change identified. The working stage allows for analysis of games and restructuring of life scripts. In the final phase, rededitions made from the Child state are validated and participants are encouraged to transfer their rededitions from the therapeutic milieu into real life and to close by sharing positive strokes with other group members.

### Future Directions

Transactional analysis provides a useful and comprehensive structural analysis system that can be applied in group, individual, family, and classroom settings. Often combined with Gestalt therapy, TA can be thought of as an educational model, viewing the individual within a systematic social context. Research on the efficacy of TA in educational, occupational, and clinical settings supports TA as a method of promoting mental health and improving interpersonal communication. According to recent research, TA may also help to increase self-esteem.

Although not as popular as in the 1970s, TA continues to thrive, in part through the International Transactional Analysis Association (ITAA). With more than 10,000 members, ITAA publishes the *Journal of Transactional Analysis*; sponsors international conferences; and provides training videos, DVDs, and Web resources.

Gary Michael Szirony

*See also* Communication (v3); Ego Strength (v2); Group Therapy (v2); Interpersonal Learning and Interpersonal Feedback (v2); Psychoanalysis and Psychodynamic Approaches to Therapy (v2)

### Further Readings

- Allen, J. R., & Allen, B. A. (1998). Scripts: The role of permission. *Transactional Analysis Journal*, 1. Retrieved from <http://www.itaa-net.org/TAJNet/articles/allen-scripts-perm.html>
- Barrow, G., Bradshaw, E., & Newton, T. (2001). *Improving behaviour and raising self-esteem in the classroom: A practical guide to using transactional analysis*. London: David Fulton.
- Berne, E. (1961). *Transactional analysis in psychotherapy*. New York: Grove Press.
- Berne, E. (1964). *Games people play: The basic handbook of transactional analysis*. New York: Grove Press.
- Dusay, J. M. (1977). The evolution of transactional analysis. In G. Barnes (Ed.), *Transactional analysis after Eric Berne* (pp. 32–52). New York: Harper's College Press.
- Dusay, J. M., & Dusay, K. M. (1989). Transactional analysis. In R. J. Corsini & D. Wedding (Eds.), *Current psychotherapies* (4th ed., pp. 405–453). Itasca, IL: F. E. Peacock.
- Harris, T. A. (1969). *I'm ok, you're ok*. New York: Avon Books.
- Massey, R. F. (1995). Theory for treating individuals from a transactional analytic/systems perspective. *Transactional Analysis Journal*, 25(3), 271–284.
- Seligman, L. (2006). *Theories of counseling and psychotherapy: Systems, strategies, and skills*. Upper Saddle River, NJ: Pearson.

---

## TRANSFERENCE AND COUNTERTRANSFERENCE

---

The concepts of transference and countertransference, together with that of transference neurosis, properly belong to the theory and practice of psychoanalysis. In Sigmund Freud's original formulations they were inextricably intertwined with his propositions about the determinants of development and neuroses, and they have very limited meaning outside that framework. Where they are so used, their meanings derive from a simple attribution of current client behavior to events in the client's past.

### Freud's Definition of Transference

Freud's earliest discussion of transference was in the case of Dora, whom he saw late in 1900. After interpreting some of her behavior toward him as a repetition of her behavior toward her father, he said that transferences were "new editions or facsimiles of the impulses and phantasies which are aroused and made conscious during the progress of the analysis [and] replace some earlier person by the person of the physician. To put it another way: a whole series of psychological experiences are revived, not as belonging to the past, but as applying to the person of the physician at the present moment" (Freud, 1905, p. 116). Here Freud did not tie transference to any complex theory of neurosis, and in his further discussion



of the case he did not go beyond the proposition that neuroses are based on repressed sexual ideas.

The first theoretical context in which Freud formulated the notion of transference was in his unpublished correspondence between 1897 and 1901 with Wilhelm Fliess, after Freud partially (and secretly) abandoned the proposition that neuroses were due to repressed memories of perverse childhood sexual experiences—the so-called seduction theory. In place of the apparently real seduction memories that Freud claimed to have discovered, Freud now substituted the notion of a perverse childhood sexual drive that generated the same oral, anal, and genital sensations as the supposed real seduction, and which provided the basis of childhood fantasies from which the symptoms of neuroses formed. Thus Dora's late recall of the smell of smoke as part of her dream was actually determined by the repressed oral component of her childhood sexual drive being directed into a longing for a kiss from the cigar-smoking Freud (as well as her attempted seducer) rather than to its original object, her father, who also smoked.

For Freud, Dora's transference was explained entirely within this early theory of childhood sexuality, and his explanation became even more complete in his fully developed sexual theory. In it, the oral, anal, and genital components of the childhood sexual drive pass through a phylogenetically determined series of stages at any of which there can be some degree of fixation and perverse choice of object. Together with abnormalities in the associated ego and superego structures, these processes contribute causally to later adult neuroses, determining their symptoms as well as the content of the transferences and the transference neurosis.

### **Transference Neurosis and Its Resolution**

The term *transference neurosis* refers to the temporary neurosis created in psychoanalysis as the revived, but unconscious, sexual feelings and object choices of the patient's past are transferred on to the analyst. Freud introduced the concept in 1914 when discussing patients whom he believed were rejecting his interpretations and avoided remembering past repressed unconscious conflicts, but unconsciously repeated behaviors based on them. In 1920, he extended the meaning to include what he saw as the patient's compulsion to repeat earlier, unpleasant experiences that helped to maintain the neurosis.

Although in one sense an artificial creation of the analytic situation, Freud came to believe the transference neurosis was an inevitable revival of the earlier infantile neurosis in which the basic neurotic symptoms were reproduced in a simplified and more readily identifiable form. By reconstructing the patient's past, the transference neurosis could be used therapeutically. In this sense, Freud regarded the resolution of the transference neurosis as a necessary condition for the cure of the ordinary or adult neurosis. He was generally optimistic that it would yield to psychoanalytic intervention although, as an unconscious resistance, it could sometimes interfere with that aim.

### **Countertransference**

Freud first mentioned countertransference in 1910 as the constellation of feelings aroused in the psychoanalyst by the patient from the analyst's unconscious complexes and internal resistances. He gave no formal definition, but characterized it negatively and said it required a deep, continuous, and productive self-analysis if the psychoanalyst was to be successful. The negative effects of countertransference were later regarded so seriously that Freud's requirement of a self-analysis was extended to requiring a personal analysis as part of analytic training.

### **Identifying the Phenomena**

Although Freud's definitions may be clear enough, studies by psychoanalysts have shown that there is little agreement among them about the manifestations of transference, and hence of transference neurosis and countertransference. The cause of this disagreement is that there is no behavior that, simply by itself, can be said to constitute transference (or countertransference). To count as a manifestation of transference, whatever the patient has expressed emotionally, verbally, or in other ways has to be interpreted within a developmental context constructed by the treating psychoanalyst. The lack of agreement among the multitudinous reinterpretations of Dora's identifications and dreams provides a good example of the problem. Each reinterpretation was made from the same set of "facts" Freud described, but the lack of agreement on the developmental context meant there could be no agreement on what counted as transference. It seems impossible for other analysts to comprehend fully the particular developmental context constructed by a



colleague. The same point explains the lack of agreement in those few studies of transference manifestations that are judged by a panel of analysts examining audio- or videotapes of a patient's behavior over a number of sessions.

The problem posed by theoretical context in identifying transference manifestations is also seen in the two main groups of empirical studies of the phenomenon, those by Lester Luborsky and his colleagues and by Susan Andersen and hers. Both note the considerable lack of agreement among psychoanalysts in defining the concept before outlining their own criteria for identifying transference. Using recordings of psychoanalytic therapy sessions and adopting a general psychoanalytic framework, Luborsky's group arrived at agreement on the presence of consistent and recurrent patterns of relationships between childhood and adult behaviors (Core Conflict Relationship Themes). They take these recurrent patterns to confirm Freud's "grandest clinical hypothesis"—that of transference—even though the relationships are not necessarily based on repressed unconscious instinctual wishes. At best, their concepts of transference are fairly bland translations of Freud's. Andersen and her colleagues explicitly differentiated their concept of transference from the drive-structure assumptions on which Freud's is based. They do not assume that repression is involved and merely endorse the simple premise that aspects of past relationships may be replayed in present ones.

### Transference and Countertransference Outside Psychoanalysis

As almost any textbook on counseling will attest, transference and countertransference are given different meanings and accorded differing degrees of importance in systems of counseling and psychotherapy other than psychoanalysis. Only in those psychotherapies explicitly basing some of their theoretical notions on Freud's does one tend to find the concepts being used with similar meaning.

On the other hand, in those systems of therapy and counseling where little emphasis is placed on the contribution of specific childhood factors to adult maladjustment, transference, transference neurosis, or countertransference are not discussed. This is not necessarily because of a lack of knowledge of these concepts. Aaron Beck and Albert Ellis, for example, both

trained as psychoanalysts before developing their own approaches, but virtually dismiss transference. Beck gave a role to childhood experience, but claimed that discussing parents is not always necessary and that transference can be dealt with in the first 5 minutes, whereas Ellis directed the whole of the client's attention to current matters. Transference does find some limited place in Carl Rogers's client-centered counseling, the progenitor of many modern approaches. According to Rogers, although transference *attitudes* may develop, the combination of the time-limited nature of his form of counseling and the accepting environment in which it takes place prevents transference *relationships* proper from developing. John Shlein, a contemporary follower of Rogers, argued that the therapist's invocation of transference was a means by which counselors avoided personal responsibility for the effects they had on their clients. Note, however, that the reference of the concept of transference here is to simple behavior rather than the theoretically based understanding proposed by Freud.

In much of the counseling literature there is a similar simplification of countertransference, so if it is discussed at all, it is as the ordinary emotional reactions of the counselor to the client. It ranges from discussions of liking or not liking the client to the more serious issue of the erotic attraction of the counselor or therapist to the client. But, whether the effect of the latter is simply to cloud the counselor's judgment or to cause a much more serious ethical violation by involving the counselor with the client sexually, it seems neither necessary nor desirable to invoke the explanatory armamentarium of Freudian theory.

*Malcolm Macmillan*

**See also** Counseling Process/Outcome (v2); Freud, Sigmund (v2); Humanistic Approaches (v2); Psychoanalysis and Psychodynamic Approaches to Therapy (v2); Relationships With Clients (v2); Working Alliance (v2)

### Further Readings

- Berk, M. S., & Andersen, S. M. (2000). The impact of past relationships on interpersonal behavior: Behavioral confirmation in the social-cognitive process of transference. *Journal of Personal and Social Psychology*, 79, 546–562.
- Freud, S. (1953). Fragment of an analysis of a case of hysteria. In J. Strachey (Ed. & Trans.), *The standard edition of the complete psychological works of Sigmund*



- Freud (Vol. 7, pp. 1–122). London: Hogarth Press. (Original work published 1905)
- Laplanche, J., & Pontalis, J.-B. (1973). *The language of psychoanalysis*. (D. Nicholson-Smith, Trans.). London: Hutchison. (Original work published 1964)
- Luborsky, L., & Crits-Christoph, P. (1998). *Understanding transference: The Core Conflictual Relationship Theme method* (2nd ed.). Washington, DC: American Psychological Association.
- Macmillan, M. (1997). *Freud evaluated: The completed arc*. Cambridge: MIT Press.
- Shlien, J. M. (1987). A counter-theory of transference. *Person-Centered Review*, 2, 15–49.
- Wood, A. B. (1951). Transference in client-centered therapy and in psychoanalysis. *Journal of Consulting Psychology*, 15, 72–75.

---

## TYLER, LEONA E. (1906–1993): HUMAN MULTIPOTENTIALITY

---

Leona Elizabeth Tyler was born on May 10, 1906, in Chetek, Wisconsin. Her mother, Bessie J. Carver, taught in a country school before marriage to her father, Leon M. Tyler, who worked as an accountant and later as a house restoration contractor. Although no one in Leona Tyler's immediate or extended family had attended college, her mother expected all of her four children to achieve career distinction. Bessie Tyler decided that passage of the suffrage amendment had established women's equality as a given, and treated her daughter as equal to her sons. Although her mother's commitment to fundamentalist religious and moral values placed severe limits on Leona Tyler's social activity, it provided a foundation for her strong spiritual and moral principles.

An omnivorous reader, Leona Tyler progressed rapidly through school, entering Virginia Junior College at the age of 15, and completing her college education at 19. She recalled that in high school a female assistant principal cautioned her not to attend a teacher's college, but rather seek out a university. This important guidance was at a time when women generally attended teaching colleges. In 1925, she graduated from the University of Minnesota with a B.S. in English Literature.

Following graduation, Leona Tyler taught English and a variety of other subjects in junior high schools in Minnesota and Michigan. She was particularly

moved by the personal accounts written by her students. Their struggles with identity and their distress associated with decisions about careers and relationships emerged as themes that sparked an interest in individual differences.

In 1937 she enrolled in a graduate course on individual differences at the University of Minnesota taught by Donald G. Paterson, an important mentor who convinced her to undertake full-time graduate study at that university. She pursued her fascination with the rich diversity of human individuality, focusing on individual differences, obtaining special training in counseling, and conducting research on the career interests of adolescent girls. The threads of her career—individual differences, counseling, and interest research—were established during this period.

Although Leona Tyler did not receive her Ph.D. until 1941, she began her university teaching career in the psychology department at the University of Oregon at Eugene in 1940. She taught a wide variety of courses, including courses on individual differences, testing, and counseling. She also supervised more advanced degree candidates than any other faculty member at her institution. In 1941, the university received funds to establish a counseling service for veterans of World War II. Tyler innovatively organized the service under the aegis of the psychology department, and thereafter divided her time between counseling and teaching. A pacifist, she also volunteered time to provide counseling to conscientious objectors.

In addition to her counseling and administrative work, Leona Tyler contributed to a number of research projects and wrote *The Psychology of Human Differences*, first published in 1947. Tyler distinguished the purpose of counseling as different from that of psychotherapy, with the former designed to encourage healthy lifelong developmental processes, the latter to deal with clinical disturbances of personality. She found that her teaching, counseling, research, and writing all interacted to stimulate integration of ideas about human personality, choice, and possibility. Her prolific research and writing activities—which ultimately included more than 100 articles and books—provided a desirable professional balance for Tyler in that she found research involvement alone unduly restricting. Textbook writing, which required consideration of a wider range of information, encouraged a broader view.

Leona Tyler took a sabbatical in London in 1951. When she returned, the ideas generated by her



research and writing, as well as teaching and counseling, inspired her to develop a coherent theoretical system to explain individuality as a matter of choice and organization. She focused on the notion that research on individual differences, based on normative measurement of hypothetical traits, would not provide insight into individuality. In her presidential address to the Western Psychological Association in 1958, she proposed that individuality is a matter of the choices people make and the cognitive structures people use to organize their experiences. This new orientation altered the field's emphasis on psychometrics and directed it to developmental and learning processes.

In a subsequent sabbatical at the University of Amsterdam from 1962 to 1963, Tyler focused on questions of individuality, such as whether environmental differences contribute to differences in cognitive organization. She collected data which indicated that the more the environment determined vocational choice, the narrower and less differentiated the student's occupational choices. The results suggested an interactive influence of environment and individual variables on choices, which fostered further development of Tyler's theory of possibilities, published in *The Work of the Counselor*.

In Tyler's theory, humans are characterized by *multipotentiality*. Essentially, development consists of potentialities for what one can become, which are transformed into actualities. All persons select which potentialities are actualized, whether consciously or unconsciously, driven by internal or environmental factors. Furthermore, Tyler suggested that people engage in spontaneous activity, which is modified and guided by their environment. As a result of this modification and guidance, organizational structures for guiding choices develop. Finally, as an individual develops more complex organizational schemas, a new, qualitatively different individual will emerge.

Tyler applied her theory of possibilities to counseling through proposing that clients seek counseling when they are confused and their cognitive structures do not adequately guide their choices. She suggested that it is the counselor's role to help clients consider all their possibilities—particularly as society becomes more complex. She also suggested that counseling is a process whereby possibility structures are examined and choices are facilitated.

Tyler later applied her theory of possibilities in exploring the choice behavior of scientists in *Thinking*

*Critically*. She suggested that the way people perceive choices for scientific inquiry can often be distorted or limited by professional education and discipline-based conformity. Tyler put forth that science would be best served if a variety of scientific paradigms could coexist, tolerate, and inform each other's work.

From 1965 to 1971, when Leona Tyler retired, she was the dean of the graduate school at the University of Oregon. Tyler expressed surprise that the position was offered to her and she required some time before she could accept it. In keeping with the views of the women of her generation, Tyler had difficulty viewing herself in such an administrative role. She thought that if the opportunity had been presented 10 years later, after the resurgence of feminism, perhaps the struggle with herself would have been easier. Tyler was challenged in that she had to adjust to having an influence on the policies, development, and structure of the university as a whole, during a time in which the graduate school was undergoing a transformation from a minor to a major institution.

Leona Tyler was elected as president of the Oregon Psychological Association from 1956 to 1957, of the Western Psychological Association from 1957 to 1958, and of the Division of Counseling Psychology (Division 17) of the American Psychological Association (APA) from 1959 to 1960. She played many leadership roles in APA during her retirement years. She served on the Board of Directors, the Policy of Planning Board, the Board of Social and Ethical Responsibility, the Publications Board, and for 3 years as president-elect, president, and past president. Tyler was the 81st APA president and the 4th woman to have that position.

In addition, she edited several journals, including *Contemporary Psychology* and the *Journal of Counseling Psychology*, and served on the editorial board of the *Annual Review of Psychology*. Her many honors include the Distinguished Achievement Award of the University of Minnesota, the E. K. Strong Gold Medal for Interest Measurement, the ABPP award for Outstanding Contribution to Professional Psychology, an honorary doctorate from Linfield College, the Founder's Award from Pacific University, and the Distinguished Service Award from the University of Oregon. Division 17 named an annual award for her.

Leona Tyler viewed her relationship to the women's rights movement as ambiguous in that she was born too early or too late to participate fully.



While she considered working to improve the position of all women as a worthy cause, her own focus was less on rights and more on fostering concern for the common good. She viewed the emphasis on women's solidarity (i.e., the idea that women should help one another) as the most significant aspect of the movement, and she saw it as an idea foreign to most women of her generation.

In sum, Leona Tyler's vision and leadership helped shape both the Division of Counseling Psychology and the American Psychological Association. In her writing and research, she integrated ideas and articulated the complexities of human multipotentiality. She exemplified such multipotentiality, excelling in a multitude of roles as a teacher, mentor, counselor, researcher, administrator, world traveler, and writer, as well as dog owner and music lover.

*Nancy Felipe Russo and Sonya Bettendorf*

**See also** Career Counseling (v4); Counseling, Definition of (v1); Counseling, History of (v1); Counseling Psychology, Definition of (v1); Counseling Psychology, History of (v1); Decision Making (v4); Diversity (v3); Individualism

(v3); Person–Environment Interactions (v2); Relationships With Clients (v2); Tyler, Leona E. (v1)

### Further Readings

- Tyler, L. E. (1959). Toward a workable psychology of individuality. *American Psychologist*, 14, 75–81.
- Tyler, L. E. (1965). *The psychology of human differences* (3rd ed.). New York: Appleton-Century Crofts/Prentice Hall.
- Tyler, L. E. (1969). *The work of the counselor* (3rd ed.). New York: Appleton-Century-Croft.
- Tyler, L. E. (1978). *Individuality: Human possibilities and personal choice in the psychological development of men and women*. San Francisco: Jossey-Bass.
- Tyler, L. E. (1978). My life as a psychologist. In T. Krawiec (Ed.), *The psychologists: Autobiographies of distinguished living psychologists* (pp. 289–301). Brandon, VT: Clinical Psychology.
- Tyler, L. E. (1983). *Thinking creatively: A new approach to psychology and individual differences*. San Francisco: Jossey-Bass.
- Tyler, L. E. (1988). Years of my life. In A. N. O'Connell & N. F. Russo (Eds.), *Models of achievement* (pp. 42–55). Hillsdale, NJ: Lawrence Erlbaum.









---

## UNDERDIAGNOSIS/OVERDIAGNOSIS

---

Assessment and diagnosis of an individual's problems and concerns represent important precursors to effective counseling. In order to help someone, the counselor must formulate an accurate appraisal of the problems to be targeted in the counseling process. Using diagnostic interviews and psychological tests, mental health professionals hope to develop an accurate diagnosis of the client, to be followed by the application of the appropriate intervention. However, both clinicians and the tests they rely on to render a diagnosis are less than perfect, and the potential to under- or overdiagnose psychological conditions remains. When a clinician or test fails to diagnose a condition when it exists, it is called a *false negative*. A *false positive* occurs when the test or clinician identifies a condition when in fact the condition does not exist. The consequences of inaccurate diagnosis can be quite costly. For example, a person might be denied a job in a preemployment screening if the test he or she is given tends to overdiagnose problems. Similarly, an individual might be denied access to a much needed treatment program if the test or interview administered to him or her tends to underdiagnose conditions.

Because mental health professionals often rely heavily on the results of psychological testing in formulating diagnoses, test developers recognize the importance of evaluating tests' diagnostic accuracy. During the test validation process, it is often the case that a *cutting score* is determined. This is a score

which, when exceeded, leads to the conclusion that the person has the condition measured by the test. Of course, to determine a test's optimal cutting score, its results must be compared to some real-world criterion. For example, a test assessing depression might be compared to whether or not an individual currently has a diagnosis of depression.

By comparing a test's outcome to some real-world criterion, it is possible to determine the test's *operating characteristics*. These include its hit rate, sensitivity, specificity, positive predictive power, and negative predictive power. The test's *hit rate* is the total number of correctly identified cases divided by the total number of cases assessed. *Sensitivity* is the rate at which the test correctly identifies the existence of disorder, whereas *specificity* represents the test's ability to accurately identify the nonexistence of a disorder. *Positive predictive power* refers to the percentage of individuals identified by the test as having a disorder who actually have the disorder, and *negative predictive power* refers to the percentage of cases identified as not having the disorder who actually do not. Both tests and clinicians can be evaluated in terms of whether such test operating characteristics concerning the diagnoses they make are optimal.

Timothy M. Osberg

*See also* Assessment (v4); Clinical Interview as an Assessment Technique (v2); Meehl, Paul E. (v2); Psychometric Properties (v2); Psychopathology, Assessment of (v2); Quantitative Methodologies (v1); Test Interpretation (v2); Therapist Interpretation (v2)



**Further Readings**

- Embretson, S. E., & Hershberger, S. L. (Eds.). (1999). *The new rules of measurement: What every psychologist and educator should know*. Mahwah, NJ: Lawrence Erlbaum.
- Meehl, P. E. (1996). *Clinical versus statistical prediction: A theoretical analysis and a review of the evidence*. Lanham, MD: Jason Aronson. (Original work published 1954)





---

## WAMPOLD, BRUCE E. (1948– )

---

Bruce Edward Wampold (born November 25, 1948, in Olympia, Washington) is widely recognized for his research on psychotherapy process and outcome and his development of research methods and statistics.

Wampold received his B.A. in mathematics from the University of Washington and taught junior and senior high school mathematics and coached wrestling for several years. He returned to school to receive his M.Ed. in Educational Psychology from the University of Hawai‘i and his Ph.D. in Counseling Psychology from the University of California, Santa Barbara, where he studied under the guidance of Donald R. Atkinson. In addition to Atkinson, Wampold acknowledges being highly influenced by Lawrence J. Hubert, Joel R. Levin, Michael J. Patton, and Ronald C. Serlin. He held faculty appointments at the University of Utah and the University of Oregon, before his current appointment in the Department of Counseling Psychology, University of Wisconsin–Madison, where he is presently a full professor and department chair. He has been licensed as a psychologist since 1983, and has been a Diplomate in Counseling Psychology of the American Board of Professional Psychology since 2001.

Wampold’s contextual model of psychotherapy provides a challenging alternative to the dominant paradigm used to explain the efficaciousness of psychotherapy. The prevailing model of psychotherapy—widely known as the medical model—claims the specific techniques advocated by different theories of psychotherapy account for the effectiveness of therapy. Wampold’s investigations demonstrated empirically that the effects

of psychotherapy are due to factors that are common to all bona fide psychotherapies, and he proposed a contextual model based on this body of evidence.

Wampold’s contextual model conceptualizes the effective components of psychotherapy as consisting of (a) a confidential therapist–client relationship, (b) a context or environment for the healing, (c) an acceptance of alternative and adaptive explanation(s) of the client’s distress, and (d) procedure(s) consistent with the explanation for reducing or resolving the client’s distress. Research by Wampold and his associates using meta-analytic and hierarchical modeling techniques has demonstrated that these common factors account for much higher percentage of the variance in therapeutic outcomes than specific techniques. The specific techniques advocated on the basis of theory failed to account for a clinically meaningful percentage of the variance in therapeutic outcome. Wampold’s research and theoretical reformulation of the therapeutic process has influenced the thinking of public and private organizations around the world, and of the APA Presidential Task Force on Evidence-Based Practice.

*Takuya Minami*

*See also* Common Factors Model (v2); Counseling Process/Outcome (v2); Evidence-Based Treatments (v2); Outcomes of Counseling and Psychotherapy (v2); Taxonomy of Helpful Impacts (v2)

### Further Readings

Wampold, B. E. (2001). Contextualizing psychotherapy as a healing practice: Culture, history, and methods. *Applied & Preventive Psychology, 10*, 69–86.



- Wampold, B. E. (2001). *The great psychotherapy debate*. Mahwah, NJ: Lawrence Erlbaum.
- Wampold, B. E., Mondin, G. W., Moody, M., Stich, F., Benson, K., & Ahn, H. (1997). A meta-analysis of outcome studies comparing bona fide psychotherapies: Empirically, “all must have prizes.” *Psychological Bulletin*, 122, 203–215.
- Wampold, B. E., & Serlin, R. C. (2000). The consequence of ignoring a nested factor on measures of effect size in analysis of variance. *Psychological Methods*, 5, 425–433.

## WECHSLER, DAVID (1896–1981)

David Wechsler, a Jewish American psychologist best known for his contributions to intelligence theory and intellectual assessment, was born in Lespedi, Romania, January 12, 1896. When he was 6, his family moved to New York City. Wechsler earned a bachelor's degree from City College of New York in 1916, a master's degree from Columbia University in 1917, and a doctor of philosophy from Columbia University in 1925, the latter degrees earned under Robert S. Woodworth.

After gaining military experience in assessment during World War I, partly under Edwin G. Boring, Wechsler was transferred to the University of London in 1919. There he studied with Charles E. Spearman and Karl Pearson. Both Spearman and Pearson were interested in the nature and measurement of intelligence, and Spearman had already introduced his two-factor intelligence theory. In 1920, Wechsler was awarded a 2-year fellowship to study psychogalvanic response (the topic of his future dissertation) at the University of Paris under Louis Lapique and Henri Piéron.

After receiving his Ph.D., Wechsler accepted an offer from James McKeen Cattell to serve as acting secretary for The Psychological Corporation. He resigned in 1927 to open a clinical practice, and in 1932 he was appointed as Chief Psychologist at Bellevue Psychiatric Hospital. The following year he was appointed as clinical professor to the Medical College at New York University, and he remained at both positions until 1967.

Based in part on his extensive clinical experience, Wechsler found current theories of intellectual assessment to be too simplistic, and he considered the available assessments to be too limited. Ultimately, Wechsler came to view intelligence as the global capacity to act purposefully, think rationally, and deal

effectively with one's environment. That view guided his work in developing batteries for assessing the intelligence of adults and children.

Wechsler's adult intelligence battery was published in 1939 as the Wechsler-Bellevue Intelligence Scale and revised in 1942 as the Wechsler-Bellevue II (“Army Wechsler”). It was renamed the Wechsler Adult Intelligence Scale (WAIS) in the 1955, 1981, and 1997 (WAIS–III) revisions. The Wechsler Intelligence Scale for Children was published in 1949 (WISC), and revised in 1974 (WISC-R), 1991 (WISC–III), and 2003 (WISC–IV). For younger children, Wechsler developed the Wechsler Preschool and Primary Scale of Intelligence in 1967 (WPPSI; currently WPPSI–III). Wechsler developed other instruments, such as the Wechsler Memory Scale (WMS) in 1945 (currently WMS–III). Wechsler realized the limitations of psychological tests and believed his scales should be used in coordination with other assessment techniques.

An important theoretical contribution was Wechsler's introduction of the Deviation Quotient. Up to that time an Intelligence Quotient (IQ) was obtained by calculating a “mental age” score based on the performance of a representative sample of the American population. The “mental age” score was then divided by the examinee's chronological age to obtain an (IQ). However, a substantial decline in cognitive processing speed occurs as a function of age. This rendered earlier IQ scores less and less useful as the individual ages. Wechsler solved this problem by developing separate norms for a variety of age groups and comparing the examinee's performance with that of individuals of similar age. Wechsler's Deviation Quotient has been universally adopted as providing the most meaningful representation of adult intelligence.

Wechsler died May 2, 1981, in New York City.

*Charles E. Byrd and Teraesa S. Vinson*

*See also* Assessment (v4); Intelligence (v2); Intelligence Tests (v3)

### Further Readings

- Matarazzo, J. D. (1981). David Wechsler (1896–1981). *American Psychologist*, 36(12), 1542–1543.
- Wechsler, D. (1944). *The measurement of adult intelligence* (3rd ed.). Baltimore: Williams & Wilkins.
- Wechsler, D. (1974). *Selected papers of David Wechsler*. New York: Academic Press.



## WEISS, DAVID J. (1936– )

David J. Weiss is widely recognized as one of the founders of computerized adaptive testing (CAT) and for directing the development of instruments to assess work adjustment. He earned his B.A. in psychology from the University of Pennsylvania in 1959 and his Ph.D. from the University of Minnesota in 1963. He has spent his entire professional career in the Psychology Department at Minnesota, where he founded and directs the Psychometric Methods Program.

### The Theory of Work Adjustment

Though the origination of the *theory of work adjustment* in 1964 is credited to René Dawis and Lloyd Lofquist, Weiss became an important part of the development group in 1964. He coauthored the first major revision of the theory in 1968 and directed the program of research that resulted in the development and validation of the major instruments used to make the theory operational. Weiss was instrumental in developing the Minnesota Ability Test Battery, the Minnesota Satisfactoriness Scales, the Minnesota Importance Questionnaire, and the Minnesota Job Description Questionnaire (MJDQ). For the last 40 years these instruments have been used extensively in vocational psychology research and practice.

### Computerized Adaptive Testing

Weiss's most significant contributions have been as a founder of computerized adaptive testing. Conventional tests of ability and achievement require that each examinee receive the same set of items, and the tests calculate a score based on the number correct responses for that item set. These tests are inefficient because people above or below the average ability level receive a set of items that is too easy (in the former case) or too difficult. In neither case do these items provide any new information about the person's ability level. Furthermore, items that are too easy can cause boredom and reduce motivation, while items that are too difficult can be highly discouraging to an examinee.

The development of computers and a theoretical model called *item response theory* enabled Weiss and others to pioneer computerized adaptive testing, a procedure in which the computer administers items that are tailored to each individual's performance

level. After an item is administered, the computer estimates the person's ability score and selects as the next item the single item that will provide the most additional information about the person's ability. CAT makes it possible to administer fewer items to a given examinee, to specify the desired precision of measurement, and to ensure that examinees receive a set of items that is neither too easy nor too difficult.

Weiss developed several major strategies of adaptive testing, and his research program laid the groundwork for future adaptive testing research. CAT is now used with major aptitude tests such as the Graduate Record Examination, and the Armed Services Vocational Aptitude Battery, with achievement testing in the schools, and in testing for licensure examinations in such fields as nursing. Currently, Weiss and other leading researchers are studying the use of CAT in measuring attitudes, interests, and personality.

### Other Accomplishments

Weiss has also written many articles on the use of multivariate statistical procedures (e.g., factor analysis and cluster analysis) in counseling psychology research. He served as associate editor and acting coeditor of the *Journal of Counseling Psychology*, and he founded and edited *Applied Psychological Measurement*. He received the Career Achievement Award from the Association of Test Publishers.

Nancy E. Betz

**See also** Achievement, Aptitude, and Ability Tests (v4); Computerized-Assisted Testing (v2); Quantitative Methodologies (v1); Test Interpretation (v2); Theory of Work Adjustment (v4)

### Further Readings

- Dawis, R. V. (2005). The Minnesota Theory of Work Adjustment. In S. D. Brown & R. W. Lent (Eds.), *Career development and counseling: Putting theory and research to work* (pp. 3–21). New York: Wiley.
- Weiss, D. J. (1970). Research methodology: Factor analysis and counseling psychology Research. *Journal of Counseling Psychology*, 17, 477–485.
- Weiss, D. J. (1995). Improving individual differences measurement with item response theory and computerized adaptive testing. In D. Lubinski & R. V. Dawis (Eds.), *Assessing individual differences in human behavior* (pp. 49–79). Palo Alto, CA: Davies Black.



Weiss, D. J. (2004). Computerized adaptive testing for effective and efficient measurement in counseling and education. *Measurement and Evaluation in Counseling and Development*, 37, 70–84.

### Web Sites

CAT Central: <http://www.psych.umn.edu/psylabs/catcentral>

---

## WORKING ALLIANCE

---

According to contemporary psychodynamic theory, the working alliance is one of three components of the psychotherapy relationship. The other two are the transference/countertransference configuration and the real relationship. Counseling psychologists across a broad range of therapeutic approaches who do not ascribe to the importance of the latter two constructs believe that the alliance is a critical component for working effectively with their clients. Thus, the working alliance is a “pantheoretical” construct applicable to every counseling approach. An effective working alliance involves an agreement between counselor and client about the *goals* of their work, and agreement about the session-by-session *tasks* (i.e., counseling techniques and activities) that are necessary to achieve these goals. The third component of an effective working alliance is an emotional *bond* between counselor and client, characterized by mutual respect and the client’s strong sense of being understood and valued by the counselor.

Research suggests that no single variable predicts more variance in the ultimate outcome of counseling than the quality of the working alliance. Several meta-analytic studies suggest that the quality of the alliance may be more important than the particular techniques that a counselor uses (although it is still important that a client believes that whatever approach the counselor selects will be effective). These studies suggest that the quality of the working alliance, measured as early as the third counseling session, predicts 20% to 25% of the eventual variability in counseling effectiveness.

Many experienced counselors believe that all three components are essential for an effective working

alliance and that, for example, a strong bond cannot compensate for a lack of agreement about the goals of counseling. Recently, experts have emphasized the importance of a counselor’s multicultural competency to understand a client’s worldview so that the goals and tasks negotiated are culturally appropriate for the client. This competency also ensures that a productive bond forms based on the counselor’s understanding of the client’s cultural perspective.

Proponents of interpersonal approaches to facilitating change believe that maladaptive patterns in a client’s relationships with significant others are likely to be manifest in the counseling relationship as well. From this perspective, *ruptures* in the working alliance are to be expected. As counselors and clients work together to heal these inevitable breaches in their working relationship, clients gain insight into their maladaptive patterns and learn new skills for relating in a more satisfactory way—first with the counselor, and then with others.

The Working Alliance Inventory, developed by A. O. Horvath and L. S. Greenberg, is one of the most widely used self-report measures of the working alliance. Separate forms assess the counselor and client perspectives on the alliance.

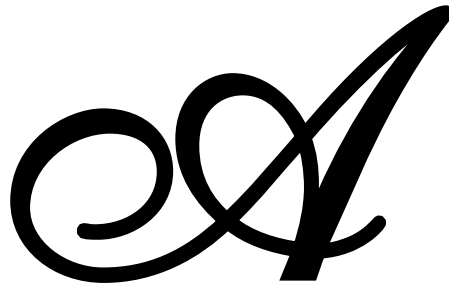
*Brent Mallinckrodt*

**See also** Common Factors Model (v2); Facilitative Conditions (v2); Gelso, Charles J. (v2); Relationships With Clients (v2); Rogers, Carl R. (v2); Self-Disclosure (v2); Taxonomy of Helpful Impacts (v2); Transference and Countertransference (v2); Wampold, Bruce E. (v2)

### Further Readings

- Gelso, C. J., & Hayes, J. A. (1998). *The psychotherapy relationship: Theory, research and practice*. New York: Wiley.
- Martin, D. J., Garske, J. P., & Davis, M. K. (2000). Relation of the therapeutic alliance with outcome and other variables: A meta-analytic review. *Journal of Consulting and Clinical Psychology*, 68, 438–450.
- Safran, J. D., & Muran, J. C. (2000). *Negotiating the therapeutic alliance: A relational treatment guide*. New York: Guilford Press.





---

## ACCULTURATION

---

Acculturation can be described as cultural change associated with social group movement, be it movement within or across nations, that results in persons who have different cultures intersecting. Since the 1990s, the immigrant population in the United States has increased by more than 13 million people. More than half of this immigrant population is from Mexico, where the Spanish language is dominant, and approximately one fifth of the children of immigrant households speak a language other than English in their home. Rates of migration from other Latin American and Pacific Rim nations to the United States also are increasing, as is immigration throughout most developed nations worldwide. These trends underscore the great impetus in understanding the processes of immigrant adaptation and all its components.

As persons from multiple social groups and cultures intersect, it would be expected that their thoughts, attitudes, values, behaviors, and (in most cases) language would be influenced. Until recently, the prevailing assumption within U.S. popular culture, as well as for most Western mental health scholars, has been that when persons from different cultures interact, one culture is dominant. However, within the United States and across the world, there is increasing cultural, social, and economic diversity, as well as the formation of dominant minority communities within larger majority communities (e.g., ethnic enclaves). The development of such communities challenges more traditional acculturation models that have guided social/behavioral scientists, educators, practitioners,

and even popular culture, where cultural change is believed to solely and linearly occur within minority group members.

### **Conceptual Origins and the Prevailing Assimilation Model**

*Acculturation* has been defined by Robert Redfield and colleagues as the “phenomenon that occurs when two independent cultural groups come into first hand contact over an extended period of time, resulting in changes in either or both groups” (1936, p. 149). References to acculturation by social scientists in the 1940s included that of Mischa Titiev titled “Enculturation.” Enculturation was described as the process of teaching a child to be a member of the society in which he or she will live, whereas acculturation was described as the process of incorporating aspects of the mainstream (host) culture into each individual’s repertoire of behaviors.

Despite a clear emphasis in the original definitions on cultural exchange and mutual influence, the majority of early theory, research, and practice on acculturation focused on unidirectional cultural change. This is best represented in the assimilationist model, where the minority traditional culture is assumed to conform over time to the majority culture, and the majority culture remains static. It was thought that external acculturation, such as changing food habits and styles of clothing, as well as learning and/or adapting to the majority language, tended to take place first, followed by internal acculturation, or the adoption of cultural beliefs, values, and more complex patterns of behaviors. Assimilation models assumed that, over time,



behavior patterns, attitudes, and beliefs of an immigrant population would come to resemble more closely those of the culture they entered than those of the culture they left behind. The process of acculturation then included dropping, modifying, and adopting cultural traits and was thought to occur at different rates over several generations for every person individually. From this perspective, acculturation also could be assessed in terms of the distance from the culture of origin to the majority culture, reflecting either movement toward acculturation or movement away from the majority culture. Also, it was thought that acculturation could be conceptualized primarily from consideration of factors such as place of origin, language preferences, and preferences for social contacts. The assimilation model of acculturation also was reflected in the philosophy that the United States had been founded on the notion of “the melting pot.” This perspective suggested that multiple immigrant groups could be welcomed and integrated into the general U.S. society, while slowly breaking all ties to their past culture and not affecting their new society. In other words, immigrants would gradually conform into the existing society norms, values, language, and all other elements characteristic of U.S. culture, while the U.S. culture itself remained uninfluenced by their entry.

However, behavioral scientists within the past 2 decades have shown empirically more closely to what previous anthropologists and many sociologists had described. Namely, the melting pot metaphor in describing the processes of immigration for most immigrants arriving in the United States, as well as in other industrial nations, was incomplete and inaccurate. For example, one assumption underlying the assimilation model was that culture change was inherently stressful, and the quickest path to eliminate this stress was complete assimilation. In other words, the healthiest way of life was for people to put behind them all aspects of their culture of origin. Many research findings indicate that the acculturation process is not inherently stressful (although parts of it may be at times) and that assimilation may result in increased stress or worse physical health for immigrants or their descendents. Furthermore, researchers continue to provide evidence that losing functioning in individuals’ original culture often is harmful to their well-being.

Another guiding assumption of assimilation-related models was that complete acceptance into the new society was thought possible for all immigrants; however, many minority ethnic groups (including

immigrants and later generations) in the United States report experiencing discrimination or being treated unfairly as a result of their ethnic group membership, language, phenotype (i.e., physical features, including skin color), or other socially recognizable characteristics. In fact, contrary to assumptions underlying the assimilation model, discrimination often is felt more strongly for later generations, who are citizens and speak English fluently, as they become more knowledgeable about the customs of their new society and interact more often with societal institutions. In short, the current social and behavioral science findings suggest that the experience of many immigrants and later generations is not reflective of the melting pot metaphor, or its extension, the assimilation model of acculturation.

### **Progress in Theories and Methods and the Emergence of Orthogonal Models**

The study of acculturation began through anthropologists’ explorations of indigenous and immigrant groups immersed within a dominant culture. Researchers employed qualitative methods of inquiry that relied on their personal contact with these groups. Often anthropologists would learn about new cultures by becoming everyday members of new societies, recording their observations, and providing rich descriptions of participants’ experiences. This research was insightful and critical to the philosophical and scientific advancement of the study of acculturation, though there were questions about the efficacy of this research to generalize to other participants.

In the past 25 years, there has been major advancement of quantitative approaches to the study of immigration and culture exchange, with aims to provide more objective research as well as generalizable theories and methods. This area of inquiry into acculturation includes economists, sociologists, linguists, psychologists, and other social and behavioral scientists. Researchers from these disciplines have relied heavily on quantitative methods and statistical analyses, along with increasingly precise and generalizable measures of language and, later, increasingly sophisticated assessments of cultural attitudes, knowledge, values, and behaviors. Additionally, the utilization of large federal surveys with massive sample sizes, such as the U.S. Census, has allowed sociologists and economists to investigate variations among ethnic



groups on such factors as family size, income, education, and language preference. Finally, cultural psychologists have explored individual perceptions and cross-cultural interactions through the use of highly controlled laboratory experiments and small-scale surveys with measures developed to assess precisely defined cultural factors.

Within the fields of counseling and clinical psychology, acculturation began to attract substantial interest in the 1970s. During this time, acculturation theory within the behavioral sciences progressed from a single-dimension theory to a multidimensional theory. Assessment of acculturation also moved from employing ethnic categories or labels, and perhaps only a single language domain, to reflecting multiple domains including attitudes, values, identities, and social network characteristics. One of the most widely used initial measures was Israel Cuéllar and colleagues' Acculturation Rating Scale for Mexican Americans (ARSMA). This scale included items assessing preferences for language, associations, entertainment and food, ethnic identification, generation, and bilingual abilities. In reviewing current multidimensional and bilinear acculturation measures, most include language and behavior items, yet only a few instruments assess elements of cultural change that include values, knowledge, or cultural identity.

Most current acculturation models emphasize cultural exchange between cultures. Two of the most widely used scales for U.S. Latinos/as, the most widely studied group regarding acculturation, include the Bidimensional Acculturation Scale (BAS) and the ARSMA-II. A commonality of these two scales is that they emphasize the *orthogonal* nature of acculturation; that is, one does not have to lose one culture to gain another. Such models of acculturation have demonstrated that individuals can adhere to more than one culture independently and come from a theoretical tradition from the study of ethnic identity where some individuals of color were maintaining their culture of origin. It is important to note that there are significant differences between the BAS and ARSMA-II. The BAS is designed as a relatively brief measure for use with Latinos/as more generally, and it is primarily centered on language (although as it is orthogonal, it is assumed that one need not give up proficiency of, and exposure to, English or Spanish). The ARSMA-II targets immigrants of Mexican descent in particular and includes multiple identities (American/Anglo, Mexican, and Chicano/a) as well as additional

domains such as cultural values and traditions. Scales for other immigrant and indigenous groups within the United States and other nations have been developed, as well as scales that can be used with multiple ethnic groups, such as Zea and colleagues' Abbreviated Multidimensional Acculturation Scale. Although more generic acculturation scales have their utility for examining general cultural change patterns across multiple cultural groups and may yield broad acculturation classifications for many individuals, it should be understood that this can occur at the cost of expressing cultural richness, cultural nuance, and cultural specificity.

### **Acculturation, Acculturative/ Cultural Stress, and Health**

Throughout the acculturation literature, there have been controversies about the effects of acculturation on health. Some researchers posit that there is a negative relationship between acculturation and mental health, where unacculturated clients experience poorer mental health due to the lack of adequate social networks and stress from exposure to unfamiliar cultural dynamics. However, others suggest that those who are more acculturated experience a greater degree of psychopathology, due mainly to the stress caused by rejection from the dominant culture within the society in the form of racism and discrimination. Also, there is some evidence that more-acculturated Asian Americans experience depression and anxiety at higher rates than less-acculturated Asians and Whites. Furthermore, higher acculturation status among native-born Mexican Americans has been associated with higher lifetime prevalence of phobia as well as alcohol/drug abuse and dependence.

Also, within many contexts, immigrants and indigenous groups who retain some traditional cultural practices are protected in mental health domains. Mexican immigrants who retain traditional cultural practices report lower divorce rates and more positive perceptions of their family. Still other data have suggested that the balance between adjusting to the host society and holding on to traditions and beliefs of the culture of origin may lead to the best mental health status.

Although the relations of acculturation to mental health are complicated and mixed, there also has been interest in examining acculturation and physical health. Typically, rapid acculturation to American values and behaviors is associated with negative health



outcomes for Latinos/as. An important framework that aims to more specifically link acculturation to health is the acculturation stress perspective, which seeks to examine the *components* of acculturation that lead to distress or poor health. This framework assumes that living in an environment with more than one culture present might generate stress due to negotiating more than one set of values, norms, and identities. People of color and immigrants who experience acculturative stress tend to report greater mental health problems.

As with most acculturation measures extant before the mid-1990s, however, few acculturative stress measures are consistent with orthogonal models (that differentiate bicultural from marginalized persons, the latter most strongly associated with poor well-being). In a study from a nonmajority community using an orthogonal measure, these stressors were most strongly reported by Latino/a and Asian American youth than non-Latino/a White youth, consistent with positions that minority ethnic groups experience more pressure to assimilate because of less power and lower status. However, non-Latino/a Whites also experienced these stressors, which were significantly associated with more negative mental health markers and health risk behaviors across all groups. Likewise, bicultural conflict has also been positively associated with depressive symptoms in Chinese Americans. This bicultural stress paradigm, with its underpinnings from the cultural exchange premise of acculturation, potentially contributes to the understanding of a wide range of persons' health outcomes (immigrants and nonimmigrants, minority and majority) as they navigate through multiple cultures.

### **Implications for Psychotherapy and Counselors**

As previously discussed, there are various conflicting theories as to the relationships among acculturation, psychological problems, and health status. However, cultural context and the acculturative process cannot and should not be left out of the therapeutic context. The question then becomes how to address acculturation and cultural beliefs in therapy. Before exploring this topic, it is important to note that acculturation issues are primarily recommended to be addressed in therapy when cultural exchanges are identified by the client as a source of incongruence and/or distress.

Clinicians and counselors should take considerable responsibility to study the available scholarship about their clients' cultures, their intersections, and clients'

individual responses. Most of the literature that focuses on psychotherapy with clients from diverse ethnic backgrounds highlights the importance of cultural competency, including understanding acculturation processes. The term *cultural competency* in this case refers to the degree to which a clinician is knowledgeable about the culture of the client. However, cultural "competence" seems to suggest that providers can study a particular culture until a certain level, and once this level is achieved, they have sufficient knowledge of the culture to competently treat an individual from that culture. Just as practitioners can never know everything about a client, they also will never have a complete understanding of ever-evolving cultures. Furthermore, practitioners may have a fairly large knowledge base about a particular culture, but that does not mean cultural ascriptions of what an individual client is experiencing are accurate. Finally, because individuals may be uniquely situated among multiple cultures, their cultural experiences may be adequately understood not by focusing on any of the cultures that influence them but rather by looking at the multiple cultures as a whole, unique, cultural context for those individuals.

Thus, the best way to learn about clients' cultural context and acculturative experience is from clients themselves. This is not to say that practitioners should rely solely on clients' self-report. Rather, while it is important that clinicians obtain a sufficient knowledge base in their clients' culture(s) from credible scientific or perhaps from nonscientific sources (history, narratives, and case studies), they also must recognize their clients' unique experiences and be cautious to avoid overgeneralizations and stereotypes represented in various public literatures and media. Also, it should be understood that clients are not their culture; rather, their cultural contexts and acculturative processes influence who they are and how they view and experience the world they live in.

Understanding clients' cultural context and acculturative process requires more than attaining culture competence or cultural knowledge. It requires awareness and acknowledgment of clients' personal experiences along with cultural context in attempts to develop empathy. Most importantly, practitioners should always inquire and avoid assumptions about clients' personalized experiences based on limited information about the person or broad cultural understandings. At times, the difference between cultural interaction processes most detrimental to mental health and those most adaptive may be subtle.



Paying close attention to subtleties and individuals' cultural context within therapy has been termed by some researchers as *cultural naïveté*, which reflects humility and respectfulness in individuals' unique, culturally influenced spaces without practitioner anxiety or self-consciousness. Data suggest that immigrant clients and clients of color care more about clinicians' attitudes and reassurance that the client will be treated respectfully than they do about clinicians' skills or perceived knowledge of clients' cultures. Furthermore, clients who have experience with a culturally responsive clinician tend to experience higher levels of satisfaction, increased trust and self-disclosure, and decreased rates of attrition. Thus, it may be more beneficial for both clients and clinicians if clinicians are focused more on being culturally responsive, which includes a high degree of openness in addition to a strong foundation of culturally relevant knowledge.

Under the assumption that it would lead to cultural competence in therapy, the costs and benefits of using client–therapist acculturative or ethnic matching in considering treatment options has been examined. Findings on the effects of client–therapist matching in mental health treatment studies have been mixed. There is some evidence that ethnic matching for Latinos/as, African Americans, Asian Americans, and White Americans is related to lower rates of early termination, increased participation, and greater treatment outcomes. However, no single culture is homogenous, and a client from China can be matched with a therapist from Korea based on the fact that they are both of Asian descent as marked in a database—but they may have little else in common besides a pan-ethnic label. Furthermore, a mismatch ignoring class, gender, education, acculturation, and their intersections could lead to greater misunderstanding and poorer treatment outcomes than if no matching was attempted. A second concern about acculturative matching follows the concept of cultural naïveté. Often, it might be beneficial to avoid ethnic or acculturative matching to further facilitate inquiry and discovery. If a client and a clinician are acculturatively matched, there may be less exploration due to the assumption that they understand each other because of their similar cultural backgrounds. Furthermore, even with ethnic or acculturative matching, a client and therapist may differ greatly in the expectations and practices of therapy as most clinicians are immersed in Western cultural norms of psychotherapy, which may interfere with the therapeutic process and therapeutic alliance.

In summary, it is essential that counselors remain empathic by being culturally responsive and by paying close attention to how their own cultural context influences their actions within the therapeutic context. When working with clients who present concerns related to acculturation, it is important to remain open and respectful, and strive to understand clients' cultural context, experiences, and level of distress most strongly guided by clients' own insights.

### Future Research and Practice

All research efforts and delivery of service where acculturation is relevant specify what is meant by acculturation and the ways in which acculturation might influence well-being, health, and behavior. Generally speaking, language or generational status reveals little about individuals' cultural context. More than likely, acculturation factors reflecting family relationships/dynamics, beliefs about health and disease, beliefs about personal responsibility, cultural conflict, and social networks will be more insightful in the quest to understand clients from immigrant populations. Likewise, it is vital to recognize that cultural change and cultural intersections may lead to mixed outcomes—at times leading to stressors such as family, social networks, and identity disturbances, but also to important strengths and resiliencies in terms of identity and adjustment. A growing area of research has identified positive cultural buffers, such as a positive and bicultural ethnic identity, that promote health and well-being. It is particularly critical for therapists and prevention program developers to recognize sources of resilience that promote well-being that many immigrants have before they transition to a new area, but that may be hard to sustain when immersed in multiple cultures or within a pervasive dominant culture.

Finally, although not widely examined in North America, researchers in other nations are examining dynamics of acculturation that are both migrant and dominant (host) culture specific. One example is the exploring of the potential match or mismatch in cultural characteristics among the interacting cultures and the associated social and health consequences. Such models may be useful if extended in the United States as well. For instance, one would expect Mien immigrants (from rural Laos) and immigrant Mexicans from Distrito Federal (an urban area including Mexico City and representing almost 20 million inhabitants) to experience different acculturation stressors depending



on the urbanity and other local cultural characteristics within a particular U.S. community. Just as one should not view immigrant groups as monolithic, host communities should not be viewed that way either, because both influence the acculturative process and outcomes for the interacting groups. This gap in North American research paradigms also further reinforces the importance of counselors recognizing the complexity of cultural exchanges and the limitations of inferring clients' particular cultural contexts and experiences from an extant literature not fully developed.

*Scott C. Carvajal and Teresa Granillo*

**See also** Acculturative Stress (v3); Adaptation (v3); Assimilation (v3); Barriers to Cross-Cultural Counseling (v3); Cultural Accommodation and Negotiation (v3); Cultural Values (v3); Culture (v3); Enculturation (v3); Ethnic Identity (v3); Immigrants (v3); Multiculturalism (v3); Orthogonal Cultural Identification Theory (v3); Person–Environment Interactions (v2); Second Culture Acquisition (v3)

### Further Readings

- Berry, J. W. (2003). Conceptual approaches to acculturation. In K. M. Chun, P. O. Balls, & G. Marín (Eds.), *Acculturation: Advances in theory, measurement, and applied research* (pp. 17–37). Washington, DC: American Psychological Association.
- Cuéllar, I., Arnold, B., & Maldonado, R. (1995). Acculturation rating scale: A revision of the original ARSMA scale. *Hispanic Journal of Behavioral Sciences, 17*, 275–304.
- Gamst, G., Dana, R. H., Der-Karabetian, A., Aragon, M., Arellano, L. M., & Kramer, T. (2002). Effects of Latino acculturation and ethnic identity on mental health outcomes. *Hispanic Journal of Behavioral Sciences, 24*, 479–504.
- Marin, G., & Gamba, R. J. (1996). A new measurement of acculturation for Hispanics: The Bidimensional Acculturation Scale for Hispanics (BAS). *Hispanic Journal of Behavioral Sciences, 18*, 297–316.
- Redfield, R., Linton, R., & Herskovits, M. J. (1936). Memorandum for the study of acculturation. *American Anthropologist, 38*, 149–152.
- Romero, A. J., Carvajal, S. C., Valle, F., & Orduno, M. (2007). Adolescent bicultural stress and its impact on mental well-being among Latinos, Asian Americans and European Americans. *Journal of Community Psychology, 35*, 519–534.
- Zea, M. C., Asner-Self, K. K., Birman, D., & Buki, L. P. (2003). The Abbreviated Multidimensional Acculturation Scale: Empirical validation with two Latino/Latina samples. *Cultural Diversity & Ethnic Minority Psychology, 9*, 107–126.

## ACCULTURATIVE STRESS

Acculturation or adaptation to a new culture involves changes in multiple areas of functioning (e.g., values, behaviors, beliefs, attitudes, etc.), and for individuals, families, and groups engaged in the acculturation process, these adjustments are often experienced as stressful. The stress that emerges from difficulties in acculturation is referred to as *acculturative stress*. Distinct from general experiences of stress, acculturative stress is understood to stem from differences in culture and language between the acculturating individual and the host culture or country. Furthermore, acculturative stress is also believed to be more closely related to symptoms of anxiety than depression and associated more with the presence of negative emotions rather than the absence of positive emotions.

Although the experience of acculturative stress is relevant for any individual living in multiple cultural worlds, which is the case for many U.S.-born ethnic and racial minority individuals, current conceptualizations of acculturative stress have emerged largely from empirical studies with immigrant groups. Within this body of literature, some of the variables that are hypothesized to be related to acculturative stress include majority language ability, assimilation pressure, acculturation style, demographic factors, distance between culture of origin and host culture, pre-immigration and migration experiences and intrafamilial acculturation levels/conflicts.

### Theoretical Underpinnings of Acculturative Stress

What is currently known about acculturative stress is the result of a conceptual integration between the well-established stress and coping literature and the growing body of literature that explores the acculturation process. More specifically, the cognitive-relational model of stress and coping put forth by S. Folkman and R. S. Lazarus, which describes the processes associated with the stress experience and coping response, along with the empirical and theoretical literature that has emerged from cross-cultural psychologists, led by J. W. Berry and his colleagues, provide a strong foundation for understanding the experience of acculturative stress. A brief synopsis of both theoretical models is given next.



## ***Stress and Coping***

In the cognitive-relational model, stress is understood as a relationship between a person and his or her context that is appraised by the individual as difficult, beyond his or her current resources, or dangerous. Lazarus and Folkman note that individuals under stress evaluate what is at stake (e.g., physical safety, anticipated losses or gains) and what coping resources and options are available to them.

Coping is understood as an individual's attempt to reduce the stress and moderate the impact of the stress through either cognitive or behavioral means. Individuals under challenging circumstances will typically evaluate their experiences and behaviors and then engage in basic coping procedures. Lazarus and Folkman have identified two key coping mechanisms for managing stress: problem-focused coping and emotion-focused coping. Both coping strategies are involved in the acculturation process, but their relationship to specific acculturation strategies is still not clear.

## ***Acculturation: Definition and Theoretical Model***

R. Redfield, R. Linton, and M. Herskovits provided one of the earliest definitions of acculturation, which they described as a process that occurs when individuals of different cultures are brought together in continuous contact and which consequently leads to changes in the cultural patterns of either or both groups. Although acculturation has been conceptualized as a dynamic process, where change occurs at multiple levels and with all involved groups (dominant cultural group and minority cultural groups), the concentration of acculturation research has largely been focused on the way in which minority immigrant individuals adapt to the norms (e.g., values, beliefs, and behaviors) of the dominant cultural group. Furthermore, earlier notions of the cultural adaptation process that focused on the assimilation of new immigrants, whereby newcomers to a country would and should "shed" their original culture to the culture of the host country, have been challenged by contemporary cultural psychology scholars that emphasize an integration strategy leading to a more bicultural or multicultural identity.

Berry's acculturation model describes individual-contextual pairs of acculturation strategies, which can be adopted by either an acculturating individual or the larger society as a response to intercultural

contact. At the individual level, Berry's acculturation strategies include (a) *assimilation*, when an acculturating individual does not wish to maintain his or her original cultural identity and primarily seeks social relationships with the dominant society; (b) *separation*, which is characterized by a maintenance of the original culture/identity with a wish to avoid social relationships with the dominant society; (c) *integration*, where an individual wishes to maintain relationships with his or her original culture/identity and wishes to develop social relationships with the dominant society; and (d) *marginalization*, when the acculturating individual does not maintain his or her original culture/identity and does not have a desire to develop social relationships with the dominant society.

## ***Theoretical Integration: A New Understanding of Acculturative Stress***

Resting on these two distinct, yet rich, theoretical and empirical traditions, acculturative stress has come to be understood as a complex psychocultural/psychosocial experience, where an individual, who is in the process of cultural adaptation, experiences stress related to the tasks associated with this change process. Furthermore, there are variables associated with the original culture, host culture, and individual, which may potentially exacerbate or minimize the level of acculturative stress experienced by the acculturating individual. However, the mechanisms through which these contextual and individual variables lower or heighten acculturative stress remain unclear. Using the impact of perceived discrimination as an example, it is possible that experiences of discrimination heighten an individual's level of acculturative stress because he or she appraises the tasks of acculturation as too demanding or because the noxious stimuli are negatively impacting the individual's personal resources (e.g., self-concept, coping).

## ***Why Study Acculturative Stress?***

Acculturative stress has emerged as an important specific kind of stress to investigate for a number of reasons. First, the significant and growing immigrant population calls for a better understanding of what may contribute or detract from the healthy cultural adaptation of these individuals. Second, because acculturative stress has been linked to other serious



psychological outcomes, researchers and clinicians are increasingly interested in its investigation. Finally, because of increased globalization, individuals, even in less densely populated areas of the United States, are increasingly in contact with people that may identify with cultures that are different from the dominant or mainstream culture. These demographic shifts result in more intercultural contact among acculturating individuals and native-born individuals, which increase the possibility of individuals experiencing both acculturative stress and positive intercultural exchanges. Research in the area of acculturative stress may illuminate factors that are related to acculturative stress as well as factors that result in more positive intercultural experiences for all individuals.

### **Comorbidity With Psychological Outcomes**

When individuals experience heightened levels of acculturative stress, they may exhibit a reduction not only in their mental health state but in their overall health. As is the case for stress in general, acculturative stress has been associated with negative mental health outcomes.

The relationship between acculturation and mental health has not been well established empirically. The data are equivocal, by supporting direct, inverse, and curvilinear relationships between acculturative stress and mental health outcomes. However, despite discrepancies in the literature regarding the way in which acculturative stress influences mental health outcomes for individuals, the significance of acculturative stress as a phenomenon of study is well documented. The emphasis on current research appears to be on examining the risk factors and protective factors associated with acculturative stress, some of which are briefly described next.

### ***Risk Factors and Protective Factors Associated With Acculturative Stress***

Most studies on acculturation focus only on the direct relationship between acculturation and mental health and not on possible explanatory mechanisms and processes. Recently, however, more attention has been focused on trying to understand the personal and contextual factors that either increase or decrease an individual's risk of developing acculturative stress. In the following section, some of the risk factors and

protective factors that have been associated with acculturative stress are discussed. It is important to note that the factors outlined here represent not an exhaustive list of variables that potentially affect an individual's acculturation pathway, but rather an important subset of variables highlighted in recent literature.

### **Pre-Immigration Factors**

Although individuals migrate to new countries for a variety of reasons, some of the most common reasons include political or economic turmoil in the country of origin and greater educational and financial opportunities in other countries. The reason that individuals decide to immigrate may have implications for their acculturation experience. For example, individuals who immigrate because their family or entire village has experienced severe financial ruin will move to the host country with very few monetary resources. The lack of financial resources may exacerbate the acculturative stress these individuals experience. Although not necessarily associated with the reason for immigration, another pre-immigration factor that potentially impacts individuals' acculturation is their language abilities. Immigrants who are fluent in English, for example, may experience less acculturative stress associated with the post-migration demands because they are more likely able to understand and negotiate the demands of cultural adaptation.

### **Migration Factors**

*Migration Trauma.* Whereas many immigrants migrate into new countries with their families in a safe and healthy manner, others come alone or come as refugees, and still others are forced to enter new countries by traffickers or smugglers. Refugees have often experienced trauma, including witnessing the death of family members and long periods of malnutrition and inadequate health care. The trauma experienced in either their native country (e.g., war, genocide, persecution, imprisonment, torture) or en route to their new destination (e.g., rape, abuse, exploitation) can affect refugees well after their arrival. Children and women are at a higher risk for abuse and harm during the migration process than are men. For instance, women crossing borders from Central to North America without their families may have encounters with *coyotes* (i.e., illegal travel brokers) for passage and may become victims of sexual assaults and forced labor



before reaching their final destinations. Consequently, the migration process, for some, becomes a major acculturative stressor.

*Pattern of Arrival.* The pattern of immigration can greatly impact the experience of acculturation for immigrant families. For a host of reasons, a significant number of immigrant families come to America in units. This pattern of arrival has been referred to in the literature as *step migration*, and there has been a great deal of agreement that these family separations are sources of acculturative stress. Intrafamilial separations differ in length of time, usually with the longer separations being the more challenging for the family.

*Documentation Status.* Undocumented immigrants are at heightened risk for experiencing acculturative stress because their acculturation is mired by the fear of deportation and, for some, the actual experience of deportation. Furthermore, their lack of documentation may cause them to avoid public institutions, such as hospitals and clinics, even if they may need these services. This, in turn, adds to their level of risk for health and mental health difficulties. Also, it is important to note that the lack of documentation also places individuals at a heightened risk for exploitation by employers who may threaten to call the authorities.

### Family Factors

*Intrafamilial Acculturation Conflicts.* It is possible that differences in acculturation levels within families will lead to difficulties or conflicts. However, when acculturation conflicts do occur between parents and their children, they have the potential to cause significant stress for members of the entire family unit. Family conflict arising from the acculturation process is beginning to be better understood. The cultural distance between families' original culture and the host country's culture can threaten the harmony of immigrant families' intergenerational relationships. Furthermore, it is by now generally accepted that younger generations of immigrants acculturate to the Western or mainstream society at faster rates than their elders, who, oftentimes, firmly maintain their traditional customs. This discrepancy in acculturation level may result in increased familial stress and feelings of separation between family generations. It is also possible that the younger generations might experience

interpersonal conflict by feeling like they must choose the host culture over their traditional, native identity.

*Language/Cultural Brokering.* Another outcome of differing rates of acculturation is the reliance on children as cultural and language brokers for their families. Oftentimes, because of limited social or financial resources, coupled with their limited English language abilities, parents rely on their children to help them manage and navigate the host culture. As language/cultural brokers, children essentially translate the language and culture for their parents and also serve as the liaison between their family and the larger cultural context. This role is associated with both negative and positive outcomes for children. On the one hand, it has been argued that this "parentified" role can be experienced as stressful, especially considering the important tasks and decisions child language/cultural brokers are engaged in (i.e., legal, school, financial). Furthermore, when children act as language/cultural brokers for their families, they may miss important social and opportunities and enrichment activities, which can be experienced as a loss. On the other hand, it has also been argued that it is precisely the serious nature of the tasks required of children who serve as language/cultural brokers for their family that positively impacts their self-esteem and social development.

### Language Use

The linguistic world of acculturative individuals is complex. English language usage and ability have been associated with acculturative stress, whereby individuals who are less fluent in English experience higher levels of acculturative stress. Given that linguistic ability is necessary not only for simple to more complex business transactions, such as buying groceries and a home, but also for developing relationships with people, language ability may be directly related as well as indirectly related, through social relationships and connectedness, to reported levels of acculturative stress. Despite evidence that suggests the importance of English language skills for acculturating individuals, this does not necessarily mean that healthy acculturation requires surrendering one's language of origin for English. Individuals who are highly acculturated or have been in the host country for many years may experience stresses or losses associated with not being able to communicate in their language of origin with members of their cultural or



ethnic enclave. Maintaining fluency in one's language of origin may be a source of pride for individuals.

### **Acculturation Level**

The level of acculturation, that is, the level of familiarity and exposure to the new culture, which is largely associated with amount of time in the host culture, is an important variable to consider when thinking about an acculturating individual's risk for acculturative stress. Unfortunately, the empirical literature that focuses on the link between acculturation level and acculturative stress and other health and mental health outcomes is mixed. For example, it has been suggested that there is a relationship between acculturative level and acculturative stress, whereby higher levels of acculturation may lead to lower levels of acculturative stress. At the same time, there is a growing body of work that suggests that, for some individuals, greater acculturation is associated with an increase in negative physical and mental health, and, for youth, negative academic outcomes.

Nonetheless, immigrants at any level of acculturation can be at risk for detrimental psychological consequences. For example, highly acculturated individuals may realize that becoming acculturated and identified with the host culture does not always result in acceptance by mainstream society and can lead to the development of interpersonal conflict, alienation from traditional supports, frustration, demoralization, and internalization of society's prejudicial attitudes. On the other hand, low-acculturated individuals often face multiple stressors when negotiating an unpredictable majority cultural milieu, which may lead to feelings of isolation, low self-esteem, and helplessness. Research proposes that positive mental health outcomes may be achieved from balancing one's multiple cultures.

### **Acculturation Strategy**

Research investigating Berry and others' fourfold acculturation model primarily focuses on investigating the outcomes for acculturating individuals who adopt different acculturation strategies, with many of the results pointing to the same conclusion: Integration, or a bicultural identity, is the healthiest acculturation strategy for individuals associated with the least amount of acculturative stress. The strategy associated with the highest level of acculturative

stress and considered the least healthy mode of acculturation is marginalization, which describes an individual who rejects his or her original culture as well as the host culture.

### **Exposure to Discrimination and Racism**

Despite evidence of the detrimental effects of discrimination and racism for individuals' well-being, these events are quite commonplace in society. Experiences of ethnic/racial discrimination can impact individuals' health and mental health. In the Harvard Immigration Study, C. Suarez-Orozco and M. M. Suarez-Orozco suggest that within immigrant groups, race significantly impacts the level of discrimination one experiences. Given the fact that the majority of recent immigrants are persons of color, the impact of the sociocultural context of the host country on the identity development of non-White immigrants needs to be taken into consideration. When immigrants enter the United States, they are quickly made aware of the racial stratification that characterizes the status quo system of access to opportunity.

### **Social Capital and Social Support**

The greater sociocultural context, determined primarily by the dominant group, greatly impacts acculturating individuals. Given that an individual's successful acculturation is influenced by the flexibility, openness, and equality of the host society, it is imperative to examine the social and cultural context of the receiving community. A. Portes introduces the theory of economic sociology and, specifically, social capital, to help explain the process by which immigrants call on the monetary and nonmonetary resources of their ethnic community to assist with jobs, launch businesses, and establish a pool of suppliers and clients. It is argued that immigrants who move to an area that is richer in social capital will find the acculturation process less challenging because they have the support and resources of an ethnic enclave.

It has been hypothesized that acculturation and acculturative stress are mediated through social and personal variables. Specifically, social support has been found to be an alleviating factor and also serves as both a mediator and moderator in the acculturation-mental health link. For individuals who are in the process of acculturation, perceived social support is a primary protector against negative mental health



outcomes. However, it is important to note that, regardless of how much social support individuals have, if they are continually exposed to serious acculturative stressors, they may possibly still experience heightened levels of acculturative stress.

## **Implications for Research and Practice**

### ***Accessing Mental Health Services***

Numerous problems and potential barriers exist in the effective delivery of mental health services to the immigrant population. Individuals experiencing heightened levels of acculturative stress and/or other psychological issues (e.g., depression, anxiety) are less likely to seek psychological help. However, the underutilization of mental health services by immigrants is still not clearly understood. There are a host of reasons why immigrants may not seek psychological services, even when they may benefit from such services. Some of these reasons include, but are not limited to, miscommunication between patients and clinicians due to language or cultural barriers; low level of multicultural competence on the part of the clinician; stigmas attached to receiving counseling; the use of culturally relevant coping strategies, such as family members or indigenous healers; fear of seeking services because of lack of documentation; and intercultural mistrust with authority figures and institutions associated with the host society.

It is important that researchers examine which factors serve as barriers to the successful delivery of services for immigrants. For example, seeking help from a mental health practitioner may be a last resort for some immigrant clients, and therefore, practitioners must be sensitive to the potential severity of the problem. Finally, it is imperative for counselors to be culturally competent when working with immigrant clients, which includes an acknowledgment of the client's specific cultural values.

### ***Acculturative Stress and Psychological Outcomes***

Successful practitioners are keenly aware of the complex interplay between acculturation and psychological distress when they are providing counseling services to immigrants. For example, given the evidence that suggests that the acculturation process can be

extremely stressful and can impact a client's presenting problem, a thorough client history that includes experiences before immigration, during migration, and during acculturation might be necessary.

It is also important for clinicians to understand the acculturation process and the types of stressors that may be associated with a client's acculturation strategy or level. For instance, low-acculturated clients (i.e., new immigrants) may experience homesickness, isolation, and grief over what they left behind in their native land. Contextual factors, such as lack of financial opportunities and discrimination, may exacerbate these stressors. On the other hand, for highly acculturated individuals, the acculturative stress they experience may be both quantitatively and qualitatively different from low-acculturated individuals. For example, highly acculturated individuals may not experience stress related to an inability to communicate in English, but they may experience the stress associated with attempting to maintain a bicultural identity.

Future research should concentrate on discovering within-group differences that exist during the acculturation process so that treatment can become specific and more effective. For instance, not all immigrants, even those within the same ethnic group, acculturate and appraise acculturative stressors in the same way; each may have unique resources (e.g., financial and family supports) and barriers (e.g., lack of education and language skills) that change the experience of acculturation and level of acculturative stress.

### ***Risk and Resilience***

Supportive sources within one's own ethnic community may be important in developing both culturally specific ethnic and host competencies. Counselors are encouraged to recognize and appreciate their clients' personal, family, and community resources, as they may serve to protect clients from harmful outcomes associated with acculturative stress. Although practitioners are heavily trained in the diagnosis and treatment of psychological disorders, this preparation may place an overemphasis on finding out what's wrong with individuals. Practitioners who work with immigrant individuals may be more successful if they balance the tasks of facilitating growth in areas of need with supporting and acknowledging client strengths. Similarly, researchers interested in understanding what impacts the acculturation pathway of immigrants



may want to investigate both the risk factors and the protective factors associated with this process.

### **Moving Beyond the Traditional Counseling Role**

Counseling psychologists in this new era may be required to move beyond the traditional counseling role, which is largely associated with humanistic approaches to individual and group counseling. Given the inextricable link between the person and the environment, counseling psychologists are increasingly assuming new roles as change agents at systemic levels while they also continue to develop effective interventions that focus on change at the individual level. Furthermore, counseling psychology, as a professional discipline, with its deep tradition and history in human development and multicultural theories, is poised to make a significant positive impact on the way in which immigrants adjust to the new cultural context and on the way in which the cultural context embraces and adjusts to its new citizens.

*Jennie Park-Taylor and Allison Ventura*

**See also** Acculturation (v3); Adaptation (v3); Assimilation (v3); Cultural Values (v3); Culture Shock (v3); Immigrants (v3); Multiculturalism (v3); Refugees (v3); Resilience (v2); Second Culture Acquisition (v3); Stress (v2); Stress Management (v2)

### **Further Readings**

- Berry, J. W. (1997). Immigration, acculturation, and adaptation. *Applied Psychology: An International Review*, 46, 5–34.
- Constantine, M. G., Okazaki, S., & Utsey, S. O. (2004). Self-concealment, social self-efficacy, acculturative stress, and depression in African, Asian, and Latin American international college students. *American Journal of Orthopsychiatry*, 74, 230–241.
- Hovey, J. D., & King, C. A. (1996). Acculturative stress, depression, and suicidal ideation among immigrant and second-generation Latino adolescents. *Journal of American Academy of Child and Adolescent Psychology*, 35(9), 1183–1192.
- Portes, A., & Rumbaut, R. G. (2001). *The story of the immigrant second generation: Legacies*. Los Angeles: University of California Press.
- Redfield, R., Linton, R., & Herskovits, M. (1936). Memorandum on the study of acculturation. *American Anthropologist*, 38, 149–152.

- Rudmin, F. W. (2003). Critical history of the acculturation psychology of assimilation, separation, integration, and marginalization. *Review of General Psychology*, 7(1), 3–37.
- Sodowsky, G. R., & Maestes, M. V. (2000). Acculturation, ethnic identity, and acculturative stress: Evidence and measurement. In R. H. Dana (Ed.), *Handbook of cross-cultural and multicultural personality assessment* (pp. 131–172). Mahwah, NJ: Lawrence Erlbaum.
- Smart, J. F., & Smart, D. W. (1995). Acculturative stress of Hispanics: Loss and challenge. *Journal of Counseling & Development*, 73(4), 390–396.

---

## **ACHIEVEMENT GAP**

---

A number of reports and studies have explored issues surrounding the education of African American, Latino/a, and other culturally and linguistically diverse (CLD) students in American school systems. Every CLD group has a different history in the United States. It is widely recognized that the educational experiences of African American students in public schools is rather unique. Specifically, African Americans as a group have been systematically and legally denied the right to an education, and past and ongoing injustices continue to affect the educational achievement of African American students. The most obvious effect is the gap between the academic performances of African American students and their White counterparts. Specifically, myriad reports indicate that Black students often graduate from high school 4 years behind White students in both reading and math. In addition to the gaps in reading and math, there are gaps between White and CLD students in grade point averages, participation in Advanced Placement (AP) classes, gifted education classes, and honors classes, as well as high school graduation rates and college enrollment and graduation rates.

The achievement gap is not a new phenomenon; it has its roots in history. One has only to recall the Supreme Court decision in the case of *Plessy v. Ferguson* to see that separate but equal was legally acceptable only 100 years ago. And it was less than 6 decades years ago that legislation was passed to desegregate education as a result of the landmark 1954 Supreme Court decision in *Brown v. Board of Education*. Although efforts to secure equity and excellence in the education of African American students have a relatively short history, there really is



no excuse for ongoing inequities in the education of CLD students.

### What Factors Contribute to the Gap?

There is no single achievement gap; the achievement gap has many faces. These achievement gaps individually and collectively contribute to Black and Latino/a students performing less well than White students relative to grades, test scores, graduation rates, and more. In essence, the omnibus “achievement gap” is a *symptom* of many other gaps, such as the funding gap, the resource gap, the teacher quality gap, the curriculum gap, the digital gap, the family involvement gap, and the expectations gap.

Essentially, the reasons behind the achievement gap are multifaceted and complex. The achievement gap starts at home, before children begin school, and then widens during the formal school years. For example, at the kindergarten level, there tends to be a 1-year gap between Black and White students; by the 12th grade, there is often a 4-year gap, as already noted. It is counterintuitive that the gap *widens* while students are in school.

Many factors contribute to the achievement gap(s). Borrowing from the work of Barton of the Educational Testing Service (ETS), this entry explains the primary correlates of the achievement gap and offers recommendation for change. Based on his review of several hundred studies that examined factors contributing to the achievement gap, Barton identified 14 variables that consistently and substantively contribute to the achievement gap. At least two contexts must be thoroughly examined to understand the achievement gap in a comprehensive manner. These two contexts are (1) school and (2) before school and beyond.

### School Correlates

Six correlates found in school settings are thought to contribute to the math and reading achievement gaps. These school correlates must be considered in terms of their cumulative impact. For 13 years, students attend school for approximately 180 days each year. Thus, what takes place in school has a major impact on students.

*Rigor of Curriculum.* Research shows consistently that students’ academic achievement depends extensively upon the rigor of the curriculum; yet, the curriculum

tends to be less rigorous for Black and Latino/a students. Instructional rigor rests on teachers’ expectations, as has been learned from research on teacher expectation and student achievement—when expectations are high, teachers challenge students. Rigor can be defined as high-level instruction and access to challenging programs, such as gifted education and AP classes. Black and Latino/a students are less likely than White students (a) to have substantial credits in academic sources at the end of high school and (b) to participate in honors, AP, and gifted education classes. Although Black students represent over 17% of the public school population, they represent only 8% of students participating in gifted education; even fewer are enrolled in AP and honors classes. Publications by the College Board, Education Trust, Educational Testing Service, and other organizations describe more extensively problems regarding lack of access to rigorous instruction, classes, and programs.

*Teacher Quality and Preparation.* The importance of teacher quality on student achievement cannot be ignored. Black and Latino/a students are more likely to be taught by teachers who are unqualified, including teachers who lack certification, out-of-field teachers, teachers with the fewest credentials, and teachers with the lowest test scores. In high-minority schools, 29% of teachers do not have at least a minor in the subject area in which they teach; in low-minority schools, the percentage is 21, according to Barton’s report. Related to the previous issue of rigor, ill-qualified teachers will have difficulty teaching and challenging students; they are unlikely to raise students’ achievement as they do not have the skills to do so.

*Teacher Experience and Attendance.* Inexperienced teachers, those with less than 3 years of teaching experience, for example, are more likely to teach in urban than suburban settings. In schools with high percentages of CLD students, 21% of teachers have less than 3 years of experience; in schools with low CLD enrollment, 10% of teachers have less than 3 years of teaching. Further complicating this issue, data indicate that teachers working in high-minority schools often have low attendance rates, resulting in classes being taught by substitute teachers. Again, teacher inexperience and poor attendance hinder the quality of instruction given to, and received by, CLD students, contributing to their poorer school achievement.



*Class Size.* In schools where there are higher percentages of CLD students, class sizes are larger. For instance, in schools where CLD students represent 75% of the population, average class size is 31. In schools where CLD students constitute less than 10% of the student population, class size averages 22. Larger classes are more difficult to manage; more time is spent on behavior than teaching, resulting in students being denied the opportunity to learn at the same rates as their White classmates in smaller classrooms.

*Technology-Assisted Instruction.* Schools with higher percentages of CLD students are less likely to have computers in the classrooms, Internet access, and updated, high-quality software; this situation is often referred to as the digital divide. Just as problematic is the issue of how teachers use technology in the classroom; 61% of students in low-minority schools are given assignments to conduct research on the Internet, compared to 35% for students in high-minority schools. As a result, CLD are less qualified to compete in situations where technological skills are essential.

*School Safety.* Classroom discipline, disruptions, and negative peer pressures (e.g., gangs and fears about being attacked at school) are reported more often by Black and Latino/a students than by other students. Students cannot learn in unsafe, threatening environments. They have difficulty concentrating and staying focused or engaged. Thus, many CLD students may have poor attendance or drop out to avoid the stresses that come with peer pressures, which adds to their poorer performance.

As just described, schools contribute to the achievement gap between CLD students and White students in significant ways. But they are not solely responsible for students' differential performance, as described next.

### ***Before School and Beyond Correlates***

Schools alone did not create the gap, nor can they close it without support from families and the larger community. Eight additional correlates of the achievement gap, based outside of school, must be addressed.

*Parent Availability.* The extent to which parents are available and spend quality time with their children varies by family structure and composition. A larger

percentage of Black and Latino/a students, compared to White students, live in single-parent homes, and many of these are low income. For those living with mothers only, the rates are 17% for White children, compared with 49% for Black children and 25% for Latino/a children. When parental presence is low, students are left to make choices for themselves. This lack of availability results in less structure and discipline for students; they may not spend their unsupervised time studying and/or participating in school-related activities, causing them to fall further behind White students.

*Parent Participation.* The extent to which caregivers are involved in their children's education affects students' achievement and behavior. Reports indicate that Black and Latino/a parents tend to participate less in their children's education than other parents. Some 44% of urban parents and 20% of suburban parents report feeling unwelcome in schools. Approximately 50% of both Black and Latino/a parents and 75% of White parents attended a school event in 1999; approximately 25% of CLD parents and 50% of White parents volunteered or served on a committee. As with findings regarding lack of parent availability, student achievement suffers.

*Student Mobility.* There are many negative consequences to changing schools; CLD students, especially those who live in poverty, have the highest rates of changing schools (25% for Latino/a students, 27% for Black students, and 13% for White students). Data from one study indicate that 41% of students who changed schools frequently were below grade level in reading, and 33% were below grade level in math.

*Reading to Young Children.* Reading positively correlates with language acquisition, literacy development, test scores, and achievement. One longitudinal study spanning 1993 to 2001 found that, among 3- to 5-year-olds, 64% of White preschoolers were read to every day in the preceding week, compared with 48% for Black preschoolers and 42% of Latino/a preschoolers in 2001. The consequences of poor reading skills are serious, with students subsequently performing poorer on intelligence and achievement tests and having difficulty keeping up in other subject areas.

*TV Watching.* In 2000, 42% of Black, 22% of Latino/a, and 13% of White fourth graders watched 6 hours or



more of TV daily. Excessive and unsupervised TV watching negatively affects students' achievement, with students doing less homework and reading, and participating in fewer after-school activities and intellectually stimulating activities.

*Health and Nutrition.* Of all households with school-age children, 14% have food issues and 4% report hunger. Black and Latino/a households have 2 to 3 times the food insecurity and hunger of White students. Poor health and hunger are detrimental to achievement, with such students showing less interest, less motivation, and lower concentration; their grades suffer considerably.

*Birth Weight.* In 2000, more Black infants (13%) were low birth weight compared with White infants (7%) and Latino/a infants (6%). Infants born with low birth weight begin life with disadvantages, many of which do not disappear. A disproportionate percentage of children born low birth weight have long-term disabilities and impaired development, as well as delayed motor and social development. These are more likely to struggle academically.

*Lead Poisoning.* The primary source of lead poisoning among children is living in old homes covered with lead-based paint. Whereas 6% of White children live in homes constructed before 1946, the percentage increases to 22% of Black children and 4% of Latino/a children. Excessive levels of lead cause reduction in IQ and attention span, increased reading and learning disabilities, and increased behavior problems. Compared to other students, CLD students are at the highest risk of being exposed to lead because a larger percentage lives in older homes.

Despite the data just presented, many of these variables can be improved. If these 14 variables are the most powerful in creating and maintaining the achievement gap, then it behooves counseling professionals to address them in a systemic, comprehensive, and collaborative manner. Families, educators (administrators, teachers, counselors, etc.), community leaders, health professionals, and others must collaborate to tackle this educational tragedy.

Educators must, for example, ensure that CLD students are taught by high-quality teachers and teachers with extensive experience in classrooms.

School personnel and staff must receive formal preparation to work more effectively with CLD students and, thus, to raise their expectations for Black and Latino/a students, as has been proposed by advocates of multicultural and culturally responsive education (e.g., Sonia Nieto, James Banks, Linda Darling-Hammond, Geneva Gay, Gloria Ladson-Billings, and Jacqueline Irvine). Furthermore, class sizes and schools must be smaller, and teachers should receive training in culturally responsive classroom management strategies. Educators must adopt and implement programs in their schools to address safety and peer pressure. Conflict resolution programs and anger management programs would be helpful to students.

In terms of homes and communities, families will need access to learning opportunities that educate, empower, and support them in working with schools and their children. Programs addressing family involvement and literacy are two timely topics. Community leaders should collaborate with schools and families to provide students with mentors and role models. Finally, it is essential that schools, families, and businesses collaborate with the social workers and healthcare providers to address problems such as poverty, hunger, health care, and lead poisoning.

*Donna Y. Ford and Gilman W. Whiting*

*See also* Academic Achievement (v2); Civil Rights (v3); Cognition/Intelligence, Assessment of (v2); Cultural Equivalence (v3); Intelligence (v2); Intelligence Tests (v3); Socioeconomic Status (v3); Stereotype Threat (v3)

## Further Readings

- Barton, P. (2003). *Parsing the achievement gap. Baselines for tracking progress*. Princeton, NJ: Educational Testing Service.
- Bridgeman, B., & Wendler, C. (2005). *Characteristics of minority students who excel on the SAT and in the classroom*. Princeton, NJ: Educational Testing Service, Policy Information Center.
- Education Trust. (2006). *The funding gaps 2006*. Washington, DC: Author.
- Ford, D.Y. (1996). *Reversing underachievement among gifted Black students: Promising practices and programs*. New York: Teachers College Press.
- U.S. Department of Education. (2006). *Secretary's fifth annual report to Congress on teacher quality*. Washington, DC: Author.



## ADAPTATION

The term *adaptation* originally derives from the biological sciences as a phenomenon of person–environment fit. In psychology, adaptation is a process by which individuals or groups make necessary or desired changes—cognitive, behavioral, and affective—in response to new environmental conditions or demands in order to meet basic needs, function, and maintain a good quality of life. Adaptation is integral to the study and practice of multicultural counseling. In a rapidly changing world with increased cross-cultural interactions, people must engage in a continuous process of overcoming internal and external obstacles in order to survive and thrive. Failure to adapt leaves individuals in a prolonged state of culture shock that can create long-term damage to mental and physical well-being.

### Important Distinctions

Several distinctions are important for understanding adaptation within the context of multicultural counseling. Although cross-cultural adaptation is similar to adaptation to other major life changes (e.g., loss of a loved one), Linda Anderson speaks to what is unique to cross-cultural adaptation; that is, a person experiencing a new culture is automatically an outsider adapting to the dominant culture. The work of John Berry delineates this acculturation process as a step toward adaptation. In response to the new environment, individuals make changes to “fit” by employing an assimilation or integration strategy or “not fit” by utilizing a separation or marginalization strategy.

Colleen Ward makes an important distinction between psychological adaptation and sociocultural adaptation. Psychological adaptation arises from the stress/coping paradigm and refers to emotional changes that vary over time until equilibrium is reached (e.g., tolerance of ambiguous situations). Sociocultural adaptation comes from the social learning paradigm and refers to cognitive and behavioral changes that follow a more linear progression (e.g., accepting new cultural mores). Although these modes of adaptation are linked theoretically and statistically, they are also distinct processes with different predictor variables.

Andrew Garrison reviews adaptation as a goal of all psychotherapy. He argues that the intrinsic problem of this goal is that it comes from an individualistic

point of view, a bias of Western culture. Using the individual as the unit of analysis in the study and practice of psychology neglects the notion of interdependence and adaptation goals that are good for all human beings (e.g., equitable distribution of resources). Furthermore, good mental health is often viewed as the individual adjusting to the environment, a conceptualization that ignores unhealthy aspects of cultures to which individuals are adjusting (e.g., unfair social conditions). Inherent to multicultural counseling is the empowerment of clients not only to adapt in new cultural contexts but also to impact the environment (e.g., managing global warming) such that humanity can adapt as a whole.

### Future Directions

The study of cross-cultural adaptation is complex. It is a process that occurs over a long period of time and, thus, calls for longitudinal studies using both qualitative and quantitative methodologies. Furthermore, each cross-cultural interaction is unique. Thus, Berry's work calls for systematic, comparative studies. Finally, research has focused on how individuals adapt to the environment. Consideration of the impact of individuals on the environment as a process of adaptation is called for as well.

*Michelle A. Swagler*

**See also** Acculturation (v3); Acculturative Stress (v3); Assimilation (v3); Enculturation (v3); Identity Development (v3); Person–Environment Fit (v4); Person–Environment Interactions (v2)

### Further Readings

- Anderson, L. (1994). A new look at an old construct: Cross-cultural adaptation. *International Journal of Intercultural Relations*, 18, 293–328.
- Berry, J. W., & Sam, D. (1997). Acculturation and adaptation. In J. W. Berry, M. H. Segall, & C. Kagitcibasi (Eds.), *Handbook of cross-cultural psychology: Vol. 3. Social behavior and applications* (pp. 291–326). Boston: Allyn & Bacon.
- Garrison, A. (1997). Adaptationism, mental health, and therapeutic outcome. *Psychotherapy: Theory, Research, Practice, Training*, 34, 107–114.
- Ward, C., Bochner, S., & Furman, A. (2001). *The psychology of culture shock* (Rev. ed.). Hove, East Sussex, UK: Routledge.



---

## ADOPTION, TRANSRACIAL

---

*See* TRANSRACIAL ADOPTION

---

## AFFIRMATIVE ACTION

---

Affirmative action refers to institutional measures taken to increase the representation of women and people of color in areas of employment, government contracts, and higher education from which they have been excluded historically. The policy began as a response to the failure of businesses with government contracts to hire women, persons with disabilities, and minorities. These groups were discriminated against and denied equal access and opportunity. Hence, following the Civil Rights Act of 1964, affirmative action was initiated by Executive Order 11246 by President Lyndon Johnson in 1965. The executive order required organizations receiving government funding or contracts to adopt programs to promote the aggressive recruitment and retention of underrepresented populations.

Three major concepts form the basis for affirmative action. First, all of society is strengthened by diversity, equality, and inclusion. Second, preferences for women and minorities help to (a) neutralize unearned advantages that favor the privileged majority and (b) prevent further exclusion of women and minorities from higher education and the workplace. Finally, the federal government has the legal and social responsibility for enforcing programs to eliminate existing discriminatory practices of institutional racial preference that infringe on equal opportunity.

Over the past 3 decades, affirmative action has faced considerable opposition in the courts and public debate forums. In the late 1970s, the establishment of racial quotas under affirmative action was criticized as an antithetical practice of promoting preferential treatment. This “reverse discrimination” argument was accepted by the U.S. Supreme Court in *Regents of the University of California v. Bakke* (1978), which let existing programs remain but reduced the use of affirmative action to voluntary programs. In 1989, the Supreme Court ruled in favor of reverse discrimination claims and eliminated the use of minority set-asides where past discrimination was unproven. Still, affirmative action is often associated with being a

quota system, when, in fact, affirmative action programs can only require that institutions take cognizance of the demographics of their constituents. Quotas have only been court ordered in instances after a finding of overt discriminatory practices by a company. Even in such cases, proving discriminatory practices was extremely difficult in that statistics were deemed inadmissible, as they did not prove intent. As a result of these rulings, the federal government’s role in affirmative action was significantly diminished.

The Civil Rights Act of 1991 was established in effort to restore government commitment to affirmative action, but a 1995 Supreme Court decision limited the use of race as a criterion in awarding government contracts. In response to that decision, President Clinton put forward a White House memorandum that called for the elimination of any program that “(a) creates a quota; (b) creates preferences for unqualified individuals; (c) creates reverse discrimination; or (d) continues even after its equal opportunity purposes have been achieved.” In 1996, Proposition 209 called for an end to the use of affirmative action in California, and the use of race- and gender-based preferences was banned in the state the following year. Affirmative action was also abolished by Initiative 200 in Washington State, further demonstrating a strong opposition to the policy on a state level.

More recently, a landmark 2003 Supreme Court decision involving the University of Michigan allowed educational institutions to consider race as one of many factors for admission as long as it was applied broadly when evaluating students and not used in a formulaic manner. As a result, more systematic affirmative action procedures—such as setting aside admissions slots for students of color or assigning weighted points for race—were eliminated. The Supreme Court ruled that affirmative action was no longer justified as a tool to redress past discrimination but was upheld as means to increase diversity at all levels of society.

These challenges to affirmative action have the potential to jeopardize minority recruitment rates and opportunities for higher education and employment. As agents of social justice, counseling psychologists must understand the issues in the controversy over affirmative action. Minimally, counselors must stay informed as to the current status of affirmative action policies and must maintain awareness of how changes to such programs affect the lives of their clients of color. Within a counseling context, clients of color may present with some of the adverse



effects of being stigmatized as beneficiaries of affirmative action programs. As a result, clients may experience doubts about their own merit and self-efficacy, stereotype threat, and enhanced pressure to demonstrate competence. Counselors must be prepared to address such issues.

Peter C. Donnelly

*See also* Civil Rights (v3); Discrimination (v3); Organizational Diversity (v3)

### Further Readings

- American Psychological Association. (1996). *Affirmative action: Who benefits?* Washington, DC: Author.
- Crosby, F. J. (2004). *Affirmative action is dead; Long live affirmative action*. New Haven, CT: Yale University Press.
- Dovidio, J. F., & Gaertner, S. L. (2001). Affirmative action, unintentional racial biases, and intergroup relations. In M. A. Hogg & D. Abrams (Eds.), *Intergroup relations: Essential readings* (pp. 146–161). Philadelphia: Psychology Press.
- Wise, T. (2005). *Affirmative action: Racial preference in Black and White*. New York: Routledge.

---

## AFRICAN AMERICANS

---

According to the most recent U.S. Census Bureau report, prepared in 2000, there were 36.4 million people, or 12.9% of the total U.S. population, who identified as Black or African American. In addition, there were 1.8 million, or 0.6% of the population, who identified as Black in combination with one or more other races.

The term *African American* is an evolutionary one that gives rise to much debate regarding categorization and inclusion. *African American* is an ethnic term that includes persons who are descended from the African continent and whose families have been in the Americas for at least one generation; in contrast, the term *Black* refers to race and includes diverse ethnic backgrounds, including Caribbean and African ethnicities. However, both terms are often used interchangeably as a racial term. Conflict may often arise between native-born Blacks and Black immigrants and their children, all of whose experiences within American society help inform their decision to identify with the term *African American*. However, concerns about

competing for limited resources are often cited as the reason for a wish to be less inclusive rather than more inclusive in terms of identifying group membership.

The need to categorize and group those who were not members of the dominant group in the United States began in the mid-1600s when Africans arrived to the newly established American colonies. Initial categorizations referred to racial/ethnic characteristics, including skin color, hair texture and physical phenotypes (e.g., lips, nose, and body shape), parentage, and land of origin. It is perhaps the overlap in early categorizations which have contributed to the confusion surrounding the present-day usage of *African American* to denote a racial category as well as an ethnicity. Ethnic and racial group labels for people of African descent have changed over time and political contexts. Early labels used to refer to African Americans as a group included *African*, *Negro*, *Black*, and the derogatory term *nigger*.

However, with growing cultural awareness (e.g., the Harlem Renaissance), increased political power (e.g., the American civil rights movement), and grassroots activism (e.g., Black Panthers), social initiatives toward self-identification and labeling arose within African American communities. Community members began to take control of how they were referred to in arenas involving the written word, mass media communication, the arts, sciences, and the political lexicon. These self-chosen identifications were reflective of a shared cultural heritage, language, history, and legacy of slavery and included terms such as *Colored*, *Afro-American*, *African American*, and, of late, the lesser-used term *Neo-Nubians*.

Despite the extensive use of *African American* as a racial/ethnic label, individuals may take issue with being presumed to identify as African American. Disagreements about inclusion and identification can be linked to an individual's generation, level of acculturation, and political affiliation. Others who do not wish to be affiliated with African Americans may deny their membership because of negative associations tied to a long history that portrays African Americans as the denigrated "other," plagued by oppression. Still, others who have some part of their ethnic identity that interfaces with the African American experience (e.g., mixed race, biracial, or foreign-born individuals) may prefer to identify themselves as multiethnic or multiracial rather than identifying solely as African American, as this label may be too confining or restrictive.

People who identify or are identified as African Americans do not comprise a monolithic people. Factors



such as gender, age, educational attainment, geographic location, socioeconomic status, religious and political affiliation, and occupational endeavor contribute to the variations of experiences among these people. Within-group differences relevant to cultural identity (e.g., racial identity attitudes and acculturation level) need to be considered and honored in the counseling relationship. Therefore, it is difficult to suggest a singular counseling approach that would address a variety of mental health concerns that affect individual members of this group.

Furthermore, the nature of African American experiences in America has significant implications for the use of counseling and mental health services by this community. In fact, for many years the counseling profession has had limited contact with African American clients. Racial boundaries in the United States have, in effect, created a national system of disparate access to societal resources. The counseling and mental health professions embedded in this culture are only now, in recent years, beginning to become more receptive to the needs and concerns of African Americans.

Thus, the impact of history has profoundly shaped the experiences of African Americans in the United States. The legacy of enslavement has embedded racism into the cultural milieu, which has had important psychological, physical, and socioeconomic consequences for African Americans and all racial and ethnic groups in the United States. African Americans, dehumanized and treated legally and otherwise as property, have worked to overcome the legacy of institutionalized racism that has been in place for more than 200 years. Many of the practices and laws that created slavery have since been overturned, and yet the legacy of racism continues.

Given the myriad within-group differences among African Americans, shared experiences related to the legacy of slavery and racism contextualize health and mental health, educational, and socioeconomic disparities evidenced among African Americans. Despite the tremendous strides African Americans have made in the United States, they remain overrepresented in lower socioeconomic strata. Psychosocial stressors arising from ongoing interactions with racism in the United States have led some African Americans to seek treatment. Yet, members of this group are disproportionately located among homeless and incarcerated populations, making it difficult to offer consistent, effective interventions.

Furthermore, with regard to mental health disparities, African Americans face numerous obstacles. These

obstacles include overdiagnosis of schizophrenia, compared with affective disorders; less availability of, and access to, services; and overall poor quality of treatment received for mental health disorders. In comparison, disparities in the treatment of physical health issues for African Americans also remain problematic. African Americans are more likely to suffer from heart disease, stroke, obesity, breast cancer, and prostate cancer than are Whites.

To this end, gross inequities impact every aspect of this group's existence in the United States, including economics, housing, and employment. Although it is clear that exposure to trauma (e.g., neighborhood violence, genocide, racial microaggressions) influences mental health, particularly with reference to race-related stress, African Americans have also demonstrated tremendous resilience in the face of such difficulty. Resilience refers to a person's ability to recover from hardship. Counselors who encounter African American clients can use a strength-based approach that focuses on positive attributes African Americans possess rather than retraumatizing or overpathologizing this population. Strengths African Americans possess that need to be considered by counselors include the family unit, their ability to recognize the importance of education, and their use of religious/spiritual coping strategies as a way of improving their life circumstances.

### **Cultural Values Relevant to African Americans**

There are several cultural values that African Americans embrace which help to sustain their communities. These values include familism and connection to spirituality and religion, values that originated with Africentric cultural values. In addition, when encountering difficulty, African Americans have been described as being more likely to face the problem to find resolution and to rely upon spirituality to aid in relief from problematic situations. It is recommended that counselors and mental health professionals consider the diversity in the endorsement of these cultural values when working clinically with African American individuals and families.

### **Families**

The family is an important social, cultural, and psychological structure within the African American



community that is subject to being classified as dysfunctional by members of the dominant culture making peripheral observations. African American family units represent diverse structures, including multigenerational, single-parent, and two-parent blended or intact. The makeup of African American families can be extensive, including several generations living together and the informal adoption of fictive kin (i.e., non-blood related members of the family). The institution of slavery had required that African Americans transform the very meaning and structure of the family because slave families were fractured by slave masters who bought and sold slaves like chattel. For slave families, the Eurocentric nuclear family model did not exist; rather, broadened definitions of family, inclusive of multiple generations and fictive kin, were adaptive forms of social support. Furthermore, fictive kin and the nature of extended family networks facilitated the African American family's ability to share limited resources (e.g., child care responsibilities, housing, and economic resources).

Regardless of the structural makeup of the African American family, the unit is faced with concerns as members of the family engage and interact with components of the dominant culture. For example, the African American family as a unit is concerned with issues related to (a) sustaining economic survival; (b) achieving financial prosperity; (c) perpetuating itself despite obstacles such as child abuse, poverty, unwed mothers, and the proliferation of AIDS; (d) meeting the challenges of day-to-day survival; (e) overcoming the undereducation of its children; and (f) protecting its community from violence associated with the illegal drug trade, police shootings, or victimization in the form of random acts of violence.

Families that have a stable economic foundation, possess racial pride, provide a consistent environment for its children, use extended family networks to create a support system, are connected with a larger community, and have the skill to obtain what they need are thought to have protective factors against the development of mental illness. On the other hand, factors such as child abuse, neglect, and substance abuse are detrimental to the family unit and can influence the prevalence of mental illness within a family unit, especially when compounded by deficiencies in the aforementioned protective factors. Biological and psychological factors also influence the onset of mental illness.

Experiences within African American families vary vastly; however, commonalities of heritage,

culture, and contexts inform counselors about unique considerations within African American families. For example, it is possible for the existence of various levels of acculturation and racial identities (i.e., refers to the spectrum of how one thinks about oneself as a racial being) within the context of a single African American family unit. Family members' differing racial identity statuses may contribute to discord and tension across multiple domains, such as education, employment, and relationships. Similarly, generational and regional cultural differences can influence family members' role expectations, such that intergenerational conflict and social class differences may arise. Counselors' ability to recognize the nuances that these variations create within the family and the tensions that may arise when differences exist is crucial.

Socioeconomic class has a tremendous impact on the African American family and its functioning. Within the same family, broad variations that exist within social classes can contribute to tensions related to education, status, and access. Despite these differences, African Americans are more likely than Whites to remain connected to their family unit regardless of these variations in socioeconomic status. For example, unlike their White middle-class peers, middle-class African Americans are often the first generation to reach this class status and thus are looked upon to provide economic, educational, and emotional support to family members who have not joined the ranks of the middle class. Dynamics created by shifts in social class may be stressful and overwhelming. Thus, the resources that may have been sufficient to sustain the individual when stretched to support an extensive family network may cause middle-class African Americans to experience a sense of economic paucity.

### Role of the Black Church

African Americans have a long and rich tradition of involvement with the Black church. The Black church has been a sanctuary, gathering place, and social change agent in the African American community. The term *Black church* in this context serves as a collective description that includes a variety of Christian denominations (e.g., Baptist, African Methodist, Episcopalian, Catholic, Jehovah's Witness, Church of God) to which African Americans belong. African Americans also practice a variety of other religions, such as Islam, Buddhism, and African religions such as Kemet or Ifa. Given its historic role in this community,



African Americans continue to depend heavily on the Black church for support. Members of the clergy are often consulted to provide advice to members of their congregation.

At times, counselors and clergy members may need the benefit of mutual collaboration to facilitate the counseling process. Collaboration is beneficial in circumstances where members of the clergy are not equipped to address various mental health concerns or the complexities associated with psychological distress and mental illness. Counselors can receive additional insights about the individual or family that only the clergy member may be able to access. However, African Americans who identify themselves as very religious may be unwilling to attend counseling for fear that it may demonstrate a lack of faith on their behalf.

In some instances, African American adults who actively attended church as children may attend church less frequently or not at all; nevertheless, they may still identify as spiritual or religious and may depend on prayer. Prayer serves as a coping mechanism for many African Americans, particularly women. Prayer plays a vital role in the lives of African Americans, affording them the opportunity to express concerns, request intervention with various life circumstances, and seek comfort and connection to a higher power.

### **Therapeutic Considerations**

A key component to working with a diverse group of people such as African Americans is developing multicultural counseling competence. Multicultural counseling competence refers to developing the ability to understand one's own cultural perspectives and developmental process in relation to diverse cultural perspectives and life experiences. Several aspects of multicultural competence involve being able to discuss issues of race, class, and culture without discomfort, whether the discussion is initiated by the therapist or client. With respect to African American clients, counselors can fortify their knowledge base through talking to informed colleagues, working collaboratively with members of the African American community (e.g., clergy, community leaders), reading about the cultural experiences of African Americans, and attending professional conferences to learn about issues African American face and how to effectively address these issues in clinical practice.

A primary vehicle that may be used to ascertain extensive knowledge of clients' experiences is the

structured clinical interview. Through the structured clinical interview, the clinician may gather information about clients' development, family experiences, and personality in order to formulate a profile and build a holistic understanding of clients' experiences and concerns. However, some clients may experience this interview as intrusive and overly reliant on verbal expression. For example, African American clients who may not have received a formal education or do not express themselves well verbally may be at a disadvantage not only in this interview but also in traditional "talk" therapy settings. African Americans who do not trust the counseling process may be unwilling to respond openly to inquiries and may withhold pertinent information. Clinical misinterpretations of Black ways of speaking and use of language can lead to missed opportunities for understanding the nuances of African American clients.

Counselors who work with African Americans need to be prepared to work with clients traumatized by racism-related stress, which has implications for the psychological functioning of African Americans. Racism-related stress is stress generated from ongoing encounters and experiences with discrimination and prejudice. It manifests itself daily in the lives of African Americans (e.g., employment, housing, commerce, and criminal justice system) and can appear as depression, lower self-esteem, sub-par school performance, and an overall sense of dissatisfaction with one's state of well-being. Racism-related stress has been linked to increased rates of high blood pressure, stroke, diabetes, and cancer among African Americans. A holistic approach, which addresses the mind, body, and spirit to alleviate negative energy located in the psyche, may be an effective alternative to traditional medicine for treating these manifestations of stress in African Americans. Exercises that use progressive relaxation and meditation may help reduce racism-related stress.

Therapists who work with African Americans also may want to consider the influence of Africentric cultural values on clients' psychological functioning and willingness to engage in the therapeutic process. Africentric cultural values are an outgrowth of African traditionalism and the historical experiences of African Americans. These beliefs and values refer to individuals' ways of viewing the world which acknowledges the importance of one's relatedness or connectedness to others by engaging in collaborative efforts, spirituality, and presentation of one's true self to the world. Despite taking these factors into account in the counseling process, counselors may find that African



American clients who embrace Africentric cultural values may be more difficult to engage in traditional counseling and therapy; clients may have stigmas about seeking therapy or have a wish to withhold their true thoughts and feelings from the therapist.

As has been previously suggested, the counseling relationship is one built on trust, an alliance, created between therapist and client. At times, this relationship can be challenged or damaged by racial microaggressions that occur at conscious or unconscious levels during the therapeutic process. Racial microaggressions are slights that occur in the counseling relationship, when the therapist expresses a racist belief or thought. Examples of racial microaggressions that can manifest in therapy include making stereotypical assumptions about members of ethnic and racial groups, suggesting that racial-cultural differences do not exist, denying that racism occurs, and dismissing the client's concerns about issues of race. In addition, racial microaggressions are likely to give rise to further cultural mistrust in the therapeutic alliance.

Cultural mistrust occurs in therapy when African American clients become concerned that the therapist is racist or biased and that the therapist's biases will prevent both members of the counseling dyad from participating genuinely in the counseling process. On the other hand, the phenomenon of cultural paranoia is described as a healthy, adaptive response to historical racial discrimination and oppression that African Americans have experienced. Both cultural mistrust and cultural paranoia have been linked to increased rates of premature termination of the counseling process among African American clients. At times, clinicians unfamiliar with the intensity of racial dynamics may diagnose patients who appear to have paranoid ideations with paranoid schizophrenia without considering the potential influence of racial dynamics within the counseling setting or the degree to which race-related vigilance has been adaptive for the client. Because paranoid schizophrenia is overrepresented, and arguably overdiagnosed, among African Americans above other mental disorders, counselors are advised to foster an awareness of cultural paranoia.

Assisting African Americans with issues of cultural mistrust and paranoia requires a willingness to acknowledge the realities of racism in the lives of African Americans. Possessing flexibility and ability to embrace diverse worldviews can help to establish a strong therapeutic alliance with clients. Using a cognitive-behavioral approach to work with clients to help them to identify irrational thoughts and beliefs can help

them to gain insight into racial dynamics as they occur and challenge fixed beliefs that all White people aim to harm African Americans. Using a cognitive-behavioral approach, counselors can assist clients with gaining control of their reactions to incidents where perceived instances of racism have occurred and can offer problem-solving techniques and strategies to address the events.

One common practice in African American family life is keeping family problems within the family. Secrets are those parts of family historical knowledge and life that distinguish family from nonfamily. Cultural values that endorse keeping family problems "within the family" may contribute to African American individuals' reluctance to enter counseling or self-disclose with their therapists. Examples of secrets that families may not want to discuss in therapy are informal adoptions, a relative with mental illness, or a family history of substance abuse. Furthermore, for many African American individuals and families, secrets related to sexual or substance abuse, marital difficulties, identity issues, or mental illness are unlikely to receive psychological attention until such concerns have escalated. Mandated individual or family therapy may engender feelings of humiliation, embarrassment, anger, and resentment, all of which need to be explored with counselors. In addition, families may view counselors as intruders into the family's business. Having an understanding of how clients become engaged in the therapeutic process can help inform counselors' strategies for overcoming personal, social, and institutional barriers toward treatment and developing a helpful working alliance. Given the tremendous influence of the family on the development of the individual member, consideration should be given to expanding the therapeutic alliance to include members of the family for assessment purposes and treatment if needed.

## Referral Sources

Compared with other ethnic/racial groups, African Americans are the least likely to use counseling services. Thus, when African Americans do arrive to counseling, the situation is usually extreme and may be reflective of African Americans' cultural perspective of immediacy, dealing in the here and now. Issues of social stigma, lack of financial resources to pay for treatment, concerns about stigmas of weakness or abnormality, as well as lack of information about the counseling process are contributing factors to African Americans' underutilization of counseling to relieve psychological distress.



Frequently, African Americans who experience psychological distress do not receive adequate relief from their symptoms because they are not connected with appropriate or culturally responsive mental health professionals (e.g., psychologists, psychiatrists). African Americans are more likely to receive mental health services from hospital emergency rooms. This approach is often ineffective because although the immediate crisis is averted, follow-up is often needed to fully address or resolve systemic problems. Furthermore, overreliance on emergency room treatment can result in misdiagnosis or the overdiagnosis of serious mental disorders in this population. Outpatient services remain underutilized by this group for similar reasons.

### Future Directions

Although African Americans may appear to be struggling and beleaguered by social injustice and racism, as a group they remain resilient. Their resilience is evidenced by the steady growth of the African American middle class, economic gains, and social progress. Although varied, their experiences share common links; thus, it is important for counselors to examine the cultural context of the issues African Americans bring to the consultation rooms. Greater efforts must be made to inform, educate, and encourage African Americans to use the therapeutic process to unburden themselves of the stress and trauma often associated with the overlays of social locations in the United States.

The counseling profession has made strides to improve the quality of treatment received by African American clients; however, a concerted effort must be made to help this population focus on their strengths rather than on the negative aspects of prejudice and racism. A strength-based approach can serve as a powerful tool in helping engage African Americans in the therapeutic process. Focusing on strengths can help them continue to adapt and thrive, relying on their families, religious affiliations, and communities for support, uplift, and advancement.

*Erica King-Toler and Vanessa Alleyne*

**See also** Acculturation (v3); Black English (v3); Black Psychology (v3); Black Racial Identity Development (v3); Career Counseling, African Americans (v4); Cultural Mistrust (v3); Cultural Paranoia (v3); National Association for the Advancement of Colored People (v3); Race (v3); Racial Identity (v3); Visible Racial/Ethnic Groups (v3)

### Further Readings

- Boyd-Franklin, N. (2003). *Black families in therapy: Understanding the African American experience* (2nd ed.). New York: Guilford Press.
- Constantine, M. G. (2007). Racial microaggressions against African American clients in cross-racial counseling relationships. *Journal of Counseling Psychology, 54*, 1–16.
- Constantine, M. G., Alleyne, V. L., Wallace, B. C., & Franklin-Jackson, D. C. (2006). Africentric values: Their relation to positive mental health in African American adolescent girls. *Journal of Black Psychology, 32*, 141–154.
- Daniels, L. A. (Ed.). (2001). *The state of Black America 2001*. New York: National Urban League.
- Grier, W., & Cobbs, P. (1968). *Black rage*. New York: Basic Books.
- Jones, R. (1996). *Handbook of tests and measurements for Black populations* (2 vols.). Hampton, VA: Cobb & Henry.
- Lewis-Coles, M. E. L., & Constantine, M. G. (2006). Racism-related stress, Africultural coping, and religious problem-solving among African Americans. *Cultural Diversity & Ethnic Minority Psychology, 12*, 433–443.
- Neighbors, H. W., & Jackson, J. S. (Eds.). (1996). *Mental health in Black America*. Thousand Oaks, CA: Sage.
- Snowden, L. R. (2001). Barriers to effective mental health services: African Americans. *Mental Health Services Research, 3*, 181–187.
- U.S. Department of Health and Human Services. (2001). *Mental health: Culture, race and ethnicity. A supplement to mental health: A report of the surgeon general*. Rockville, MD: Author.
- Utsey, S. O., & Ponterotto, J. G. (1996). Development and validation of the Index of Race-Related Stress. *Journal of Counseling Psychology, 43*, 490–501.
- Whaley, A. L. (2001). Cultural mistrust: An important psychological construct for diagnosis and treatment of African Americans. *Professional Psychology: Research and Practice, 32*, 555–562.

---

## AFROCENTRICITY/AFROCENTRISM

---

Afrocentricity/Afrocentrism is better referred to as *African-centered thought*. The term has endured several political and vernacular changes, but conceptually it has remained consistent. African-centered thought symbolizes the intellectual, psychological, and social struggle of descendants forcibly removed from Africa and placed in the Americas. It is representative of an intellectual and practical effort to reclaim a cultural legacy, consciousness, and history that positions an authentic cultural unity of the continent of Africa as the



worldview lens from which human endeavors are interpreted and engaged.

## Background

Afrocentricity/Afrocentrism is relatively recent nomenclature. The precursor to stake a modern literary claim recognizing a distinct cultural identity of African Americans can be found in the pioneering work of W. E. B. Du Bois in 1913, *The Souls of Black Folk*. Indirectly anchored in African-centered thought, Du Bois articulated a paradoxical condition of being an African in America. Du Bois's concept of "double consciousness" is a historical reference point for acknowledging an alternative worldview at conflict with the hegemonic Eurocentric worldview in America. Contemporary African-centered anthropologists, social scientists, and psychologists have articulated an authentic African worldview for such concepts as personality, identity, and optimal health and behavior.

## African-Centered Worldview

Based on the pioneering scholarship of Cheikh Anta Diop and G. G. James in 1954, Afrocentricity/Afrocentrism postulates that an African-centered worldview places African cultural unity, history, and philosophy as the central perspective for which the world is experienced, interpreted, and engaged. Contemporary scholars such as Marimba Ani, Molefi Kete Asante, Asa Hillard, Maulana Karenga, and John Mbiti have stated that the African worldview provides a method and process of analysis that reflects the historical continuity, collective consciousness, and cultural unity of ethnocultural groups on the continent of precolonial Africa. Afrocentricity/Afrocentrism, although similar to Pan-Africanism or Black Nationalism, is not a political ideology but a cultural consciousness.

Some themes of an African worldview are ancestor veneration, social collectivity, and spiritual basis of existence. *Ancestor veneration* in Africa is the belief that ancestors are deities, much like saints and prophets in other traditions, and they are very much part of the cosmology and influence daily living. They are respected and celebrated but not worshipped. In a therapeutic setting ancestors play an important role in the healing process. *Social collectivity* by clan groupings influences the distribution of wealth and labor. Social roles are flexible to meet the needs of the collective.

Research investigating African Americans must include the impact on the community or other systems that are connected to their lives. *The spiritual basis of existence* refers to the belief that all things are spiritually manifested. Spirit is the essence of existence. There is only one God, a Divine energy that flows through all things and thus creates our interdependence. Truth is revealed through signs, the rhythm of nature, symbolic imagery, the cosmos, and the human being. This value introduces the notion and acceptance of phenomena, which are critical to the analysis of human behavior from an African-centered worldview. In essence the African worldview takes a teleological orientation.

## African-Centered Psychology

African-centered psychology is concerned with defining African psychological experiences from an African-centered worldview. According to Na'im Akbar, Kobi K. K. Kambon, and Wade Nobles, an African-centered worldview assumes a philosophical premise that utilizes an affective inclusive metaphysical epistemology and that employs an axiology that is based on a member-to-member values orientation, an ontology that is di-unital (the attraction of opposites or curricular thought), and a cosmology that acknowledges the interdependence of all things seen and unseen, which is the essence of the Divine Spirit. In essence African-centered psychology is conscious and unconscious.

African-centered psychological theory has emerged from roughly three general periods on the continuum of African world civilization: *Africa in antiquity*, *traditional*, and *re-establishment*. African-centered psychology situated in ancient Africa draws on the wisdom of the world's first known and recorded scholars of the world. During this period covering several dynasties and thousands of years, there was a particular focus on teleological orientation (attention to purpose) and maintenance of the self in a God-like fashion. Spiritual illumination through harmonious and balanced behaviors (actions and thoughts) was the criterion for a functioning African mind. During the *traditional* period African-centered conceptualizations of the self continued to focus on spiritual connectivity as the central purpose of existence. As the previous dynasties expanded and then fell, populations shifted with migrations. During this period the basic concepts for understanding the African mind remained consistent with those of the



previous period, though the models and practices (i.e., rituals) were adapted for new environments. The central teleological orientation (attention to purpose) remained consistent. In fact this provided the foundation for cultural unity that preserved the various ethnic groups during hostile Arab and European invasions and colonization. During this current period of *re-establishment*, African-centered psychological theory has adopted and integrated the language and practices of its colonizers while maintaining its core theoretical tenets from the previous periods. While challenges to African cultural unity, as a result of colonial hegemony and religious missionaries, have created contention within postmodern African cities, African-centered and non-African-centered praxes coexist.

### Future Directions

Afrocentricity/Afrocentrism is a representation of African thought and worldview that is placed at the central perspective of analysis. As a unit of analysis, African-centered thought is both individual and institutional. An Afrocentric/Africentric orientation can inform individual and institutional behaviors, methods, and practices. In particular, African-centered thought can provide a framework for understanding such concepts as spirituality, humanity, functioning, illness, identity development, purpose, assessment, personality, community, and civilization.

In the future, Afrocentricity/Afrocentrism, as influenced by African-centered thought, should be placed as the primary unit of analysis for the development of appropriate interventions, assessments, and theories for addressing the health of people of African descent. Non-African-centered perspectives should be seen as supplemental or alternative.

The challenge of an African-centered thought is inclusion in the traditional canon of psychological theory. Dominant Western theories have produced a condition of scientific colonialism that employs “different equals deficient” logic. Eurocentric thought, institutionally, has taken the position that alternative intellectual traditions are alternatives, deserve prolonged empirical scrutiny, and are seen as supplemental to its original position. As the issues of, for example, ethnic-specific health and educational disparities continue to exist, the claims of intellectual supremacy and universal applicability of Western thought will be difficult, if not impossible, to defend.

Worldview-oriented psychological thought offers a true depiction of humanity’s cultural pluralism.

*Leon D. Caldwell*

**See also** African Americans (v3); Black English (v3); Black Psychology (v3); Black Racial Identity Development (v3); Nationalism (v3); Racial Identity (v3); Racial Pride (v3); Worldview (v3)

### Further Readings

- Kambon, K. K. K. (1992). *The African personality in America: An African centered framework*. Tallahassee, FL: Nubian Nation Publications.
- Myers, L. J. (1988). *Understanding an Afrocentric worldview: Introduction to an optimal psychology*. Dubuque, IA: Kendall/Hunt.
- Nobles, W. W. (1980). *African psychology: Towards its reclamation, reascension, and revitalization*. Oakland, CA: Black Family Institute.
- Parham, T. A. (2002). *Counseling persons of African descent: Raising the bar of practitioner competence*. Thousand Oaks, CA: Sage.

---

## ALASKA NATIVES

---

Alaska Natives comprise three distinct ethnic groups: Eskimos, Aleuts, and Indians, each with their own distinct histories, cultures, customs, and traditions. American Indians/Alaska Natives constitute approximately 1% of the U.S. population. However, in Alaska, Native people comprise approximately 17% of the 625,000 people that make up the state’s total population. Thus, Alaska has the 10th largest Native population and the largest Native population per capita in the United States. Alaska Native peoples live primarily in northern and western Alaska, accounting for more than 50% of the total population in those regions. Only 7% of Alaska Natives live in urban settings. The rest live in rural and bush areas, often in isolated tribal villages 40 to 60 miles apart.

Alaska Natives have a rich, proud, and varied history. Although protectors of Alaska’s vast natural resources and contributors to the rich cultural heritage of the state, they also experience acculturation stresses brought on by initial and ongoing contact, first with French and Russian Europeans and then



with European Americans. As a result, Alaska Natives confront social and psychological challenges that are similar to those confronted by Native Americans from other parts of the United States, including quickly changing social expectations, underemployment, high rates of incarceration, high rates of alcohol and drug abuse, and extremely high rates of suicide.

## Alaska Native Cultural Groups

### *Eskimos*

Eskimos (also known as Inuit) are the largest of the three Alaska Native ethnic groups. They comprise 52% of all Alaska Natives. Eskimo subdivisions include the Inupiat (Greenland to northern Alaska), the Yu'pik (western and southwestern Alaska), and the Siberian Yu'pik (St. Lawrence Islanders). Historically, Eskimos lived in extended and multifamily units in tents during the summer and in large underground sod houses during the winter. Although outside temperatures range from  $-80^{\circ}\text{F}$  in winter to  $+40^{\circ}\text{F}$  in summer, these sod houses were kept at a comfortable  $70^{\circ}\text{F}$  to  $85^{\circ}\text{F}$  by fires, sod roofs, and igloo overhouses.

Alaska Eskimos are related to, and share many of the same cultural beliefs and lifeways as, Eskimos living in Siberia, Greenland, and Canada. Historically, Eskimos practiced an animistic religion that prescribed times of social gathering, rituals, and feasts, as well as religious beliefs and practices concerning the care and respect for all living things (including people, animals, and the environment). Their religion, along with the cultural habits of summer hunting and storage, helped regulate the daily rhythm of arctic life, especially during the 3 months of total darkness and the 3 months of total light that occur in the arctic every year.

Before European contact, Eskimos practiced subsistence living by catching fish and hunting seals, walruses, whales, caribou, musk oxen, and polar bears. They used animal skins to make tents and clothes, which protected them from the extreme arctic weather. They constructed hand tools and weapons from antlers, horns, teeth, and animal bones. In summer, they hunted in boats covered with animal skin, and in winter, they traveled on sleds pulled by dog teams. When traveling in search of game, they built igloos as shelters from blocks of snow and ice.

### *Alaska Indians*

Alaska Indians comprise 36% of the Alaska Native population. There are four major tribes of Alaska

Indians: the Athabascans, the Tlingits, the Tsimshians, and the Haida. In pre-contact times, people from these four tribes inhabited the whole of Alaska, the western portions of Canada, and the northwestern portions of America. They lived in both coastal and interior regions of the Alaskan territories. They lived in highly structured societies centered on clan membership, with people in each of these clans related by genealogy, history, and possessory rights.

Alaska Indians lived in villages or in camps that followed wild game migrations. Village housing was built with local materials, such as birch bark. Migrant housing tended to be animal skin teepees or lean-to shelters. Dietary practices as a whole depended on hunting and gathering with some farming, but these practices varied somewhat among geographical regions and tribal groups. Alaska Indian religion centered primarily on respect and reverence for nature, belief in an afterlife, and, for some tribes, belief in reincarnation. After Alaska Indians' first contact with Europeans, many became Russian Orthodox or Protestant Christians. However, in recent years, some younger Alaska Indians have reconverted to their traditional tribal religions.

### *Aleuts*

Aleuts comprise 12% of the Alaska Native population. They live on the Aleutian Islands, a chain of more than 300 small volcanic islands extending westward from the Alaskan Peninsula toward the Kamchatka Peninsula in Russia.

Alaska Eskimos and Aleuts were historically one people who migrated across the Bering Land Bridge between 8,000 and 15,000 B.C. Those who migrated south became Aleuts, and those who migrated north became Eskimos. The first reported settlement of Aleuts was in Nikolski Bay, which is suspected by some archaeologists to be the oldest continuously occupied community in the world.

Aleuts are seagoing people living on meats and processed pelts from the sea lions, otters, whales, and other animals that inhabit the north Pacific. In the relatively warmer climate of the Aleutians (with temperatures ranging from  $11^{\circ}\text{F}$  to  $65^{\circ}\text{F}$  year round), these hunting and fishing activities are carried on in all seasons. Before their initial contact with European and American cultures, there was an estimated 16,000 to 20,000 Aleuts living in the Aleutian Islands. There are approximately 12,000 Aleuts today. The dominant religion in many Aleutian communities is the Russian Orthodox faith.



## Social and Psychological Challenges

### *Social Challenges*

Before contact with European people (in the early 1700s), Alaska Natives lived free and independent lives. However, upon discovery of the rich resources of the northern Pacific and Alaskan interior by Europeans and non-Native Americans, Alaska Natives as a whole experienced both personal and economic exploitation. Early enslavements of Alaska Native peoples and population decimations from deadly European diseases (e.g., smallpox and tuberculosis) changed Alaska Natives' life ways and caused severe damage to social structures supporting psychologically healthy lives.

The traditional way of life has ended for most Alaska Natives. Most now live in wooden houses made from imported wooden planks rather than igloos, sod houses, or teepees. They wear modern clothing instead of animal skin garments. They speak English, Russian, or Danish in addition to their native languages. They now must compete in the modern economic world. The kayak and the umiak have given way to motor boats, and the snowmobile has replaced the dog team. Fishing villages are connected with a ferry system, and previously inaccessible mountain and river villages are connected by ski trails, boats, bush pilots, or snowmobiles. Telecommunication devices (e.g., televisions, telephones, and computers), needs for petroleum, and other lifestyle changes have necessitated a cash economy to supplement ancient subsistence practices. Yet, access to full participation in the modern U.S. economy has been slow among Alaska's Native people.

In 1968, the Senate Interior Committee issued a report that stated that more Alaska Natives were unemployed or seasonally employed than had permanent jobs. More than half of the Alaska Native workforce was jobless most of the year. Year-round jobs were typically few and were limited to such types of employment as school maintenance worker, postal worker, airline station agent, village store manager, or teacher's aide. Some income was gained through the sale of furs, fish, or arts and crafts. Some Natives found seasonal employment away from their villages, as firefighters, cannery workers, or construction laborers. Most provided for the bulk of their food supply by fishing, hunting, and trapping, and most relied upon a combination of means to obtain the cash needed for fuel, food staples, tools, and supplies. The wage gap was continuing to grow precipitously as

immigration into Alaska by other ethnic and cultural groups continued to increase.

In 2004, a report issued by the Center for Educational Research stated that even with the increasing wage gap, Alaska Natives had gained thousands of new jobs and improved their incomes in every decade since 1960. Native women, in particular, had continued to move into the workforce. However, in the 1990s the gains were smaller, and thousands of Natives who wanted jobs could not find them. The modest income gains were not in wages but mostly in transfer payments, including the state Permanent Fund dividend.

Today Native incomes on average remain just over half those of other Alaskans, and Natives are still about a third less likely to have jobs. Native households are 3 times more likely to be poor; poverty is especially high among households headed by women. These economic problems are worse for Natives in remote rural villages. Subsistence hunting and fishing continue to be the only source of provision for many Native families, even as external pressures to maintain a contemporary economic lifestyle are increasing.

The social stress that many Alaska Natives face is even more evident as one examines the breakdown of Alaskan Native families and communities. Alaskan Native adults, who represent about one third of the state's inmate population, commit crimes that are considered to be among the most violent in nature: assault, sexual assault, sexual abuse of a minor, and murder. Alaska Natives are overrepresented in cases of child abuse by twice what would be expected given the population statistics. Among Alaska Native adolescent males, nearly one in every eight between the ages of 14 and 17 has been, or is currently, in juvenile detention.

Alaska Natives continue to be in a period of cultural, economic, and social transition. Their acculturation has not always been voluntary, and they have not had control over the extent or pace of change. As a result, many experience tremendous stress, which permeates all aspects of their lives. Whereas some Alaska Natives have successfully adjusted to a new way of life, the consequences of this constant and massive stress have put many others at risk for leading lives that are characterized by poverty, violence, and cycles of personal and social destruction. The psychological consequences of living in such circumstances can lead otherwise psychologically healthy people to overuse maladaptive coping strategies. Among Alaska Natives,



the coping strategies most often used have been alcohol abuse, drug abuse, and suicide.

### ***Alcohol and Drug Abuse/Dependence***

The primary mental health challenge among Alaska Natives is alcohol and drug abuse/dependence. Alcohol was introduced to Alaska Natives only 300 years ago. Since then, alcohol and drug abuse has been a constant source of sorrow and destruction for Alaska Natives. Although exact rates of alcohol and drug abuse/dependence are not available, among Alaska Natives the alcohol-related mortality rate is 3½ times greater than the rate among non-Natives. The rate of fetal alcohol syndrome for Alaska Natives is 3 times that of the rest of the population of Alaska. The impact of alcohol and drug use has been particularly dramatic among Alaska Native youth. In 1998, of all court referrals of Native youth in the state, 55% were for the offense of possession and/or consumption of alcohol. Among Alaska Natives, alcohol contributes to high rates of motor vehicle crashes, cirrhosis, suicide, homicide, domestic abuse, and fetal alcohol syndrome.

The pattern of abuse among most Alaska Natives is drinking to pass out rather than engaging in social drinking. Moreover, alcohol abuse is chronic, and many Alaska Natives become dependent on alcohol at the same time they become users. Drug abuse, which is a newer phenomenon among Alaska Natives, has nevertheless become a serious threat to their communities. For example, in some isolated Alaskan Native villages, there is a 48% lifetime risk of inhalant abuse.

Theories about the magnitude of alcohol abuse among Alaska Natives include genetic predisposition, enculturation pressures, social prohibition, and integration theories. Genetic predisposition theories cite the lack of acetyl dehydrogenase (which breaks down the toxic substances created by alcohol metabolism in the liver) as a causal factor. This genetic variation, which is shared with some Asian races (e.g., Chinese and Japanese), causes distinctive facial reddening, accelerated heartbeat, and increased blood pressure upon the consumption of alcohol. However, this theory cannot fully account for Alaska Native alcoholism, in that Chinese and Japanese Americans have the lowest rates of alcoholism of all American ethnic groups, whereas Alaska Natives and American Indians have the highest.

Enculturation theories examine the poor fit between Native indigenous values and those of the broader American culture. These theories examine the

diathesis-stress dimensions of alcohol abuse, citing desperate social and economic conditions as precursors to alcoholism. Through the self-destructive behaviors that result from internalized oppression, Alaska Natives express massive grief over the loss of their cultures and the traditional ways of life. Boredom, stoicism, intense pride, and the lack of cultural models for seeking help reinforce this proclivity to alcoholism among Alaska Natives.

Prohibition theories suggest that Alaska Natives learned binge-drinking behavior from the trappers, miners, and traders with whom they had initial contact. Alaska Natives, according to these theories, invest alcohol with tremendous power and readily accept that they cannot control its effects. In contrast, Chinese and Japanese Americans (who have the lowest rates of alcoholism in the United States) believe that alcoholism is a weakness and that people can and should control their drinking.

Finally, integration theorists combine genetic, enculturation, and social prohibition theories. They assert that alcohol abuse is fundamentally a symptom of a much more complex set of problems within the Native community, that these problems have yet to be identified, and that alcoholism, although a symptom, is also a unique contributor, in that it breeds an abundance of negative personal and community outcomes. Integration theorists remind us that regardless of the physiological, social, or psychological origins of alcoholism, the disease of alcoholism (and drug abuse as well) must be successfully treated if there is to be a livable future for Alaska's Native people.

### ***Suicide, Depression, and Other Mental Health Issues***

The Alaska Native suicide rate, which did not significantly differ from nationwide averages throughout the 1950s, began to take a dramatic turn upward in the 1960s. In the quarter-century between 1964 and 1989, the rate of Alaska Native suicides increased 500%. Today, although Alaska Natives make up just under 20% of the Alaskan population, they represent 41% of all suicides. Although rates have decreased slightly in the past 15 years, the problem continues to be widespread. In all populations, suicide rates are generally higher for adolescents. Among Alaska Natives, the number of adolescent suicide victims is even more pronounced.

Alcohol abuse is a factor in a large majority of Alaska Native suicides. Seventy-nine percent of all



Alaska Native suicide victims have detectable levels of blood alcohol. Although there is very little research on the correlates of suicide among Alaska Natives, some theorists believe that suicide in this population is associated with rapid and unpredictable social change, childhood and interpersonal losses, a limited ability to grieve, poor affective relatedness, and very high rates of depressive disorders.

Although there is less empirical research on the prevalence and treatment of other mental health issues among Alaska Natives per se, there are studies of American Indian children and adults that include samples of Alaska Natives. These studies report increasing rates of depression, low self-esteem, and anxiety, citing that Native people do not fit well into the American way of life. Learning disabilities are the second most frequent major diagnosis among American Indians and Alaska Natives. Furthermore, American Indians and Alaska Natives are slightly overrepresented among HIV/AIDS patients, suggesting greater sexual risk behaviors than are found in the U.S. population at large.

The U.S. Department of Health and Human Services Substance Abuse and Mental Health Services Administration (SAMHSA) reports that Native Americans/Alaska Natives are more likely to experience mental disorders than are other racial and ethnic groups in the United States. Of great concern is the high prevalence of depression, anxiety, substance abuse, violence, and suicide. Other common mental health problems include psychosomatic symptoms and emotional problems resulting from disturbed interpersonal and family relationships. According to SAMHSA, failure to address the "historic trauma" and culture of American Indians/Alaska Natives in health care only adds to the oppression they experience. Nevertheless, disentangling socioeconomic factors, cultural influences, civil rights issues, and the effects of race/ethnicity is difficult when seeking to understand any health condition, and even more so when seeking to understand mental health disorders.

### **Service Provision and Treatment Issues**

Alaska Natives represent almost 30% of the public mental health clients in Alaska at an overrepresentation of almost 2 to 1 based on the general population. Nevertheless, public health officials believe that Alaska Natives are woefully underrepresented in relation to the magnitude of the mental health challenges they face.

The burden of mental illness looms over Alaska Native people, extracting vitality and interrupting their futures. Worse, the stigma attached to mental illness often deters people from seeking help, thus prolonging illnesses that could be treated or even prevented.

Stigma is not the only challenge to providing mental health services to Alaska Native people. Other challenges include cultural, philosophical, and communication style differences between mental health providers and their Alaska Native clients. Moreover, some Alaska Natives believe that mental health providers use their counseling/psychology positions to extend social dominance and control over Native people's lives.

### ***More Effective Treatments***

Experts in multicultural psychology agree that effective treatments for ethnic minority clients should be based on those clients' worldview and cultural precepts. Among Alaska Natives, these cultural precepts include respect for traditional knowledge, connections with the land and all living things, use of inductive analysis (inference of a generalized conclusion from particular instances), emphasis on discovering how, and verification of individual facts derived primarily from oral forms of communication. In contrast, European American mental health providers tend to value scientifically derived knowledge, mastery and control of one's physical and social environments, deductive analysis (the conclusion about particulars follows necessarily from general premises), emphasis on discovering why, and verification of general principles derived primarily from written forms of communication. The primary challenge for European American mental health providers then is to find ways to understand and enter into the world of Alaska Natives to provide the most effective psychological treatments possible.

Within the context of providing culturally sensitive and effective treatments for Alaska Natives, several innovative programs are being introduced. Among the most promising are intertribal, business, and public service consortia, as well as tribally centered programs, that identify and treat alcohol and drug dependency as primary dysfunctions and co-occurring disorders as secondary dysfunctions. These programs typically are designed to (a) treat alcohol and substance abuse in ways that control the availability of alcohol, (b) provide educational and treatment efforts, and (c) reduce the social and environmental factors



that increase the risk of harm to both the individual and the community. The treatment programs include using culturally familiar symbols, pictures, signs, and stories, addressing the impact of intergenerational trauma and chemical abuse on both families and communities, using Native languages and art forms, and employing traditional interpersonal techniques, such as talking circles and ceremonial protocols. In these programs, tribal elders often are employed both as consultants and as service providers.

A sample program, which has used this psychological treatment/community action model, has shown great success. In this program, which is operating in the Aleutian Pribilof Islands, responsibility for the mental health care of island inhabitants has been undertaken through a consortium of municipal and tribal governments and corporate management. Alcoholism and drug use decreased when island employers began to enforce sobriety policies and conduct random drug testing. Employees with substance addictions were sent off the islands for treatment, and they participated in a mentorship program when they returned. As a result, violence, felonies, suicides, and murders decreased, and psychological adjustment continued to increase as a new pride in island inhabitants' cultural heritage and self-sufficiency emerged. Social and community support was established for people who suffered with mental health issues. Moreover, there were abundant opportunities for all workers to obtain sustained year-round employment. The affluence in the communities hosting this treatment program currently matches that of many other American cities.

Finally, there has been success in helping American Indians/Alaska Natives establish more productive and fulfilling lives by providing Native-based career counseling. In programs established by the Division of Indian and Native American Programs of the Workforce Investment Act, Alaska Natives are helped to achieve economic self-sufficiency through job training, job counseling, career counseling, academic counseling, and financial aid and educational assistance. These programs provide ongoing case management in a manner that is culturally appropriate and holistic in nature. Through individual development plans, counselors and clients work together to set goals, identify needs, and find referrals to other programs and outside community agencies. Nearly 90% of the individuals served in 2000 under this program were highly satisfied with the services they received.

### ***Future Directions for Mental Health Treatments***

Although there have been some successes in providing more effective mental health treatments to Alaska Natives, through the combination of culturally relevant treatments offered within a broader social support structure, there is still a tremendous need to look at short-, medium-, and long-term solutions to alcohol and drug abuse, depression, suicide, and other mental health issues among Alaska Native peoples. There is little empirical research that investigates the correlates of treatment effectiveness, although there is some evidence that consortium and community efforts are effective. Nevertheless, Alaska Native mental health, including the mental health of future generations, will depend on both preventive and remedial efforts that (a) provide empirically validated psychological treatments; (b) address the underlying economic, sociocultural, and other factors that cause Alaska Natives to seek refuge in alcohol and other chemicals; (c) create real economic opportunities; and (d) empower Alaska Natives to participate in crafting their own solutions to potentially devastating mental health challenges.

Sherri Turner

**See also** Acculturative Stress (v3); Career Counseling, Native Americans (v4); Community-Based Health Promotion (v1); Depression (v2); Discrimination and Oppression (v2); Diversity Issues in Career Development (v4); Evidence-Based Treatments (v2); Multicultural Counseling (v3); Secondary Trauma (v2); Substance Abuse and Dependence (v2); Suicide Potential (v2)

### **Further Readings**

- Grandbois, D. (2005). Stigma of mental illness among American Indian and Alaska Native nations: Historical and contemporary perspectives. *Issues in Mental Health Nursing*, 26(10), 1001–1024.
- Gregory, R. J. (1994). Grief and loss among Eskimos attempting suicide in western Alaska. *American Journal of Psychiatry*, 151(12), 1815–1816.
- Harris, K. M., Edlund, M. J., & Larson, S. (2005). Racial and ethnic differences in the mental health problems and use of mental health care. *Medical Care*, 43(8), 775–784.
- Hesselbrock, V. M., Hesselbrock, M. N., & Segal, B. (2003). Alcohol dependence among Alaska Natives and their health care utilization. *Alcoholism: Clinical and Experimental Research*, 27(8), 1353–1355.



- Lee, N. (1995). Culture conflict and crime in Alaska Native villages. *Journal of Criminal Justice*, 23(2), 177–189.
- Segal, B. (1997). The inhalant dilemma: A theoretical perspective. *Drugs & Society*, 10(1–2), 79–102.

---

## ALLOCENTRISM

---

*Allocentrism* is a personality trait that characterizes the attitudinal, cognitive, affective, and behavioral patterns and preferences shared among people of a collectivist culture. Among those who are allocentric, self is defined as more interdependent than independent; ingroup goals and harmony take priority over individual goals and autonomy. People who hold allocentric beliefs tend to value social norms, self-sacrifice, cooperation, equality, and relatedness more than social recognition, self-reliance, competition, equity, and rationality. Allocentrism is usually conceptualized as an end point of a continuum, with idiocentrism as the opposite construct. The individual levels of the allocentric and idiocentric tendencies correspond to the cultural dimensions of collectivism and individualism.

### Current Research

The theorization of allocentrism has sparked 2 decades of research on the relationship between allocentrism and other individual and contextual variables. Multimethod measures have been developed to assess various dimensions of allocentric tendencies, such as the INDCOL scale, individualism–collectivism scales, the Self-Construal Scale, value surveys, sentence completion exercises, and scenario stimuli.

Research has demonstrated that there are more allocentrics than idiocentrics in collectivist cultures and vice versa. Women tend to be more allocentric than men across cultures. In the United States, racial and ethnic minorities appear to be more allocentric than White Americans. Among allocentrics, high self-esteem is related to self-efficacy in forming positive interpersonal relations. Allocentric persons reported having more and better social support than did idiocentrics. Moreover, they tend to transmit values such as obedience and obligations to their children. Allocentrics, compared to idiocentrics, also are more likely to perceive their group as homogeneous (regardless of how “homogeneous” the group actually

is), which in turn may affect their behavioral patterns in a group setting (e.g., workplace performance).

Allocentrism is a complex construct that is multidimensional in nature and context dependent. Allocentric tendencies can be *vertical* (i.e., defining themselves as different from others and yet subordinate to the ingroup, thus likely to sacrifice for the interests of the group) or *horizontal* (i.e., perceiving themselves to be the same as others within the group, thereby unlikely to self-sacrifice for ingroup goals). Also, individual allocentric tendencies may differ depending on the tasks, groups, and settings. For example, a person may be a vertical allocentric at home and yet a horizontal allocentric at work. Furthermore, the strength of the relationship between allocentric tendencies and other psychosocial correlates (e.g., subjective well-being) may vary depending on the level of collectivism or individualism within a given cultural context.

### Future Directions

Due to the contextualized multidimensional nature of the allocentric construct, individual allocentric tendencies may shift or intersect with a plethora of other factors, such as age, ethnic values, acculturation levels, socioeconomic status, religious/spiritual affiliation, sex roles, and situated contexts. Thus, conceptualizing and measuring allocentric and idiocentric tendencies as the end points of a single, bipolar continuum is a common practice, yet may be overly simplistic. Contemporary researchers have advocated the employment of multimethod and domain-specific approaches to assess the varying dimensions of allocentrism. At the same time, the use of myriad measurements for allocentrism also makes it difficult to interpret results. More longitudinal and qualitative research may provide better information about the complexity of this construct. Finally, the construct of allocentrism has significant implications for cross-cultural counseling. In working with clients, particularly those who identify with or whose values are influenced by a collectivist culture, counselors and psychologists should pay special attention to the potential impact of allocentric tendencies on psychosocial adjustment levels, work–family issues, and intergenerational or intergroup relations. Specifically, counselors should be aware that relationships with members of the ingroups play an essential role in the self-esteem and well-being of clients who subscribe to an allocentric perspective; counselors and mental health professionals may



overpathologize allocentrics as “dependent,” without considering the cultural relevance and primacy of group-orientation versus self-orientation. Allocentrics may experience difficulties when pressured to compete and assert themselves in an individualist culture that values individual recognition over ingroup harmony. Also, because allocentric tendencies are multidimensional and context dependent, allocentric individuals may exhibit different behavioral patterns and value preferences when dealing with multiple ingroups in various settings (e.g., sacrifice family for work or vice versa). Younger generations who were reared by allocentric parents but grew up in an individualist society may face value conflicts and acculturation stress. Counselors should examine the cultural appropriateness of applying counseling theories and approaches that were developed in individualist contexts to working with allocentric clients. This will help counselors understand sources of conflicts and examine self-identity, as well as identify ways for clients to cope with acculturation stress.

*Yu-Wei Wang and Frances C. Shen*

*See also* Collectivism (v3); Cultural Values (v3); Identity (v3); Idiocentrism (v3); Individualism (v3)

### Further Readings

- Hui, C. H. (1988). Measurement of individualism-collectivism. *Journal of Research in Personality*, 22(1), 17–36.
- Triandis, H. C. (1995). *Individualism and collectivism*. Boulder, CO: Westview Press.
- Triandis, H. C. (2000). Allocentrism-idiocentrism. In A. E. Kazdin (Ed.), *Encyclopedia of psychology* (Vol. 1, pp. 118–119). New York: Oxford University Press.
- Triandis, H. C., Leung, K., Villareal, M. J., & Clark, F. L. (1985). Allocentric versus idiocentric tendencies: Convergent and discriminant validity. *Journal of Research in Personality*, 19, 395–415.

---

## AMERICAN INDIANS

---

American Indians (herein referred to as Indians, Native Americans, or Natives) have a rich and heart-rendering history and continue to contribute to the fabric of American society. The history of Native people is important for mental health professionals

and researchers to understand in order to grasp the present implications of history and how they may affect psychological, familial, and social interactions. The following overview of Indian country, past and present, is divided into several sections. A brief history of Native–White relations serves as an introduction to Native peoples. This section is followed by a presentation of demographics and an introduction to the complex definitions that surround being Native. Several myths that are commonly held by non-Indian “others” regarding Native Americans are presented and clarified. This is followed by an overview of health and mental health issues affecting Natives today. The final section presents traditional Native and contemporary approaches to healing, examining the physical, spiritual, and psychological community and group approaches to mental health.

### History

The history of Native peoples can be divided into two major periods: pre-contact and contact. The contact period is generally divided into several subsets, including the periods of Manifest Destiny (1492–1890), Assimilation (1890–1970), and Self-Determination (1970 to the present). Pre-contact was a period of autonomy for tribes that inhabited the Americas. Tribes adapted to the environment they lived in. Varieties of lifestyles included those of hunting and gathering, agrarian lifestyles, and a combination of both, which were determined by the environment and terrain where tribes lived. Complex social and political systems were developed by each tribe. Each group had its own set of attitudes, beliefs, social organizations, men’s and women’s societies, and views of creation, self, and nature. Wicki-ups, teepees (hide and bark), sod housing, and cave dwellings served as homes across the continent. Political practices included input from both men and women in clans or bands and honor societies; this latter respect for women ran contrary to European patriarchy and contributed to the cultural dissonances between colonialists and Natives.

### ***Manifest Destiny, Assimilation, and Self-Determination***

With the arrival of Christopher Columbus, a lost sailor who worked for the Spanish, in 1492, Natives were removed from ancestral homes, starved to death,



and massacred as a means to secure land and resources. This westward movement was justified under the auspices of Manifest Destiny. This movement was a form of what has come to be known as *ethnic cleansing*. Native Americans suffered new sicknesses and diseases brought by colonists, illnesses that claimed more lives than combat claimed.

The assimilation era was between 1890 and 1970 and was characterized by efforts to socialize Natives through missionary activities and the practices of boarding schools. Both of these acts of forced assimilation served destructive cultural, social, and psychological influences on Native groups. With the advent of the boarding schools, children often witnessed the loss of tribal life ways. These practices represented the shift from physical genocide to cultural genocide. Common practices of corporal punishment and sexual abuse impeded healthy psychological development and, in many cases, impeded the ability to develop appropriate relationships with others.

This collective past of broken promises, discrimination, and oppressive practices has had resounding effects that have shaped the psychological well-being of many Native peoples today. These effects have been described as historical trauma, the reliving of events, oppressive and violent in nature, retold and experienced in the present through stories shared among families and in social settings. These historical traumas are intertwined with current traumas, the impacts of alcohol and other drug abuse, child abuse and maltreatment, unemployment, poor health care, and death, all of which have profound psychological and social effects.

## Demographics

American Indians comprise many different groups, including over 569 federally and state recognized tribes, each with their own commitment to cultural and spiritual beliefs and practices. There are many tribal groups that are not federally or state recognized by treaties. There are tribes without signed treaties, and, through what is known as the termination period during the 1950s and 1960s, there are tribes who ceased their treaty relationships with the U.S. government. Processing treaties for federal recognition is a complex and lengthy task, as exemplified by the Little Shell Band of Montana, whose struggle has lasted more than 38 years. In deciding to terminate their quest for federal recognition, tribal

groups compromise their ability to have a land base and become ineligible for health care or psychological services.

Differences within Native people are evidenced through tribal diversity and rates of intermarriage. According to recent census estimates, there are 4.5 million self-identified American Indians and Alaskan Natives, excluding Hawaiians. Specific tribal populations vary widely in their enrollment. For example, the Diné people (Navajo Tribe) maintain a membership exceeding 298,000 strong. In contrast, the Confederated Salish and Kootenai Tribes of Montana currently have a membership of 7,000, due to blood quantum enrollment criteria (i.e., the degree to which an individual can claim his or her heritage as Native). Many tribes anticipate similar declines in enrollment as a function of blood quantum criteria.

American Indians vary by level of acculturation, often paralleling the acculturation level and degree of collective forced assimilation of their tribes. Individual variations in acculturation level may be related to Native cultural identity development attitudes; length of time away from reservations, including nonparticipation in familial and cultural activities; degree of commitment to learning the culture of one's tribe(s); and generation level.

Within-group differences can be found across age, language, and social class. American Indians appear to constitute a young cultural group, as a recent estimate indicated that the median age of the population was 29, compared to 36 years for the White population. Furthermore, approximately 1.3 million Native Americans were reported to be under 18, and 336,000 were 65 years or older. However, Native elder population is growing at dramatic rates; specifically, between 1989 and 1999 the Native population aged 65 and older grew by 33%, while the non-Native population of adults over 65 increased by 9%. Additionally, there is linguistic diversity among Native people, such that 28% of all Indians/Natives 5 years of age and older speak a language other than English in their home; of that number, 18% speak English proficiently. Lastly, although there is variability in socioeconomic status among Native people, 26% were reported to live at or below the poverty level, according to recent census reports based on a 3-year average.

Many myths abound regarding Native Americans. The following section provides an overview of several of the most commonly held notions about American Indians/Alaskan Natives.



## Myths

*Myth 1: All Natives get a U.S. government check monthly.* Natives are eligible for monies such as general assistance, housing support, and other services available to the general population, but do not receive monthly checks from the government. Some tribes do pay tribal members a “per capita” payment. These are proceeds earned by the tribe and paid out to tribal members in a fashion similar to that of dividends paid to shareholders in a corporation. Treaty-bound services not available to the general public include health and education services.

*Myth 2: Natives do not pay income taxes.* Native Americans pay taxes like any other group. There are some exceptions, which may include monies earned within reservation boundaries in some states.

*Myth 3: All Indians look like the Plains Indian, with a dark complexion, high cheek bones, and brown eyes.* Many Natives have intermarried, changing the gene pool and diversifying phenotypes among Native people. Nearly 70% of Indians/Natives are in mixed marriages, whether with Indians/Natives of other tribes and bands or with other racial and ethnic groups. Furthermore, during the Civil War, many slaves that escaped were adopted into tribes and, as a result, there are many Black Indians.

*Myth 4: Natives possess knowledge of all Native American experiences across tribes.* There is an expectation or myth held by the non-Native “other” for Native individuals to possess knowledge of other Native groups, contemporary, historical, or both. Combined with this false expectation is that an individual Native can speak for other groups. This can present itself as a stressor.

*Myth 5: Tribes should share the wealth.* This myth is grounded in the assumption that all Indian groups are one. The diversity within Native tribes can be seen in the extent to which there are alliances among groups. Tribes can be compared to corporations, in that, for example, the Ford Motor Company would not assist Chevrolet in times of financial crisis. This myth also serves as an example of how stereotypes are negotiated, building one stereotype upon another, only to develop a set of erroneous assumptions that may drive perception and behavior.

*Myth 6: Native families often neglect their children.* Native families had been broken historically through forced assimilation strategies. In addition, child care differences and conflicting worldviews contributed to the removal of Native children from their homes and tribes. It wasn’t until the 1970s that this myth was challenged in the courts, with pleas to legislatures to change the adoption process of Indian children. This change was brought about by the lobbying of many tribes and the action of concerned individuals in the federal legislative arenas. The Indian Child Welfare Act (ICWA) became law in 1978 and subsequently was implemented in 1979. ICWA established a new set of strict requirements for child welfare cases and placed authority for Native children with tribes. This ushered in a new era for Indian/Native child welfare. This act changed adoption practices in the United States, giving preference to family and tribal members for the provision of a culturally appropriate living environment.

## Health and Psychosocial Concerns

### Health

The health status of Natives lags behind all other ethnic groups in the United States. The top 10 leading causes of death, in no specified order, are tuberculosis, chronic liver disease and cirrhosis, accidents, diabetes, stroke, chronic lower respiratory diseases (e.g., pneumonia), suicide, homicide, cancer, and heart disease. In addition, rates of obesity, substance abuse, sudden infant death syndrome, and mental health concerns (e.g., depression and posttraumatic stress disorder) are disproportionately higher among Native Americans. Socioeconomic conditions, including unemployment, lack of economic opportunities, and lack of availability of and access to appropriate health care, influence health status and contribute to high mortality rates. These conditions, combined with geographic isolation, limited access to medical care, high costs, and other barriers, create invisible boundaries that stand between Native peoples and appropriate health care.

Through examining rates of diagnoses, prevalence, and mortality, barriers to adequate health care and far-reaching health disparities are evidenced. For example, the Centers for Disease Control and Prevention reported that Natives are 3 times more likely than Whites to be diagnosed with diabetes. Native American adults are at greater risk than their White counterparts of developing cardiac concerns, and



Natives are less likely than Whites to be informed of having hypertension. In addition, Native Americans are reported to be twice as likely to be diagnosed with stomach or liver cancers as White men, and Native women are reported to be 20% more likely than White women to die of cervical cancer.

Although health outcomes are slowly improving for this population, Native Americans experience relatively compromised health, with one of the primary factors being substance abuse. Alcohol-related deaths are 4 to 5 times the national average among Native people, and at least one third of all visits to Indian Health Services are alcohol related. This also influences the number of deaths by accident for this group, both vehicular and nonvehicular accidents.

### **Crime in Indian Country**

Data from the Bureau of Justice Statistics, highlighted in *A BJS Statistical Profile, 1992–2002: American Indians and Crime*, reveals a wealth of information and statistics about crime in Indian country. For example, American Indians were reported to be more likely to be arrested for aggravated assault than arrested for robbery. Native children under 17 years of age were less likely to be arrested for a violent crime than youth of all races, with the exception of murder. Native adults were twice as likely as their non-Native peers to be arrested for driving under the influence or alcohol violations, and Native youth (i.e., under 17 years) were nearly twice as likely to be arrested than non-Natives for alcohol-related offenses.

Gangs have emerged onto the reservation areas. About 23% of respondents to the *2000 National Gang Survey* indicated that they had gang problems on their reservation or Native community. Alcohol and/or drug use was a factor in 51% of the violent crimes against all races. Among victims of violence that were able to describe use by offenders, American Indians were more likely than any other racial group to report an offender under the influence of alcohol or drugs.

The combination of stress, depression, substance abuse, and psychological frustration contributes to the increases of violent and abusive behaviors throughout Indian/Native communities. The rate of violent victimization among American Indian women was more than double that among all other women. Indians/Natives were twice as likely to experience a rape/sexual assault. Violence and resultant trauma can have vast effects on the survivor or bystander. Among the manifestations

include child physical and sexual abuse, child neglect, domestic violence, assault, homicide, and suicide. Suicide is 3 to 6 times greater in Indian country.

### **Indian Child Welfare**

Before the institutionalization of the Indian Child Welfare Act (ICWA), displaced Native children had been assigned to care outside of their homes at rates between 5 and 30 times higher than their non-Native peers. Tribes responded to these alarming conditions by demanding more control over the rights to rear their own children and began to advocate for federal policy to support their position on child care. The passage of the ICWA indicated a federal initiative to address one form of institutional discrimination against Native Americans.

There are eight provisions to ICWA, two of which are noted. First, tribes were given exclusive jurisdiction over children who live on the reservations, except in cases in which federal law already has designated jurisdiction to the state. Second, agencies that place children must provide culturally appropriate services to Native families before placement occurs. The provision of ICWA becomes more complicated when the out-of-home care takes place in urban settings, where access to culturally appropriate services may be limited. Presently, American Indian children are placed in care outside of the home 4 times more often than are non-Indian children.

### **Considerations of Healthcare Services**

Health disparities among Native Americans have been related to cultural mistrust, geographic isolation, and socioeconomic factors. For example, through the 1970s, the practice of sterilization without consent was not uncommon. Such behaviors, enacted primarily by Indian Health Service (IHS) personnel and other governmental agencies, have engendered distrust for some healthcare providers among Native Americans. In addition, urban Indians are geographically dispersed in comparison to other populations, which may compromise their access to tribe-specific health-related information and services.

There are unique considerations relevant to receiving health care services and programming on and off the reservation. On-reservation programming is provided by the IHS generally, under the Behavioral Health Program, or contracted by the tribe with IHS or



other providers. Health care available off the reservations is funded at only about 2% of the IHS budget in urban areas. This leaves the majority of Indians without access to adequate health care.

Urban health and mental health services are not as clear-cut. Only about 2% of all IHS funding goes to urban Indian programs, where up to 60% of all Natives live. According to the Surgeon General's report in 1999, only 20% of Natives reported access to IHS clinics, most of these found on reservations. Medicaid is the primary insurer for about 25% of this population, and only 50% of Natives have employer-based insurance coverage, compared with 72% of Whites. Twenty-four percent of all Natives do not have health insurance, compared with 16% of Whites. When scarce resources are needed for survival, mental health becomes a luxury item.

## Mental Health

Mental health needs among Native populations vary, yet there appears to be some commonalities across tribes. Similar rates of lifetime diagnosis in Native populations have been reported concerning alcohol dependence, posttraumatic stress disorder (PTSD), and major depressive episodes. For example, the Surgeon General's Report of 2000 stated that depression ranged from 10% to 30% among Native populations.

## Effects of Trauma

Considerations of the profound effects of direct, vicarious, and historical trauma on Native peoples have implications for substance use, violent behaviors, and depression. The many precipitating factors of PTSD include service in combat zones; exposure to violent accidents, homicides, and suicides; sexual victimization; and poverty and homelessness. The higher rate of traumatic exposure results in a 22% rate of PTSD for Native peoples, compared with 8% in the general population. Moreover, the Vietnam Veterans Project found lifetime prevalence of PTSD to be from 45% to 57% among Native veterans, rates significantly higher than among other Vietnam veterans. Prevalence rates for current alcohol and drug abuse or dependence among Northern Plains and Southwestern Vietnam veterans have been estimated to be as high as 70% compared with 11% to 32% of their White, Black, and Japanese American counterparts.

The rate of violent victimization of Natives is more than twice the national average. Given the exposure of

this population to potential stressors beyond the "norm," mental health professionals must be versed in PTSD and potential referral sources that may include traditional healing ceremonies or activities.

## Values and Mental Health

Cultural values among Native people are, among themselves, very diverse. However, when considered as a collective, Native cultural values tend to contrast significantly with individualistic and dualistic orientations of Western psychology. In Indian country, traditional groups view life as a function of the interconnectedness of all things, and behavior is considered to be motivated through the interconnections with others. In these philosophies, balance among the reciprocal effects of actions and changes in the entire system leads to wellness. Furthermore, the interplay of these worldly and otherworldly (i.e., spirited) systems creates a whole. Attention to both of these systems often is desirable to effect long-lasting and effective change for clients, such that therapeutic goals include balance among individual, spiritual, and community systems.

## Interventions

Effective interventions are dependent upon many factors. Counselors' attention to clients' levels of acculturation facilitates effective care. It is also critical for mental health professionals to have an understanding of the Native family and extended family systems and clients' roles in these systems. In urban and reservation settings, the therapist needs to be known and trusted in the community. This can be facilitated by attending open social gatherings and attending local school functions.

There are traditional interventions that have been found to work across settings. These include the talking circle, sweat lodge ceremonies, smudging ceremonies, and others. It is recommended that the non-Native therapist seek Native spiritual leaders with whom to develop relationships so that they may later refer clients for spiritual assistance. Non-Native therapists can work with clients on therapeutic goals while learning about clients' cultural experiences through the therapeutic process.

*John J. Peregoy*

*See also* Acculturative Stress (v3); Alaska Natives (v3); Bureau of Indian Affairs (v3); Career Counseling, Native Americans (v4); Community-Based Health Promotion (v1); Depression (v2); Diversity Issues in Career



Development (v4); Evidence-Based Treatments (v2); Indian Health Service (v3); Society of Indian Psychologists (v3); Substance Abuse and Dependence (v2); Suicide Potential (v2)

### Further Readings

- Beals, J., Novins, D. K., Whitesell, N. R., Spicer, P., & Manson, S. M. (2005). Prevalence of mental disorders and utilization of mental health services in two American Indian reservation populations: Mental health disparities in a national context. *American Journal of Psychiatry*, 162, 1723–1732.
- Centers for Disease Control and Protection, Office of Minority Health & Health Disparities. (2005). *American Indian and Alaskan Native (AI/AN) populations*. Retrieved April 5, 2007, from <http://www.cdc.gov/omhd/Populations/AIAN/AIAN.htm>
- Evans-Campbell, T. (2006). Indian child welfare practice within urban American Indian/Alaskan Native American communities. In T. M. Witko (Ed.), *Mental health care for urban Indians: Clinical insights from Native practitioners* (pp. 33–54). Washington, DC: American Psychological Association.
- Perego, J. J. (1999). Revisiting transcultural counseling with American Indians and Alaskan Natives: Issues for consideration. In J. McFadden (Ed.), *Transcultural counseling* (2nd ed., pp. 137–170). Alexandria, VA: American Counseling Association.
- Perego, J. J. (2001). Counseling with American Indian/Alaskan Native clients: Perspectives for practitioners to start with. In E. Welfel & R. E. Ingersoll (Eds.), *The mental health desk reference* (pp. 306–314). New York: Wiley.
- Perry, S. W. (2004, February). *A Bureau of Justice statistical profile, 1992–2002: American Indians and crime*. Washington, DC: U.S. Government Printing Office.
- U.S. Census Bureau. (2006). *We the people: American Indians and Alaskan Natives*. Washington, DC: U.S. Government Printing Office.
- U.S. Department of Health and Human Services. (2001). *Mental health: Culture, race, and ethnicity, supplement to mental health: A report to the Surgeon General*. Rockville, MD: U.S. Government Printing Office.
- Witko, T. M. (Ed.). (2006). *Mental health care for urban Indians: Clinical insights from Native practitioners*. Washington, DC: American Psychological Association.

of religious adherence, and observances of Jewish holidays and customs. Despite the myriad ways in which one can be a Jew, however, there remains a common history, ethnocultural heritage, and, for many, a religious practice that unites this unique group. This entry introduces contemporary issues salient to understanding American Jews, including (a) the diversity of Jewish heritage and denominations, (b) Jewish identity, (c) psychological stressors for Jews, and (d) counseling issues with American Jewish clients.

Recent estimates of the number of American Jews range between 5 and 6 million, representing a substantial proportion of the estimated 12 to 17 million Jews worldwide. However, given the U.S. population has been estimated at nearly 300 million, Jews are clearly a numerical minority. Because more than one third of American Jews live in large urban centers concentrated in the Northeast and the East Coast (e.g., New York), as well as in California and Chicago, there may be a misperception concerning the actual number of American Jews. This might be especially noticeable in the three U.S. cities with the largest Jewish populations: New York, Miami, and Los Angeles.

## Definitional Terms

### Bicultural

The experience of American Jews might be best described as bicultural. That is, given that one's cultural self-identification is context specific, American Jews are likely to see themselves as both Jewish and American; this dual identification provides them with two different lenses from which to view the world. In addition, there are many ways to be Jewish. All at once, Judaism is a culture, a religion, an ethnicity, and a set of traditions that is embedded in Jewish people's expectations, belief systems, and family dynamics. As a result, Jews do not fit easily, if accurately at all, into the current demographic taxonomies; this may have contributed to the previous lack of attention to Jewish issues in counseling.

### American Jews Versus Jewish Americans

The semantic categorization of racial and ethnic groups is often a matter of critical relevance for group members. *American Jew* has emerged within both the Jewish community and social science literature as the preferable term for individuals who identify as both Jews and citizens of the United States in that the term

---

## AMERICAN JEWS

---

American Jews are a diverse group of people, with varying cultural and ethnic self-identification, degrees



emphasizes the primacy of being Jewish through use of *American* as a descriptor of *Jew*. Furthermore, the term serves to acknowledge the nomadic heritage of Jews as a Diaspora people and the needs of Jews from many nations to flee those countries when oppression and antisemitism reached dangerous levels. Despite this trend, within-group differences certainly exist, and individuals whose nationality takes precedence over their Jewish heritage may be most comfortable with the use of the term *Jewish American*.

### Diversity of Jewish Heritage

There is tremendous within-group variability among American Jews. For example, there are three main lineages for American Jews (i.e., Ashkenazim, Sephardim, and Mizrachim). The Ashkenazim are Jews who trace their family history to Eastern Europe, and they are the largest group (numerically) among American Jews. The Sephardim are Jews who trace their family history to the Iberian Peninsula (i.e., Spain and Portugal). Finally, the Mizrachim are Jews who trace their family history to Northern Africa and/or Western Asia. In addition to these three main lineages, there are also communities of Jews who have lived in China, India, and Ethiopia for centuries.

### Diversity of Denominations

There are several active denominations among American Jews. The groups are presented in order from most to least adherent to Jewish Orthodoxy. It is important to note that most Jews omit the *o* in spelling *G-d*. This is done because Judaism prohibits erasing or destroying any Hebrew name of G-d. Finally, there are some Americans who identify as secular or cultural Jews; these people self-identify as Jewish without it having any religious connection.

#### **Hasidic**

Hasidic Jews are readily identifiable, as men wear black coats, pants, and hats, as well as peyos (i.e., side curls); women wear very modest clothing (e.g., long, conservative skirts), and some married women shave their heads and wear wigs. Yiddish is the first language, followed by Hebrew and then English. These Jews are totally immersed in Jewish life and traditions, and they strictly adhere to the three tenets

of the Orthodox lifestyle: (a) keeping kosher (dietary practices), (b) observing the Sabbath (following prescribed religious traditions concerning behaviors on *Shabbat*, which occurs from sundown Friday to sundown Saturday), and (c) following family purity laws (which address sexual relations and ritual cleanliness). Secular culture is avoided; hence, Hasidic Jews live in self-contained communities. Men and women sit apart during religious services, and the Torah is believed to be the literal translation of G-d's law.

#### **Non-Hasidic Orthodox**

The dress of these Jews is similar to most Americans, except that men wear a yarmulke (head covering) and women dress more modestly. Unlike the Hasidic Jews, secular culture is an important part of the lives of the non-Hasidic Orthodox. These Jews are similar to the Hasidim in their (a) adherence to the Orthodox lifestyle, (b) belief that the Torah is the word of G-d, and (c) having men and women sit separately during religious services (which are conducted entirely in Hebrew).

#### **Conservative**

This denomination was created as a response to Reform Judaism. Men and women sit together in religious services, which are performed mostly in Hebrew. These Jews are more likely to keep kosher and observe the Sabbath than are Reform Jews, but there are many Conservative Jews who do not adhere to the Orthodox lifestyle. Like the Reform Jews, Conservative Jews have a positive attitude toward and involvement with modern, secular culture and a non-fundamentalist teaching of Judaism.

#### **Reform**

Reform Jews see Judaism as an evolving entity. This denomination was developed as a reaction to Orthodoxy to modernize Judaism during the European Enlightenment. Men and women sit together during religious services, which are conducted in both Hebrew and English. Reform Jews believe that not only the Torah but also individual conscience and informed choice guide decision making. In addition, most Reform Jews do not follow the Orthodox



lifestyle. This was the first denomination to ordain women as rabbis.

### ***Reconstructionist***

Reconstructionist Jews see Judaism as an evolving tradition, with three primal elements: G-d, Torah, and the People of Israel. These Jews accept and interact with modern culture. Although the religious services and rituals are traditional, the group ideology is very progressive. For example, one's personal autonomy supersedes traditional Jewish law. Finally, this was the first denomination to hold a Bat Mitzvah ceremony for Jewish girls.

## **American Jewish Identity**

### ***Multidimensional Construct***

*American Jewish identity* is a term used to designate those uniquely Jewish attributes shared among group members. Such attributes may include religious and spiritual beliefs and practices, as well as the customs, attitudes, values, and cultural practices that reflect the characteristics of Jews as an ethnic group. However, neither ethnicity nor religion alone adequately captures the complexity of what it is to be a Jew.

The term *Jewish identity* also has been used to reflect one's national heritage, language (e.g., Hebrew, Ladino, and Yiddish), culture, and, historically, race. Mordecai Kaplan's conceptualization of Judaism as a civilization included ethics and philosophies, in addition to knowledge, skills, literature, tools, arts, and laws, as critical elements that help shape the identity of American Jews. This list of shared attributes has been expanded to include those who identify with the political elements of Judaism arising from one's relationship with the State of Israel and opposition to antisemitism. Clearly, neither a single construct nor a set combination of them goes far enough to encompass Jewish identity.

Historical events and geography provide additional context for understanding American Jewish identity. The processes of immigration and acculturation have shaped the American experience for Jews, as have the unique sociopolitical, historical, and economic realities in their new country. Though many Jews have prospered in the United States, Jewish identity cannot be understood without consideration of how Jews

have been affected by the forces of oppression and discrimination.

### ***Dynamic Construct***

Jewish identity may best be viewed as a dynamic construct in which Jews continually engage in a process of discovery and self-definition. Although the term *Jewish identity* may be used to capture common attributes of the Jewish people as a collective group, it is also used to express the way in which the individual, as a member of the Jewish community, reflects such attributes. That is to say, the identification of commonalities attributed to the Jewish people is not meant to imply that all Jews have the same relationship to being Jewish. Each American Jew may choose to express his or her sense of Jewish identity with behaviors or beliefs that either converge or diverge from the collective in a variety of contexts. Additionally, although it would be much simpler to understand Jewish identity as a static or fixed construct, many individuals experience significant changes related to their Jewish identity over time. As one develops personally and professionally, the importance of being Jewish may fluctuate. Moreover, the way that one expresses his or her Jewish identity may also fluctuate throughout one's life.

### ***Core Jews***

Such complexities have made the scientific study of American Jews challenging in that there is no consensus as to the specific inclusion or exclusion criteria for this group. One approach to providing such criteria is the construct of *core Jews*, a term which has been used in social science research to account for Jewish identification. These criteria, centered in one's own subjective sense of identity, include (a) all those born Jewish and who identify Judaism as their religion, (b) secular-ethnic Jews who do not report any other religion, and (c) those who have converted to Judaism. Exclusion criteria include individuals who were born Jewish and have formally adopted another religion and those who do not acknowledge being Jewish.

### ***Empirical Research***

Research that has explored Jewish identity may be divided into three levels, each aiming to explore the relationship of American Jewish individuals to



perceived group attributes. The three levels are (1) cognitive, which includes one's perceptions of Jewish attributes and the salience of them in one's life; (2) affective, which is one's feelings regarding such attributes; and (3) behavioral, which is the extent to which one's actions are consistent with one's conceptualization of being Jewish. Furthermore, it is important to note that in addition to measuring the consistency of one's behavior to one's own conceptualization of being Jewish, behavioral assessments commonly measure one's actions in accordance with traditional standards (e.g., observing holidays).

Although observing and measuring the numerous ways that American Jews are capable of expressing their Jewish identity is clearly a worthwhile pursuit, it fails to provide a complete picture of the identity of American Jews. In modern society, one's identity may be defined not only in terms of religion or ethnicity but also in terms of one's gender, social class, sexual orientation, career, nationality, and numerous other collective identities. Rather than ignoring these other dimensions, research has begun to consider their relative, and sometimes competing, importance in relation to one's Jewish identity.

### **Psychological Stressors**

The relative socioeconomic success that some Jews have attained in America, compared with other oppressed groups, may lead to the erroneous conclusion that American Jews have been fully embraced by the dominant culture. Antisemitism still operates currently, and the effects from past antisemitic atrocities, most notably the Shoah (i.e., the Jewish Holocaust), are still carried by many Jews. The psychological stress that results from being oppressed and marginalized is of central importance for understanding the reality of many American Jews.

### **Acts of Oppression**

While the construct of Jewish identity has been defined largely by American Jews, antisemitic views propagated by those critical of group members have had a major impact on the Jewish people and beyond. Antisemitism includes the oppression, condemnation, and systematic discrimination of Jews. Throughout history, antisemitic acts of hatred against Jews have been directed at the religious, cultural, and intellectual heritage of the Jewish community. The impact of such actions include the stereotypes held both inside and

outside the Jewish community that devalue Jewish people, as well as the negative ways Jews themselves have internalized such negative images. Contrary to beliefs that antisemitic activity disappeared with the Shoah, indications exist that Jews may be increasingly vulnerable to being viewed negatively and to being victims of antisemitic crimes of hate.

### ***The Self-Hating Jew***

In attempting to conceptualize the psychological impact of acts of oppression directed toward Jews, the concept of the self-hating or self-loathing Jew has emerged. Consistent with the initial stage of racial and ethnic identity development models, such terms have been used in reference to the internalization of antisemitic views held toward Jews by the dominant group and the experience of being marginalized or devalued within society. The presence or perception of antisemitism in society is therefore a precondition of developing such a negative view of oneself and entails the incompatibility of being oppressed by dominant standards while at the same time being unable to achieve them. This process reflects the acceptance of the dominant culture's belief of Jewish inferiority as one's own. Identity rejection has been observed to result most typically in feelings of anger, embarrassment, and guilt. The experience of shame has been documented as an additional response to antisemitism, reflecting feelings of inferiority, alienation, and indignity.

### ***Antisemitism and Fear***

Another observed result of antisemitism is the experience of fear. A desire to remain out of public view and, in some cases, be "invisible" are the consequences of this fear. Practically, this means avoiding the use of wearing or carrying Jewish symbols in public and keeping one's Jewish identity a secret from outsiders. Consequently, voicing concern regarding Jewish issues is not an option. Although non-Jews might conceptualize this behavior as paranoia, the historical reality of being persecuted based solely on being Jewish has conditioned this behavior within the American Jewish community. In other words, past experience has provided unfortunate empirical support for retaining this pessimistic view. Given the relative position of privilege that many Jews have attained in America, the theoretical risk of losing these privileges is simply not worth calling attention to oneself for many of Jewish descent.



## **The Shoah**

While a history of Jewish culture is beyond the scope of this entry, it is essential to understand the contextual forces that gave rise to and sustain antisemitism both at home and abroad. The Shoah (Hebrew for *catastrophe*) refers to the genocide of approximately 6 million Jews in Nazi Germany. The Shoah is a critical incident to understand, as the majority of Jews in Europe (approximately 65%) and over one in three Jews throughout the world were killed. Although the precise psychological impact of this catastrophic event may never be known, potential consequences include beliefs that the world is dangerous for all Jews and that being Jewish is inextricably tied to suffering. These and other issues may be particularly relevant for the children and grandchildren of survivors of the Shoah. While the Shoah is, without question, the most devastating event for Jews in modernity, antisemitic acts of violence and oppression extend throughout history. It is precisely this history that has made Jews in America sensitive to any act conveying antisemitic intent. For this reason, it is the perception of antisemitism, and not any set of objectively defined acts, that becomes relevant when conceptualizing the psychological implications of oppression for the American Jew.

## **Numerical Minority**

Another relevant contextual factor for understanding the psychological experience of the American Jew is the religious makeup of the United States. Currently, Jews comprise less than 2% of the national population. Compared to the presence of Christians (approximately 84% of the population), those identifying as non-Christian are without question a numerical minority. Furthermore, non-Christians living in the United States often experience the impact of living in the predominantly Christian society based on assumptions made as to one's practices and beliefs and the strong Christian influence in national politics. Consequently, Jewish clients may feel as though their issues and identity hold little value in the dominant culture.

## **Privilege and Passing**

The fact that many Jews can, to some degree, make choices regarding their visibility may itself be considered a privilege. This differs from racial minorities (including many Jews) with phenotypes clearly distinguishable from the dominant group, making the

option of "passing" as White not available. For many Jews of European descent, however, this may well be possible. Whereas until the 1940s Jews were considered a separate and inferior race in America, a redefinition of "Whiteness" now allows for the potential of Jews gaining equal access to becoming members of the privileged class. Many Jews in America now possess the choice of whether or not to renounce being Jewish. Despite the potential benefits of gaining access to this privileged status, the psychological toll of hiding one's identity may come with a cost. Underlying this decision may be a shame, terror, and embarrassment of one's Jewish identity and oneself.

## **Jews and the Origins of Counseling**

In an effort to contextualize the experience of American Jews, it bears mentioning that Jews played a prominent role in the origins of counseling. Many scholars erroneously contend that the majority of counseling theories are products of White dominant culture. In fact, the origins of counseling can be traced to Freud and his colleagues in Europe, who were assimilated Ashkenazi Jews. Although these Jews had white skin, they were culturally dissimilar from the dominant group of White Christians. Since Freud's time, a multitude of Jews have had a lasting impact on the field. The continued inattention regarding Jewish contributions to the counseling profession reflects the perceived invisibility of Jews and the unfortunate persistence of antisemitism.

## **Counseling Issues With American Jewish Clients**

### ***Awareness, Knowledge, and Skills***

It is important for all counselors, both Jewish and Gentile, to engage in a self-assessment regarding their thoughts and feelings about Jews, Judaism, and Jewish culture. This way, any negative stereotypes or beliefs regarding American Jews can be dealt with via education, supervision, and/or personal counseling. Because there are many ways to be Jewish, Jewish counselors must not assume that their American Jewish clients have the same beliefs and practices where Judaism is concerned. As such, these counselors need to understand the client's thoughts and feelings about his or her own Jewishness. The Jewish counselor must also be cognizant that internalized antisemitism could play a role in the therapeutic



process, either in oneself or in the client. When a non-Jewish counselor is working with an American Jewish client, the issues are different. The main issue would be for the non-Jewish counselor to be knowledgeable about Judaism. For example, these counselors should understand that Judaism is more than a religion and that Jewish identity is quite complex.

### ***Disclosure and Identification***

Some American Jews will not openly identify as Jews unless they perceive the environment to be safe. This is because identifying oneself as Jewish can be perceived as potentially hazardous due to the long history of antisemitism. Complicating matters here is the client's level of awareness and insight. The client might think it implausible that her or his Jewish identity has relevance to the presenting problem. In this way, counselors need to tread cautiously when inquiring about religious and ethnic background. The counselor should follow the client's lead with regard to the level of disclosure about the client's Jewishness, while also creating a safe environment for the discussion of these issues. Once a client's Jewish identity has been confirmed, counselors might inquire about the client's adherence to the practice of Judaism, including identification with a particular denomination. Of course some will define themselves as secular or cultural Jews; that is, they will not practice any of the religious aspects of Judaism, yet they will self-identify as Jews.

### ***Therapeutic Relationship***

Establishing a good rapport and a positive working alliance is central to the beginning of treatment with American Jews. Some ways the counselor can succeed at this task are by knowing about the history and present experiences of Jews, including antisemitism and stereotypes. At the same time, it is important for counselors not to let assumptions guide their treatment plan. Thus, being Jewish should not be the only factor in understanding the client.

### ***Healthy Paranoia***

Another skill for counselors concerns the ability to discern clinical paranoia from healthy paranoia or cultural mistrust in American Jews. This is important because American Jews, like other oppressed cultural

groups, might be appropriately mistrustful of outsiders (in this case, non-Jews). Hence, counselors should be cautious not to misinterpret the actions of American Jewish clients. Survivors of the Shoah and their descendants bring an additional dynamic with them to counseling. These American Jews may view the world as a dangerous place because of overprotective parents who were traumatized during the Shoah.

### ***Identity Issues***

Counselors working with American Jews also need to understand Jewish identity, which can be a difficult task given the complexity of the issues. As previously stated, there are both religious and secular/cultural aspects to Jewish identity, and Jewish identity is both multifaceted and context specific. Hence, to provide culturally competent care, counselors need to understand the client's perspectives on his or her own Jewish identity.

### ***Importance of Family***

For American Jews, the family is often the primary social structure, and there are emotional consequences for going against the wishes of the family. It is important to remember that because American Jews are bicultural, they may experience value conflicts between individualistic American culture and the more collectivistic nature of Jewish culture. Hence, counselors need to attend to family issues and the bicultural identity of American Jews.

### ***Presenting Concerns***

Scholars have theorized the following common presenting concerns for American Jewish clients: (a) Jewish identity issues, (b) body image and gender identity, (c) child rearing practices, (d) interfaith or interdenominational couples, (e) issues surrounding conversion to or from Judaism, (f) sexual orientation and religion, and (g) antisemitism-related experiences. Of course, American Jews may seek counseling for personal growth and development, as well as to receive treatment for any psychological disorders.

### ***Conclusion***

In conclusion, American Jews are a small yet culturally distinct group in the United States. Despite



stereotypes of widespread financial success and the appearance of fitting into the dominant culture, anti-semitism persists and grows. This perpetuation of anti-semitism contributes to potential biases in counseling, especially when there is a lack of information and a reliance on stereotypes. By learning about Jews and Jewish culture, counselors can provide culturally competent treatment for their American Jewish clients.

*Lewis Z. Schlosser and Daniel C. Rosen*

**See also** Acculturation (v3); Acculturative Stress (v3); Antisemitism (v3); Bicultural (v3); Cultural Mistrust (v3); Cultural Paranoia (v3); Enculturation (v3); Ethnic Identity (v3); Ethnic Pride (v3); Identity (v3); Identity Development (v3); Individual Therapy (v2); Religion/Religious Belief Systems (v3); Spirituality (v3); Spirituality/Religion (v2)

### Further Readings

- Brodin, K. (1998). *How Jews became White folks and what that says about race in America*. New Brunswick, NJ: Rutgers University Press.
- Chesler, P. (2003). *The new anti-semitism: The current crisis and what we must do about it*. San Francisco: Jossey-Bass.
- Cohen, S. M., & Eisen, A. M. (2000). *The Jew within: Self, family, and community in America*. Bloomington: Indiana University Press.
- Dershowitz, A. M. (1997). *The vanishing American Jew: In search of Jewish identity for the next century*. New York: Little, Brown.
- Friedman, M. L., Friedlander, M. L., & Blustein, D. L. (2005). Toward an understanding of Jewish identity: A phenomenological study. *Journal of Counseling Psychology*, 52, 77–83.
- Gilman, S. L. (1990). *Jewish self-hatred: Anti-semitism and the hidden language of Jews*. Baltimore: Johns Hopkins University Press.
- Herman, S. N. (1977). *Jewish identity: A social psychological perspective*. Beverly Hills, CA: Sage.
- Horowitz, B. (2003). *Connections and journeys: Assessing critical opportunities for enhancing Jewish identity* [Report to the Commission on Jewish Identity and Renewal, United Jewish Association-Federation of New York]. New York: UJA-Federation.
- Langman, P. F. (1999). *Jewish issues in multiculturalism: A handbook for educators and clinicians*. Northvale, NJ: Jason Aronson.
- Schlosser, L. Z. (2003). Christian privilege: Breaking a sacred taboo. *Journal of Multicultural Counseling and Development*, 31, 44–51.

## ANTISEMITISM

Antisemitism is prejudice, hostility, and/or discrimination toward Jews as a racial, religious, and/or ethnic group on an individual, community, institutional, and/or societal level. Antisemitism can be categorized into three central forms: religious (anti-Judaism), racial/ethnic (classical antisemitism), and political (anti-Israeli or anti-Zionist). This definition underscores a major problem with defining and understanding antisemitism; that is, Jews cannot be adequately classified using the established taxonomies for cultural demography. This is primarily because Judaism is often viewed only as a religion and because of the erroneous assumption that all Jews are White; this inaccurate view of Judaism ignores the within-group diversity of Jews. In fact, the term *anti-Semitism* originally and erroneously referred to a Jewish racial group: Semites. There are differences in Jewish racial and ethnic origins (i.e., Ashkenazim, Sephardim, and Mizrahim) and different identities both within the diverse Jewish religious denominations (e.g., Orthodox, Hasidic, Reform, Conservative, and Reconstructionist) and within nonreligious Jews. Hence, antisemitism consists of more than religious bias.

The term *anti-Semitism* was first used by Wilhelm Marr, a German national and political conservative, in 1879 to express anti-Jewish feelings. Marr's original intent was for political purposes, which was developed more fully into a "racial" concept when applied by the Nazis and later used as an anti-Israeli referent after the creation of the State of Israel. Finally, many scholars no longer hyphenate this term as *anti-Semitism* to cease the use of this word for anything other than its original intent: Jew-hatred. This has been done because some have attempted to use the term *anti-Semitism* for other purposes. Specifically, some Arabs have claimed they cannot be anti-Semitic because they themselves are Semitic.

Others have attempted to use the term to be critical of Israel's interactions with other Semitic peoples of the Middle East. Hence, eliminating the hyphen takes the focus away from the term *Semitic*.

### Prevalence of Antisemitism

Although there have been some suggestions that antisemitism is no longer a problem, a 2005 Anti-Defamation League poll found that roughly one in six



Americans (14%) hold “strongly antisemitic” views. In addition, there was a 17% increase from 2003 to 2004 with regard to the number of antisemitic incidents that were reported (i.e., 1,557 to 1,821); the 2004 figure represents the highest number of incidents in the past 9 years. Finally, of the 1,374 religiously motivated hate crimes in the United States committed during 2004, 954 (70%) were exclusively anti-Jewish, accounting for 12% of all 2004 bias crimes.

### Examples of Antisemitism

Antisemitism has existed for more than 4,000 years and has manifested in a variety of ways, including negative stereotypes, oppression, discrimination, segregation, forced expulsion, pogroms, and genocide. Anti-Jewish prejudice dates back to when the ancient Hebrew people refused to accept foreign deities, particularly under Greek and Roman domination. Some examples of antisemitism from history include the (a) exile of Jews from their homeland, (b) persecution of Jews after Constantine established Christianity as the official religion of the Roman Empire, (c) centrality of Christian teachings of Jewish deicide from antiquity until Vatican II, and (d) establishment of racial antisemitism as Hitler’s Third Reich came to power in Nazi Germany.

One of the most prominent examples of antisemitism is the perpetuation of the deicide myth, which is the erroneous belief that the Jews killed Jesus. Deicide, which literally means to kill a G-d or a divine being, has frequently been used to describe the death of Jesus (most Jews omit the *o* in spelling *G-d* because Judaism prohibits erasing or destroying any Hebrew name of G-d). However, it is a historical fact that the Romans, and not the Jews, were responsible for the death of Jesus. Hence, continuing to blame Jews for the death of Jesus is both antisemitic and historically inaccurate. Next is a list of other examples of antisemitism; this list is neither exhaustive nor mutually exclusive. These examples include (a) the use of anti-Jewish slurs (e.g., “heeb,” “kike”); (b) the perpetuation of the blood libel myth (i.e., the belief that Jews killed Christian children for religious ceremonies); (c) violence against Jews, Jewish communities, and Jewish symbols (e.g., synagogues); (d) questioning the Jewish identity of Jews based solely on adherence to religious practices (e.g., accusing secular Jews of not being Jewish); (e) Holocaust denial; (f) accusing Jews of cosmic evil (e.g., stereotyped belief that the Jews are plotting to take over the

world); and (g) asserting that Jews have no claim to Israel. Some of the more prevalent antisemitic stereotypes include (a) all Jews are simultaneously wealthy and miserly; (b) Jews control the media, the banks, and Hollywood; and (c) Jews are secretly plotting to take over the world. Antisemitism manifested itself until the end of World War II in open discrimination in jobs and housing, quotas in colleges, and myths of cowardice among Jewish soldiers. Modern antisemitism, like racism and other forms of discrimination, has become more subtle and insidious.

### Internalized Antisemitism and Gender Stereotypes

Antisemitism is psychologically harmful regardless of one’s ethnic or religious identification as a Jewish person. Internalized antisemitism refers to the owning of a negative self-image or identity rejection as a Jew. It may manifest in feelings of fear, anxiety, ambivalence, depression, alienation, isolation, shame, low self-esteem, identity conflict, and self-hatred related to being Jewish.

Antisemitism combined with sexism often results in gender stereotypes of Jewish men and women. Both positive and negative stereotypes have been perpetuated. For example, Jewish men are typically portrayed as intelligent and good providers who neither abuse alcohol nor hit their spouses. At the same time, they have been portrayed as neurotic, weak, boring, and unmasculine.

Caricatures of Jewish women often fall into one of two contradictory categories: the Jewish American Princess (J.A.P.) or the Jewish mother. The former is presented as pushy, aggressive, domineering, shallow, materialistic, and demanding, yet simultaneously passive, dependent, and helpless. Jewish mothers are often portrayed as overprotective, self-sacrificing, and tending to induce guilt in their children. Distorted body image and eating disorders may manifest in Jewish women who have internalized negativity related to the pervasive devaluation of “Jewish” features.

The acceptance of these negative evaluations and stereotypes may lead Jews to attempt to change or distance themselves from their Jewishness to try and escape the stereotype. Attempts to erase signs of Jewishness manifest in changing one’s name, hair, accents, and physical features. Judaism, the use of the Yiddish language, or any manifestation of Jewish culture may be viewed with disdain.



## Antisemitism in Counseling

Antisemitism may be related to a variety of psychological problems. For example, depression and low self-esteem may be related to internalized antisemitism. Anxiety may be related to a history of family trauma related to antisemitism, often present in Holocaust survivors and their descendants. The manifestation of antisemitism in counseling varies depending on (a) whether it lies within the counselor or the client (i.e., because of the inherent power differential), and (b) whether each of the members is Jewish or non-Jewish.

### Counselors

Jewish counseling professionals should consider that Jewish clients may not view antisemitism in the same way that they do. This is especially important because of the diversity both within and between various groups of Jews. In addition, Jewish counselors must be aware of the possibility of internalized antisemitism, both in themselves and in clients. Non-Jewish counselors must consider any biases and preconceptions they might have about Jews before working with Jewish clients. Failure to do so could have serious negative implications for the Jewish client in that he or she could be harmed psychologically by the counselor who holds conscious or unconscious antisemitic views.

### Clients

Jewish clients could present to counseling with problems related to internalized antisemitism. Hence, learning about one's feelings about being Jewish is important, and the skilled counselor (i.e., who is knowledgeable about antisemitism) may be able to assist the client as well. Jewish clients' discussions of antisemitic experiences need to be validated and processed. In addition, Jewish clients might encounter antisemitism from a counselor, and this could also negatively impact treatment.

*Lewis Z. Schlosser and Julie R. Ancis*

**See also** Acculturative Stress (v3); American Jews (v3); Cultural Paranoia (v3); Discrimination (v3); Ethnocentrism (v3); Oppression (v3); Racism (v3)

### Further Readings

Beck, E. T. (1988). The politics of Jewish invisibility. *National Women's Studies Association Journal*, 1, 93–102.

- Chesler, P. (2003). *The new Anti-Semitism: The current crisis and what we must do about it*. San Francisco: Jossey-Bass.
- Feldman, S. M. (1997). *Please don't wish me a Merry Christmas: A critical history of the separation of church and state*. New York: New York University Press.
- Gilman, S. L. (1990). *Jewish self-hatred: Anti-Semitism and the hidden language of Jews*. Baltimore: Johns Hopkins University Press.
- Josefowitz Siegel, R., & Cole, E. (Eds.). (1997). *Celebrating the lives of Jewish women: Patterns in a feminist sampler*. New York: Haworth.
- Langman, P. F. (1999). *Jewish issues in multiculturalism: A handbook for educators and clinicians*. Northvale, NJ: Jason Aronson.
- Lewis, B. (2006). The new Anti-Semitism. *The American Scholar*, 75(1), 25–36.
- Schlosser, L. Z. (2003). Christian privilege: Breaking a sacred taboo. *Journal of Multicultural Counseling and Development*, 31, 44–51.
- Weinrach, S. (2003). I am my brother's (and sister's) keeper: Jewish values and the counseling process. *Journal of Counseling & Development*, 81, 441–444.

---

## ARAB AMERICANS

---

Arab Americans are defined, in this entry, as individuals and families with ancestry from one or more of the 22 Arab League states. The Arab League includes Algeria, Bahrain, Comoros, Djibouti, Egypt, Iraq, Jordan, Kuwait, Lebanon, Libya, Mauritania, Morocco, Oman, Palestine, Qatar, Saudi Arabia, Somalia, Sudan, Syria, Tunisia, United Arab Emirates, and Yemen.

The Arab League countries span Asia and Africa. The United States and other Western countries often refer to this particular region of the world as the Middle East; however, many countries within the Middle East are non-Arab, such as Turkey, Afghanistan, and Israel; and still others, such as Iran, represent different regions (e.g., Persia) altogether. Some Arab League states are Arab speaking; others are not. Many Arab League states are predominantly Muslim, although the Arab Middle East represents only a small percentage of the world's Muslims.

### Demographics

This diversity in origin, religion, language, and the like, serves to account for the respective variety of



demographics within the Arab American population in the United States.

The 2000 U.S. Census was the first opportunity for selected respondents to indicate their affiliation with ethnic groups. Among all self-identified Arab Americans surveyed, 39% indicated Lebanese ancestry, 18% Arab, 12% Egyptian and Syrian ancestries, and smaller groups of Palestinians, Moroccans, Iraqis, and those signifying “other Arab.”

Most metropolitan cities have sizeable Arab populations, with some identifiable community center, such as a church or mosque, community center, or even restaurant. Larger established Arab American communities, rich in Arab heritage and traditions, can be found in New York, Dearborn (Michigan), Los Angeles, Chicago, Houston, Detroit, San Diego, Jersey City, Boston, and Jacksonville (Florida). States with the largest populations of Arab Americans are California, Florida, Michigan, New Jersey, New York, Illinois, Massachusetts, Ohio, Pennsylvania, and Texas.

Although the U.S. Census numbers the Arab American community in the United States at just over 1 million, most Arab American advocacy groups consistently estimate the population to be over 3 million. These groups attribute the Census Bureau’s undercount of Arab Americans, like for that of other ethnic groups, to problems in the methodological procedures of the census, particularly pertaining to the study of ethnic minority populations. Census data identify a 40% increase in Arab Americans over the decade of 1990 to 2000. The Arab American Institute (AAI), one of the leading national advocacy groups within the Arab American community, works closely with the U.S. Census Bureau, as well as conducting its own independent census and cultural research. Many of the statistics cited in this entry are taken from either U.S. Census Bureau data or AAI’s Internet and written resources.

Contrary to the stereotype of Arab Americans as being Muslim, the majority are actually non-Muslim. Approximately 42% of Arab Americans are Catholic, representing Roman, Maronite, and Melkite (Greek) traditions; 23% are Orthodox, including Antiochian, Syrian, Greek, and Coptic faiths. Twenty-three percent of the Arab Americans who are Muslim represent Sunni, Shi’a, and Druze traditions.

Compared with other ethnic groups, the Arab American population comprises more younger and foreign-born individuals, as well as being somewhat more educated. According to AAI, 85% have high school diplomas, over 40% have at least a bachelor’s degree (compared with the national average of 24%),

and 17% have postgraduate degrees (compared with 9% of U.S. citizens).

Arab Americans represent a wide array of careers. About 64% are in the labor market, similar to the national average. The majority of working Arab Americans, at 88%, are employed within the private sector, and 73% hold managerial, professional, technical, sales, or administrative positions. AAI reports that Arab Americans are less likely to be found in governmental and service positions than their non-Arab American counterparts nationally. The mean income for Arab American households is slightly higher (i.e., 8%) than the national average.

## History and Culture

According to well-known Arab American historians (e.g., Gregory Orfalea, 1988) immigration from the Arab world to the United States has taken place in waves. These waves seem to parallel various strategies of acculturation among Arab Americans.

The earliest wave, at the turn of the 20th century, paralleled that of many other ethnic groups who came to the United States in search of better educational and economic opportunity and, for some Arabs, to escape the Ottoman regime. This immigrant group was made up primarily of Christians, many of whom were uneducated merchants, from Lebanon, Palestine, Syria, and Jordan. It also included a group of scholars and writers in search of academic freedom, such as Khalil Gibran, who was among those founding the New York Pen League, or “immigrant poets,” which has historically showcased some of the most important of Arab American literature of the 20th century.

The next two waves, in contrast, were primarily composed of educated Muslims. During the post–World War II, or “brain drain,” wave, Palestinians, Egyptians, Syrians, Jordanians, and Iraqis, along with smaller groups of Lebanese and Yemeni left their countries, dissatisfied with political leadership in the region. Shortly thereafter, the next wave began immigrating during the 1960s, partly in response to the lessening of U.S. immigration restrictions. This group came for similar reasons and included large numbers of Palestinians who came to escape the Israeli occupation.

More recently, a fourth wave has emerged. This most recent wave has occurred as a result of the Gulf War of 1990–1991. Thousands of Iraqis have entered the United States to join their earlier counterparts. Many of these are political refugees, and many



others came to flee the economic conditions caused by external sanctions imposed by other countries.

In terms of acculturation, the first wave quickly established close-knit community ties with one another in the places they settled. They also quickly became immersed, or assimilated, into the overall U.S. culture, similar to their other ethnic group counterparts at the turn of the century. The second and third waves became quickly reestablished professionally and economically, yet they maintained their own cultural traditions and values. The final wave, similar to other refugee populations, have struggled to resettle in the United States, and many suffered significant pre-immigration, immigration, and post-immigration traumas that have been difficult to overcome.

### **Religion and Values**

Although the majority of Arab Americans are non-Muslim, Islam, the religion of the Muslim world, has had a significant influence upon Arab culture historically. Thus, there is overlap of some of the spiritual values, such as the focus on collectivism, held by both Christian and Muslim Arab Americans. Similarly, many Arab Americans, Christians and Muslims alike, value their religious faith and traditions as a symbol of their cultural heritage.

Islam is a religion that was brought to the Arabian Peninsula (known as the Saudi Arabian Peninsula of modern times) between A.D. 7 and A.D. 10 by the Prophet Muhammad. Muslims believe that he was a messenger of God, delivering God's word that was given to him by the Archangel Gabriel. These words became written as the *Qur'an*, the holy book of Islam. Islam is viewed as a religion that embodies the same messages God revealed in the previously founded world religions of Judaism and Christianity, and Muslims believe that Jesus was one of God's many prophets. The *Qur'an* is considered a continuation of the Bible's Old and New Testaments.

The Five Pillars, or traditions, are commonly practiced by many Muslims. *Shahadah* speaks to the belief in Allah as one God and to his Servant, the Prophet Muhammad. *Salat* requires formal worship five times daily. This ritual includes reciting a formal liturgy followed by a moment of personal meditation. *Sawm* represents the fasting period during the month of Ramadan, to demonstrate self-restraint, patience, endurance, obedience to God, and solidarity with those less fortunate. *Zakah* requires that Muslims donate 2.5% of their income toward causes of economic

justice. Finally, *Hajj* prescribes journeying to the city of Mecca, Saudi Arabia. This journey is ideally undertaken during the early part of the 12th month of the Islamic (lunar) calendar.

For Muslim Arabs, the biggest holidays include Eid al-Fitr and Eid al-Adha. Eid al-Fitr is the celebration at the end of the month of Ramadan; Eid al-Adha is celebrated at the end of the pilgrimage to Mecca, usually on the 10th day of the 12th Islamic lunar month. The holy day is Friday, although in the United States, many religious institutions hold their services and other programs on weekends.

There are other important beliefs within Muslim and Arab culture, including accountability to God, self-responsibility for one's deeds, global unity, racial equality, peace, and social harmony. Beyond these spiritually oriented values, collectivism and extended family are perhaps the most significant values for Arab Americans. Despite the vast diversity in subcultures of origin across the League of Arab States, Arab American communities, or enclaves, typically have families representing multiple Arab ethnicities. Even those families choosing not to reside within such an enclave tend to value social relationships with their extended family members and other Arab Americans.

Educational and economic achievements also are highly valued. This holds true for boys and girls, men and women alike. These accomplishments are often seen as a source of family pride. Likewise, civic activities, such as leadership positions, are seen as community accomplishments and honor. Although Arab Americans are less likely to establish governmental sector careers, the sense of collectivism and altruism for the Arab American community, either locally or nationally, leads many to become involved in the political arena. Arab Americans have provided leadership to the Senate, the House of Representatives, state legislatures, and city governments, as well as having served in critical military positions in every U.S. war. High-ranking officials such as Chief of Staff John Sununu under President George Bush and Health and Human Services Secretary Donna Shalala under President Bill Clinton, along with counterparts in the U.S. military, sports, business, law, entertainment, education, fashion, arts and literature, and science and medicine, are detailed in a publication titled *Arab Americans: Making a Difference*.

### **Gender and Family**

Male and female gender roles have been defined within Arab cultures since well before the inception of



Islam. Some early Arab societies were tribal and nomadic, and the survival of the tribe or clan relied upon each individual taking on his or her prescribed role. Males have the responsibility of economic support and therefore are more likely to engage in social relationships outside of their families and communities. Females are largely responsible for keeping kinship ties; thus, they interact more within the familial structure.

According to Islam, men and women have an equal footing before God. Compared with Western societies, Muslim women have held rights to own and inherit property, obtain educations, and seek divorce for 1,400 years. In some Arab countries, governmental restrictions may preclude these rights from being realized. In the United States, many women also have the same relative freedoms as their mainstream counterparts. On the other hand, those individuals from newer immigrant groups, as well as those who reside in close-knit Arab American enclaves, may practice more controlled gender roles, such as prohibiting dating and other coeducational activities. Some Muslim parents and families report, in fact, that they impose more restrictions on their children, specifically their daughters, than they did or would do in their countries of origin, because of perceived environmental threats to traditional values.

For example, Arab/Muslim American families and individuals interpret the Muslim practice of veiling, or wearing a *hijab* (an Arab headdress), in a wide variety of ways. Some Arab American women believe that the practice was designed by male-dominated governments to oppress women, whereas others use it as a symbol of their personal interpretation of religious or cultural values, as a political expression against Western influences in the Middle East, or because they feel safer and more valued in coeducational settings.

Although divorce is not uncommon within Arab American communities, promoting the maintenance of the nuclear family is of primary importance; thus, Arab Americans tend to have a lower divorce rate than their non-Arab American counterparts. Within traditional marriages, individuals do not place as much reliance on their partners to meet all of their needs; rather, they may rely on other family and community members. In fact, multiple generations and family members may reside within a single household, and elders are integral to the family unit. Parenting styles may tend more toward the authoritarian approach than the Western authoritative one.

## Sociopolitical History and Contemporary Issues

The Arab world has historically had a troubled relationship with the United States, and this relationship extends into contemporary issues for Arab Americans.

Some scholars have attributed negative images of Arabs and Muslims within society to historical events such as the Crusades and the Ottoman Empire. In more recent times, the ongoing Palestine-Israel conflict and Iraq wars (e.g., Gulf War, Second Gulf War) have perpetuated the perception that Arabs and Arabism are a threat to U.S. interests.

Within this historical context, many Arab American advocacy groups perceive an image linking Arabs with terrorism both as faulty and inaccurate and as damaging to Arab Americans as individuals, families, and communities. Human rights organizations such as the Human Rights Watch and the Washington Report on Middle East Affairs document incidents ranging from harassment to hate crimes such as arson, vandalism, and physical assaults toward Arab Americans and others perceived to be of Muslim or Arab origins. These organizations also document the effect this backlash can have on Arab American communities locally, regionally, and nationally. Periods immediately following events and tragedies linked, either accurately or inaccurately, with individuals or groups of Arab descent appear to serve as triggers for such backlash.

Juxtaposed with some of these historical and political events over the past century are corresponding immigration and other legal issues facing the Arab American community. Over the years, according to H. H. Samhan, Arab Americans have been classified by the U.S. government as being from "Turkey in Asia," "Syrian," "Asiatic," and "Colored." These fluid yet compulsory labels have regulated immigration from the Middle East. For example, during the early 1900s, because "Syrians" were neither White nor of African descent or birth, they were deemed as ineligible for citizenship according to the immigration statutes of that time. "Asiatic" was ascribed to Arab Americans during a time period in which Asian immigration was sharply restricted. "Colored" was based on skin tone rather than country of origin.

Issues surrounding immigration and classification, in general, continue to be salient ones among Arab Americans today. Similarly to the relationship between sociopolitical and immigration histories addressed earlier in this entry, contemporary issues such as the War



on Terrorism, the U.S. military engagement in Iraq, and Palestine, are intertwined with current concerns such as civil liberties and Arab American census data.

### **Current Issues**

Advocacy groups such as the AAI and the American Arab Anti-Discrimination Committee often link contemporary issues among Arab Americans with global events involving Arab regions. Leading issues in contemporary U.S. society include those related to civil liberties, Iraq, and Palestine.

Since the World Trade Center bombings in New York City on September 11, 2001, civil rights legislation in the United States has held challenges for Americans. Though some has been associated with the profiling and targeting of Arab Americans, Muslims, and other specific groups in order to ensure homeland security, the debate about its legality affects all citizens.

Arab Americans, parallel to non-Arab American mainstream counterparts, have not been unified in their opinions about the series of Gulf Wars in Iraq. Some may have supported initial or more recent military tactics. However, many stand with other Americans in concerns about foreign policy and moral issues involved in contemporary military tactics in Iraq.

Surveys of Arabs in the Middle East as well as of Arab Americans consistently yield the perspective of impartial handling of the Palestine-Israel conflict, with the United States being perceived as operating in favor of Israel's interests, as well as its own. One Zogby International Poll indicated that, although majorities of younger-generation Arabs throughout the Middle East have favorable attitudes toward American science and technology, democracy and freedom, American entertainment (i.e., movies and television), and American-made products, the lowest attitude ratings were given for U.S. policy toward the Arab nations and Palestine. In the same poll, the "Palestinian issue" was viewed as the most critical contemporary issue of our time, with respondents overwhelmingly reporting that they would react more favorably to the United States if it were to "apply pressure to ensure the creation of an independent Palestinian state."

### **Counseling Issues**

Taken together, the culture of origin, coupled with the sociopolitical history of Arab Americans, yields potential risks and resiliencies among this ethnic group that

warrant consideration among psychologists, counselors, and other mental health service providers. Within the context of psychosocial issues for Arab American clients, effects of discrimination trauma and ethnic identity development are of primary importance.

Sylvia Nassar-McMillan has found that Arab Americans tend to somaticize their mental health concerns. For example, their anxiety may manifest in headaches or digestive problems. Thus, it is important for counselors to work in collaboration with medical and other health service providers to develop appropriate referral systems, as well as educational interventions, for their mutual clients. Arab Americans are most likely to seek medical treatment for disorders for which there are specific observable, physical symptoms; thus, they may focus more on their physical versus psychological health. They also may favor a medical model, in which the service provider is in an expert role and gives concrete advice and guidance.

Although psychological services have been provided within Arab societies for centuries, often by religious or spiritual healers, according to Alean Al-Krenawi and John Graham, there remains a stigma attached to admitting and seeking help for a psychological complaint, particularly for women. Moreover, going beyond the Arab American community to speak to an "outsider" may pose additional stigma and shame to the identity of an individual or family.

Within a counseling context, it is imperative that practitioners take into account a variety of psychosocial factors when assessing and preparing to work with an Arab American client. The first of these involves the demographic background of the client. Gender, age, religion, and sexual orientation, as well as educational level and socioeconomic status, all represent issues that may provide important historical information in understanding Arab American clients' socialization processes.

Another layer of relevant information, according to Nassar-McMillan, is the status arena—that is, the individual or family client's status in the United States. If they are permanent residents or U.S. citizens, then learning about how long the family of origin has lived in the United States is important, as is whether they reside within or outside an Arab American ethnic community. These details may shed light onto clients' level of attachment and commitment to their cultural background or heritage. Language spoken in the home also may provide a similar perspective. Country of origin also is important,



because the level of Westernization of a country of origin can impact the level of acculturation of individuals or families.

### ***Discrimination Trauma and Ethnic Identity***

In light of the increasing phenomenon of hate crimes toward Arab Americans, and the fact that most Arab Americans have experienced acts of prejudice or discrimination or have witnessed fellow Arab Americans experiencing them, backlash may include mild to severe discrimination traumas. Negative stereotyping toward Arabs and Arab Americans can manifest in educational texts, in school and college settings, within employment arenas, and from news and other popular media sources; such stereotyping can further impact the trauma experience. For some individuals, this type of trauma may cause a conscious or unconscious disengagement with country of origin, especially for those who are more likely to physically “pass” as White, or European American. For others, the trauma can serve as a catalyst for becoming involved in advocacy movements to combat the perceived oppression.

In determining that individual or family clients came to the United States as refugees, counselors must be aware of the unique traumas faced by refugees in general. Levels of anxiety and depression may be higher in this group of clients. For those who served in or observed combat or other horrors of war, posttraumatic stress disorder may be pervasive. Immigrants from the Arab world, most recently from Iraq, are likely to have suffered a series of traumas spanning their pre-immigration, immigration, and post-immigration experiences. These clients may be most likely to present for counseling and other human services to meet their basic life needs, such as coping with financial, language, employment, and other barriers. In addition, they may seek medical services in response to some of their somaticized psychological issues.

Regardless of the demographic backgrounds and life experiences of Arab American clients, it is not unlikely that negotiating ethnic identity issues may become relevant within a counseling context. Individuals’ level of ethnic identity as Arab Americans may vary widely depending on all of the variables described earlier. The levels to which they have internalized the oppression, both overt and subtle, over their lifetime, may also affect their ethnic pride and commitment to their Arab American ethnic identity and sense of community.

In summary, assessment strategies must be culturally relevant and appropriate. They need to focus significantly upon clients’ level of acculturation and ethnic identity development. In addition, although a variety of counseling approaches may be effective when working with Arab American individual and family clients, some may be more culturally appropriate. For example, although some clients may gain valuable insight through counseling and psychotherapy, cognitive-behavioral and problem-solving strategies (e.g., solution-focused counseling) may be more effective. In addition, Arab American clients may be most familiar with a medical, authoritative model on the part of the therapist, along with relatively directive approaches. Finally, constructivist approaches may help clients explore and construct their own perceptions, as well as those involving their communities of origin.

Sylvia C. Nassar-McMillan

**See also** Acculturation (v3); Acculturative Stress (v3); Adaptation (v3); Antisemitism (v3); Assimilation (v3); Constructivist Theory (v2); Cultural Paranoia (v3); Discrimination (v3); Ethnic Identity (v3); Ethnocentrism (v3); Panic Disorders (v2); Racism (v3); Religion/Religious Belief Systems (v3); Spirituality (v3); Spirituality/Religion (v2)

### **Further Readings**

- Abinader, E. (2000). Children of Al-Mahjar: Arab American literature spans a century. *U.S. Society & Values: Electronic Journal of the Department of State, Vol. 5*. Retrieved June 7, 2007, from <http://usinfo.state.gov/journals/itsv/0200/ijse/abinader.htm>
- Ajrouch, K. (1999). Family and ethnic identity in an Arab-American community. In M. Suleiman (Ed.), *Arabs in America: Building a new future* (pp. 129–139). Philadelphia: Temple University Press.
- Al-Krenawi, A., & Graham, J. R. (2000). Culturally sensitive social work practice with Arab clients in mental health settings. *Health & Social Work, 25*(1), 9–22.
- Barry, D., Elliott, R., & Evans, E. M. (2000). Foreigners in a strange land: Self-construal and ethnic identity in male Arabic immigrants. *Journal of Immigrant Health, 2*(3), 133–144.
- Cainkar, L. (2000). Immigration to the United States. In M. Lee (Ed.), *Arab American encyclopedia*. Detroit, MI: Gale.
- Council on Islamic Education. (1995). *Teaching about Islam and Muslims in the public school classroom: A handbook for educators* (3rd ed.). Fountain Valley, CA: Author.



- Dwairy, M. (2006). *Culturally sensitive counseling and psychotherapy: Working with Arabic and Muslim clients*. New York: Teachers College Press.
- Kasem, C. (2005). *Arab Americans: Making a difference*. Washington, DC: Arab American Institute Foundation. Retrieved from [http://aai.3cdn.net/eb843914472c84a043\\_efm6ibdbq.pdf](http://aai.3cdn.net/eb843914472c84a043_efm6ibdbq.pdf)
- Nassar-McMillan, S. C. (in press). *Counseling Arab Americans*. Boston: Houghton Mifflin/Lahaska Press.
- Samhan, H. H. (2001). Arab Americans. In *Grolier multimedia encyclopedia*. Grolier Inc. Retrieved from <http://gme.grolier.com>
- Shaheen, J. G. (1997). *Arab and Muslim stereotyping in American popular culture*. Washington, DC: Center for Muslim-Christian Understanding.
- Smith, H. (1991). *The world's religions: Our great wisdom traditions* (Rev. ed.). San Francisco: HarperCollins. (Original work published 1958)

### Web Sites

Arab American Institute: <http://www.aaiusa.org>

---

## ARREDONDO, PATRICIA (1945– )

---

Patricia Arredondo, born July 17, 1945, is a nationally acclaimed Latina psychologist who has achieved prominence through her work on multicultural counseling competencies. Additionally, she is an international leader in the areas of counseling, counseling psychology, and psychology and is the founder of Empowerment Workshops, Incorporated, a consulting company that focuses on issues of diversity as they relate to the workplace. Through her research, outreach, and leadership, she has guided and inspired a generation of counselors and psychologists to examine what it means to be culturally competent to work with diverse populations. As someone who has negotiated several tensions in the field of mental health (e.g., counseling vs. counseling psychology, ethnic minority psychology vs. psychology), Arredondo serves as a visionary leader and role model for all mental health professionals.

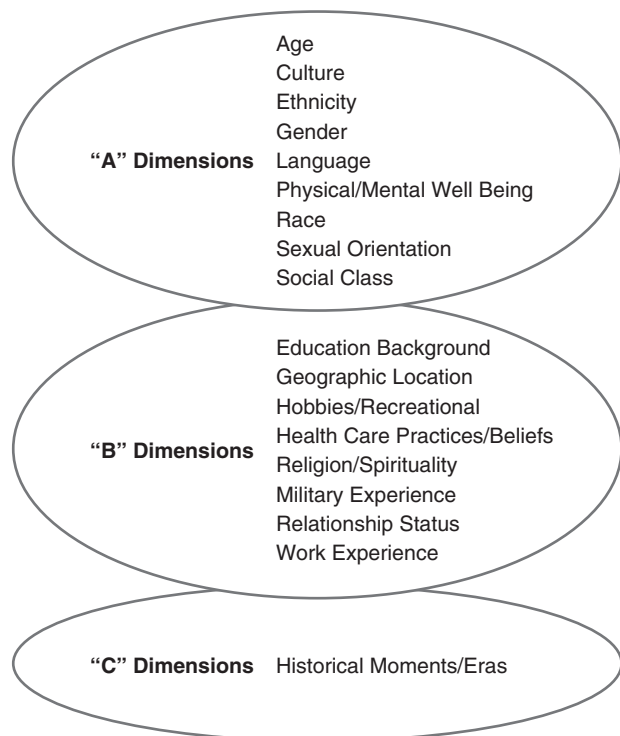
Arredondo, a Mexican American, grew up in Loraine, Ohio, a town with a small Latino/a population at the time. Arredondo was a second-generation American on her father's side and third generation on her mother's side. Her grandmother was a Zapotec

Indian from Oaxaca, Mexico, who later worked as a laborer at the steel mills in the small town near Cleveland, Ohio. The experiences of her family in the United States inspired and informed Arredondo in her work. Arredondo received her undergraduate degree in Spanish and journalism from Kent State University, received her master's in counseling from Boston College, and was the first in her extended family to receive her doctorate in counseling psychology (from Boston University). She began her career as an assistant professor in counseling psychology at Boston University, where she found her academic competence questioned; some suspected that she was hired to be a token woman and ethnic minority in her department. Arredondo left Boston University in 1985 to launch a career as the founder and president of Empowerment Workshops, Incorporated, a consulting company based in Boston.

Through her work as the founder and president of Empowerment Workshops, Arredondo took on the roles of entrepreneur, psychologist in private practice, and organizational consultant. She worked with a variety of organizations providing a range of services, including training workshops and diversity initiatives with assessments, management consultations, and management training. Arredondo's consulting company focused on assessing workplace culture, addressing barriers to workplace diversity, and offering business strategies to increase workplace diversity. Through Empowerment Workshops Arredondo reported that she gained a sense of personal and professional success.

Arredondo pioneered the use of the dimensions of personal identity model in her consulting work (see Figure 1). The model partitions identity into three dimensions: A, B, and C. The A dimensions include the following: age/generational status, culture, ethnicity, gender, language, physical/mental status, race, sexual orientation, and social class. These dimensions can have positive and negative valences, which impact self-concept, self-esteem, and empowerment, and they are the least changeable. The B dimensions are less visible and are developmental in nature: They include educational background, geographic location, hobbies/recreation, healthcare practices/beliefs, religion/spirituality, military experience, relationship status, and work experience. The C dimensions emphasize historical contexts and external forces that individuals and families must deal with. The C dimensions are personal/familial/historical, eras/events, and sociopolitical forces. Through the use of this model counselors can conceptualize clients in context and





**Figure 1** Dimensions of personal identity

Source: © Patricia Arredondo. Used with permission.

focus their interventions on specific dimensions. There is some emerging empirical support in the research literature for the use of the model, and the model has been adapted for use with specific populations (e.g., Latinos/as).

A highlight of her work was presenting her first book on diversity management to her parents, which Arredondo dedicated to them. In 1999, after several years with Empowerment Workshops, she returned to academia at Arizona State University (ASU) in the Department of Counseling and Counseling Psychology. At ASU she had to confront the challenge of navigating a new social network and once again having to prove her competence. Arredondo was able to continue her pattern of success and was tenured and promoted to the rank of full professor. In 2006 she became the Deputy Vice President and University Dean for Student Affairs at ASU.

Arredondo provided national professional leadership through being the first Latina president of the American Counseling Association (ACA) and the Association for Multicultural Counseling and Development, president of the Society for the Psychological Study of Ethnic

Minority Issues (Division 45 of the American Psychological Association [APA]), and founding president of the National Latina/o Psychological Association. She served as chair of the Board for the Advancement of Psychology in the Public Interest of APA, cochair of the Executive Committee of the Latino Professional Network, chair of the ACA Publications committee, president of the Chicano Faculty and Staff Association of ASU, cochair of the Latino Professional Network, and member of the Board of Directors for the People of Color Network in Phoenix, Arizona.

Arredondo is best known for her work in creating, operationalizing, and advocating for the adoption of the multicultural counseling competencies. She has played a crucial role in bringing multiculturalism and culturally competent counseling to the forefront of the profession. Arredondo has promoted counselor awareness of their own cultural values and biases, counselor awareness of the client's worldview, and use of culturally appropriate intervention strategies. The multicultural counseling competencies assert that culture is core to everyone's (not just racial/ethnic minorities') life experiences. The competencies state that in human interactions there are many personal dimensions of identity to consider, including different manifestations of culture based on varying historic, ethnic, economic, and other forms of diversity. Beginning with a seminal article in 1992, Arredondo has provided leadership in the operationalization of the multicultural competencies and the adoption of the multicultural competencies and guidelines by various professional groups, including the ACA and the APA. Arredondo's work has helped to make counseling and counseling psychology relevant and responsive to an increasingly diverse and global workplace.

Arredondo has received several major recognitions, including being named a fellow of APA in Divisions 17 (the Society of Counseling Psychology) and 45 and receiving the Samuel H. Johnson Memorial Award from the Association for Multicultural Counseling and Development, the Distinguished Professional Service Award from ACA's Association for Counselor Education and Supervision, the Kitty Cole Human Rights Award from ACA, and the inaugural Distinguished Professional Career Award from the National Latina/o Psychological Association. In recognition of her lifetime contributions to the profession of counseling, Arredondo was designated a "living legend" by ACA in 2004. In addition, Arredondo was awarded an Honorary Doctorate of Humane Letters



from the University of San Diego for her multicultural leadership.

Arredondo has consistently been a pioneer in terms of being an ethnic minority and woman who has broken through barriers and achieved power, prestige, and influence in the business and academic worlds. For example, in 2006 she became the highest-ranking Latina in senior administration at ASU. Although in her career she has often been the “first” woman or Latina to achieve distinctions or take on leadership roles, she has made sure that others have followed behind her; thus, her career has been consistent with her empowerment mission and an example of how culture can be the source of personal power in a career.

*Edward A. Delgado-Romero  
and Stephanie Clouse*

*See also* Counseling Psychology, History of (v1); Multicultural Counseling (v3); Multicultural Counseling Competence (v3); National Latina/o Psychological Association (v3); Society for the Psychological Study of Ethnic Minority Issues (v3); Tokenism (v3)

### Further Readings

- Arredondo, P. (1999). Multicultural counseling competencies as tools to address racism and oppression. *Journal of Counseling & Development, 77*, 102–108.
- Arredondo, P. (2002). Mujeres Latinas—santas y marquesas. *Cultural Diversity & Ethnic Minority Psychology, 8*, 1–12.
- Arredondo, P., Toporek, R., Brown, S. P., Jones, J., Locke, D. C., Sanchez, J., et al. (1996). Operationalization of the multicultural counseling competencies. *Journal of Multicultural Counseling and Development, 24*, 42–78.
- Sue, D. W., Arredondo, P., & McDavis, R. (1992). Multicultural competencies and standards: A call to the profession. *Journal of Counseling & Development, 70*, 477–486.

---

## ASIAN AMERICAN PSYCHOLOGICAL ASSOCIATION

---

The Asian American Psychological Association (AAPA) is a national organization dedicated to the advancement of Asian American psychology and advocacy for Asian American communities and their psychological well-being. Its advocacy efforts include

the promotion of culturally responsive mental health services for Asian and Asian American communities, the advancement and dissemination of psychological research on Asian Americans, the education and training of Asian American mental health service providers, the development of culturally appropriate mental health policies, and the establishment of professional collaborations and networks within the field of mental health. Founded in December 1972 in the San Francisco Bay Area, the AAPA has grown from a local organization with 10 regular members to a national organization of approximately 600 members in 2006. Parallel to their growth in the United States, Asian Americans constitute approximately 4% to 5% of the doctorates awarded in psychology, according to the National Science Foundation.

Despite the AAPA's contemporary origins, its formation occurred within a historical context of discrimination and toward Asian Americans within the United States. Since the arrival of Chinese immigrants in the United States in the mid-1800s, subsequent groups of Asian immigrants from a variety of ethnic groups have encountered strikingly similar patterns of individual, institutional, and cultural forms of racism. Historically, Asian Americans have been the targets of numerous anti-immigration, anti-naturalization, and anti-miscegenation laws. Currently, Asian Americans, despite their diverse ethnic origins and histories, continue to be treated as a homogeneous community and stereotyped as a “model minority” (i.e., presumably a uniformly successful racial group in terms of educational and economic achievement) and “perpetual foreigners” (i.e., a racial group of untrustworthy outsiders). Moreover, Asian Americans continue to be the targets of modern-day forms of racism ranging from homicide and physical assaults to glass ceiling barriers in the workplace to implicit quotas within higher education. Recognizing this shared history of discrimination and inspired by the larger civil rights and antiwar movements, predominantly Japanese American and Chinese American activists coined the term *Asian American* in the late 1960s to unite the various Asian ethnic groups in recognition of their shared experiences. More importantly, Asian American activists across the nation formed a range of organizations to challenge racial inequities in areas such as physical and mental health, education, and politics. Within this context, AAPA was formed in recognition of the neglect of Asian American issues within psychology and the sense of isolation among Asian American mental health professionals.



The cofounders of AAPA were two brothers, Derald Wing Sue and Stanley Sue. Both men recognized their own lack of training in working with Asian and Asian American communities and the lack of a professional network for mental health service providers. As a result, the two brothers began to organize informal gatherings to discuss Asian American issues and their roles as Asian American clinicians and scholars. D. W. Sue was chosen to be the first president of AAPA out of respect for his status as the older brother, and S. Sue was elected as secretary. In the initial days of AAPA with so few Asian American psychologists, many members of the organization were social workers, counselors, educators, and other allied health and mental health professionals. Additionally, interdisciplinary alliances with fields such as Asian American studies and with community leaders were key to the initial formation of AAPA. Indeed, one of the seminal papers in the field of Asian American psychology, S. Sue and D. W. Sue's "Chinese American Personality and Mental Health" was published in 1971 in *Amerasia Journal*, the first Asian American studies journal. At an organizational level, AAPA drew inspiration from the newly formed Association of Black Psychologists, which was founded in 1968, also in San Francisco. In particular, the activism of organizations such as the Association of Black Psychologists and academic disciplines such as ethnic studies inspired AAPA to strive for organizational and systemic transformation within the field of psychology.

AAPA has been involved at a national level in advocating for greater awareness of both Asian Americans and the issues that affect their psychological well-being. For instance, AAPA has been involved with ensuring the accurate representation of Asian Americans in the U.S. Census and in advocating against English-only language initiatives. Additionally, AAPA leaders have advocated for Asian American issues before President Carter's Commission on Mental Health, President Clinton's Race Advisory Board, President George W. Bush's New Freedom Commission on Mental Health, as well as authoring portions of the supplement to the Surgeon General's Report on Mental Health. Within psychology, AAPA and its members have been instrumental in fostering the recognition of Asian American issues within the field of psychology in general and in professional organizations such as the American Psychological Association (APA) and the National Institute of Mental Health (NIMH). Within APA,

AAPA has worked toward the inclusion of Asian Americans at all levels of APA governance, the formation of the Board of Ethnic Minority Affairs and the Office of Ethnic Minority Affairs, and the inclusion of Asian Americans in editorial positions and journal review boards. As a result of this emphasis on leadership development, Asian Americans have been elected to numerous governance boards, committees, task forces, and division leadership positions within APA. Indeed, Richard Suinn, an early AAPA member, was elected as the first Asian American president of APA. Both Suinn and Alice Chang served on APA's board of directors. Moreover, Christine Iijima Hall, the first female president of AAPA, also served as the director of APA's Office of Ethnic Minority Affairs. Currently, AAPA is a member of the Council of National Psychological Associations for the Advancement of Ethnic Minority Interests, composed of all the national ethnic minority psychological organizations, and an observer on APA's Council of Representatives.

Within NIMH, AAPA has been effective in advocating for Asian American issues since its inception. In particular, the support of K. Patrick Okura, an executive assistant to the director of NIMH and an early member of AAPA's board of directors, was instrumental to AAPA's visibility. Okura organized the first Asian American mental health conference in 1972 and was vital in securing NIMH funding for the National Asian American Psychology Training Conference in 1976 under the leadership of Robert Chin and S. Sue. In 1988, the NIMH also provided funding for the National Research Center on Asian American Mental Health, with S. Sue as its first director. Additionally, Okura, along with his wife, Lily, established the Okura Mental Health Leadership Foundation with the reparations money that they received for their internment during World War II. The foundation provides leadership development opportunities to emerging Asian American mental health professionals from a variety of disciplines.

AAPA is led by an executive committee selected from its membership. The president, vice president, secretary-historian, president-elect, past president, and a four-member board of directors are all elected for 2-year terms. One member of the board is designated as a student representative. Additionally, the following officers are appointed positions: membership, communications, financial affairs, and editor of the newsletter. A central focus of AAPA's leadership is hosting a national convention on the day before the



APA convention. The convention has served as an integral event for the dissemination of the latest research and best practices within the field, mentorship across all levels of AAPA membership, and the recognition of the achievements of its members. AAPA publishes a newsletter, the *Asian American Psychologist*, three times a year to communicate with its membership about events, issues, and position announcements. AAPA also maintains an active Listserv, open to all individuals who are interested in Asian American psychology, as well as a Web site. The Web site provides information about AAPA, its activities, resources for mental health professionals, and access to online forums on a variety of research and practice-oriented topics.

Currently, AAPA also has two divisions that address issues specific to segments of the professional community: the Division on Women (DoW) and the Division of Students (DoS). The DoW was founded in 1995 under the leadership of Alice Chang. The DoW provides a forum for collaboration and mentorship among Asian American women within the field and provides a platform for the advocacy of women's issues. Similarly, the DoS was founded in 2006 by a cohort of students under the leadership of Szu-Hui Lee to give voice to, and in recognition of, the large student community within AAPA.

Alvin N. Alvarez

*See also* Asian Americans (v3); Civil Rights (v3); Sue, Derald Wing: Contributions to Multicultural Psychology and Counseling (v3); Sue, Stanley (v3)

### Further Readings

- Leong, F. T. L. (1995). *A brief history of Asian American psychology, Vol. 1*. San Francisco: Asian American Psychological Association.
- Leong, F. T. L., & Gupta, A. (in press). History and evolution of Asian American psychology. In N. Tewari & A. Alvarez (Eds.), *Asian American psychology: Current perspectives*. Mahwah, NJ: Lawrence Erlbaum.
- Munsey, C. (2006). A family for Asian psychologists. *American Psychologist*, 37(2), 60–62.

### Web Sites

Asian American Psychological Association:  
<http://www.aapaonline.org>

## ASIAN AMERICANS

Asian Americans are Americans of Asian descent. Based on the U.S. Census report, there are approximately 14.0 million U.S. residents who identified themselves as Asians. Heterogeneity is particularly important to address when it comes to a group such as Asian Americans, given that this population comprises approximately 43 different ethnic groups with more than 100 languages and dialects represented. According to the recent Census, 2.3 million individuals speak Chinese at home, the second most widely used non-English language in the United States. Immigration history and status are also diverse within this group: 8.7 million U.S. residents are born in Asia, and 25% of the nation's total foreign-born population and 52% of foreign-born Asians are naturalized U.S. citizens. The median household income for Asians in 2004 was \$57,518, the highest among all race groups. Diversity of income within the Asian population was also evident. For example, median household income for Asian Indians was \$68,771 and \$45,980 for Vietnamese. The poverty rate for Asians was 9.8%. Asians have the highest proportion of college graduates of any race or ethnic group in the United States, with 49% of individuals ages 25 and older holding a bachelor's degree or higher level of education, 87% of individuals with high school diplomas, and 20% with an advanced degree (e.g., master's, Ph.D., M.D., or J.D.). Sixty percent of Asian households consist of a married-couple family. The projected number of U.S. residents who will identify themselves as Asian in 2050 is 33.4 million, 8% of the total projected U.S. population.

Counseling psychologists must consider the cultural context of the individuals and the cultural lens from which they view themselves and the world. Understanding the worldviews of Asian Americans from the cultural perspective is critical for an accurate understanding and assessment of how Asian Americans may respond to counseling and psychotherapy. Without accounting for the differences that exist within Asian American ethnic subgroups, it is inevitable that there will be errors of omission, that is, failures to account for culture, ethnicity, or cultural differences, as well as making false generalizations of individuals within a given culture. In this entry, key aspects of the Asian cultural perspective are highlighted. Systematic and practical barriers that impede service utilization and compromise service effectiveness as well as ways of



overcoming those barriers through culturally responsive services are outlined. Recommendations for counseling Asian Americans are presented throughout this entry.

## **Client Variables Within the Asian Cultural Context**

### ***Cultural Values and Worldview***

Asian American worldview emphasizes humility, modesty, treating oneself strictly while treating others more leniently, obligation to family, conformity, obedience, and subordination to authority. This cultural context also values familial relations, interpersonal harmony versus honesty emphasis, role hierarchy versus egalitarianism, and self-restraint versus self-disclosure.

Awareness of these values sheds light on why research and clinical findings have shown Asian Americans to exhibit greater respect for counselors, preference for a counselor who is an authority but is not authoritarian, tendency to exhibit lower levels of verbal and emotional expressiveness, preference for directive counseling styles, and crisis-oriented, brief, and solution-oriented approaches rather than insight and growth-oriented approaches. Asian Americans are likely to find difficulty with the Western model of counseling and psychotherapy, which is filled with ambiguity by design and typically conducted as an unstructured process. For Asian Americans who tend to be less tolerant of ambiguity, the mismatch with insight-oriented psychotherapy may account for the early termination and the underutilization rates that exist. Similarly, Asian cultural values of reserve, restraint of strong feelings, and subtleness in approaching problems may come into conflict with the Western model of counseling and psychotherapy, which expects clients to exhibit openness, psychological mindedness, and assertiveness.

An example of error of omission leading to false generalizations and conclusions about Asian Americans can be found in career counseling. Asian Americans report significantly high parental expectations and involvement when making career decisions and are likely to be influenced by their families. From a Western cultural worldview the inclusion of parental expectations and wishes may be interpreted as being immature and maladaptive, whereas from an Asian cultural perspective it would be aligned with the

cultural norms and values. It is important to know the person being helped, understand his or her cultural context, and use his or her cultural worldview rather than other worldviews to prevent misunderstandings and inappropriate services.

### ***Family***

Family plays a central role in the mental health of Asian Americans. Families not only have the potential of facilitating mental health, but they can also serve as potential mental health stressors. Immigrant families may face difficulties with social isolation, adjustment difficulties, and cultural and language barriers, and cultural and language barriers may contribute to parent-child conflicts. Characteristics of immigrant families include a husband-wife dyad, families with dependent children, families with adult children, aging parents, split households, and reunifications, all of which render unique adjustment and relational concerns. Parenting styles also impact the life experiences of Asian Americans. Studies have found that authoritative parenting styles and the number of years lived in the United States are predictive of higher academic competence. Authoritarian and permissive parenting styles are predictive of lower self-reliance, whereas number of years lived in the United States is related to higher self-reliance. Family constancy and equilibrium, duty, obligation, and appearance of harmonious relations are important. Whereas Asian families emphasize connectedness of the family, the Western worldview prioritizes separateness and clear boundaries in relationships, individuality, and autonomy. Therefore, counselors should note that the preferred direction of change may be toward a process of integration rather than differentiation.

### ***Acculturation***

Acculturation involves a minority individual's behavioral, cultural, and social adaptations that take place as a result of contact between the individual's ethnic society and the host dominant society. Experiences of culture conflicts are inevitable during this process, resulting in mental health issues and interpersonal conflicts. Asian Americans are often caught between the Western worldviews and the traditional cultural values as they attempt to negotiate between the two. As Asian Americans became exposed to Western influence via the schools, mass media, and



their peers, intergenerational conflicts often result within family units. Studies have found that Asian American women tend to acculturate faster than their male counterparts. One way that Asian Americans attempt to resolve the cultural conflicts generated by the acculturation process is by developing a sense of ethnic identity to their heritage culture.

Sue and Sue have developed a conceptual scheme for understanding how Asian Americans adjust to these conflicts. They observed that Asian Americans exhibited three distinct ways of resolving the culture conflicts experienced. First of all, there is *the traditionalist* who remains loyal to his or her own ethnic group by retaining traditional Asian values and living up to expectations of the family. Second, there is *the marginal person* who becomes over-Westernized by rejecting traditional Asian values and whose pride and self-worth are defined by the ability to acculturate into White society. The third way of resolving cultural conflict is the *Asian American*, who is also rebelling against parental authority but at the same time is attempting to integrate his or her bicultural elements into a new identity by reconciling viable aspects of his or her heritage with the present situation.

It has been suggested that an Asian American's level of acculturation may influence his or her response to both therapy process and outcome. It also is important for clinicians to be cognizant that acculturation also plays an important role in the career development of Asian Americans. For example, a high level of acculturation had been found to be positively related to job satisfaction and negatively related to occupational stress and strain. There is a wide research and clinical consensus that there is a significant relationship between levels of acculturation and attitudes toward seeking professional psychological help. More specifically, the more acculturated Asian Americans are, the more likely it is they will seek professional psychologist help. The less acculturated they are, the more likely it is they will seek help from community elders, religious leaders and communities, and student organizations. Individuals who are most acculturated are most likely to recognize the need for professional psychological help because they are most tolerant of the stigmas often associated with seeking psychological assistance.

### **Help-Seeking Attitudes**

Asian Americans have shown patterns of underutilization of health services. Those that do make use of

mental health services have shown significant dropout rate. As mentioned earlier, acculturation is found to account for ethnic differences in help-seeking behaviors of Asian American students. Those with a high acculturation level are more willing to seek help than those who are less acculturated. Levels of acculturation can also impact the attitudes held by Asian Americans toward mental health services. For example, most acculturated individuals are likely to recognize need for professional psychological help, more tolerant of stigmas, and more open to discuss problems with a psychologist than individuals who are not acculturated.

Underutilization can also be explained by the stigmas that are often attached to seeking professional psychological services by the Asian community. There are correlations found between Asian Americans' levels of acculturation and stigma tolerance and their confidence in mental health practitioners. In some cultures, there is not a cultural analogy to psychological therapy; therefore, utilization of mental health services may not be viewed as a treatment option. Stigmas and lack of understanding also account for the lower frequencies of self-referrals. In response, efforts have been placed on how to minimize premature termination among Asian American clients by accounting for cultural values, ethnocentrism and the cultural uniformity myth, cultural attitudes and beliefs, styles of interpersonal communication, and cultural determinants of the nature of interpersonal relations.

### **Psychological Distress and Coping Mechanisms**

The prevalence of mental health problems among Asian Americans is noteworthy despite the stereotype of being the "model minority." Much literature and research attention has been paid to the unique needs and experiences of Asian Americans. The cultural context helps practitioners to understand the experiences and the expression of symptoms of distress. For Asian Americans, there may be a tendency to replace psychological symptoms with somatic ones. This tendency to somaticize may extend beyond the diagnosis stage to influence the actual therapy process itself. Failure to recognize this client characteristic among Asian Americans may result in both diagnostic and therapeutic errors. Cultural experience of Asian Americans is further contextualized by understanding their ethnic identity. Asian Americans' experience with racism and discrimination should also be taken into



consideration in the therapy process. Immigration experiences and acculturative stress have been found to have predictive effects on mental health. Examining within-group differences of immigration status (e.g., international, permanent residents, and naturalized citizens) while taking into account clients' immigration history will further contextualize the life experiences of the individual Asian American client.

Asian Americans tend to endorse coping sources and practices that emphasize talking with familial and social relations rather than professionals such as counselors and doctors. In one study, among the ethnic groups examined (Chinese, Korean, Filipino, and Indian), Korean Americans were found to be more likely to cope with problems by engaging in religious activities. Indigenous coping resources such as traditional folk healers, spiritual identifications, and religious practices such as Buddhism are support resources that Asian Americans utilize. Social support is also an instrumental tool for coping among Asian Americans. Social support, including friends, family, and even international student offices, has been found to provide buffering effects on the mental health issues faced by Asian Americans. Social support variables have also shown to be predictive of academic persistence.

### **Barriers to Asian Americans Using Counseling Services**

Cultural differences in mental health concepts, idioms of distress, stigmatization of the mentally ill and mental health service use, and preference for alternate coping strategies may contribute to the underutilization of psychological services by diverse Asian American groups. Cultural values of self-reliance and emotional self-restraint explain why Asian Americans prefer to work out issues independently. Strong stigmatization of the mentally ill and mental health service use accounts for why Asian Americans are more likely to seek support from family and friends than reaching out to professional service providers. Mainstream mental health services being inaccessible or culturally insensitive to the needs of Asian communities continue to be barriers to Asian Americans seeking services. Structural barriers include lack of knowledge of service availability, time constraints, distance, cost of treatment and lack of financial resources, access to transportation, and English-language proficiency. Practical barriers such as cost, time, and language accessibility have been shown to pose more of a

problem for less-acculturated individuals, who must learn to navigate an entirely new health care system while also adjusting to life in a new culture.

Counselor's lack of culture-specific knowledge about Asian Americans may act as a barrier to effective counseling, resulting in Asian American clients not receiving appropriate care. Misdiagnosis frequently occurs, and the existence of culture-bound syndromes points to a lack of precise correspondence between indigenous labels and established diagnostic categories. Counselors should view clients on both macro and micro levels while maintaining cultural sensitivity. Assuming homogeneity among Asian Americans and falling prey to stereotypes would compromise the therapeutic process. It is theorized that counselors' bias toward Asian Americans and other minorities comes from at least two sources: their own cultural and personal backgrounds and their professional training. When counselors' cultural background and personal characteristics are in contrast to those of Asian Americans, there is potential for cultural misunderstandings. In addition, the cultural bias of counselors toward minority groups in general can operate against Asian Americans in particular.

The professional training received by counselors can be another source of bias in working with Asian Americans. Training bias tends to operate in the form of using traditional psychotherapeutic procedures acquired from training with culturally different clients, such as Asian Americans, without first evaluating if those procedures would be culturally appropriate. Given that social and cultural variables affect Asian Americans' help-seeking behaviors, experiences of distress, manifestation of symptoms, and therapeutic process and outcome, it is important that training curriculum place emphasis on these variables as clinicians learn to implement their learning into care of Asian American clients.

Most counselors trained with Western models of psychotherapy possess certain characteristics and assumptions inherent in these models that may conflict with the cultural background of Asian Americans and thus serve as barriers to effective therapy or counseling. The major characteristics of Western models include (a) language variables, such as the use of standard English; (b) class-bound values, such as strict adherence to time schedule and an unstructured approach to problems; and (c) culture-bound values, such as emphasis on the individual (as opposed to the group or family) and verbal and emotional expressiveness. In



light of some of the characteristics of Asian Americans already reviewed (e.g., intolerance of ambiguity), counselors using a Western approach with Asian American clients may run into a considerable amount of resistance. The universal applicability of Western approaches to psychotherapy and mental health services has been challenged by several investigators, and some investigators have begun developing training models that are intended to be sensitive to the Asian American cultural background and experiences.

### **Overcoming Barriers Through Culturally Responsive Services**

Sue proposed a number of solutions to account for the barriers to receiving effective psychological services. His recommendations include (a) augmenting existing services, (b) establishing parallel or ethnic-specific services programs, and (c) creating nonparallel programs that are culturally tailored to a particular group. Many changes have taken place, including the implementation of these suggestions in ethnically dense communities.

One implementation is to provide racial/ethnic client and therapist matching within the existing public mental health system. Providing clients with a therapist of his or her same racial/ethnic background has increased some service utilization by Asian American clients. Ethnic match, language match, or both, are particularly important for Asians who did not speak English as a primary language. Ethnic and language matches are found to be associated with lower rates of premature termination and greater number of sessions. Clinical and research data show that ethnic/racial matching may have important effects in increasing the utilization of mental health services by Asian Americans. Some research shows that Asian Americans who were receiving mainstream services but were ethnically matched with their therapist returned more often than their unmatched counterparts. This approach has proven to be an effective way to augment existing services.

Ethnic-specific mental health services (ESS) is another response to Sue's call for action. The emergence of ESS involves modifications on the systemic level. Rather than just augmenting existing services, ESS is designed to improve the cultural fit of service offerings and the clients served. ESS programs are designed to address cultural barriers faced by the specific ethnic groups they treat. For example, ESS programs are frequently located within ethnic enclaves with extended service hours to accommodate

transportation or work hour conflicts. ESS programs also work cooperatively with family members, indigenous healers, and community elders, which is rare within the existing public mental health system. Extensive case management services are also provided to address unique social service needs of immigrants. Mental health services may also be integrated with primary care to capitalize on the preference for integrating health and mental health treatments. Recent studies provide preliminary evidence that ESS programs are more effective than mainstream programs. Asian Americans attending ESS programs had a higher rate of return after the first session and attended a greater number of treatment sessions, even if there was no ethnic matching. Studies have found that when psychiatric inpatient units incorporate the systemic-level change of ESS, longer treatment stays and improved referral to follow-up treatment after discharge result. Inpatients are more willing to accept outpatient or residential treatment referrals. Organizational improvements to afford cultural match and/or fit are aimed to enhance service effectiveness, increase service utilization, and result in therapeutic gain to those in need.

Nonparallel programs that are culturally tailored to a particular group are also important. Such programs address the specific cultural concerns and social contexts of a particular ethnic group. Indigenous healing practices are key components to such nonparallel programs. One example of a nonparallel community program is one designed for native Hawaiians, Hale Ola Ho'opakolea. This program incorporates indigenous Native Hawaiian therapies to assist clients in overcoming their concerns. The program has reportedly led to increased mental health service use and has received high client satisfaction ratings. Although it might be difficult to obtain funding support for such innovative programs and reimbursement from insurance companies, there is some preliminary evidence that such programs play an increasingly important role in meeting the service needs of specific populations.

### **Overall Recommendations for Counseling Asian Americans**

When working with any racial/ethnic minority individuals, it is important to consider the cultural context of that individual and the cultural lens from which the individual views himself or herself and the world. Furthermore, service providers must also acknowledge their own cultural biases and learn about the



cultures, histories, and values of their Asian clients to determine the appropriateness of their therapeutic approaches and goals. To understand the cultural context and worldview of their clients, service providers should also assess the levels of adherence to Asian cultural values of their Asian American clients. Adherence to Asian cultural values would shed light on the relevance of specific cultural factors impacting therapeutic process and outcome. Service providers who are willing and able to discuss culturally specific and relevant aspects of one's life experiences would certainly highlight the counselors' levels of multicultural competency. Cultural competency on the part of the service provider would result in perceived credibility and positive impact on the therapeutic relationship. Having counselors with similar cultural backgrounds, values, and experiences may also help to foster stronger therapeutic relationships. In essence, counselors should view cultural values held by clients as an avenue for connection, mutual learning, and a window toward a more complete understanding of their clients.

Understanding the cultural context of Asian Americans would also highlight ways to work effectively with Asian American clients. Structured therapeutic interventions and directive approaches, such as cognitive-behavior therapy and problem-focused approaches, are effective, particularly for more traditional Asian American clients. Working collaboratively with clients' families, support networks, and other treatment providers is also important. Similarly, it is important for researchers and practitioners alike to note that although seeking professional help is one resource option for people of Asian descent, not choosing to utilize it does not necessarily mean there are no other, more appropriate coping methods available. Effectiveness of integrating alternative belief systems and healing approaches into service provisions certainly deems continued clinical and research attention.

Finally, it is critical that service providers be aware of the heterogeneity within Asian American groups. Within-group differences include, but are not limited to, ethnic identity, cultural background, degree of acculturation, experiences within the majority culture, circumstances of immigration, family structure, values, social class, and religious affiliation. These aspects of an individual's background and life experiences are essential to the understanding of that individual client. In essence, efforts should be made to prevent the impact of error of omission by honoring the differences

that exist within Asian American ethnic subgroups and the influence of cultural context and the worldview of Asian Americans.

*Frederick T. L. Leong and Szu-Hui Lee*

**See also** Acculturation (v3); Acculturative Stress (v3); Allocentrism (v3); Barriers to Cross-Cultural Counseling (v3); Career Counseling, Asian Americans (v4); Collectivism (v3); Cultural Values (v3); Discrimination and Oppression (v2); Help-Seeking Behavior (v3); Model Minority Myth (v3); Multicultural Counseling Competence (v3)

### Further Readings

- Gamst, G., Dana, R. H., Der-Karabetian, A., & Kramer, T. (2001). Asian American mental health clients: Effects of ethnic match and age on global assessment and visitation. *Journal of Mental Health Counseling, 23*(1), 57–71.
- Gim, R. H., Atkinson, D. R., & Whiteley, S. (1990). Asian-American acculturation, severity of concerns, and willingness to see a counselor. *Journal of Counseling Psychology, 37*(3), 281–285.
- Kim, B. S. K., Atkinson, D. R., & Umemoto, D. (2001). Asian cultural values and the counseling process: Current knowledge and directions for future research. *Counseling Psychologist, 29*(4), 570–603.
- Kim, J. M. (2003). Structural family therapy and its implications for the Asian American family. *Family Journal Counseling and Therapy for Couples and Families, 11*(4), 388–392.
- Leong, F. T. L., Chang, D. F., & Lee, S. H. (2006). Counseling and psychotherapy with Asian Americans: Process and outcome. In F. T. L. Leong, A. G. Inman, A. Ebreo, L. Yang, L. M. Kinoshita, & M. Fu (Eds.), *Handbook of Asian American psychology* (2nd ed., pp. 429–447). Thousand Oaks, CA: Sage.
- Leong, F. T. L., & Lau, A. S. L. (2001). Barriers to providing effective mental health services to Asian Americans. *Mental Health Services Research, 3*(4), 201–214.
- Leong, F. T. L. & Lee, S. H. (2006). A cultural accommodation model for cross-cultural psychotherapy: Illustrated with the case of Asian Americans. *Journal of Psychotherapy: Theory, Research, Practice, Training, 43*(4), 410–423.
- Sue, D. (1998). The interplay of sociocultural factors on the psychological development of Asians in America. In G. Morten & D. R. Atkinson (Eds.), *Counseling American minorities* (5th ed., pp. 205–213). New York: McGraw-Hill.
- Sue, S. (1977). Psychological theory and implications for Asian Americans. *Personnel & Guidance Journal, 55*(7), 381–389.



- Takeuchi, D. T., Mokuau, N., & Chun, C. A. (1992). Mental health services for Asian Americans and Pacific Islanders. *Journal of Mental Health Administration*, 19(3), 237–245.
- True, R. H. (1990). Psychotherapeutic issues with Asian American women. *Sex Roles*, 22(7–8), 477–486.
- Yeh, C., & Wang, Y. W. (2000). Asian American coping attitudes, sources, and practices: Implications for indigenous counseling strategies. *Journal of College Student Development*, 41(1), 94–103.

---

## ASSIMILATION

---

Contemporary use of the term *assimilation* has involved two processes: (a) the process whereby an individual or a group of diverse ethnic and racial minority or immigrant individuals comes to adopt the beliefs, values, attitudes, and the behaviors of the majority or dominant culture; and (b) the process whereby an individual or group relinquishes the value system of his or her cultural heritage and becomes a member of the dominant society. The early use of the term *assimilation* refers mainly to the process by which people of diverse racial and ethnic backgrounds occupying a common territory came to achieve a cultural solidarity to sustain a national existence. Since the 19th century, the use of *assimilation* has been a political rather than a cultural concept. It has been used to justify selective state-imposed policies aimed at the eradication of minority cultures. As globalization results in ever-expanding trading and political relations, understanding the history and the process of assimilation becomes important as we support multicultural sensitivity and well-being of all cultural groups and individuals.

### Historical Background

Sarah Simons in 1901 suggested that the word *assimilation* is rarely or inconsistently used in social science. The concept can be traced back to the first U.S. general treatise on immigration, published in 1848. It recorded that the United States was composed of immigrants from all over the world and that the policy of the United States was to transform everyone into British-like individuals. Scholars later called it Anglo-conformity theory. Although the practice of assimilation can be traced back thousands of years to the ancient conquerors, so well documented in the histories of Europe or Asia, this entry mainly addresses the

use of the word *assimilation* in psychology, sociology, and anthropology.

Milton Gordon, in his 1964 book, noted that the early use of the word *assimilation* can be traced to the concept of the melting pot, which was first proposed by the agriculturalist J. Hector St. John Crèvecoeur in 1782. In the following century, assimilation became influential in the field of American historical interpretation after Frederick Jackson Turner, in 1893, presented his paper discussing the fusion of Western frontier immigrants into a mixed English group—a new composite of American people. Politicians in the early 20th century maintained that the new types melting into one were already shaped by the American frontier in the process of nation making. The newer immigrants, mainly Southern and Eastern European at the time, were indoctrinated with the Americanism that had been established by earlier arrivals. Sociologists of that era equated assimilation with Americanization. While the concepts of Anglo-conformity and the melting pot dominated 20th-century thoughts, in the mid-1940s the sociologist Ruby Jo Reeves Kennedy studied intermarriage. She found that although intermarriage took place across national lines, there was a strong tendency for marriage to stay confined within three major religious groups, namely, Protestants, Catholics, and Jews. She posited that religion rather than nationality should determine or define assimilation and called it the “triple melting pot” theory of American assimilation.

### Assimilation as a Process

Assimilation is consistently treated as a process rather than a result. It is a process that is continuous in nature and varies in degree. It is not a concept that can be dichotomized. Direct contact between an individual or a racial minority group and persons of the majority or dominant culture is required for assimilation to take place. Contacts can also be described as primary and secondary contacts. Primary contact refers to a personal network, including marriage or strong personal friendships, whereas secondary contact refers to the wider range of interactions other than with primary contacts. In general, the more numerous the points of interactions are, especially in the primary contacts, the faster the process of assimilation occurs.

Assimilation also requires both a positive orientation toward and identification with the dominant group on the part of the assimilating individual or group. In addition, assimilation is contingent upon



acceptance by the dominant group because becoming a member of the dominant or host society necessitates acceptance by that society. Furthermore, assimilation comprises both internal and external change. It is more than making individuals look alike in appearance, language, or manners, that is, external change. It also involves changes in beliefs, values, and attitudes, that is, internal change. Both internal and external changes form the components of the assimilation process; changing one without the other is only partial assimilation. Other conditions, such as common language, racial and class equality, and religion, all play a significant role in the process of assimilation.

### Individual Versus Group Assimilation

Whether assimilation is to be treated as a group process, individual process, or both, has been discussed among scholars. For some, assimilation occurs when one enters into social relations, absorbs meaning generated from the interactions, and passes its significance to others. To these scholars, assimilation occurs at the individual level. Other scholars, such as Sara Simons and Bernard Siegel, restrict their discussions of assimilation to the group level, thereby implying that it is a group process. An example of group assimilation would be the Indian-Anglo of India in the early 1900s. As a group, they collectively identified with British and desired to be assimilated into British. They wore European clothes and regarded England as their home, despite the fact that they had never been there.

The popular position in the literature has treated the concept of assimilation process as an individual or a group phenomenon. Some scholars suggest that for minority groups that continually receive cultural influences from a larger parent cultural group, group assimilation could be difficult or even impossible. An example of this might be the continuing influence of Mexican immigrants in the United States. In such a case, individual rather than group assimilation becomes the norm. It is important to recognize that group isolation does not necessarily dictate group assimilation. Groups may resist being assimilated as a whole or may adopt an antagonistic acculturative attitude that also will affect group assimilation.

Dominant groups have justified segregation, mass expulsion, and even genocide on the grounds that certain groups are inassimilable because of their innate inferiority. For many years, Black Americans were barred from consideration as an assimilable element

of the American society, despite the fact that they made up nearly one fifth of the total population at the time of the American Revolution.

In contrast to forced segregation or expulsion, there are also programs designed for forced assimilation. This was the case in Russia where a program was designed to assimilate Jews by getting rid of their communal life at the end of 1950s. Similarly, the governments of the United States and Australia designed programs to force assimilating of their native populations in the 19th and 20th centuries.

### Direction and Dominance

The assimilation process has traditionally been regarded as a unidirectional process. It implies that the assimilating individuals or groups are always being pulled toward the dominant culture. The dominant culture serves as an active element, and the assimilating individuals or groups serve as a passive element. Simon, in 1901, proposed three factors that determine the direction of the assimilation process:

1. The relative culture stage of the element involved. Simon proposed that if a culture is perceived to be superior, it is likely to be the dominant culture irrespective of the number of people in that cultural group.
2. The relative mass of the two elements. Although the number of people in a group is not as influential as the perceived superiority of a culture, the number of people in a cultural group is still a determining factor in the direction of the assimilation process.
3. The relative intensity of race-consciousness. That is, the greater the intensity of the assimilating group's racial consciousness, the more resistance is displayed by the assimilating individual or group. This consciousness may be so intense as to prevent all assimilation from taking place. For instance, the intense cultural awareness of the ancient Greeks caused the Roman conqueror to adopt the Greek culture rather than assimilate the Greeks into the Roman culture.

Some scholars also support the view of history that suggests that the majority of nationalities resulted from conquest and assimilation. This leads those thinkers to postulate that conquest changes not only the conquered, the assimilating group, but also the conquerors, the dominant group. This mutually interactive process is usually referred to as *acculturation*. Most scholars maintain that assimilation is a unidirectional



process pulling the minority individuals or groups from the minority culture to the dominant culture.

### Assimilation and Acculturation

It is almost impossible to study assimilation without considering the process of acculturation. These concepts are often treated as being identical or as stages of one another. The anthropologists and sociologists, who began the study of acculturation, often used these terms interchangeably. In the current literature on intercultural interactions, assimilation and acculturation are seen as separate processes that can be related to one another. Acculturation can be described as a process that involves changes in cultural practices or behaviors as well as social and institutional structural changes among individuals or groups of two or more cultural backgrounds or cultural systems as a result of contacts. It continues for as long as there are culturally different groups in contact. Both assimilation and acculturation are long-term processes that may take years or even generations to change. Sometimes this process may take centuries. They both take place most rapidly and completely in primary social contacts, which include intermarriage and other forms of intense personal relationships.

The process of assimilation differs from the process of acculturation in several important aspects. First, acculturation does not require dominant group acceptance, whereas assimilation does require such acceptance. Second, assimilation requires that the minority group have a positive orientation and identification toward the dominant group. Simply making oneself appear and act like the dominant cultural group does not constitute assimilation. Assimilation requires internal value change; that is, individuals come to be a part of an association, absorb the meaning of the association, and contribute to the correction and improvement of the association. Furthermore, assimilation requires the assimilating individual or group to relinquish the identification with the heritage group and seek identification with the dominant group that results in becoming less distinguishable from them. Acculturation does not require such a unidirectional process. It involves a two-way reciprocal relationship in which the dominant and acculturating groups make changes. Also, one may acculturate but not lose his or her personal heritage.

Whether assimilation is a phase of acculturation or vice versa has also been discussed among scholars. Robert Park, for example, is known for his notion that

assimilation is the final stage of a natural progressive, inevitable, and irreversible race relations. He posits that when stabilization is achieved, race relations would assume one of three configurations: (1) a caste system, (2) complete assimilation, or (3) the unassimilated race constituting a permanent racial minority. Milton Gordon further proposed that acculturation is the first stage of assimilation and, although it does not lead to structural assimilation, inevitably produces acculturation. Among anthropologists, as documented in the Social Science Research Council 1953 Summer Seminar, acculturation is commonly treated as a necessary but insufficient condition of assimilation, which is treated as a second type of progressive adjustment. The first type of progressive adjustment is cultural fusion, which refers to a formation of a third sociocultural system through a process of intercultural contacts among two or more autonomous systems.

Other scholars, such as John Berry and his colleagues, advocate for assimilation as a phase of acculturation. They developed a bidimensional model that focuses on the process of group and individual adaptation within pluralistic societies. These two dimensions allow for a fourfold classification and four acculturation strategies. In this model, individuals or groups decide whether to maintain their cultural identity and customs or to engage in and pursue intergroup contacts. Integration occurs when one chooses to engage in intergroup contacts while maintaining one's own cultural identity. Assimilation occurs when one chooses to engage in intergroup contacts while relinquishing one's cultural identity. Separation occurs when one chooses to maintain one's cultural identity and customs while giving up intergroup contacts. When one loses cultural and psychological contacts to both cultures, the result is marginalization. In this model, assimilation is considered a phase of the process of acculturation, and integration is the preferred way to acculturate.

*Chun-Chung Choi and Jun-chih Gisela Lin*

*See also* Acculturation (v3); Adaptation (v3); Cultural Accommodation and Negotiation (v3); Cultural Values (v3); Enculturation (v3); Person–Environment Fit (v4); Person–Environment Interactions (v2)

### Further Readings

Berry, J. W. (2005). Acculturation: Living successfully in two cultures. *International Journal of Intercultural Relations*, 29, 697–712.



- Gordon, M. M. (1964). *Assimilation in American life: The role of race, religion and national origins*. New York: Oxford University Press.
- LaFromboise, T., Coleman, H. L. K., & Gerton, J. (1993). Psychological impact of biculturalism: Evidence and theory. *Psychological Bulletin*, 114, 395–412.
- Sayegh, L., & Lasry, J. (1993). Immigrants' adaptation in Canada: Assimilation, acculturation, and orthogonal cultural identification. *Canadian Psychology*, 34, 98–109.
- Simons, S. E. (1901). Social assimilation. *American Journal of Sociology*, 6, 790–822.
- Social Science Research Council. (1954). Acculturation: An exploratory formulation. *American Anthropologist*, 56, 973–1002.
- Teske, R. H. C., & Nelson, B. H. (1974). Acculturation and assimilation: A clarification. *American Ethnologist*, 1, 351–367.

---

## ASSOCIATION OF BLACK PSYCHOLOGISTS

---

The Association of Black Psychologists is a professional organization born out of the need to have issues of mental health and the psychological well-being of persons acknowledging African descent addressed more effectively. In the social context of racism and monocultural hegemony common in the United States, the profession of psychology had not escaped historic bias. The need for a cultural relevance and cultural congruence had not been acknowledged in a meaningful manner. The Association of Black Psychologists is the first organization of ethnic-minority professional psychologists to step forward and demand the American Psychological Association begin to address and better meet the mental health needs of people of color.

The foundation upon which Western psychology, and European American psychology in particular, rests with regard to its capacity to identify, address, and respond appropriately to the mental health needs of persons of African descent, more specifically those whose ancestors' forced labor built the wealth upon which the U.S. economy is built, is quite tenuous. Such a history in the evolution of psychiatry and psychology cannot be ignored because it has a great impact on the mental health and well-being of those African Americans in the society who have been and are reliant on the mental health system, its institutions, and its professionals for meeting their mental health needs.

Further, great consideration must be given to the issue of the training, policies, and practices in place, or not in place, designed to address and overcome the monocultural bias that has characterized the development and delivery of mental health services for nondominant populations. The Association of Black Psychologists would encourage practitioners and researchers to ask themselves the following series of questions: What has been and is the historical relationship between strongly held societal beliefs and professional mental health practices? When did these biased, self-serving, oppressive perspectives change? What has caused or can cause a shift toward greater recognition and appreciation of the full humanity of these people of African descent and their progeny? To what extent are the prevailing societal beliefs and attitudes reflected in current mental health perceptions, policies, and practices?

## History

The Association of Black Psychologists was founded in San Francisco in 1968 by a number of Black psychologists from across the country. They united to actively address the serious problems facing Black psychologists and the larger Black community. Guided by the principle of self-determination, these psychologists set about building an institution through which they could address the long neglected needs of Black professionals. Their goal was to have a positive impact upon the mental health of the national Black community and, later, international community by means of planning, programs, services, training, and advocacy. This goal was to be met by pursuing the following objectives: (a) to organize their skills and abilities to influence necessary change, and (b) to address themselves to significant social problems affecting the Black community and other segments of the population whose needs society has not fulfilled.

The Association of Black Psychologists has grown from a handful of concerned professionals into an independent, autonomous organization of over 1,400 members. Its membership now comprises people of color from all over the world.

## Mission, Purposes, and Goals

African American psychologists were the first group of ethnic minority professionals to take the courageous step of forming an organization focused on



identifying and meeting the mental health needs of persons acknowledging African descent. Articulating a mission to liberate the African mind, illuminate the African spirit, and empower the African character, the Association of Black Psychologists has charted its destiny based on very high goals and ideals. In that regard, it is committed to improving health and mental health, promoting social change toward a more just and sustainable society and world, and advancing African psychology and the capacity of humanity to heal and become holistically sustainable.

The Association of Black Psychologists is committed to solving the plethora of problems confronting Black communities and the communities of other ethnic groups. To accomplish these aims, the association is governed by its board of directors and organized into local chapters. Dedicated to fulfilling its mission, the association performs several functions geared toward the establishment and maintenance of a strong core and critical mass of Black psychologists organized to support and advance research, scholarship, and practice. This agenda has included publishing the *Journal of Black Psychology* and also offering various professional and paraprofessional training programs to address the critical needs of African descent people. Among the organization's other foci are recruiting students to the field, supporting and mentoring faculty in the field, developing and promoting community mental health care programs, articulating and disseminating psychological research and knowledge grounded in the African cultural tradition and cultural frame of reference, and pursuing its mission via all available avenues.

The organizational goals of the association are many and varied, and enhancing the understanding and psychological well-being of people acknowledging African descent in the United States and throughout the world is high among them. This goal is furthered by the promotion of solid, culturally congruent and consistent research methods, strategies, and approaches to the study of Black people, their experiences, and the impact of extended oppression and multigenerational trauma. Requiring the development of theories and constructs consistent with the experience and cultural realities of Black people, the association has been a key forum for the dissemination and proliferation of such knowledge. It has also led to the establishment of guidelines and standards for researching and treating persons acknowledging African descent. A strong international component and network of support systems for Black psychologists has

been developed and is being maintained for professionals and students.

The Association of Black Psychologists has also worked to develop policies on the local, state, and national levels to improve mental health outcomes, provide culturally competent services, and support effective human service delivery methods. Much of this work has come about because of the keen awareness of the pervasive racial biases and discriminatory social policies and practices common to U.S. society and evidenced throughout the world, making the association a key force in monitoring and promoting the survival and well-being of members of the racial and ethnic communities it represents. The association works with other organizations sharing its vision and mission to aid in the development and support of institutions geared toward enhancing the psychological, cultural, educational, social, and economic health of persons acknowledging African descent and their communities.

Linda James Myers

*See also* African Americans (v3); Afrocentricity/Afrocentrism (v3); Black Psychology (v3); Black Racial Identity Development (v3); Career Counseling, African Americans (v4); White, Joseph L. (v3)

### Further Readings

- Belgrave, F. Z., & Allison, K. W. (2005). *African American Psychology: From Africa to America*. Thousand Oaks, CA: Sage.
- Bynum, E. B. (1998). *The African unconscious: Roots of ancient mysticism and modern psychology*. New York: Teachers College Press.
- Guthrie, R. (2003). *Even the rat was white: A historical view of psychology* (2nd ed.). Boston: Allyn & Bacon.
- Jones, R. L. (Ed.). (2003). *Black psychology* (4th ed.). Hampton, VA: Cobb & Henry.

### Web Sites

Association of Black Psychologists: <http://www.abpsi.org>

---

## ATKINSON, DONALD RAY (1940–2008)

---

Donald Ray Atkinson (born February 10, 1940, in Union City, Indiana) is best known for his pioneering



work in the area of multicultural counseling psychology and his leadership in mentoring doctoral students of color into prominent professional positions in counseling psychology across a career spanning more than 30 years. The story of his life exemplifies the values that he promoted during his career. He grew up on the margins of poverty and served in the military before working his way through school, rearing a family on his own, and becoming one of the most frequently cited scholars in the area of multicultural or cross-cultural counseling.

### Early Life

Atkinson spent his childhood in poverty in the mid-western United States, first in Indiana and then in Wisconsin. His family lived in an assortment of apartments, trailer parks, and unfinished garages while his parents worked a variety of different jobs trying to make ends meet. Atkinson was diagnosed with rheumatic fever when he was 15 years old. His only sibling died at an early age from cerebral palsy. After graduating from high school and serving in the U.S. Navy for 2 years, Atkinson moved on to college at Wisconsin State College in La Crosse where he received a B.S. in teacher education in 1964. He was able to attend college only because of a meager life insurance policy paid to his family after his brother died. For a short period of time, he worked as a teacher at a small high school in Menominee Falls, Wisconsin, while he continued his education at the University of Wisconsin–Milwaukee to earn a degree in guidance and counseling in 1966. He later became a guidance counselor at his old high school in Baraboo, Wisconsin. Eventually, Atkinson moved on to pursue his doctorate at the University of Wisconsin–Madison in 1968, where he studied under the tutelage of Marsh Sanborn.

It was during his doctoral studies that Atkinson met his first wife and started a family with the birth of two sons, Jimmy and Robert. Soon, however, Atkinson found himself raising his sons on his own as a single parent after his wife left under the stress of Jimmy Atkinson's severe developmental disability. Following a brief stint at a college counseling center at Moorhead State College, Minnesota, Atkinson moved to the University of California, Santa Barbara (UCSB), in 1972 to become an assistant professor in the counseling psychology program.

### Early Career

Atkinson joined Jules Zimmer and Ray E. Hosford to become only the third faculty member in the counseling psychology program at UCSB. Over the course of Atkinson's career, the counseling psychology program at UCSB became one of the most prominent training grounds for multicultural counseling psychology. Although Atkinson was joined by numerous colleagues of considerable prominence, including such psychologists as J. Manuel Casas, Gail Hackett, Tania Israel, Chalmer Thompson, Nolan Zane, Glenn Good, Louise Fitzgerald, Elizabeth Holloway, Patricia Wolleat, Gayla Margolin, Steven Brown, Michael Mahoney, and Larry Beutler, the reputation and achievements of the program in the area of cross-cultural counseling can be substantially attributed to Atkinson's efforts and accomplishments.

During Atkinson's early years at UCSB, the counseling psychology program was not ranked among the top contributors in the field's flagship research outlet, the *Journal of Counseling Psychology (JCP)*. Later, however, UCSB began to appear among the highest-ranked institutions in *JCP* publications, placing 10th in 1983, 6th in 1994, and 9th in 2000, largely as a consequence of Atkinson's scholarly works. Yet again, he was recently ranked 4th among scholars contributing to the literature on multicultural counseling competencies empirical research over the course of 20 years. Furthermore, Atkinson was ranked 10th in a study of contributions to the *Journal of Multicultural Counseling and Development* from 1985 to 1999, and he was identified as the top-ranked contributor of racial-ethnic minority research in *JCP* from 1988 to 1997.

Over the course of his career, Atkinson published 109 peer-reviewed journal articles, along with three books and 15 book chapters. Nevertheless, he has won only a few awards over the course of his career for his outstanding achievements, in part because he actively avoided the limelight. He achieved fellow status in the Society of Counseling Psychology (Division 17 of the American Psychological Association [APA]), the Society for the Psychological Study of Ethnic Minority Issues (Division 45 of the APA), and the American Psychological Society. In 2000, he was recognized in a Division 17 symposium at the annual APA convention as one of the "Multicultural Scholars of the Millennium." He was recognized in 2001 for his Distinguished Career Contributions to Research by Division 45, and in 2005 he was given a



Presidential Citation and Elder Recognition Medal at the National Multicultural Conference and Summit. In 2006, Atkinson was honored with the Leona Tyler Award by the Society of Counseling Psychology, the society's highest form of recognition.

## Major Contributions

Although Atkinson is best known for his contributions in the area of multicultural counseling, his career did not begin on that path. In fact, Atkinson credits his doctoral students for propelling him into the field of study that became his life's commitment. Despite his active efforts to recruit women and students of color into the doctoral training program at UCSB, it was not until his sixth year as a professor there that his first publication in the area of multicultural counseling appeared (his 17th publication overall). Until that time, Atkinson's publications included a combination of topics such as behavior modification, student personnel services, and counselor training. After 1983, however, the vast majority of his scholarship began to focus on multicultural issues and many of his works became seminal to the field.

In 1983, Atkinson published one of his most frequently cited articles in *The Counseling Psychologist*, "Ethnic Similarity in Counseling." In 1993, Atkinson published (with Chalmer Thompson and Sheila Grant) "A Three-Dimensional Model for Counseling Racial/Ethnic Minorities," one of only a few major theories of multicultural counseling. Across time, Atkinson's focus within multicultural counseling began to broaden to diversity issues beyond race and ethnicity. This trend was most noticeable in the publication of his two early books: *Counseling American Minorities* (now in its sixth edition), which focused on race and ethnicity, and *Counseling Diverse Populations*, which focused on gender, sexual orientation, aging, and disability. In this way, Atkinson became one of very few scholars in the field to produce such a broad array of works that exemplify the true meaning of *multiculturalism*.

During one of the more difficult periods in his career, Atkinson often discloses that he contemplated changing the focus of his scholarship in the face of criticism that as a European American, he should not be conducting research about people of color. To this

day, he credits Teresa LaFromboise with convincing him to stay the course and continue his line of research. His many graduate students, colleagues, and consumers of his scholarship are grateful that she held sway on that dilemma.

Among his numerous accomplishments during his career as an educator, Atkinson recounts tremendous fulfillment in the number of doctoral advisees he mentored who went on to pursue academic careers in counseling psychology, including but not limited to Bruce Wampold, Michael Furlong, Ruth Gim Chung, Cindy Juntunen, Jose Abreu, Linda Mathews, Susanna Lowe, Bryan Kim, Sheila Grant, and Roger Worthington, many of whom are members of racial and ethnic minority groups. There also were many others, too numerous to mention, who studied under Atkinson's mentorship and went on to make important contributions in careers outside of academic psychology. Beyond his own professional triumphs, Atkinson has been known to express his greatest pride in the accomplishments of his students. He died on January 11, 2008, from pancreatic cancer.

*Roger L. Worthington and Bruce E. Wampold*

*See also* Casas, Jesús Manuel (v3); LaFromboise, Teresa Davis (v3); Multicultural Counseling (v3); Tyler, Leona E.: Human Multipotentiality (v2)

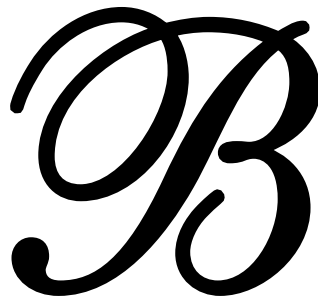
## Further Readings

- Atkinson, D. R. (1983). Ethnic similarity in counseling. *The Counseling Psychologist*, 11, 79–92.
- Atkinson, D. R. (2004). *Counseling American minorities* (6th ed.). Boston: McGraw-Hill.
- Atkinson, D. R., & Hackett, G. (2004). *Counseling diverse populations* (3rd ed.). Boston: McGraw-Hill.
- Atkinson, D. R., Maruyama, M., & Matsui, S. (1978). The effects of counselor race and counseling approach on Asian Americans' perceptions of counselor credibility and utility. *Journal of Counseling Psychology*, 25, 76–83.
- Atkinson, D. R., Thompson, C. E., & Grant, S. K. (1993). A three-dimensional model for counseling racial/ethnic minorities. *The Counseling Psychologist*, 21, 257–277.
- Atkinson, D. R., Wampold, B. E., & Worthington, R. L. (2007). Our identity: How multiculturalism saved counseling psychology. *The Counseling Psychologist*, 35, 476–486.









---

## **BARRIERS TO CROSS-CULTURAL COUNSELING**

---

When counseling culturally diverse clients, counselors will often encounter many obstacles or barriers. These barriers can stem from the counselor's lack of cultural knowledge to language differences between the counselor and client. Barriers to cross-cultural counseling can negatively influence the counseling relationship as well as the outcome of counseling. The literature has even linked these cultural barriers to the underutilization and premature termination of counseling services by ethnic minorities and low-income persons. An increasing awareness of these barriers has led to changes in counselor preparation and the delivery of counseling services to culturally diverse populations. In this entry, seven barriers to cross-cultural counseling are described.

### **Lack of Counselor Cultural Self-Awareness**

A major barrier to effective cross-cultural counseling is the counselor's lack of cultural self-awareness. Cultural self-awareness refers to the counselor's awareness and acknowledgment of his or her own cultural beliefs, attitudes, and values as well as an awareness of his or her biases and faulty assumptions about other groups. Essentially, a counselor with a heightened sense of cultural self-awareness acknowledges and recognizes when his or her culture is contradictory to a client's culture. When a counselor does not recognize that he or

she has biased views and stereotypical beliefs about other groups, he or she will likely provide ineffective counseling services and experience high rates of client dropout. Also, a culturally aware counselor is able to recognize when he or she is conceptualizing a client's case based on prejudiced and/or stereotypical beliefs about a particular group of people.

### **Lack of Counselor Cultural Knowledge**

In many cases, the counselor's lack of cultural knowledge can serve as a barrier to effective cross-cultural counseling. Cultural knowledge includes the counselor's understanding and knowledge of other cultural groups' behaviors, norms, beliefs, and attitudes. Both counselors and clients bring to counseling a set of cultural norms that have been reinforced for long periods of time. These norms then influence the way in which the counselor and client perceive their world, each other, and their approach to counseling. Counselors who are knowledgeable of their clients' cultural preferences and norms are better equipped to make appropriate clinical decisions. For example, in some cultures, passivity rather than assertiveness is revered. A counselor adhering to the Western culture may have great difficulty understanding a Chinese client's unwillingness to "demand" more from others. However, after learning more about the client's culture, the counselor introduces counseling interventions that take into account Chinese cultural norms.

When counselors lack knowledge of varying cultural groups, they will often rely on stereotypes to better understand clients from different cultural



backgrounds. Stereotypes are often negative, based on faulty perceptions, and are of unspecified validity. Many argue, however, that some stereotypes or generalizations can be helpful in the process of learning to understand other cultures. African Americans are an example of an entire ethnic minority group that has been subject to historical and contemporary stereotyping. African American stereotypes have ranged from portrayals of African Americans being lazy and intellectually inferior to being violent and poor. For example, a White career counselor might assume that an African American client is not able to pay for a series of career-exploration courses. The counselor, therefore, fails to share information about the workshops with the African American client but she shares the information with a White client. Her faulty assumption is based on the stereotype that all African Americans are poor, from low-income backgrounds, or both.

Counselors are often ineffective with culturally diverse clients because they view cultural differences as deficits rather than strengths. In addition, counselors will often neglect to discuss a client's problems in the context of current social issues facing the client. Counseling professionals create barriers in counseling when they do not consider clients' problems in the context of educational, economic, social, political, legal, and cultural systems. The deficit perspective, coupled with a neglect to address social contextual issues, can hinder the cross-cultural counseling process.

Because of the vast number of cultures that clients may ascribe to, it is impossible for a counselor or therapist to know everything about every culture. Working together with a counselor, healer, or helper from an unknown culture can vastly improve a counselor's ability to be effective and the probability of success in implementing appropriate interventions.

### **Lack of Culturally Appropriate Counseling Skills**

Distinctions can be made between general counseling skills, which may include active listening, empathy, and illustrating genuineness, and the specific skills that are central to working with a client who is culturally different. Counselors who lack multicultural counseling skills are at risk of providing culturally insensitive counseling. Examples of skill requirements specific to cultural competency are (a) determining effective ways to communicate with a client that may use a different style of thinking, information

processing, and communication; (b) discussing race and racial differences early in the counseling process; (c) engaging in multiple verbal and nonverbal helping responses, recognizing responses that may be appropriate or inappropriate within a cultural context; (d) using resources outside of the field of psychology, such as traditional cultural healers; and (e) modifying conventional forms of treatment to be responsive to the cultural needs of the client. Some counseling professionals have indicated that there is no simple methodology or approach that can easily define the "how-to" in the counseling session with the culturally diverse client. One of the greatest dilemmas in the area of cultural competency is determining what counseling strategies and interventions are most effective with different cultural groups.

### **Language Barriers**

Language may be a barrier in the cross-cultural counseling process. Language differences in counseling can lead to miscommunications, misdiagnoses, and misinterpretations. A lack of language or communication skills often emerges as a major stressor for clients who are bilingual, immigrant, or both. It is also important to consider immigrant clients' level of acculturation, which might be linked to their command of their native and English languages. Bilingual clients may have the ability to express themselves in English in a rudimentary way but may need to use their native language to discuss more emotional subjects. Because of language barriers, many immigrants will avoid counseling services for fear of being unable to communicate with counselors. Likewise, counselors may avoid immigrant clients because the language barrier frustrates them.

Because counseling is a process of interpersonal interaction, communication is paramount to the counseling process. Both parties in counseling interpret the information transmitted between them, and if interpreted inaccurately, the counseling process and outcomes can be negatively influenced. The difficulties related to communication are most prevalent when interpreting nonverbal patterns because nonverbal communication is highly influenced by culture. Types of nonverbal communication that are important in cross-cultural counseling include proxemics, kinesics, paralanguage, high-low context communication, and kinesthetic. *Proxemics* is the use of personal space and appropriate distance in social interactions. For example, Latinos/as tend to stand close, touch, and avoid



eye contact, whereas White Americans ascribe to greater physical distance between individuals, avoid touching, and maintain eye contact. *Kinesics* are bodily movements such as facial expressions, gestures, posture, and eye contact. Different cultures have different meanings attached to these bodily movements and expressions. *Paralanguage* refers to vocal cues that are used to communicate, such as volume and intensity of speech and turn taking. For example, in some cultures, speaking loudly may not indicate anger, hostility, or poor self-control and speaking softly may not be a sign of weakness, lack of confidence, shyness, or depression. *High-low context communication* refers to an individual's primary communication style. For example, high-context communicators rely on nonverbal cues and behaviors, whereas low-context communicators rely on the verbal part of the interaction or the spoken word. *Kinesthetic* refers to touching. Touching in some cultures indicates a very personal and intimate gesture, whereas in other cultures extensive touching is commonplace and expected.

### Client Distrust and Fears

When counseling ethnically and culturally diverse clients, counselors might encounter clients whose past experiences with oppression will hinder the development of a trusting relationship. It is not uncommon for clients of marginalized and historically oppressed groups to approach counseling with feelings associated with past experiences of discrimination and oppression. These clients might come to counseling with a great deal of "healthy suspicion" and distrust based on racial and cultural biases in the larger society. This unconscious process of bringing past conflicts into counseling is called *transference*. For example, an African American client may have difficulty trusting a White counselor because of African Americans' history of oppression in the United States. Understanding sociopolitical events and forces in the larger society is critical for counselors of culturally diverse clients.

*Counselor countertransference* can also create a barrier to effective cross-cultural counseling. Counselor countertransference is defined as those responses to the client that are based on the counselor's past significant relationships and experiences with persons in the client's cultural group. For example, a heterosexual male counselor may respond angrily to a homosexual male client based on the counselor's disappointment and anger with his homosexual brother. Effective cross-cultural

counselors must then recognize transference and countertransference, as both are important to understanding the feelings, behaviors, and attitudes in the cross-cultural counseling relationship.

Many persons from ethnic minority and low-income backgrounds have little or no prior understanding of counseling. Therefore, when they do come to counseling, they may be distrustful of the process. Fear of being labeled "crazy," fear of deportation, and fear of disclosing "family issues and secrets" may all be experienced by culturally and ethnically different clients. Because of distrust and fears regarding the counseling process, counselors may experience clients who make an appointment but do not show for the first appointment or come to their first appointment and never return. For instance, a doctor has referred a Latina client with very little English proficiency to counseling. Without any prior information about the nature of counseling, the client is frightened by the paperwork and extensive intake procedures at the counseling agency, and she does not return for her next counseling appointment.

### Racial Identity Development

Racial identity has been identified as an important concept when examining cross-cultural relationship development. Racial identity theory refers to an individual's racial self-conception as well as his or her beliefs, attitudes, and values relative to other racial groups. Racial identity development is a maturational process in which an individual uses more complex cognitive-affective ego statuses to perceive of herself or himself as a racial being. It is also assumed that the individual is also developing racial meanings about members of his or her own affiliated and reference racial groups. There is a relationship between racial identity and the quality of the client-counselor relationship. In particular, a difference in the counselor's and the client's racial identities might become a barrier to effective cross-cultural counseling. It is even possible that the psychological meaning that individuals attribute to their race and racial group affiliation can determine how a client and counselor will interact with each other. For instance, an African American counselor who harbors anger and self-hatred about her racial group may transmit her anger and frustration in counseling sessions with an African American adolescent who is immersed and exploring racial meaning. The adolescent terminates counseling



after one session because she states that she “can’t relate to the counselor’s views on Black people.” Clients and counselors of the same cultural group may experience tension or lack of rapport as a result of differing levels of racial identity development.

### Lack of Multicultural Counseling Training

There is extensive literature suggesting that “traditional” and “culturally insensitive” counselor training leads to ineffective cross-cultural counseling. As such, one barrier to effective cross-cultural counseling is the lack of multicultural counseling training among counseling professionals. Despite the fact that many counselor training programs have revised their curricula to include issues pertaining to race, culture, and ethnicity, there are still counselors who have not received adequate multicultural counseling training to effectively counsel clients of culturally different backgrounds.

*Cheryl Holcomb-McCoy*

*See also* Bilingual Counseling (v3); Career Counseling (v4); Communication (v3); Counseling Skills Training (v2); Counseling Theories and Therapies (v2); Counselors and Therapists (v2); Cross-Cultural Psychology (v3); Cross-Cultural Training (v3); Multicultural Counseling Competence (v3); Racial Identity (v3); Therapist Techniques/Behaviors (v2)

### Further Readings

- Baruth, L., & Manning, M. L. (2006). *Multicultural counseling and psychotherapy: A lifespan perspective*. Upper Saddle River, NJ: Prentice Hall.
- Ponterotto, J. G., Casas, J. M., Suzuki, L. A., & Alexander, C. M. (2001). *Handbook of multicultural counseling*. Thousand Oaks, CA: Sage.
- Sue, D. W., & Sue, D. (2008). *Counseling the culturally diverse: Theory and practice* (5th ed.). New York: Wiley.

---

## BERNAL, MARTHA E. (1931–2001)

---

Martha E. Bernal was the first Latina to earn a Ph.D. in psychology. She is best known for pioneering effective ways to treat children with behavioral disorders, her model of ethnic identity for Latino/a children, and

providing leadership to the American Psychological Association (APA) for redressing problems with training minority students. Any one of these achievements would be sufficient for claiming a successful career; combining all three sets of accomplishments into a single career is truly meritorious. How did she accomplish so much? She did so through commitment to high standards and clarity of vision. She set high standards and goals for herself and expected much of others, including the APA, and worked tirelessly until she and others met these expectations. Moreover, her clarity of vision helped her imagine possibilities that others around did or could not. She imagined herself going to college at a time and place when women, particularly Mexican American women, were not viewed as legitimate for a college education. She imagined a new way of treating behavioral disorders despite resistance from the field. Finally, she had a vision in which the APA could promote the training of minority students who could go out and provide effective mental health treatment to underserved populations. The challenges she faced along the way to meeting her goals reveal that overcoming personal and sociocultural barriers may be as impressive as her professional accomplishments.

### Childhood

Bernal’s is a compelling personal story deserving of admiration and respect. Born in San Antonio, Texas, to parents who had recently immigrated from Mexico, she was raised in El Paso, Texas, in the context of significant discrimination against her and her Mexican American peers. She arrived in kindergarten to learn that speaking her native language, Spanish, would lead to punishment by teachers and administrators. Her early public schooling reflected the actual and symbolic silencing of her and her peers’ voices and ambitions. This discrimination socialized them in their second-class social status relative to Anglo peers and population. Her memories of the discrimination of Mexican Americans in El Paso remained painful into adulthood. Through these early experiences, Bernal later realized she had internalized some of this racism, which required reflective and contemplative work to overcome.

She described her family as reflecting traditional Mexican values, which she considered a blessing but also a challenge to carving out a nontraditional role for her as a Mexican American woman. Despite her negative experiences in El Paso’s larger community, she had warm and fond memories of growing up in a



tight-knit extended family and circle of friends. She was forever thankful for the love, support, and companionship she received while growing up. One of the biggest sacrifices she made in forging a nontraditional career was the loosening of these bonds as she entered the world of academic psychology. Nonetheless, many of her childhood friendships were maintained throughout her life despite her pursuing a lifestyle that was very different from the rest of her peers.

## Education

As she set her sights on a nontraditional career path, she faced many doubts from school teachers and school counselors and pressure from her Mexican American family and community not to pursue a college degree. In breaking with cultural tradition, Bernal defied her father's wishes and announced she was attending college. She worked for a year to save enough to start her long academic career. Despite his misgivings, her father provided much needed financial support to his daughter even though this posed financial hardships for him. In 1952, Bernal graduated from the Texas Western College, now the University of Texas at El Paso. She then set her sights on a graduate education, which reawakened the cultural and familial prohibitions against pursuing a nontraditional career and occupational path. She somewhat naively sought an assistantship at Louisiana State University but quit after a year when she realized the assistantship was no more than a clerical position and would not provide the training in psychology for which she yearned. She earned a master's degree in special education at Syracuse University in 1959 and eventually enrolled in Indiana University's Ph.D. program in clinical psychology. While in graduate school, she and her female classmates faced sexism and sexual harassment. Despite her dissertation mentor's death prior to her finishing dissertation, Bernal received her Ph.D. in psychology in 1962, the first Latina to have ever received that degree in that field. Bernal had overcome significant personal, familial, cultural, and gender-based challenges before she could even face the significant academic challenges. Earning the Ph.D. is a testament to Bernal's intelligence and perseverance.

## Research Career

Having overcome significant barriers and challenges to obtain her Ph.D. and having entered an elite status

as the recipient of a Ph.D., it would be natural to assume most of the challenges related to racism and sexism were behind her. Yet, sexism and probably racism continued to influence her career. In response to applications for faculty positions, Bernal received notice that some positions did not hire women. Instead, she obtained a postdoctoral position at the University of California, Los Angeles (UCLA), before securing a faculty position at the University of Arizona in Tucson, where she stayed only 1 year, in part because of isolation, before returning to UCLA.

## *Pioneering Behavioral Treatment of Children*

During the first half of her academic career, Bernal pioneered work on behavioral strategies for working with those with psychiatric and behavioral disorders. At the time, the field of psychology was still enamored with a psychoanalytic view of disorders in which schizophrenia, for example, was attributed to bad parenting, typically bad mothering, and for which the treatment (e.g., psychoanalysis) was costly, arguably inefficient, and not available to many. Instead, Bernal offered very humane treatment that provided cost-effective treatment to long-standing problems and symptoms. Despite receiving scorn from her psychoanalytic colleagues, Bernal persevered and received National Institute of Mental Health and other federal grants supporting her innovative work at a time when there was no affirmative action program and her minority status probably worked against her in securing these important grants. Her work, along with other colleagues, developing behavioral treatments revolutionized the field in ways that continue to be practiced in schools for children with behavioral disorders and inpatient and outpatient facilities that provide effective treatment for debilitating disabilities. Her work focused on training parents and other adults to assist in the treatment of children's psychological problems. In this way, her work was effective in reducing the psychological distress of many children. She was widely recognized as one of the nation's foremost authorities and experts in this area of research.

## *Latina Researcher*

Bernal refocused her research in the second half of her career, beginning in the early 1980s. This re-tooling corresponded to a period of reflection and introspection as a Mexican American woman. She made the painful



realization that she was not immune to the pervasive bias against the abilities of minority students and faculty. Subsequently, she sought to re-educate herself and experienced a personal transformation that led to her passion to work toward equity in psychological training for historically underrepresented groups. She was part of the early efforts for minority psychologists to organize as an influential body to provide leadership to psychology and facilitate the next generation of minority psychologists. She became active in the APA's efforts to diversify its training and make it more relevant for recruiting and training more diverse cohorts of psychologists and to help the APA provide the necessary resources to meet more of the diverse mental health needs of the nation. She called attention to the small number of minority faculty and students in clinical and counseling psychology programs and worked with the APA to develop practices that have helped to diversify the field. She quickly became the national authority on the training of minority psychologists. She had since moved from UCLA to the University of Denver. In 1986 she joined the psychology faculty at Arizona State University and joined the Hispanic Research Center. She shifted her own empirical focus to investigate Hispanic children. She proposed a groundbreaking model of Hispanic children's ethnic identity development and conducted an influential program of research with colleagues while mentoring the next generation of Hispanic scholars.

Her distinguished career was recognized with a long list of awards, including a distinguished lifetime career award from Division 45 (Society for the Psychological Study of Ethnic Minority Issues) of the APA and the Award for Distinguished Senior Career Contributions to the Public Interest by the APA. Throughout her career, Bernal could envision and realize goals for her education and psychology that others did not. Through considerable perseverance, Bernal realized these goals and, in the process, made meritorious contributions to the treatment of children's behavioral disorders, to the understanding of Hispanic children's ethnic identity, and to the training of minority students in psychology. Sadly, on September 28, 2001, Bernal succumbed to her third bout with cancer and died. Despite her passing, her work lives on, and the world and field are better because of her.

*Stephen M. Quintana*

**See also** Ethnic Identity (v3); Ethnic Minority (v3); Latinos (v3); Racial Pride (v3); Racism (v3); Sexism (v3); Social Justice (v3)

## Further Readings

- Bernal, M. (1988). Martha E. Bernal. In A. O'Connell & N. Russo (Eds.), *Models of achievement: Reflections of eminent women in psychology* (Vol. 2, pp. 263–276). Hillsdale, NJ: Lawrence Erlbaum.
- Bernal, M. E. (1980). Hispanic issues in psychology: Curricula and training. *Hispanic Journal of Behavioral Sciences*, 2, 129–146.
- Bernal, M. E. (1990). Ethnic minority mental health training: Trends and issues. In F. C. Serafica, A. I. Schwebel, R. Russell, & P. Isaac (Eds.), *Mental health of ethnic minorities* (pp. 249–274). New York: Praeger.
- Bernal, M. E., Klinnert, M. D., & Schultz, L. A. (1980). Outcome evaluation of behavioral parent training and client-centered parent counseling for children with conduct problems. *Journal of Applied Behavior Analysis*, 13, 677–691.
- Bernal, M. E., & Knight, G. P. (Eds.). (1991). Ethnic identity and psychological adaptation [Special issue]. *Hispanic Journal of Behavioral Sciences*, 13(2).
- Bernal, M. E., & Knight, G. P. (Eds.). (1993). *Ethnic identity: Formation and transmission among Hispanics and other minorities*. Albany: State University of New York Press.
- Bernal, M. E., & Knight, G. P. (1997). Ethnic identity of Latino children. In J. G. Garcia & M. C. Zea (Eds.), *Psychological interventions and research with Latino populations* (pp. 15–38). Boston: Allyn & Bacon.
- Bernal, M. E., Knight, G. P., Garza, C. A., Ocampo, K. A., & Cota, M. K. (1990). The development of ethnic identity in Mexican-American children. *Hispanic Journal of Behavioral Sciences*, 12(1), 3–24.
- Bernal, M. E., Sirolli, A. A., Weisser, S. K., Ruiz, J. A., Chamberlain, V. J., & Knight, G. P. (1998). Relevance of multicultural training to students' applications to clinical psychology programs. *Cultural Diversity & Ethnic Minority Psychology*, 5, 43–55.
- Vasquez, M. J. T. (2002). Complexities of the Latina experience: A tribute to Martha Bernal. *American Psychologist*, 57, 880–888.

---

## Bias

---

*Bias* is defined as distortion of judgment or perception of a person or group based on the person's or group's race, religion, ethnicity, gender, age, sexual orientation, heritage, or ancestry, resulting in differential treatment in clinical work, diagnosis, and testing. The term *bias* has been used interchangeably with *prejudice*, specifically related to holding a distinct point



of view or ideology. Stereotypes contribute to biases and negative perceptions of people who are different than oneself or perceived as an “outgroup.” Concurrently, individuals may use stereotypes to form biases and predict or explain behavior of members of an outgroup, although it is possible for individuals to hold biases and believe a stereotype but not apply it to certain individuals from that group.

A recent decrease in biases may be attributed to social norms that promulgate politically correct attitudes and behaviors rooted in conformity rather than an authentic reduction of prejudice. Subsequently, outright expressions of bias have become less acceptable causing some people to appear unbiased while holding biased viewpoints and creating a close link between internalizing and expressing personal bias and social acceptability.

Individuals typically are exposed to family bias during early childhood and learn to disparage those who are different from them. During later years, children learn biases from peer groups, surrounding communities, and the mass media when they are exposed to overrepresentations of negative stereotypes and gross generalizations of groups such as ethnic and racial minorities. Bias also may occur from direct experience or conflict between one’s own group and other groups that may cultivate irrational assumptions and attitudes.

Theories of bias and prejudice have historically emerged in response to circumstances and events, causing shifting theories about the origin of bias that parallel particular circumstances at a given time. A brief historical summary of racial bias provides an excellent framework for understanding current biases. During the 1920s, racial differences became a prominent social theme so theories of prejudice focused on understanding racial differences and antipathies. Race theories looked at inferiorities of outgroups and discussed the backwardness of inferior races in terms of lacking intelligence and evolutionary backwardness, which, in the 1930s, shifted dramatically away from inferiority of outgroups and the superiority of Whites to causes of bias. Social scientists began examining attitudes and beliefs held within the dominant European American group toward other racial and ethnic minority groups and the unjustness and flaws of these biases, leading to an emphasis of White prejudice rather than ethnic and racial minority inferiority.

The 1940s evolved into an era of understanding about White racism. The concepts of unconscious psychological processes and defense mechanisms were

introduced as roots of prejudice, exploring psychodynamic processes and bias. The 1950s shifted away from intrapsychic processes and an individual focus presenting prejudice as a by-product of personality development and social conditioning, related to Nazi racial ideology and personality traits conducive to developing biases. The next 2 decades deemphasized individual bias, focusing on group conformity and social norms as the cause of bias. At the same time a growing civil rights movement and heightened concern with other social and political issues led to emphasizing social conditions as underlying roots to prejudice, a view that continued through the 1980s and beyond.

Bias in testing and clinical assessment, as well as treatment and service delivery, also presents issues of concern in psychology. Test disparities between racial and ethnic groups, social strata, genders, and geographic regions raise serious questions about the standardization and construction of test instruments that are culturally unbiased. Despite attempts by the *Diagnostic and Statistical Manual of Mental Disorders* to promote consistency and reduce bias, critics argue that diagnostic biases continue to result in overdiagnosis, underdiagnosis, and misdiagnosis and that testing and diagnosis perpetuate inequality, discrimination, and oppression rather than promote fair assessment and diagnosis. The result of clinical biases in testing, assessment, and treatment is culturally insensitive services and client dropout.

There are a number of theories that have been developed to explain various types of bias and prejudice. One is the justification-suppression model which explained holding back on expressing prejudice because of social norms that suppress the public expression of certain biases. When guilt or shame is absent, it is easier to justify expressing biases publicly. Another similar theory, the self-presentational theory, explains how individuals privately display prejudice while not sharing their views publicly unless the prejudicial values are acceptable as the norm. Aversive racism theory describes how racist beliefs may be repressed and denied and become unconscious, causing individuals to share their biases publicly only in situations that allow them to rationalize their unconscious values. The social dominance theory argues that there are group-based hierarchies with dominant and subordinate groups within society. Dominant groups have power over other groups and enjoy disproportionate privilege; individuals in dominant groups then support and maintain their hierarchical position. The



personality model of prejudice emphasizes individual traits that are immutable across situations as the cause of prejudice. A variation of this model is the person X situation model, which asserts that situational variables, such as power or social status, interact with personality to develop prejudice. Also emphasizing the social context is the group socialization model, whereby the groups determine personal beliefs and the expression of bias, and the group normative theory, which looks at the development of prejudicial norms and social pressure for conformity in social groups.

Within these different theories, individuals are motivated to adopt certain beliefs and attitudes and frequently adopt prejudicial views to meet personal needs. Personal motivations may increase stereotyping behavior and justify the bias, generating a “blaming the victim” mentality whereby people get what they deserve.

Bias serves many purposes while negatively impacting people who are targets of discrimination and prejudice and negatively influencing counseling practice, testing, and diagnosis. Bias helps predict stereotypical behaviors from people different than oneself while solidifying negative values and inaccurate stereotypes. Bias assists in perpetuating stereotypes and heightens sensitivity to those values in ways that can be socially supported and highly destructive. Furthermore, bias explains and normalizes behavior toward members of outgroups, reaffirming one’s “rightness and worthiness,” and doesn’t take into account differences that affect testing, service delivery, and counseling. The cultivation and perpetuation of “we” versus “they,” ingroup versus outgroup mentality, and a right versus wrong way of thinking diminishes tolerance, openness, and respect toward diversity and differences and effective counseling.

*Fred Bemak*

*See also* Classism (v3); Discrimination (v3); Ethical Decision Making (v1); Ethnocentrism (v3); Oppression (v3); Prejudice (v3); Racism (v3); Sexism (v3); Stereotype (v3)

### Further Readings

- Dion, K. (2002). The social psychology of perceived prejudice and discrimination. *Canadian Psychology*, 43(1), 1–10.
- Gaines, S. O., & Reed, E. S. (1995). Prejudice: From Allport to DuBois. *American Psychologist*, 50(2), 96–103.

---

## BICULTURAL

---

The term *bicultural* describes a state of having or inheriting two or more cultures (e.g., one of an ethnic heritage and one of culture lived in) or two or more ethnic traditions. Central to the discussion of biculturalism is the construct of culture. Culture can be defined as a learned system of meaning and behavior for a group that is defined by geographic boundaries; it includes the customs, values, and traditions that people learn from the environment, family members, peers, and the community or society in which people live. Individuals within a culture have common shared values, customs, habits, and rituals; systems of labeling, explanations, and evaluations; social rules of behavior; perceptions regarding human nature, natural phenomena, interpersonal relationships, time, and activity; symbols, art, and artifacts; and historical developments.

In 1980, Raymond Buriel and Delia S. Saenz defined *biculturalism* as an integration of the competencies and sensitivities associated with two cultures within an individual. Similarly, bicultural individuals were described as having had extensive socialization and life experiences in two or more cultures and as participating actively in these cultures. These descriptions apply to a growing population of people within the United States who have affiliations with other countries and cultures (e.g., given the predominance of immigration and the increased emphasis on ethnic pride). These individuals have feelings and experiences that contribute to their becoming both a part of and separate from the dominant American culture. This duality can be seen in the number of “hyphenated” Americans among ethnic and racial minority groups such as Vietnamese Americans and Dominican Americans as well as among dominant White American groups such as Italian Americans and Irish Americans.

Biculturalism also carries with it expectations regarding cultural practice, mastery, or competence. In essence, biculturalism can manifest in the state of being comfortable with, knowledgeable of, aware of, and competent with at least two distinct cultures. However, two dichotomous perspectives on what it means to be bicultural exist, and both have empirical evidence to support them. In the first, bicultural individuals perceive their dual cultural identities as compatible and complementary, whereas in the second,



bicultural individuals describe them as oppositional and contradictory. Bicultural individuals also have been seen as either individuals who have a healthy balance of two or more cultures or individuals who are confused and conflicted. Clearly, being bicultural is not as simple as being on one or another end of a cultural spectrum. Biculturalism can involve feelings of pride, being special, being unique, and having a sense of community and history. It can also include identity confusion, dual or multiple expectations, and value clashes.

Bicultural individuals differ in how they subjectively organize their dual cultural orientations (i.e., variations in orientations are associated with different patterns of contextual, personality, and performance variables). In fact, although individuals want to maintain positive ties with both cultures, certain psychosocial pressures and individual variables lead to significant variations in the process, meanings, and outcomes. The experience of navigating the world as an individual with a hyphenated identity has been described by Alan Roland as walking on a “bicultural tightrope.” Bicultural individuals constantly face the challenge of integrating different cultural demands, messages, expectations, and issues of discrimination. In spite of the challenges, however, many bicultural individuals succeed at developing a bicultural identity. There are two types of bicultural individuals identified in the literature. In the first type, bicultural individuals identify with both cultures simultaneously but may do so at differing levels. They identify with being “both” (e.g., I am Haitian American). They do not perceive their ethnic minority culture and the dominant cultures as being mutually exclusive or conflicting. They integrate their cultures into their lives, are able to demonstrate competency in both cultures, and are able to switch behaviors depending on contextual demands. A second type of bicultural individual perceives the dominant and ethnic minority cultures as oppositional in orientation. Although these individuals also identify with both cultures, they are acutely aware of the discrepancies in their cultures and see these discrepancies as a source of internal conflict. Thus, these individuals keep their two cultural identities separate and often report that it is easier to be from their minority culture or from the dominant culture but hard to be both at the same time. For example, they may identify as being Korean or American as opposed to Korean American. They feel

they have to choose one or the other because of the differing perspectives of their cultures.

## Stereotypes

For many years, it was thought that living in two cultures has a negative impact on the development and lives of individuals. In fact, one common assumption has been that individuals who try to engage in two cultures experience identity confusion and even marginality. To help diminish this assumed confusion, parents of bicultural children were often encouraged to have their children speak only one language, most often the dominant one (e.g., in the United States, English). There are a number of colloquial expressions that highlight the negative perceptions of bicultural individuals. For example, Indians born in the United States may be called “ABCDs” which stands for American Born Confused Desi (of the Indian subcontinent). This term implies that because these individuals are U.S. born and not born in India, they do not really understand or accept their roots. It was thought that being born into or developing competence in one culture leads to the loss of identification with the other. Similarly, negative terminology has developed that is used to imply that racial and ethnic minorities may appear a certain way but have internally identified with and adopted values, norms, and behaviors of White U.S. culture. For example, African Americans may be referred to as “Oreos” (black on the outside, white on the inside), East Asian Americans may be referred to as “Bananas” (yellow on the outside, white on the inside), Latinos/as (and South Asians) may be referred to as “Coconuts” (brown on the outside, white on the inside), and Native Americans or American Indians may be referred to as “Apples” (red on the outside, white on the inside). Although the stereotypes are still deeply embedded in our cultures, it is known now that being bicultural gives individuals an opportunity to access more than one culture, and being bilingual or multilingual is often an advantage (e.g., research has found that being multilingual promotes brain development).

## Ethnic Identity

There are many definitions of *ethnic identity*, some of which put it in relation to other terms such as *biculturalism* and others that define ethnic identity independently. Ethnic identity has been defined as the totality of individual’s feelings about the values,



symbols, and common histories that identify one as a member of a distinct ethnic group. It has also been defined as a social identity based on the culture of one's ancestral group or groups (national or tribal), as modified by the culture in which one's group currently resides. The dimensions on which ethnic identity vary are self-identification, knowledge of one's culture, and preferences toward an ethnic group. Ethnic identity can be divided into two parts—an *external* ethnic identity and an *internal* ethnic identity, whereby external ethnic identity refers to observable social and cultural behaviors and internal ethnic identity includes cognitive, affective, and moral domains. For ethnic minorities, ethnic pride, or a positive ethnic identity, can help individuals cope with the demands of the dominant culture. A number of models of ethnic identity development apply to various ethnic groups in the United States. These models typically incorporate various developmental stages or statuses that follow individuals' progression from lower levels of ethnic pride to higher levels of pride and ethnic self-appreciation.

The psychological literature has alluded to a connection between *ethnic identity*, *biculturalism*, and *acculturation*, and these terms are sometimes (incorrectly) used interchangeably. Whereas biculturalism and ethnic identity can be seen as states of being, acculturation is a process. Furthermore, whereas an individual with an ethnic identity is not necessarily bicultural, a bicultural individual will have at least one ethnic identity.

### ***Ethnic Belongingness***

Included in models of ethnic identity is the concept of ethnic belongingness. This construct refers to the state of feeling affiliation with or connection to those belonging to the individuals' own ethnic group. The feelings and perceptions that individuals have about their own ethnic group are also likely to impact the degree to which these individuals feel belongingness to their ethnic group. For bicultural individuals, this process is complicated by awareness of stereotypes, assumptions, and judgments that the dominant group has toward individuals' own ethnic group and that their ethnic group has toward the dominant group. Thus, the very awareness (of bias) that often accompanies biculturalism can either facilitate or hinder individuals' ethnic belongingness.

## **Bicultural Models**

Bicultural models describe how members of racial and ethnic minority groups go through an adaptive process whereby they learn two or more behavioral repertoires. An important bicultural model is the bicultural "alteration model," which outlines the process of second culture acquisition experienced by individuals. The model suggests that it is possible for individuals to gain competence in two cultures without having to choose one culture over another or lose their original cultural identity.

In opposition to the assumption that living in two cultures is confusing or problematic for individuals, biculturalism and the ability to develop and maintain competence in both cultures is actually psychologically beneficial to individuals. Moreover, negative psychological impact from contact with both cultures can be reduced through the development of bicultural competence. In turn, bicultural competence and second culture acquisition are facilitated by the presence of a strong personal identity. It is important to note, however, that the acquisition of culture and achievement of bicultural competence tend to occur at varying rates for individuals.

To navigate two cultures effectively, individuals need to acquire competence in six dimensions:

1. Knowledge of cultural values and beliefs such as awareness of history, rituals, and everyday practices for each cultural and ethnic group with whom one has contact
2. Positive attitudes toward the goal of bicultural competence and toward both groups with whom one has sufficient contact (but not necessarily equal regard)
3. Bicultural efficacy, or the belief that one can live in an effective and satisfying way within more than one group
4. The ability to appropriately and effectively communicate verbally and nonverbally in each culture
5. Knowledge of, and competence to perform, a range of situationally appropriate behaviors and roles for each cultural group
6. Existence of a sufficient social support system in both cultures that provides a source of practical information

This model can be seen as applicable to immigrants and second-generation bicultural individuals, as well



as interracial, interethnic, intercultural, and transracial individuals. It can also be seen as valuable for multicultural individuals or those affiliated with more than two cultures.

### **Assimilation, Acculturation, and Biculturalism**

Some experts believe that the development of a bicultural identity occurs through acculturation. Research on bicultural individuals has focused predominantly on the process of acculturation. Acculturation is the process of cultural change and adaptation that occurs when different cultures come into contact within an individual. More narrowly, acculturation refers to the adaptation process of one group to the rules and behaviors of another group. For many years, the assimilation model was the only acculturation model. This model was built on the idea that the United States is a “melting pot.”

Biculturalism is an important aspect of acculturation because the preexistence of a minority community can lead to the process in which individuals retain the culture of origin while also acculturating to the host culture. Acculturation and biculturalism can be differentiated by recognizing that acculturation refers to a cultural shift in which elements of the majority culture progressively predominate, whereas biculturalism refers to a cultural orientation in which elements of both minority and majority cultures are increasingly found in equal proportions. For example, a man from Senegal might begin to acculturate and strive to live, act, and speak as Americans do, so that in seeking to be more “Americanized,” he might give less time and attention to retaining his Senegalese culture. Were this same man to be considered bicultural, he would have equal skills, knowledge, and comfort in both American and Senegalese cultures so that he would not subvert one to learn the other.

### ***Bicultural Unidimensional Scales***

Quantitative methods, primarily through use of scales, have been used to study these variables. Unidimensional and multidimensional models of biculturalism and acculturation have emerged. Unidimensional or unilinear bicultural models conceptualize acculturation along a single, linear continuum, with one end reflecting high adherence to the

indigenous or ethnic minority culture and the other end reflecting high adherence to the dominant culture. There are a number of biculturalism scales used to measure biculturalism unidimensionally, including (a) the Acculturation and Biculturalism Scale (ABS) that was developed using a Latino/a sample and includes Acculturation and Bicultural subscales; and (b) the Bicultural/Multicultural Experience Inventory (B/MEI) that was developed using a Mexican American sample and measures the behavioral dimensions of acculturation and cultural identity.

Critics of these unilinear models argue that they are unable to truly represent biculturalism, which includes adherence to both indigenous and host cultures. The limitations in these models lead to more complex conceptualizations of biculturalism.

### ***Bicultural Multidimensional Scales***

Bidimensional, bilinear, or multidimensional models conceptualize acculturation along two or more dimensions, each representing higher or lower levels of identification with a culture (e.g., the culture of the indigenous/ethnic minority and the dominant culture). In these models, the bicultural identity is often seen as the optimal identity. John Berry, Joseph Trimble, and Esteban Olmedo’s acculturation framework is one such model. The authors present four degrees of acculturation (i.e., bicultural, traditional, assimilated, and marginal) that take into account both identification with an ethnic group and identification with the dominant group. Individuals who strongly identify both with the dominant group and with their ethnic group are considered to be acculturated, integrated, and bicultural. These bicultural individuals are considered the ideal, and biculturalism is the goal for those who are in the process of acculturation. If individuals identify strongly with their own ethnic group and minimally with the dominant group, they are considered traditional, or ethnically embedded, separated, and dissociated. Traditionalists do not adapt in any way to their new culture. If, on the other hand, individuals identify strongly with the dominant group and weakly with their ethnic group, they are considered to be assimilated. With assimilation, there is a loss of ethnic or cultural identity. Finally, if they identify with neither group, they are considered marginal.

Similarly, bilinear or multidimensional scales were designed to measure the adaptation process on two



continua—one that reflects adherence to the indigenous or ethnic minority culture and the other, adherence to the dominant culture. Two such measures include (1) the Bicultural Involvement Questionnaire, which was developed for Cuban Americans and measures the behavioral dimension of acculturation and has Hispanicism and Americanism subscales; and (2) the Bicultural Scale for Puerto Ricans.

The unilinear and bilinear scales used to assess biculturalism are not able to capture the complexity of this construct (though the latter appears to be a better measure than the former). Increasingly, researchers use qualitative measures either to complement quantitative measures or as the primary means of data collection.

### **Culture as Frame and Navigating Biculturalism**

Individuals have culturally specific meaning systems (i.e., learned networks of ideas, values, beliefs, and knowledge) that are shared with others within the same culture. These meaning systems are interpretive frames that affect feelings, thoughts, and behaviors. Given the pervasive nature of culture as the lens or frame through which individuals filter, understand, and internalize the meaning assigned to experiences and interactions, bicultural individuals' navigation through culture can be thought of as doubly complex.

Because one's cultural identity is influenced by language, generational/immigration status, sociopolitical climate, and situational cues, bicultural individuals often have dual cultural identities that they must navigate between and which become of greater or less salience depending on the environment, situation, and goal that is of concern.

### ***Biculturalism and Frameswitching***

More recently, the idea of cultural frameswitching has emerged, or the process in which cultural meaning systems guide individuals' sociocognitive processes. Research suggests that for bicultural individuals, this frameswitching allows bicultural individuals to move between two different culturally based interpretive system lenses (i.e., in response to situational cues) that are rooted in their dual cultural backgrounds. Thus, bicultural individuals have access to multiple cultural meaning systems and switch between culturally appropriate behaviors depending on context. For example, Chinese American individuals possess both

Asian and Western cultural meaning systems, and each system can be independently activated by culturally relevant icons or primes. There is much variability, however, in how bicultural individuals manage and experience these meaning systems.

### ***Bicultural Identity Integration***

Differences in bicultural identity affect how cultural knowledge is used to interpret events. Veronica Haritatos and Jana Benet-Martinez discussed a construct they call Bicultural Identity Integration (BII), which is the way bicultural individuals organize their two cultural identities. Bicultural individuals high on BII describe their two cultural identities as compatible (i.e., fluid and complementary), whereas bicultural individuals low on BII experience their two identities as oppositional (i.e., conflicting and disparate). Cultural frameswitching is moderated by BII or the perceived compatibility (vs. opposition) between the two cultural orientations. In Haritatos and Benet-Martinez's research, Chinese Americans who perceived their cultural identities as compatible (high BII) responded in culturally congruent ways to cultural cues. They made more external attributions (more Asian behavior) after being exposed to Chinese primes (e.g., picture of a Chinese dragon) and more internal attributions (more Western behavior) after being exposed to American primes (e.g., picture of an American flag). On the other hand, Chinese Americans who perceived their cultural identities as oppositional (low BII) demonstrated a reverse priming effect. That is, individuals with a low BII had more external attributions (Asian behavior) after being exposed to American primes and more internal attributions (Western behavior) after being exposed to Chinese primes.

Variations in BII, however, do not define a uniform phenomenon. Instead, the variations encompass two separate independent constructs: perceptions of distance (vs. overlap) and perceptions of conflict (vs. harmony) between an individual's two cultural identities.

### ***Culture and Transracial Adoption***

Transracial adoption, or the practice of placing (for adoption) children of one racial group with parents from another racial group, by its very nature, has long been expected to result in multiple forms of biculturalism as well as bicultural conflicts. In fact, common expectation for transracial adoptees is for them to



demonstrate some degree of biculturality. However, many transracial adoptees are raised by adoptive parents who are racially different from the child, typically rearing them within the adoptive parents' own cultural traditions. These parents often do not practice, identify with, or subscribe to the values, beliefs, and traditions found in the adoptees' birth culture. Moreover, the separation (physical, environmental, and social) from the birth culture often results in little, if any, familiarity or real affiliation and identification with the birth culture. As a result, the culture with which the transracial adoptee often identifies is that of his or her adoptive parents. Furthermore, for transracial adoptees to truly become bicultural, they must become competent in, knowledgeable about, aware of, and competent within their birth culture—achievements that are even less likely to occur when the adoptions are international. Thus, for many transracial adoptees biculturalism is difficult to achieve. Because the adoptees often do not have adequate or full access to their birth culture and because they are reared by parents with cultural values, beliefs, and traditions from a culture other than their birth culture (often the dominant culture), they are most often described as assimilated rather than truly bicultural. Biculturalism, however, is sought by many adult transracial adoptees. It is achieved by visits to their birth countries and immersion into their birth culture and birth communities. Thus, the process of becoming bicultural is often one that reverses the target culture in the acculturation process; that is, the birth culture (often nondominant) becomes the target culture.

### Current Issues in Biculturalism

A bicultural framework often does not take into account multiple identities, such as socioeconomic status, (dis)ability status, sexual orientation, and gender. For example, studying ethnicity and gender as separate variables would result in reductionism and denial of the full experience of ethnic women. Also, it is simplistic to assume that ethnicity is a combination of heritage and modification. Ethnicity cannot be summed up as something simply passed on from generation to generation, taught and learned. Rather, it is dynamic and has to be inclusive of many components of one's identity.

Although bicultural identities have been discussed in relation to immigrant and ethnic minority groups, it has been posited that biculturalism can be applied to globalization as well. Because of international travel

and communication through media technology (e.g., television, the Internet), modern youth have developed a global identity in addition to their local identities (e.g., ethnic, cultural identities). This global identity gives them a sense of belonging to a worldwide culture that includes an awareness of global events, practices, and information. Biculturalism has also become more globally prominent. Modern conceptualizations of identity incorporate ethnic origins and heritage as parts of individuals.

*Muninder K. Ahluwalia and Amanda L. Baden*

*See also* Acculturation (v3); Acculturative Stress (v3); Adaptation (v3); Assimilation (v3); Cultural Accommodation and Negotiation (v3); Cultural Values (v3); Culture (v3); Enculturation (v3); Ethnic Identity (v3); Person–Environment Interactions (v2); Second Culture Acquisition (v3); Transracial Adoption (v3)

### Further Readings

- Arnett, J. J. (2002). The psychology of globalization. *American Psychologist*, 57(10), 774–783.
- Benet-Martinez, V., & Haritatos, J. (2005). Bicultural Identity Integration (BII): Components and psychosocial antecedents. *Journal of Personality*, 73(4), 1015–1050.
- Benet-Martinez, V., Leu, J., Lee, F., & Morris, M. W. (2002). Negotiating biculturalism: Cultural frameswitching in biculturals with oppositional versus compatible cultural identities. *Journal of Cross-Cultural Psychology*, 33(5), 492–516.
- Hong, Y. Y., Morris, M., Chiu, C. Y., & Benet-Martinez, V. (2000). Multicultural minds: A dynamic constructivist approach to culture and cognition. *American Psychologist*, 55, 709–720.
- LaFramboise, T., Coleman, H. L. K., & Gerton, J. (1993). Psychological impact of biculturalism: Evidence and theory. *Psychological Bulletin*, 114, 395–412.
- Padilla, A. (Ed.). (1980). *Acculturation: Theory, models and some new findings*. Boulder, CO: Westview Press.
- Park, R. E., & Burgess, E. W. (1921). *Introduction to the science of sociology*. Chicago: University of Chicago Press.
- Phinney, J. S., & Devich-Navarro, M. (1997). Variations in bicultural identification among African American and Mexican American adolescents. *Journal of Research on Adolescence*, 7, 3–32.
- Szapocznik, J., Kurtines, W. M., & Fernandez, T. (1980). Bicultural involvement and adjustment in Hispanic-American youths. *International Journal of Intercultural Relations*, 4, 353–365.



Triandis, H. C., Kashima, Y., Hui, C. H., Lisansky, J., & Marin, G. (1982). Acculturation and biculturalism indices among relatively acculturated Hispanic young adults. *Interamerican Journal of Psychology*, 16, 140–149.

---

## BILINGUAL COUNSELING

---

*Bilingual counseling* is defined as therapeutic discourse that accommodates the client's linguistic characteristics and incorporates bilingual or multilingual factors as vital components of psychological and contextual functioning. Because language and culture are closely embedded, attention to language diversity responds to competent multicultural counseling that includes self-awareness of the counselor, knowledge of bilingual processes, and skills in bilingual interventions. The discussion that follows applies not only to bilingual individuals but also to multilingual individuals, who may exhibit a more complex language presentation in counseling.

### Foundations of Bilingual Counseling

#### ***Brief Historical Perspective***

In the initial stages of psychodynamic theory, Sigmund Freud documented treatment with bilinguals, but language factors per se were not addressed as instruments of therapeutic change. In the 1930s, some psychodynamic clinicians explored bilingualism, and by the late 1940s a more definite view emerged of language choice as a defense mechanism. Case studies published in the 1950s described the impact of multiple languages on psychodynamic processes such as repression, ego functions, and transference. Further investigations in the 1970s reported differential client presentation in two languages, diagnostic errors, and unique processes and interventions. The multicultural movement that followed and contributions from psycholinguistics, cognitive and clinical psychology, psychometrics, and education have widened the understanding of relevant processes evident in bilingual counseling, which are relevant regardless of the theoretical orientation of the professional.

#### ***Bilingual Processes***

Bilinguals are described as having a *dual sense of self* that responds differently to distinct contextual

stimuli. Language duality allows for the conceptualization of two worlds, communication of thoughts and emotions differently, bicultural dynamics, different organizational sets of knowledge, and multiple self-identities. Intact cognitions and emotions that are specific to each language help store memories in different language domains that can be retrieved by the most meaningful language at a particular period of time.

*Bilingual language development* may be sequential or simultaneous. Maintenance of the first language (L1) and the second language (L2) depends on ecological support, acculturation level, language use, and sociopolitical factors. Language development encompasses learning to label emotions and cognitions that are associated with early attachments. Thus, a bilingual individual may be prone to experience affective content in L1 or the language that endorses emotional meaning while affective detachment may be expected in L2. Similarly, a sense of logic and maturity may influence accessing L2 in decision making. When both languages are learned simultaneously and supported equally, the affective component may be accessible in both languages. Knowledge of the following bilingual concepts is necessary for competent practice.

*Language switching, or code-switching*, is a pattern where a word or phrase is replaced by another language within a sentence or a language shift for an extended period of time. The shift occurs from L1 to L2 as well as from L2 to L1, may be involuntary or voluntary, and may be predictable by context. A voluntary shift can be (a) a purposeful strategy to be better understood, (b) a result of lack of fluency, or (c) an avoidance response. Code-switching is associated with memory of emotional content, defense mechanisms, cognitive coping skills, spontaneity, creativity, diverse attributions and interpretations, taboo words, and word retrieval problems. Words that are concrete or overlap semantically are easier to translate than words having unique meanings or abstractions such as emotions. *Language mixing* integrates characteristics of two languages into one word or phrase (e.g., *Spanglish*).

*Language dominance* refers to the individual's most fluent language. Once a level of fluency is mastered and supported by high levels of use, L2 may shift to become the base, more accessed language.

*Language proficiency* involves high-order verbal cognitive abilities required in reading, writing, and oral expression. An individual may be proficient in



English but may be dominant in Spanish. In 1984, Jim Cummins indicated that non-English speakers require a period of 5 to 7 years to attain proficient English abilities, whereas interpersonal communication skills develop within 2 to 3 years of natural and informal exposure to a second language.

### **Best Practices**

The establishment of the therapeutic alliance, language sensitivity, non-English language acceptance, multicultural competence, and the language match between counselor and client modulate successful bilingual interventions. Sound clinical practice with bilinguals targets the motives leading to choices in language use and phenomenological experiences associated with a *dual self*. Application of core counseling skills is important, particularly focusing on nonverbal messages and communicating clearly without the use of idioms or regionalisms.

The professional counselor needs to engage in self-evaluation to ascertain whether he or she has the language skills to best respond to the bilingual client. Inadvertently, the practitioner may project unintentional prejudices and power imbalances by choosing the client's L2 as the primary therapeutic language. Parallel bilingual skills between counselor and client are the ideal match to ensure understanding, maximize the applications of bilingual interventions, and provide a natural flow in therapeutic interactions as figures of speech are difficult to translate and many regional and national variations coexist within the same language. Monolingual counselors are generally not recommended but may be effective in some situations as long as the client's L2 level is highly proficient, bicultural and bilingual issues are addressed, and expression in L1 narratives is encouraged.

A bilingual practice requires availability of assessment tools and documentation in two languages. A brief telephone conversation before the face-to-face interview is valuable to assess language preference. Generally, working with two languages duplicates in-session work and case management responsibilities.

### **Assessment Methods**

Bilingual language skills may be assessed with formal and standardized instruments as well as through interviews. Several norm-referenced tests are available to measure bilingual language dominance and language proficiency (e.g., Riverside Publishing

instruments: *Woodcock Language Battery-Revised Tests* and the *Bilingual Verbal Cognitive Abilities Tests*). These instruments need to be administered by assessment specialists and may be useful for counseling goals associated with educational and vocational issues.

Comprehensive clinical interviews need to include language factors such as patterns of language use and bilingual development and history. Other areas to assess are conversational proficiency, acculturation level, language used to express emotions and cognitions, language use contexts, coping strengths associated with language use, language of prayers and dreams, general literacy skills, and ecological factors that hinder or endorse specific language usage.

Assessment also requires counselor sensitivity to the interplay of cultural, linguistic, and verbal and nonverbal communication processes. Communicating in the non-dominant language may interfere with the accurate presentation of the client. Verbal and nonverbal features may be affected by limited verbal fluency, anxiety, and emotional inhibition. Affective content may be hampered by communication in a language that lacks emotional meaning. Clients may present as distant and with dissonant affect when verbalizing emotionally laden events. Frequent translations disrupt the flow of therapeutic interactions, risking client distraction and affective disengagement as well as counselor misinterpretations and excessive focus on content instead of meaning.

### **Bilingual Interventions**

Several counseling interventions have been useful with bilingual clients. Language switching has received the most attention in research and practice. Strategically, changing languages during counseling has been used to follow the client's language and to intervene clinically. When applied in the first manner, code-switching facilitates rapport, connects with phenomenological expressions, clarifies conceptualizations, and enhances the client's construction of reality. By strategically shifting into the emotional language, the counselor may access affective catharsis, memories, and insights. In contrast, redirecting the shift to L2 will generate an inhibition response, producing a more rational and controlled stance to unrestrained or painful emotions.

In systemic interventions, bilingualism adds another dimension to family and couples therapy with shifts in languages representing systemic dynamics of conflict, resistance, ethnic identity, and acculturation. Cross-cultural couples and family members that share



weak skills in a common language may require the counselor to assume the role of *language broker*.

Counselors with weak L1 fluency may encourage clients to express events and emotions to elicit affective catharsis followed by the client's translation. The client may benefit from the comparison of different affective perspectives evident in the original and translated narrative. *Language-culture-based* strategies (e.g., metaphors, proverbs, *dichos*, music, storytelling, poetry) may be powerful therapeutic tools, and combining two languages enhances spontaneity, disclosure, and problem-solving skills.

Language is also linked to ethnic identity, social justice, and environmental stressors. Addressing language issues (e.g., loss of first language, language acquisition problems) may reveal pertinent clinical data (e.g., pressure to communicate in L2 to avoid discrimination, loss of cultural membership, ethnic identity confusion, educational problems, family conflicts).

Open communication with the client about the counselor's bilingual language skills may address the client's comfort level with the counselor's linguistic abilities as well as any foreign accent evident, which may reflect biases and communication issues.

To prevent process interference, the professional literature unfavorably supports counseling with *language facilitators*. Special circumstances such as low-incidence languages, emergencies, and assessment needs justify the use of a trained language facilitator. David Bradford and Abilio Muñoz (1993) and Freddy Paniagua (2004) provide useful guidelines.

### Future Directions

Bilingual counseling requires adequate supervision and training as well as clear delineation of the competency level of the bilingual practitioner. This emerging specialty will require substantially more empirical exploration, new training models, and innovative practice methods.

Maritza Gallardo-Cooper

**See also** Barriers to Cross-Cultural Counseling (v3); Career Counseling (v4); Career Counseling, Asian Americans (v4); Career Counseling, Immigrants (v4); Career Counseling, Latinos (v4); Communication (v3); Counseling Skills Training (v2); Multicultural Counseling (v3); Multicultural Counseling Competence (v3); Translation Methods (v3)

### Further Readings

- Ali, R. K. (2004). Bilingualism and systemic psychotherapy: Some formulations and explorations. *Journal of Family Therapy*, 26, 340–357.
- Altarriba, J., & Santiago-Rivera, A. L. (1994). Current perspectives on using linguistic and cultural factors in counseling the Hispanic client. *Professional Psychology: Research and Practice*, 25, 388–397.
- Bradford, D. T., & Muñoz, A. (1993). Translation in bilingual psychotherapy. *Professional Psychology: Research and Practice*, 24, 52–61.
- Burck, C. (2004). Living in several languages: Implications for therapy. *Journal of Family Therapy*, 26, 314–339.
- Clauss, C. S. (1998). Language: The unspoken variable in psychotherapy practice. *Psychotherapy: Theory, Research, Practice, and Training*, 35, 188–196.
- Cummins, J. (1984). *Bilingualism and special education: Issues in assessment and pedagogy*. Clevedon, UK: Multilingual Matters.
- Fabbro, F. (1999). *The neurolinguistics of bilingualism*. East Sussex, UK: Psychology Press.
- Javier, R. A. (1989). Linguistic considerations in the treatment of bilinguals. *Psychoanalytic Psychology*, 6, 87–96.
- Marcos, L. R. (1976). Bilinguals in psychotherapy: Language as an emotional barrier. *American Journal of Psychotherapy*, 30, 552–560.
- Marcos, L. R., & Urcuyo, L. (1979). Dynamic psychotherapy with the bilingual patient. *American Journal of Psychotherapy*, 33, 331–338.
- Paniagua, F. (2004). *Assessing and treating culturally diverse clients: A practical guide* (3rd ed.). Thousand Oaks, CA: Sage.
- Perez-Foster, R. P. (1998). *The power of language in the clinical process: Assessing and treating the bilingual person*. Northvale, NJ: Jason Aronson.
- Santiago-Rivera, A. L., & Altarriba, J. (2002). The role of language in therapy with the Spanish-English bilingual client. *Professional Psychology: Research & Practice*, 33, 30–38.

---

## BILINGUALISM

---

*Bilingualism* is defined as the ability to communicate or be fluent in two languages. *Multilingualism* (a related term) refers to the ability to communicate or be fluent in three or more languages. Early definitions dating back to the 1930s refer to bilingualism as having “native-like” control of two languages. Nevertheless, research in the fields of linguistics, psychology,



sociology, education, neurology, and politics has expanded the concept of bilingualism far beyond the simplistic view of communicating in two languages. Current definitions are as complex as each of the languages a bilingual individual chooses to communicate in.

An important distinction necessary to begin to understand the concept of bilingualism is the difference between *ability* (or degree of bilingualism) and *use* (or function of bilingualism). To communicate proficiently in a given language, an individual must possess four basic skills: listening, speaking, reading, and writing. Some have argued for the inclusion of thinking as a fifth language ability. To use the abilities properly, a bilingual individual must exist in what is known as a *language community*, for these abilities do not develop in a vacuum. Moreover, contact between different language communities provides the bilingual individual with the context to know when to listen, speak, read, write, and think in which language.

### Language Ability

Human beings are uniquely equipped for language production. The brain performs all the executive functions (such as information processing and controlling the physical aspects of speech). The diaphragm muscle, lungs, nose, mouth, lips, tongue, and vocal cords are all involved in speech production and regulation. The ear, ear bones, cochlea, brain stem, and auditory cortex are involved in hearing. Facial expressions and hand gestures also play a role in spoken language as well as sign language.

These actions of *language performance* represent the outward evidence that an individual has language competence. *Language competence* is the general term that lets us know an individual is proficient in a given language (e.g., that an individual has a mental system established for that particular language and can analyze and produce it). *Language abilities* are the more specific, direct, and quantifiable evidence that an individual can communicate in a given language.

Language abilities are multidimensional in nature. They include active skills (e.g., speaking and writing) and passive skills (e.g., listening and reading). A person may speak a language but not be able to read in that language or understand the spoken language. An individual may understand others who speak in a given language but not be able to speak it themselves. These abilities can be developed formally (e.g.,

school, continuing education classes), informally (e.g., contact with another language community such as friends or the media), or through a mixture of both formal and informal methods (e.g., language immersion programs, living abroad).

An individual who can only communicate in one language is referred to as a *monolingual* (or *monoglot*). An individual who has developed an approximately equal level of proficiency in her or his language abilities across a variety of situations in both languages is commonly referred to as a *balanced bilingual*. This is what most people typically think of when referring to bilingual individuals: a person who is equally fluent and has the same knowledge base in two languages. It is important to note that being monolingual may not necessarily be a good reference point to compare with or understand bilinguals.

*Dominant bilingualism* is another type of bilingualism used to describe a person who can communicate in two languages but is partial to one of them because she or he is more proficient in it. Although not always the case, this more proficient language is usually the one the person learned first (e.g., their *first language*, *native language*, or *mother tongue*). Another type of bilingualism is called *semilingualism* (or *distractive bilingualism*). This controversial term describes an individual who has some deficiencies in both languages when compared with monolinguals in each of those languages. These deficiencies typically include a smaller vocabulary, incorrect grammar, lack of creativity and spontaneity with both languages, and a difficulty with thinking and expressing emotions in either language. The term has been wrought with controversy because of its negative connotations and its emphasis on expectations of failure and underachievement.

### Language Use

The experience of a bilingual individual is not independent of her or his context. Contact between different language communities helps languages grow, helps individuals learn their language(s) better, and helps communities relate better with each other. Studying functional bilingualism facilitates the understanding of a bilingual individual's language use in the context of her or his language community.

Understanding language use in bilingualism entails exploring the following questions: (a) Who is the speaker? (b) Who is the listener(s)? (c) What is the situation or context? (d) What is the specific topic of



conversation? and (e) What is the purpose of language use? For example, why does speaker A change from Spanish to English when talking to listener B at location C about topic D? How is it that speaker E can talk in English to speaker F when the topic is G but not when the topic is H? Understanding bilingual communication thus moves beyond the concept of language proficiency and language skills.

The term *diglossia* refers to the notion of a community having more than one language available for use. The situation typically involves a majority (or high language variety) and a minority (or low variety) language. Language communities often perceive a majority language as more prestigious and as the key to upward mobility. They thus tend to use it in formal or official contexts (e.g., school, business, correspondence with the government). Minority languages are more often used in informal or personal situations (e.g., home, family, correspondence with friends). For example, a television reporter in Hawai'i may talk about a football game during a broadcast in standard English but discuss it with her friends at home in pigeon English (a form of English that retains its basic grammatical rules while integrating those of other languages such as Hawaiian, Japanese, Chinese, and Portuguese).

This phenomenon of language shift is often visible in immigrant populations. First-generation immigrants maintain their own language while attempting to learn the host language. Second-generation immigrants intent on assimilating to the majority culture embrace the host language and begin using it in contexts once reserved for their native language. By the time third-generation immigrants choose a language in which to communicate, the majority language may be the only choice available to them.

Code-switching is a common phenomenon that occurs when a bilingual individual alternates between languages. It can happen in complete sentences, within one sentence, or at the single word level. "Voy a printear el homework" (I'm going to print the homework) is an example of code-switching. Code-switching is what some members of the Spanish-English bilingual community have termed *spanglish*.

### Bilingualism Myths and Cognitive Advantages

The predominant belief during the "period of detrimental effects" (early 1800s to 1960s) was that

bilingualism had a negative impact on individuals. It was thought that learning more than one language could confuse a child in the learning of their first language, could cause a decrease in intelligence (e.g., lower IQ), could decrease spiritual growth, and could cause cultural identity or split personality problems in children. Some also argued that two languages were learned independently of each other and that the knowledge of learning one did not transfer into the other. Others believed that as more was learned in one language, less could be learned in the other.

The "period of additive effects" (1960s–present) represented a shift in the understanding of bilingualism and its effects in cognitive development. Recent research has demonstrated that being mindful that there is more than one way to communicate enhances a number of cognitive skills. Flexibility, creativity, concept formation, memory, analogical reasoning, classification skills, divergent thinking, and inhibitory control are some of the advantages of bilingualism. Research has also shown that bilinguals develop increased *metalinguistic skills* (e.g., the ability to talk about language, analyze it, think about it, separate it from context, and judge it). This analysis of one's own knowledge of language and control over this internal language process has been shown to facilitate earlier reading acquisition, which can lead to higher levels of academic achievement. Independent of academics, being able to communicate in two or more languages increases career opportunities and options for places to live, as well as a range of options for interpersonal interactions (which in turn enhances interpersonal skills). Finally, recent research has also shown that the increased cognitive activities inherent in bilingualism delay the onset of Alzheimer's disease and other cognitive disorders.

Luis A. Rivas

*See also* Acculturation (v3); Barriers to Cross-Cultural Counseling (v3); Bicultural (v3); Bilingual Counseling (v3); Career Counseling, Immigrants (v4); Communication (v3); Counseling Skills Training (v2); Immigrants (v3); Multicultural Counseling (v3); Multicultural Counseling Competence (v3); Second Culture Acquisition (v3); Translation Methods (v3)

### Further Readings

Baker, C. (2006). *Foundations of bilingual education and bilingualism* (4th ed.). Philadelphia: Multilingual Matters.



- Baker, C., & Jones, S. P. (1998). *Encyclopedia of bilingualism and bilingual education*. Clevedon, UK: Multilingual Matters.
- Bhatia, T. K., & Ritchie, W. C. (2004). *The handbook of bilingualism*. Oxford, UK: Blackwell.
- Bialystock, E. (2001). *Bilingualism in development: Language, literacy, and cognition*. Cambridge, MA: Cambridge University Press.
- Hakuta, K. (1990, Spring). Bilingualism and bilingual education: A research perspective. *FOCUS: Occasional Papers in Bilingual Education* (No. 1). Washington, DC: National Clearinghouse for Bilingual Education.
- Wei, L. (2000). *The bilingualism reader*. Oxford, UK: Routledge.

---

## BIRACIAL

---

The term *biracial* refers to individuals who are born to parents who are each of a different racial background. For example, the child of an African American mother and an Asian American father would be considered biracial. Similarly, a person with one White parent and one Native American parent would also be considered biracial. The term *multiracial*, which is used to describe individuals of two or more races, is inclusive of the term *biracial*. An example of a multiracial individual would be someone with White, Native American, and African American parentage.

It is important to note that distinctions between race and ethnicity are complex and, at times, controversial within U.S. society. Currently the U.S. Census considers *Hispanic* an ethnicity rather than a racial category. Therefore, an individual with one Latino/a parent and one White parent, for example, would not be considered biracial, though he or she may feel as though he or she is of a mixed cultural background. This is complicated by the fact that many social scientists believe that race is a social construct, with racial groupings being based on historical classifications rather than true genetic differences among people. The term *multiethnic*, which refers to individuals of multiple ethnic backgrounds, is sometimes preferred to describe individuals of mixed heritage because ethnicity is a broader term that denotes a shared identity and ancestry among members of a particular cultural group. However, the term *multiethnic* would also describe someone of Japanese and Chinese descent, and this experience would be seen as different from a

more traditional multiracial (e.g., Japanese and White) experience.

It is also important to recognize that many individuals who fit the definition of *biracial* may not choose to use this term to describe themselves. They might elect to identify with only one side of their racial background (opting for a monoracial identity) or use other terminology such as *mixed*. Indeed, individuals of mixed racial background have various options of self-identification that are based on demographic background, familial influences, skin color, and other cultural experiences.

## Historical Perspectives

The number of biracial individuals has increased over the years, particularly with increasing rates of interracial relationships and the repeal of antimiscegenation (racial mixing) laws in the late 1960s. Dating back to the early 18th century, antimiscegenation laws sought to maintain the purity of White European bloodlines in U.S. society by limiting the birth of biracial children. Such norms held to the rule of *hypodescence*, or “one-drop rule,” a rule that even the slightest degree of racial mixing eliminated the possibility for an individual to legally identify as White. Although the offspring of interracial relationships have been noted in American history for centuries, it was not until the civil rights movement and the repeal of antimiscegenation laws that the U.S. government was pushed to formally acknowledge and give equal liberties to the many adults involved in interracial relationships as well as those who were of mixed racial background.

In addition to the legal and cultural norms that implied that biracial offspring and mixed race relationships were taboo, the government also traditionally classified individuals in a way that limited how people of mixed racial heritage could identify themselves. For the 210-year span between the first national census in 1790 and the recent decennial census in 2000, individuals had to identify themselves as belonging to only one racial group. At times, however, efforts were made to track individuals of mixed African/White heritage. On the 1890 national census a *mulatto* was defined as someone three- to five-eighths Black; a *quadroon* was one-quarter Black, and an *octoroon* was one-eighth Black. These definitions applied only to Black/White biracial combinations and were eliminated by the next census in 1900, as they had very little rational justification or public support. Between 1900 and 2000, no



effort was made to distinguish people of mixed racial heritage, and the classification trend fell back to using the “one-drop rule” to determine who could and could not identify as White. Any individual with “one drop” of non-White blood had to identify legally with the non-White portion of her or his racial background, thus emphasizing the importance of purity in White ancestry.

The 2000 U.S. Census marked the first time in history in which respondents were allowed to indicate more than one race for their self-classification. This landmark change allowed biracial and multiracial individuals to acknowledge their mixed background. An estimated 6.8 million, or 2.4% of the U.S. population, selected more than one race. This modification of the traditional census format was not met without controversy, however, as many civil rights groups viewed the counting of individuals belonging to more than one race as a potential threat to their political strength. Nevertheless, the change seemed to mark a cultural shift that has allowed for individuals of biracial or multiracial backgrounds to express the full range of their heritage and not be artificially placed into specific minority groups. This new option for classification, along with the legalization of interracial marriages over the past 30 years, has led to what researchers have called a *biracial baby boom*. Indeed, there is increased visibility and awareness about individuals of mixed racial background in the media as well as in academic arenas. It is expected that the biracial population will continue to grow, and in turn, counselors and psychologists will come in contact with more youth and adults of mixed heritage.

### Biracial Identity Development Models

Researchers and clinicians across many areas of psychology have worked to understand the process by which individuals of mixed racial heritage develop conceptualizations of themselves and their racial identity. The primary effort in this area has been the development of models to identify and examine how biracial individuals create personal and racial identity. These models have changed over time, paralleling changes in historical and sociopolitical perspectives regarding biracial individuals in the United States, as well as increased research about biracial development.

The earliest description of biracial development was Everett Stonequist’s marginal person model. In 1937 Stonequist wrote about biracial individuals as individuals

who were linked to two different worlds but never truly belonged in either. Stonequist believed that mixed racial heritage would complicate normal identity development by creating confusion with a person’s ability to identify with a specific social, racial, or ethnic group. This negative description of identity stood as the primary source of understanding for biracial individuals for many years, until models were introduced that described biracial development as somewhat less pathological and, proceeding through a series of distinct stages, could explain various identity outcomes.

The first of the stage models of racial identity was a 1971 model by William E. Cross, Jr., which focused on Black racial identity. Although not specific to individuals of mixed heritage, Cross’s model was highly influential to subsequent models of biracial identity development. In his model, Cross saw racial identity development occurring across a series of distinct stages. Soon, many authors were producing models of biracial development that portrayed biracial individuals as going through a series of distinct, linear, developmental stages throughout their life span. James Jacobs, another contributor to the body of literature about stage models, saw biracial individuals as first noticing racial and ethnic differences between people, then understanding what personal meaning these differences held, and finally synthesizing these meanings to become an individual of combined heritage. Similarly, George Kich saw biracial individuals first becoming aware of statuses of differentness, then personally struggling for acceptance, and finally accepting a biracial identity.

Many stage models, although significantly different from Stonequist’s first description of biracial identity, still held onto the basic premise that biracial development would be inherently more difficult or less healthy than monoracial development. This assumption began to shift with W. S. Carlos Poston’s five-stage model of biracial identity development. Poston’s model suggested that biracial individuals progress through five stages: (1) awareness of personal identity; (2) choice of a specific group categorization; (3) enmeshment or denial from having to select one identity that may not perfectly fit the biracial individual; (4) appreciation for having broader, multiple, ethnic identities; and (5) integration of all different identities into one unified self. This model was one of the first that provided a positive outcome for biracial individuals by incorporating the idea that biracial individuals could create a healthy, integrated sense of racial identity.



Stage models dominated the literature about biracial identity development until recently, when limitations of these models became evident. One concern with stage models was that newer research suggested that biracial identity development may not proceed in a linear fashion or be uniform for all individuals. In addition, many stage models fail to recognize the significance that environmental influences, such as early life experiences, family settings, culture, and other salient aspects of life, could influence the identity development of biracial individuals. These limitations have led many researchers to advocate for more complex, fluid, and multifaceted models of development that highlight biracial identity within specific cultural and environmental contexts.

Maria Root's ecological identity model is a recent model designed to incorporate contextual influences on biracial identity. This model highlights the myriad influences that can affect an individual's racial identity, including history, geographic location, family, physical appearance, gender, socioeconomic status, and sexual orientation, among others. Root's model also suggests that there are several outcomes of identity development for biracial individuals, without claiming that these outcomes will either occur in a specific order or even necessarily occur for all biracial individuals. The five identity outcomes in Root's model are (1) acceptance of ascribed identity as labeled by others, (2) identification with dual racial or ethnic groups, (3) personal identification with a single racial group, (4) identification with a new group, such as biracial, or (5) adoption of a symbolic race or ethnicity by taking more pride with or placing more emphasis on one side of the individual's race. According to Root's model, biracial individuals may elect any of these outcomes at various points in their lives, depending on personal experiences and contextual influences.

Changes in basic understanding and conceptualization of biracial individuals across both the scientific community and the culture of the United States are largely reflected by changes in models of biracial identity development. Understanding of biracial identity started by society initially viewing biracial existence as inherently problematic and maladaptive out of the belief that biracial individuals could never wholly identify with, or fit into, a larger racial group. This perception has changed over time to eventually conclude that biracial individuals may form a cohesive identity, but to do so these individuals would have to go through universal and concrete steps before

forming a positive identity. Finally, modern perspectives are reflected in current identity models, which identify the roles that external ecological forces play in the lives of biracial individuals and the fluid process of identity.

### **Psychological Functioning in Biracial Individuals**

Researchers have studied biracial children, adolescents, and adults to better understand their psychological functioning. Psychologists have been interested in whether early descriptions of biracial individuals as confused and marginalized were accurate and how biracial identity develops in different situations. These studies have highlighted the influence of historical and societal perspectives on race and how these can affect the well-being of biracial individuals. One of the most common findings relates to the experience of discrimination, based on being biracial, and the negative effects of stereotypes. Biracial individuals often describe experiences of discrimination, particularly those involving physical appearance, that took place during their childhood and even as adults. Furthermore, stereotypes about biracial individuals as confused and unhealthy contribute to widespread assumptions that being of mixed race is problematic. Other stereotypes, particularly of biracial women, include perceptions of exotic and sexualized behavior. Like stereotypes of any other groups, these generalizations can be internalized and negatively affect biracial individuals and can also contribute to discrimination targeted toward them.

Research also suggests that biracial youth may experience additional challenges and benefits as a result of their mixed racial heritage. One example is developing a personal identity. Whereas all adolescents grow and struggle with their sense of identity, multiracial adolescents also must integrate aspects of a racial identity that is unique because of its complexity and because of the fact that it does not fit into rigid, monoracial categories. Although being multiracial does not necessarily predict negative consequences for youth and adolescents, research suggests common challenges faced by multiracial youth, such as pressure (from family or others in society) to identify with one ethnicity over the other. For example, an African American/White female may be persuaded to identify with her African American background from her parents although she identifies more with her White peers, who may also reject her. Rejection from either



family or peers can contribute to identity confusion and internalized negative stereotypes.

Whereas early research and theory focused on the negative aspects of mixed heritage individuals, recent research has highlighted strengths and positive aspects of biracial identity. Researchers have recognized that biracial individuals have the opportunity to be exposed to more cultural traditions and languages and may develop increased respect and appreciation of their parents' cultures. In addition, some studies have noted that biracial individuals have more positive attitudes toward other groups of different races than do those of monoracial backgrounds, highlighting the utility of being exposed to multiple cultures.

Qualitative studies also have shed light on the positive aspects of being biracial. In some studies, biracial adults noted there were challenges in various contexts of their lives, especially when they were growing up, but that overall they appreciated and took pride in being of mixed race. Furthermore, many of these individuals exhibited resilience and positive coping strategies as they faced various challenges, such as discrimination and prejudice. Taken together, there are many strengths that contribute to positive and healthy psychological functioning in biracial individuals, and it is expected that researchers will continue to elucidate these assets and resources as they work to understand the complexity of the biracial experience.

### Counseling Biracial Individuals

Clinicians who work with biracial clients should be aware of challenges and strengths possessed by individuals of mixed race, as well as current research about identity development and psychological functioning. It is important to remember that biracial individuals may not present to counseling with racial identity as their primary concern; however, their identity will likely influence various other presenting concerns they may bring to therapy. Thus, it is important for clinicians to explore the meaning of race and ethnicity in the lives of clients to better understand their importance and role.

Clinicians working with biracial individuals are also encouraged to remember that identity development may not be linear and that each person may not pass through the same set of stages or changes. Although it is expected and likely that an individual will grapple with identity factors during adolescence,

for example, it also is possible for individuals to revisit various identity issues throughout life, depending on personal and contextual factors. For example, a biracial college student who grew up in a diverse community may find herself moving to a less diverse city where her university is located. At this new setting she may find that she is confronted with challenges regarding how others perceive her identity and understand ethnicity. She may find that she revisits issues related to her racial background and may work to redefine herself in this new context.

Though there is some research to suggest that having an integrated identity may be helpful and adaptive for individuals of mixed race, it is not necessarily the only healthy or functional identity outcome for everyone. Indeed, many individuals may choose to identify as monoracial and still experience well-being and healthy psychological functioning. Clinicians should be aware of the multiple options for identification that exist for an individual and should not assume that choosing a biracial label is the only marker of positive psychological functioning.

Finally, because biracial identity can be influenced by numerous contextual factors, it is important for clinicians to understand a client's environment and the ways it influences a client's identity. Root's ecological model of identity serves as a useful framework for identifying the various aspects of a client's context that may play a role in his or her choice of identity, such as geographic location or physical appearance. Clinicians are also encouraged to explore the difference between how others see the client (the public or ascribed identity) and how the client sees himself or herself (the personal or private identity). Understanding the degree of convergence or divergence of these identities, as well as its influence on a client's well-being, can help provide a deeper understanding of a client's identity.

### Multiracial Families

Interracial relationships are those relationships formed between two individuals whose racial backgrounds differ from one another. Two individuals with different racial heritages in a romantic relationship are often identified as an *interracial couple*. A U.S. Census 2000 brief reported an estimate of 246,000 Black–White unions that exist out of the 50 million marriages within the United States. Although



Black–White unions dominate the percentage of interracial marriages within the United States, interracial relationships are not limited to these two racial backgrounds. Other examples include an Asian female and an African American male, a Latino male and a White female, and a Native American male and an African American female. Although interracial relationships are still met with opposition, historical and societal changes have led to greater acceptance of younger generations who choose to become romantically involved with individuals of a different race.

Despite this growing acceptance, interracial couples may face additional issues that are not encountered by couples of the same race. Interracial couples sometimes experience hostility from society as well as from their own families and, in extreme cases, may be excluded from the family if relatives are not accepting of the relationship. Negative stereotypes and myths about biracial offspring may also contribute to negative attitudes toward adults who choose partners who are of a different race from themselves. Furthermore, the challenges of an interracial relationship can be exacerbated by the potential differences in the couples' cultural values. These cultural values will influence various aspects of the relationship such as gender roles and expectations of partners, communication styles, and parenting styles, among many others.

Researchers have discussed various counseling interventions to use with parents and children of multiracial families. It is important for counselors to examine their personal views and biases on interracial marriages and biracial or multiracial individuals so as not to bring those biases into the therapeutic relationship. Adolescents especially may be in great need of support from someone with a nonjudgmental stance who does not ascribe judgments based on stereotypes. For these youth, bibliotherapy, for example, reading about experiences that are similar to their biracial experiences, may be a useful intervention. Also, helping clients communicate their questions or concerns to other family members about being biracial is important for clients' acceptance of themselves. Children of mixed racial heritage may question why their physical appearance is different than that of their parents. Parents can communicate with their children an appropriate label to consider for their family so that children know what to say when confronted with the question, "What are you?" Clinicians can also provide psychoeducation to

parents and families as they attempt to learn about the experience of having a mixed family and the unique issues they may be facing.

## Future Research

Psychologists have noted that research about biracial individuals is still in the early stages of development but is definitely growing. With the increasing numbers of biracial individuals and clients in the United States, it is expected that researchers will continue to explore issues of identity, psychological functioning, and counseling interventions with these populations over the next years. There are several areas for future research that will further the field and expand our understanding of biracial individuals. One area includes conducting studies that explore more diverse samples. Past research has focused primarily on biracial individuals of Black and White heritage, but little research exists with combinations of other races. To understand the common experiences faced by all biracial individuals, as well as the unique issues related to those of specific racial combinations (e.g., Native American–Black), more research is needed.

Another area for further research relates to the methodology that is employed to study biracial issues. The majority of past research has relied on qualitative studies, and although this has provided useful models and frameworks, the field is poised to begin studying the biracial experience with larger populations to identify findings that can be generalizable. Indeed, many identity development models that were developed through qualitative studies can be tested with larger, diverse samples of biracial individuals. In addition, researchers may consider utilizing mixed method studies that combine qualitative and quantitative approaches to explicate processes of identity development that change over time.

Another area for further research is the exploration of issues related to multiple identities. It is clear that being biracial is only one aspect of any individual's identity, as every person also represents diversity with respect to gender, age, sexual orientation, disability, and other aspects of culture. To have a comprehensive understanding of the experiences and background of any individual, it is critical to understand the complexity of identity and how various aspects of culture interact. Some researchers have begun to explore biracial lesbians, for example, in an



effort to understand the experience of being of mixed race, female, and attracted to the same sex. Continued research about multiple identities will further the field in understanding the complexity of biracial identity and psychological functioning.

*Lisa M. Edwards, Noah E. Adrians,  
and Elizabeth P. McCadden*

**See also** Bicultural (v3); Cultural Relativism (v3); Ethnic Identity (v3); Ethnicity (v3); Identity Development (v3); Multiracial Families (v3); Race (v3); Racial Identity (v3); Social Identity Theory (v3); Transracial Adoption (v3)

### Further Readings

- Gillem, A. R., & Thompson, C. A. (2004). *Biracial women in therapy: Between the rock of gender and the hard place of race*. Binghamton, NY: Haworth Press.
- Miville, M. L. (2005). Psychological functioning and identity development of biracial people: A review of current theory and research. In R. T. Carter (Ed.), *Handbook of racial-cultural psychology and counseling* (pp. 295–319). Hoboken, NJ: Wiley.
- Poston, W. S. C. (1990). The biracial identity development model: A needed addition. *Journal of Counseling & Development*, 69, 152–155.
- Root, M. P. P. (1992). *Racially mixed people in America*. Thousand Oaks, CA: Sage.
- Root, M. P. P. (1996). *The multiracial experience*. Thousand Oaks, CA: Sage.
- U.S. Census Bureau. (2001, November). *The two or more races population: 2000*. Retrieved from <http://www.census.gov/population/www/cen2000/briefs.html>
- Wehrly, B. (2003). Breaking barriers for multiracial individuals and families. In F. D. Harper & J. McFadden (Eds.), *Culture and counseling: New approaches* (pp. 313–323). Boston: Pearson Education.

### Web Sites

Association of MultiEthnic Americans:  
<http://www.ameasite.org>  
MAVIN Foundation: <http://www.mavin.net>

---

## BLACK ENGLISH

---

Black English, also referred to as Black English Vernacular (BEV), African American Vernacular

English (AAVE), or Ebonics, is a dialectal adaptation of Standard American English found primarily within the African American community. The term refers primarily to patterns of speech that some scholars believe developed during the slavery period in America, as Africans learned English by adapting it to the linguistic patterns of their native dialect. Other scholars argue that Black English developed out of pidgin English, an amalgamation of Standard American English and several African dialects, which facilitated communication within a culturally heterogeneous slave population. It is largely held that this method of communication, while varying regionally, gained a level of permanence throughout the African American community because of the segregation it frequently experienced. Although Black English has traditionally been depicted negatively within American society, contemporary pop culture has adopted many Black English colloquialisms and added them to the American English lexicon.

### Syntax of Black English

Studies of the syntax of Black English have frequently attributed its deviations from Standard English to West African language rules. For example, the lack of consonant pairs in many West African languages is seen as responsible for the elimination of consonants in Black English; thus, for example, the word *just* becomes *jus*. Similarly, the lack of *r* and *th* sounds in West African languages leads to substitutions such as *souf* for *south* and *dis* for *this*. Frequent absence of the verb *be* in present-tense Black English (e.g., “They so noisy!”) can be attributed to the lack of such an equivalent in many West African languages.

### Controversy Involving Black English

In 1996, the Oakland Unified School District of Oakland, California, sought to increase academic performance among African American students by recognizing Black English, or Ebonics, as a distinct language and its speakers as bilingual. The school district intended to enhance English proficiency among poorly performing African American students by, among other things, linking their experience to that of English as a second language learners. It was the school district’s contention that Black English was the primary language of the home for many African American students, and their limited English proficiency was, as with other ethnic groups, related



to interference from their most commonly spoken tongue.

This proposed curricular conceptualization met significant resistance within the field of education as well as within segments of the African American community itself. Many saw Black English as simply incorrectly spoken English or as broken English and not a language deserving of recognition or curricular considerations. Others misinterpreted the intentions of the Oakland Unified School District as seeking to instruct students in Black English as opposed to Standard English. Although the Oakland School District's initial attempt to incorporate vernacular speech patterns into English instruction was met with opposition, this topic continues to surface among educators of African American students.

*Hammad S. N'cho*

*See also* African Americans (v3);  
Afrocentricity/Afrocentrism (v3); Communication (v3);  
Ethnic Identity (v3); Racial Identity (v3)

### Further Readings

- Mufwene, S. S., Rickford, J. R., Bailey, G., & Baugh, J. (1998). *African-American English: Structure, history and use*. New York: Routledge.
- Rickford, J. R., & Rickford, R. J. (2002). *Spoken soul: The story of Black English*. New York: Wiley.
- Smith, E. (1995). Bilingualism and the African American child. In M. Ice & M. Saunders-Luca (Eds.), *Reading: The blending of theory and practice* (pp. 90–91, 93). Bakersfield: California State University.
- Smitherman, G. (1977). *Talkin and testifyin: The language of Black America*. Boston: Houghton Mifflin.
- Van Keulen, J. E., Weddington, G. T., & Debose, C. E. (1998). *Speech, language, learning and the African American child*. Boston: Allyn & Bacon.

---

## BLACK PSYCHOLOGY

---

Black psychology is an emerging discipline broadly defined as an evolving system of knowledge concerning elements of human nature, specifically study of the experience and behavior of people of African descent (Black populations). Historically, Black psychology stems from African philosophy, yet early perspectives in the United States focused on reacting to

Western psychology's characterization of Blacks as psychologically inferior. Contemporary perspectives proactively create racially sensitive models and establish African-centered models of human behavior for understanding the Black experience. Drawing upon emerging Black and African-centered psychological perspectives will contribute to the future of cross-cultural counseling with people of African descent.

## The Emerging Discipline of Black Psychology

### *Historical Foundations*

The historical foundations of Black psychology extend back to the educational systems of Ancient Egypt (Kemet, 3200 B.C.). During that time, African scholars developed complex philosophies, or systems of knowledge, which predated Greek philosophy. The African philosophical belief systems, contemporarily known as worldviews, informed members of society about how to understand reality and the structure of all things in the universe, including human relations and values. Duadi Azibo, Kobi K. Kambon, Linda James Myers, and Wade W. Nobles are a few of the notable Black psychologists who discuss the philosophical foundations of Black psychology based on four major components of African worldview: (1) Cosmology, the structure of the universe or reality, reflects interdependence, collectivism, and unity with nature; (2) ontology, the essential nature of reality, including the self, is a spiritual divine energy manifesting in the physical or material realm; (3) epistemology, the nature of knowledge, regards knowing reality through affective and cognitive self-knowledge using symbolic imagery and rhythm; and (4) axiology, the basic value system, focuses on positive human relations. Prior to the emergence of these African worldview concepts in Western academia, early Black psychologists were establishing their legitimacy and researching the inferior status of Blacks in traditional psychology.

### *Early Black Psychologists*

In 1920, Francis Summer became the first Black person in America to earn a Ph.D. in psychology. In 1938, Herman Canady convened the first group of Black educators in psychology as a caucus within the American Teachers Association (ATA) at its annual convention in Tuskegee, Alabama (the ATA was the



primary professional organization for Black educators at the time). The group's main goal was to promote the teaching and the application of psychology, particularly at Black schools and among Black scholars.

Subsequently, numerous Black psychologists in the early 20th century published theories and research critiquing racist social policies. The research of Kenneth and Mamie Clark on racial preferences among Black preschool children helped to determine the 1954 landmark case *Brown v. Board of Education*, which affirmed the unconstitutionality of separate but equal schools. Ironically, early theory and research also fostered a perspective of Blacks as deficient, claiming that the effects of discrimination and oppression left Blacks with few strengths, self-hatred, and low self-esteem. In the late 1960s, the emergence of the Black Power movement and Black Nationalism inspired some African American psychologists to combat the deficit view and eventually form the first independent Black psychological association.

### ***Association of Black Psychologists***

The Association of Black Psychologists was founded in 1968 following a formative group of African American psychologists voicing frustration and outrage with the policies and practices of the American Psychological Association (APA). The Black psychologists attending the APA San Francisco conference in 1968 made several proposals requesting that APA address concerns regarding the effects of racism in multiple settings, such as the Black community, educational settings, psychological research, testing, and graduate training programs. Dissatisfied with the response, the formative group decided to establish an organization that would advance a Black psychology, separate and distinct from Western psychology.

In 1972, numerous Black scholars under the editorship of Reginald L. Jones published the inaugural text *Black Psychology*. Here, Wade W. Nobles introduced the African philosophical foundations of Black psychology and Joseph White formally advocated for a theory of Black psychology out of the authentic perspective of Black people in the United States. By 1974, under the inaugural editor William David Smith, the Association of Black Psychologists launched the *Journal of Black Psychology* to provide a peer review platform for publishing empirical research, original theoretical analysis of data, and discussions of current literature in the domain of Black populations. In 1984 the journal published a 10-year content analysis

indicating a small increase in empirical articles using the traditional deficit view to explain Black behavior and a need for explanatory models based upon African descent values and the diverse cultural experiences among Blacks. During the journal's second period of self-evaluation (1985–1999), the results of which were published in 2001, the trend of articles focused on Black personality development addressing racial/cultural identity and racial/cultural consciousness. In recent years the journal has focused on a number of health psychology special issues addressing substance abuse prevention, HIV/AIDS, gender, sexuality, and suicidal behavior and articles examining the psychological impact of racism and discrimination among Blacks. Today both the Black and African-centered perspectives contribute to the diversity of publications in this emerging discipline.

### **Black and African-Centered Psychology Perspectives**

The Black (also called African American) psychology perspective is the study of the experience of Black populations, particularly in the United States, using principles adapted from traditional psychology to create racially and culturally sensitive models. The perspective uses traditional empirical methods to dismantle the prevailing view of the 1960s through 1980s that African Americans are culturally deficient against the normative standard of European American beliefs, values, and lifestyles. Unlike the deficit view, Black psychology's racial and cultural models emphasize cultural strengths and limitations in the context of social and environmental factors.

Alternatively, the African-centered psychology perspective concerns understanding human nature, using African philosophical values, thus going beyond oppressive social contexts. The perspective defines experience from an African-centered psychological orientation, emphasizing worldview dimensions of spirituality, collectivism, oral tradition, affective senses, and harmony in relationships. Equivalent to using traditional empirical methods of observing behavior is understanding human nature through feelings or emotional and cognitive processes of self-knowledge or self-realization. Although systematic research is limited, African-centered psychology models for understanding people of African descent—for example, the Azibo nosology diagnostic system of psychopathology and Na'im Akbar's classification of mental disorders—are emerging. Models of positive



Black identity, Black families, and education are but a few examples of both Black and African-centered psychology perspectives.

### **Black Identity**

First theorized by Charles Thomas (cofounding chair of the Association of Black Psychologists), William E. Cross, Jr.'s 1971 linear stage-based racial identity theory, labeled the Nigrescence model, gave rise to extensive research on how Blacks identify with and psychologically interpret the meaning of their racial group in the context of racism and social oppression. Most notably Janet E. Helms and other scholars went on to revise and expand racial identity theory, which now includes status-based, life-span development perspectives, multidimensional models, and measures of racial identity such as the Cross Racial Identity Scale and the Black Racial Identity Scales. A decade of empirical inquiry using the scales examines within-group differences of racial identity and its association with demographic variables, academic achievement, problem behaviors, acculturation, socialization, racism-related variables, and counselor preference of Blacks in cross-cultural counseling.

Concurrently, Wade Nobles's 1972 theory of African self-concept or African self-consciousness laid the foundation for decades of African-centered psychology research. Using African philosophical assumptions about human nature, the African self-consciousness view stresses awareness of one's past history, one's collective spiritual consciousness, and one's individual and group self-concept. Subsequent models of African-self consciousness focus on a spiritual and collective identity as the core of the Black personality. Various scholars conducted assessment and research of the African personality with such scales as the African Self-Consciousness Scale and the Black Personality Questionnaire. Psychometric scales such as the Afrocentrism Measure, the African Value for Children Scale, and the Spirituality Scale continue in use to advance understanding of the Black experience via the African-centered perspective.

### **Black Families**

Black families are defined as extended family networks that involve immediate family, friends, neighbors, church members, and fictive kin or members not biologically related. African American perspectives examine both structural and functional aspects of

family, emphasizing acculturation, socialization, and coping factors. Black perspectives also take care not to pathologize or highlight deficit views of Black families, but to promote the strengths and consideration of socioeconomic, historical, and political factors that affect families. African-centered perspectives additionally emphasize the family values of spirit, interconnection, children, cooperation, responsibility, and respect for elders.

### **Education**

Black psychology perspectives on education are defined by emphasis on the educational experiences, needs, and career development of African Americans. Perspectives of the 1960s and 1970s addressing elementary school age children included combating culturally deficient paradigms about intelligence, language, dialect, and learning styles. In the past 2 decades researchers have turned to emphasizing the role of culture and advocating for culturally congruent education acknowledging racial/ethnic identity, socialization, home, spirituality, and community practices among youth and college-age students. Emerging African-centered initiatives teach youth about unique cultural concepts such as the *Nguzo Saba* principles (*Umoja*—unity, *Kujichagulia*—self-determination, *Ujima*—collective work and responsibility, *Ujamaa*—cooperative economics, *Nia*—purpose, *Kuumba*—creativity, and *Imani*—faith) of the African American holiday Kwanzaa and the *Ntu* (meaning “energy”) system of health and healing. The concept of *Maat*, referring to the principles of truth, justice, righteousness, reciprocity, harmony, balance, and order, is another cultural value system emerging in educational and Black psychological initiatives.

### **Future Directions**

Black psychology is an emerging discipline transformed from reacting to Western psychology to constructing models that explain the Black experience from perspectives that are racially sensitive and emphasize the strength of African cultural values. Future theory and research will likely employ overlapping Black and African-centered approaches to generate practice models supportive of adaptive functioning and the diverse counseling needs of African Americans. Counseling paradigms that articulate the Black experience in both the context of racial oppression and the African worldview will increase



Black psychology as a resource for cross-cultural counseling with people of African descent.

*Ma'at E. Lewis-Coles*

**See also** Acculturation (v3); African Americans (v3); Afrocentricity/Afrocentrism (v3); Association of Black Psychologists (v3); Black Racial Identity Development (v3); Clark, Kenneth Bancroft (v3); Clark, Mamie Phipps (v3); Cross, William E., Jr. (v3); Discrimination (v3); Helms, Janet E. (v3); Kwanzaa (v3); Racism (v3); Spirituality (v3); Worldview (v3)

### Further Readings

- Belgrave, F. A., & Allison, K. W. (2006). *African American psychology: From Africa to America*. Thousand Oaks, CA: Sage.
- Cokley, K., Caldwell, L., Miller, K., & Muhammad, G. (2001). Content analysis of the *Journal of Black Psychology* (1985–1999). *Journal of Black Psychology*, 27(4), 401–438.
- Guthrie, R. V. (1976). *Even the rat was white: A historical view of psychology*. New York: Harper & Row.
- Jones, R. (Ed.). (2004). *Black psychology* (4th ed.). Hampton, VA: Cobb & Henry.
- Kambon, K. K. (1998). *African/Black psychology in the American context: An African-centered approach*. Tallahassee, FL: Nubian Nation.
- Nobles, W. (1986). *African psychology: Towards its reclamation, reascension & revitalization*. Oakland, CA: Black Family Institute.
- Parham, T. A. (2002). *Counseling persons of African descent: Raising the bar of practitioner excellence*. Thousand Oaks, CA: Sage.
- Parham, T. A., White, J. L., & Ajamu, A. (1990). *The psychology of Blacks: An African-centered perspective*. Upper Saddle River, NJ: Prentice Hall.

### Web Sites

Association of Black Psychologists: <http://www.abpsi.org>

---

## BLACK RACIAL IDENTITY DEVELOPMENT

---

Black racial identity development (BRID) theory explains the processes by which Black people (the term *Black* is used here, rather than *African American*, to reflect the terminology in models of identity

development) develop a healthy sense of themselves as racial beings and of their Blackness in a toxic sociopolitical environment. BRID is generally viewed as a derivation of more general racial/cultural development theory, in that it describes the importance of race in an individual's self-concept. However, BRID is distinctive in its attention to the unique experience of Black people in dealing with racial discrimination and oppression.

The concept of race has played a historically important role in the lives of Black people in the United States, as reflected in the early writings of W. E. B. Du Bois. In the most recent literature, Black identity development has been associated with factors such as psychological health, academic achievement, acculturation, psychosocial competence, self-actualization, self-esteem, and student involvement.

### Models of Black Racial Identity Development

Black racial identity development has often been conceptualized in models that describe linear stages through which Black individuals move from a negative to a positive self-identity in the context of their racial group membership. One of the earliest and most influential models of BRID was developed by William E. Cross, Jr., as part of his Nigrescence (the process of becoming Black) theory. Cross used a five-stage model to describe a Black person's feelings, thoughts, and behaviors as he or she moves from a White frame of reference to a positive Black frame of reference: pre-encounter, encounter, immersion/emersion, internalization, and internalization/commitment.

In the *pre-encounter* stage, Black people consciously or unconsciously manifest an anti-Black worldview while seeking to assimilate and acculturate into dominant White society. Low self-esteem and poor psychological health are characteristic of individuals at this stage. The *encounter* stage is marked by two processes: (1) an experience that challenges the pre-encounter individual's pro-White/anti-Black worldview, and (2) a reinterpretation of one's racial identity as a result of this experience. At this stage, a Black person finds support in the search for a Black identity and makes the conscious decision to identify with being Black. A strong pro-Black attitude and withdrawal from, and hostility toward, dominant White culture typifies the *immersion/emersion* stage, signifying a switch from the "old" anti-Black/pro-White worldview. The individual has an acute sense of Black pride, but a positive Black identity has not yet been internalized.



Feelings of guilt and anger at having been conditioned by White culture are common. At the *internalization* stage, Black people succeed in reconciling the antagonism of their pre-encounter and immersion/emersion worldviews. The individual's resentment of White culture subsides and a nonracist, multicultural orientation prevails. Social action demarcates the ultimate stage, *internalization/commitment*, from the previous stage. Here, Black people not only incorporate a positive Black racial identity into their self-concepts, but they also make a commitment to activities that promote social justice and civil rights.

The Nigrescence model has received the most attention in the psychological literature of all the BRID models, particularly for its association with a measurement instrument developed by Janet Helms—the Racial Identity Attitude Scale–Black—which has been used to operationalize BRID in a number of studies. Cross and his colleagues have since revised the Nigrescence model, collapsing the internalization and internalization/commitment stages into one stage (internalization) and expanding each stage into multiple “identity clusters” to address the criticism that numerous identities may be manifested at each stage.

Another model of BRID, proposed by Bailey Jackson, explains a slightly different version of racial identity development. Whereas Cross suggested that dominant culture worldviews could be internalized on a subconscious level, characteristic of his pre-encounter stage, Jackson's four-stage model describes an initial *passive acceptance* stage in which Black people accept and conform to White cultural norms. The second stage, *active resistance*, is characterized by the rejection of, and feelings of anger toward, White culture. The *redirection* stage is associated with pride of one's Black culture and a mollified anger toward White culture. Thus, although Cross combined elements of these two identities into one stage, immersion/emersion, Jackson conceptualizes them as two distinct processes. Finally, the *internalization* stage is marked by both an acceptance of the healthy aspects of the dominant White culture and a commitment to taking action to redress the deleterious aspects.

### Mainstream Versus Underground Theories

The BRID theories previously described focus on the universal processes of group identity development that Black people undergo to arrive at a psychologically healthy racial self-concept. These models have been

referred to as *mainstream* theories of Black racial identity. Another set of theories—called *underground* theories for their relative noninclusion in the broader psychological community—generally take a more Africentric perspective and do not hold the assumption that all Black individuals begin the process of identity development with anti-Black attitudes. Historically, W. E. B. Du Bois argued that Black sociocultural influences can aid in racial identity development and that one's self-concept is not necessarily a reaction to racial oppression. According to underground theories, the reconciliation between one's “African self” and one's “American self” is the essential task in developing a healthy BRID. However, there is disagreement among underground theorists over how to reconcile these two “selves”: Some theorists claim that African Americans benefit from attending to both their “Blackness” and the broader White society, whereas others argue that an integrated identity comes only when one strongly identifies with all things Black.

### Applications for Training and Counseling

BRID theories have important practical implications in their capacity to help counselors recognize the differences in racial identity development among Black clients. An individual's level of racial identity development has an important bearing on his or her attitudinal and behavioral predispositions in the counseling relationship. Helms used the updated four-stage Nigrescence model to project the nature of counseling relationships with a Black counselor and client across the stages of identity development.

For example, a pre-encounter client would likely be disappointed about being assigned a Black counselor and would exhibit hostility or embarrassment toward the counselor. A pre-encounter counselor may treat Black clients in a punitive, condescending fashion. Black clients in the encounter stage may be hypersensitive to the approval of a Black counselor and may, accordingly, be apologetic and avoid issues they deem non-Black. A counselor in this stage can show fear over whether or not the Black client will approve of him or her and also anticipation for the opportunity to connect with a member of his or her racial group. Clients in the immersion/emersion stage will feel positively toward a Black counselor only after determining that the counselor has a high enough level of “Blackness.” There may, therefore, be an early combative, testing element to the relationship.



The internalizing client may prefer a Black counselor, but race no longer has primacy in the selection process. Counselors in the internalizing stage aim to help the client achieve self-actualization, and they focus on the issue of race inasmuch as it is an important part of actualization.

Helms states that for a counselor to help a client progress through stages of racial identity development, he or she must be at least one stage ahead of the client in his or her own development. If the counselor and client are at the same stage, or if the client is at a more advanced stage than the counselor, then a counseling impasse may occur.

Another important application of BRID to counseling is its role in helping counselors understand the role that oppression plays in Black clients' development. This awareness serves as a clarion call for many to explore systemic interventions and take action outside the confines of their offices to combat sociopolitical factors, such as racism and poverty, that impact clients' psychological health.

### Future Directions

Early formulations of BRID, such as Cross's Nigrescence model, have been criticized for conceptualizing BRID as a linear process and focusing upon BRID in late adolescence/early adulthood. However, Thomas Parham and Janet Helms have reconceptualized BRID to reflect a more fluid notion of identity development in which individuals can move both forward and backward through the different statuses across the life span.

Eleanor Seaton and colleagues recently found that Black individuals may both progress and regress across BRID stages over time, supporting this more fluid conceptualization of racial identity development. Tabbye Chavous and colleagues have further illuminated the complexity of BRID via cluster analyses, suggesting BRID may also involve the salience of race in one's identity, feelings regarding one's racial group, and attitudes regarding how Blacks are perceived by others in the United States. The complexity of BRID in recent research provides promising future directions for theory and research.

Although theories of BRID have done much to explain an individual's racial identity, there has been less exploration of the intersections of BRID with other aspects of identity, such as gender, class, and sexual orientation. The interactions of these factors

with Black identity may have important implications. Likewise, there may also be important yet unexplored geographic considerations in BRID. Most BRID theories were conceived in the climate of Western cultures; the development of Black people's racial identities in non-Western cultures is much less understood. Similarly, theories of BRID, and underground theories in particular, emphasize the importance of reconnecting with aspects of one's African heritage, yet the processes for doing so are still unclear.

*Adam M. Voight and Matthew A. Diemer*

**See also** African Americans (v3);

Afrocentrism/Afrocentricity (v3); Ethnic Identity (v3);

Identity (v3); Identity Development (v3); Multicultural

Counseling (v3); Oppression (v3); Racial Identity (v3)

### Further Readings

Chavous, T. M., Bernat, D. H., Schmeelk-Cone, K., Caldwell, C. H., Kohn-Wood, L., & Zimmerman, M. A. (2003). Racial identity and educational attainment among African American adolescents. *Child Development, 74*, 1076–1090.

Constantine, M. G., Richardson, T. Q., Benjamin, E. M., & Wilson, J. W. (1998). An overview of Black racial identity theories: Limitations and considerations for future theoretical conceptualizations. *Applied & Preventive Psychology, 7*, 95–99.

Cross, W. E. (1971). The Negro to Black conversion experience: Toward a psychology of Black liberation. *Black World, 20*, 13–27.

Helms, J. E. (1984). Towards a theoretical explanation of effects of race on counseling: A Black and White model. *Counseling Psychologist, 12*, 153–165.

Sellers, R. M., Shelton, J. N., Cooke, D. Y., Chavous, T. M., Rowley, F. A. J., & Smith, M. A. (1997).

Multidimensional model of racial identity: A reconceptualization of African American racial identity. *Personality and Social Psychology Review, 2*, 18–39.

Vandiver, B. J., Cross, W. E., Worrell, F. C., & Fhagen-Smith, P. E. (2002). Validating the Cross Racial Identity Scale. *Journal of Counseling Psychology, 49*, 71–85.

---

## BUREAU OF INDIAN AFFAIRS

---

As one of the oldest agencies within the U.S. government, the Bureau of Indian Affairs (BIA) shares a



complex and traumatic history with Native Nations. Originally part of the War Department, the BIA was transferred to the Department of the Interior in 1849 by an act of Congress. Since its establishment as a federal agency, the BIA as well as its precursors have been tasked with managing and overseeing most matters relating to Indian affairs and relations between Indian Nations and the U.S. government; examples include educational services, land and other asset management, health care, and economic development.

As the relations between Native Nations and the United States have changed dramatically since colonization, the roles of the BIA have also transformed. The agency's responsibilities have changed to reflect evolution of the U.S. government's policies toward Native Nations that have been shaped by treaties, laws, and court rulings. These responsibilities have ranged from enforcing policies of removal, "civilization," assimilation, and termination of American Indian tribes to implementing policies that support tribal sovereignty, self-determination, and self-government. However, the relationship between the BIA and Native Nations remains complex.

## Historical Context

### *Removal and Reservations*

From 1824 to 1849, the BIA was housed within the War Department; the agency was then known as the Office of Indian Affairs. The placement of the agency was reflective of the mostly constant hostile and conflictual nature of U.S. and Native relations. Through warfare, other uses of military force, and the creation of treaties (many of which were fraudulent) with Native Nations, the United States gained control of more than 90% of Indian lands. As part of the removal policy and also the treaty-making process, the government created the reservation system, lands where tribes were permanently removed to or relocated and forced to remain under military sanction. In exchange for ceding their ancestral lands, Native Nations were promised in treaties they would be provided food, education, other goods, and annuities, thereby creating a state of dependency on the U.S. government. However, treaties were chronically violated through official corruption within the government, specifically, the Office of Indian Affairs, and continued hostile acts of European American settlers against Native peoples.

Following the Indian Removal Act of 1830, the Office of Indian Affairs oversaw the removal of southeastern tribes (primarily Cherokee, Muscogee Creek, Seminole, Choctaw, and Chickasaw) to what was then called Indian Territory, today known as the state of Oklahoma. Whereas some citizens of these tribes had relocated to lands west of the Mississippi prior to the removal act, the U.S. military, under the auspices of the Office of Indian Affairs, forcibly removed others to Indian Territory. For example, in 1838, the Cherokees, most of whom had not migrated to Indian Territory, were forcibly removed from their ancestral lands on a thousand-mile march that became known as the Trail of Tears. More than 4,000 people died on the journey. The primary objective of the removal was to open up more than 25 million acres of eastern land to European American settlement.

### *Assimilation*

In 1847, the Office of Indian Affairs was renamed the Bureau of Indian Affairs, and 2 years later the agency was transferred to the Department of the Interior, which had been newly established by Congress. Following the era of removal, relocation, and creation of the reservation system, the official U.S. policy toward American Indians changed to one of assimilation. This policy aimed to extinguish Native culture and "civilize" or "Americanize" Indians; it was enforced mostly through the boarding school system formally administered by the BIA, and it continued governmental control of land also under the auspices of the BIA.

The General Allotment Act, or Dawes Act of 1887, abolished communal title of reservation lands and forced families onto individual allotments typically of 80 to 160 acres to be held in trust by the government. Whatever reservation land was left after allotment was sold. In less than 4 years, more than 12 million acres had been designated as "surplus," and just 10 years later, nearly 29 million acres had been designated as surplus. One result of the Dawes Act was the fragmentation of reservation land, further disrupting tribes' communal relationship with the land and placing physical distance between tribes' citizens and families. For the U.S. government, the primary aim of the act was twofold: to obtain more land, opening it up for European American settlement, and to "civilize" Native Nations into European American society and culture.

In 1879, the Carlisle Indian Industrial School was founded by Captain Richard Pratt in Carlisle,



Pennsylvania, and operated until 1918. Pratt is infamous for saying, "Kill the Indian and save the man." The Carlisle School was the model upon which all other governmental boarding schools were based and operated, most under regimented military-style rules. Indian children were forced to attend boarding schools that were generally located very far away from their tribes and families; separations from family members would often last for years. Everything from clothing, haircuts, language use, food, and lifestyle in the schools were "American" and were meant to "civilize" the children mandated to attend those schools. In addition to the subjects of arithmetic and U.S. history, children were taught to read, write, and speak English. Speaking their Native languages or practicing any cultural activities or traditions was prohibited and typically met with severe physical punishment. Less than 10 years after the founding of the Carlisle School, 41 boarding schools operated under the BIA's management, most of which were administered through Christian religious organizations.

When tribes and parents refused to allow their children to be taken away to boarding schools, BIA agents would incarcerate parents and withhold rations of food, clothing, blankets, and other necessities from the tribe, forcing them to submit to the government's will. Indian boarding schools, rather than being institutions that fostered healthy child and adolescent development, were institutions that allowed perpetration and perpetuation of emotional, physical, and sexual abuse of the children who attended them. The boarding school system operated in much the same way into the 1960s. The abuse that occurred in the schools, as well as the resulting disastrous and traumatic effects on Native Nations and cultures, are felt in nearly every aspect of life and have been well documented. Loss of language, religious and spiritual practices, cultural knowledge, traditional parenting practices, and cultural identity and heritage have profoundly damaged Native Nations, communities, families, and individuals. This damage is evident in the high incidence of suicide, alcoholism and other substance abuse/dependence, child abuse and neglect, domestic violence, and other social and behavioral problems within many Native communities.

### ***Termination***

Beginning in the early 1950s, in an effort to permanently cut federal funding of Native Nations and

further assimilate American Indians into American society, federal Indian policy was that of termination. This referred to the U.S. government terminating federal relations with Native Nations. The government withdrew federal recognition of many tribes during this time, which effectively disallowed federal benefits and services to such Nations. For affected Nations, this policy was economically and politically crippling.

Another aspect of federal termination policy included relocation programs. These programs, administered via the BIA, relocated American Indian families to urban areas for perceived job training and economic opportunities, again perpetuating the belief that assimilation was a means to a better life. One major effect of relocation programs was further dilution in Native community strength, as relocated members were seldom able to travel back home because of economic reasons. The descendants of this relocated generation experienced even further disconnection from their cultures and communities.

## **Contemporary Policies**

### ***Self-Determination and Self-Governance***

The late 1960s and into the 1970s saw passage of several congressional acts that seemed to support Native self-determination, for example, the 1968 Indian Civil Rights Act, the 1975 Indian Self-Determination Act, the 1978 Indian Child Welfare Act, and the 1978 Indian Religious Freedom Act. Each act reaffirmed tribal sovereignty and the special trust relationship between Native Nations and the United States. Additionally, they provided Native Nations greater jurisdiction over their affairs in each of these important areas.

This policy has transformed today to one of self-governance in which the United States recognizes Native Nations' governments; Nations are able to directly address and negotiate with the U.S. government for their own interests. In terms of the BIA, the policy of self-governance provides Native Nations much more autonomy over administration of federal monies and economic and social programs. However, conflicts of interest still arise, for example, protection of water and land rights. Oftentimes the BIA, whose task is to protect such rights on behalf of Native Nations, is confronted with competing interests from other Department of Interior agencies (e.g., Bureau of Land Management). Such conflicts of interest may



result in poor outcomes for Native interests, thereby maintaining tension in an already complex relationship.

*Jill S. Hill, Rockey R. Robbins, and Megan Correia*

**See also** Alaska Natives (v3); American Indians (v3); Career Counseling, Native Americans (v4); Indian Health Service (v3); Society of Indian Psychologists (v3)

### Future Readings

Henson, C. L. (1995). From war to self-determination: A history of the Bureau of Indian Affairs. *American Studies Today Online*. Retrieved from <http://www.americansc.org.uk/Online/indians.htm>

Reyhner, J., & Eder, J. (1989). *A history of Indian education*. Billings: Eastern Montana College, Bilingual Education Program.

Smith, A. (2005). *Conquest: Sexual violence and American Indian genocide*. Cambridge, MA: South End Press.

Wilkins, D. E. (2007). *American Indian politics and the American political system* (2nd ed.). Lanham, MD: Rowman & Littlefield.

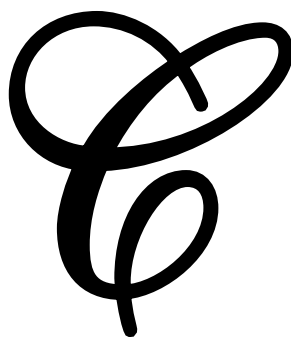
Wilson, J. (1998). *The earth shall weep: A history of Native America*. New York: Grove Press.

Witko, T. M. (2006). *Mental health care for urban Indians: Clinical insights from Native practitioners*. Washington, DC: American Psychological Association.









---

## CASAS, JESÚS MANUEL (1941– )

---

Jesús Manuel (Manny) Casas was born in the small town of Avalos, Chihuahua, Mexico. His rich racial/ethnic heritage includes roots in Spain and indigenous Mexico. His paternal great-grandmother was Apache, having been saved by Mexican wagon masters from U.S. cavalry raids on her village and subsequently taken to Mexico where she was raised by his great-grandfather's family. Something that ties him historically to California, the state in which he has lived most of his life, is the fact that in the 1800s his paternal great-grandfather spent a major portion of his life driving a wagon train from the north central part of Mexico to Sacramento, California, and back again.

Casas immigrated to the United States at a young age and was educated in the racially hostile environs of the U.S. educational system during the late 1940s and 1950s. Part of this historical period is best captured in Casas's own words from his 2001 published life story:

On the first day of school, my mother, along with a limited-English speaking friend, walked me and a friend to school, got me to the classroom and left. As I entered the classroom, I experienced the kind of aloneness, fear, and alienation that, if it were in my power, no other child would ever have to experience. No one looked like me. No one spoke my language. I couldn't communicate with anyone, including the teacher. To solve this communication problem, the teacher came up with a unique and intellectually challenged strategy. I would be seated in the back of the room—not the bus—the room, where I could listen

and with time eventually pick up the English language. (Casas et al., 2001, p. 84)

And so began Casas's lifelong devotion to advocating for immigrant families—particularly poor Latino/a families and children.

Despite the discrimination he experienced during his primary and secondary schooling, he graduated at the top of his high school class and went on to college at the University of California, Berkeley. After graduating, he taught in the public schools for 5 years before going on to graduate school. He earned his Ph.D. at Stanford University in 1975. After 2 years as a counseling psychologist at the University of California, Los Angeles, he began his career at the University of California, Santa Barbara. Over the course of his more than 30 years as a psychologist, Casas has become widely recognized as a distinguished scholar of Chicano/a psychology. He is now the senior Chicano faculty member in the University of California system.

Though Casas is best known for his work in developing the field of Chicano/a psychology, he has also done considerable work in general multicultural counseling. He is a Fellow of the American Psychological Association (APA) Division 17 (Society of Counseling Psychology) and Division 45 (Society for the Psychological Study of Ethnic Minority Issues). He is also the recipient of many awards, most recently the National Latina/o Psychological Association Psychologist's Distinguished Contributions to Latino(a) Psychology Award in 2006, and he was honored as an elder at the 2007 APA National Multicultural Summit and Conference.



He has been a reviewer or editorial board member for 19 journals, including *The Counseling Psychologist*, *Journal of Counseling Psychology*, *Journal of Multicultural Counseling and Development*, *Cultural Diversity & Ethnic Minority Psychology*, and *American Psychologist*. He has authored or coauthored 140 articles and has presented 129 papers at professional conferences internationally. He has published in the flagship journals of his field and has either written, edited, or contributed to most of the seminal works in multicultural counseling. Casas's works are among the most frequently cited in the field of multicultural counseling, and his works have literally contributed to defining the field and pushing it to use more rigorous research methods.

With all of these accomplishments, one of Casas's greatest strengths is as a teacher and mentor. To produce scholars who are also caring teachers, he combines his immense knowledge of the literature and Socratic teaching style with the care and interest of a parent. Among his many protégés who have gone on to establish their own records of excellence in multicultural counseling psychology are some of the field's most dedicated and eminent counseling psychologists. Casas has collaborated with dozens of prominent multicultural counseling psychologists—far too many to name here.

Casas's role as a practitioner has been primarily in the area of advocacy and consultation. He has consulted with over 50 governmental and nongovernmental organizations, mostly as a multicultural or diversity consultant. To this point, Casas was one of the only Latino psychologists to work toward increasing the sensitivity, knowledge, and practices of selective Fortune 500 companies who, early on, acknowledged their need to reach and access the growing Latino/a population. Through this work, he developed training models and manuals that are still in use today. More importantly, Casas has been an advocate for the Chicano/a communities and other oppressed groups during his career. Very few people know the amount of time, energy, and resources that he has poured into the local Chicano/a community in Santa Barbara. For instance, he has served on numerous boards of non-profit organizations that work toward increasing the educational and social well-being of Latino/a children and families (e.g., Head Start). He continues to be a member of the Santa Barbara Mental Health Commission. In this position he serves as an advocate for those populations that are inappropriately served or underserved by the mental health system. More to the

point, when asked why he wanted to be on the Commission, Casas said, "Someone needs to watch how they are spending the money and to make sure it gets to the families that need it."

Casas has secured millions of dollars worth of grants from public and private foundations. He has been responsible for channeling more than \$10 million of grant money to the County of Santa Barbara for use in the development of interventions for high-risk children. In addition, he has served as the cochair of the University of California Chancellor's Outreach Advisory Board, overseeing the distribution of millions of dollars earmarked for increasing the pipeline of students of color eligible for admission to the University of California.

Casas continues his work as an advocate, consultant, educator, and researcher. As an advocate, he is directing much of his energy to work with the local community to identify and implement the best practices and interventions that can be used to combat the growing menace of gang violence. As a consultant, Casas is volunteering his time to work with the Universidad del Valle de Guatemala to help the university to develop the first Ph.D.-level counseling psychology training program in Guatemala. He welcomes this venture because it gives him a chance to test the generalizability of many existing multicultural theories and practices with the very diverse and indigenous population of Guatemala. With respect to research, he is "examining old wine in new bottles." More specifically, to increase the understanding of ethnic identity, he is examining, comparing, and contrasting this construct with other psychological constructs that together are the essence of the "self."

Casas's lifelong devotion to bettering the conditions of his people through his work has taken a more personal turn in recent years. It is common to see him out in the community with his two young, recently emigrated godsons, Joel and Manuelito, in whom he is already instilling the love of learning and commitment to the community. These boys are now benefiting from the care, nurturing, and structure that so many students and clients have received from Casas. In their eyes are reflected Dr. Casas's dream . . . and the love they have for their *abuelito*.

*Michael I. Loewy and Roger L. Worthington*

**See also** Career Counseling, Latinos (v4); Cross-Cultural Training (v3); Diversity (v3); Ethnic Minority (v3); Immigrants (v3); Latinos (v3); Machismo (v3);



Multicultural Counseling (v3); National Latina/o Psychological Association (v3); Organizational Diversity (v3); Racism (v3); Society for the Psychological Study of Ethnic Minority Issues (v3)

### Further Readings

- Brady, S., Casas, J. M., & Ponterotto, J. G. (1983). Sexual preference biases in counseling: An information processing approach. *Journal of Counseling Psychology, 30*, 139–145.
- Casas, J. M., & Keefe, S. E. (Eds.). (1978). *Family and mental health in the Mexican-American community*. Los Angeles: University of California, Los Angeles, Spanish-Speaking Mental Health Research Center.
- Casas, J. M., Ponterotto, J. G., & Gutierrez, J. M. (1986). An ethical indictment of counseling research and training: The cross-cultural perspective. *Journal of Counseling & Development, 64*, 347–349.
- Casas, J. M., Turner, J. A., & Ruiz de Esparza, C. (2001). Machismo revisited in a time of crisis: Implications for understanding and counseling Hispanic men. In G. R. Brooks & G. E. Good (Eds.), *The new handbook of psychotherapy and counseling with men: A comprehensive guide to settings, problems, and treatment approaches* (Vol. 2, pp. 754–779). San Francisco: Jossey-Bass.
- Ponterotto, J. G., & Casas, J. M. (1987). In search of multicultural competence within counselor education programs. *Journal of Counseling & Development, 65*, 430–434.
- Ponterotto, J., & Casas, J. M. (1991). *Handbook of racial/ethnic minority counseling research*. Springfield, IL: Charles C Thomas.
- Ponterotto, J. G., Casas, J. M., Suzuki, L. A., & Alexander, C. M. (Eds.). (1995). *Handbook of multicultural counseling*. Thousand Oaks, CA: Sage.
- Ruiz, R., & Casas, J. M. (1981). A model of culturally relevant and behavioristic counseling for Chicano college students. In P. Pedersen, J. C. Draguns, W. J. Lonner, & J. Trimble (Eds.), *Counseling across cultures*. Honolulu: University of Hawaii Press.

nation, pueblo, village, or community. Generally, the tribal rolls of federally recognized tribal nations are used to determine parental lineage and, therefore, blood quantum for Bureau of Indian Affairs–issued CDIBs. A CDIB is established through genealogical documents that verify ancestral bloodlines through one or both Native parents. Though possession of a CDIB does not establish membership in a tribe, some tribes do require a minimum degree of blood for both membership and/or access to benefits such as health care, education, and others. Membership rules vary from tribe to tribe. For example, in 1985, Congress passed the Quarter Blood Amendment Act that declared that Indian students must be at least one-quarter blood to receive financial support for higher education. A CDIB was the document used to establish eligibility.

The Ute tribe has the highest blood quantum requirement for membership (five eighths) whereas other tribes, such as the Western Cherokee, require only a traceable roll number. The most common blood quantum requirement by many tribes is one fourth.

CDIBs are not without controversy. There is evidence that colonization initiated blood quantum in an effort to deny civil rights to “inferior persons” identified as “Negroes and Indians.” According to J. D. Forbes, many colonies used blood quantum to determine who should be afforded the “privileges of Whiteness.” Those with greater amounts of White ancestry were thought to be more competent than those with lesser amounts. A greater degree of White blood entitled an Indian citizen to greater privileges, such as the ability to buy and sell property and the right to vote. This literature suggests that it was believed by early colonists that Indian people would not sustain their culture, and the CDIB was one way to monitor how quickly the bloodline was assimilated into the majority culture. Controversy exists for other reasons as well:

1. Census rolls of the 1800s and early 1900s are not always correct. If ancestors were not included in the original rolls, for whatever reason, it is impossible to accurately trace lineage.
2. Because of the politics and privilege of the times, not all tribal people claimed Indian blood.
3. Not all tribes are federally recognized and therefore not entitled to CDIBs or to the benefits that the CDIB may afford them even though they are indigenous people.

---

## CERTIFICATE OF DEGREE OF INDIAN BLOOD

---

A Certificate of Degree of Indian Blood (CDIB) or Alaska Native Blood is a federal document that certifies that an individual possesses a specific degree of blood of a federally recognized tribe, band,



4. Many Freedmen, or descendants of Black slaves “owned” by tribes, consider CDIBs to be racist and believe that the CDIB promotes discrimination. These Freedmen were often given tribal membership when freed but were not entitled to CDIBs because they did not possess an Indian bloodline. This situation resulted in Freedmen who were tribal members being excluded from any tribal rights.
5. Finally, and the reason stated often, many people believe that no government agency has the right to determine who is and who is not Indian.

*Pamela Jumper Thurman*

*See also* Alaska Natives (v3); American Indians (v3); Bureau of Indian Affairs (v3); Ethnicity (v3); Indian Health Service (v3); Race (v3); Visible Racial/Ethnic Groups (v3)

### Further Readings

Department of the Interior, Bureau of Indian Affairs (BIA), 25 CFR Part 70; RIN 1076-AD98. Certificate of Degree of Indian or Alaska Native Blood. *Federal Register*, April 18, 2000 (Vol. 65, No. 75).

Forbes, J. D. (2000, November 27). Blood quantum: A relic of racism and termination [Native Voice column]. *People's Voice*. Retrieved from <http://www.thepeoplespaths.net/Articles2000/JDForbes001126Blood.htm>

---

## CHANGE AGENT

---

The term *change agent* has been used generally to denote any person, activity, or experience that facilitates change. An alteration in both psychological and behavioral functioning is the expected result of the interplay between individual and organizational competencies, such as knowledge, skills, and awareness. The basis for measuring this change relates to movement along a continuum of Self-System awareness.

Originally, *change agent* was used to refer to leaders or facilitators of change induction groups, or T-groups (basic skills training groups). Early change induction groups in the early 1900s were utilized by only a few, isolated individuals. The focus of the early T-groups was varied and unstandardized, based on the specific focus of the facilitator's goal for the population. In the first quarter of the century, no true effort was made to combine the philosophies of groups or group leaders.

World War II proved to be the catalyst for research on change agents. With the need to quickly modify the everyday living practices of people to meet the requirements of military systems, much emphasis was placed on the potential effects of group dynamics. The inefficiency and limited availability of psychiatric and psychological personnel precluded individual efforts of classification and remediation. Consequently, group therapy and the role of change agents became a noteworthy topic, and the notion of efficient psychological and behavioral change still drives most of the individual and group therapy today.

Self-System awareness in psychotherapy may be conceptualized best by Julian B. Rotter's notion of internal versus external locus of control and how it produces change or motivates individuals to change. As noted earlier, the term *change agent* may refer to any persons, activities, or experiences. Change produced at the Self (internal locus of control) end of the continuum concerns attitudes, beliefs, and thoughts—all of which are unobservable but often produce the most permanent and stable change. Change seen at the System (external locus of control) end is often quantifiable, or, at least, observable—however, not necessarily linked to authentic or lasting change. Change agents must focus on both behavioral and cognitive aspects when addressing individuals' intrapersonal/interpersonal functioning.

Mental health clinicians serving as change agents look to enhance individuals' self-regulation. Rather than place external pressures, forces, or consequences on behavior and affective expression, clinicians seek to assist individuals in satisfying, productive intrapersonal and interpersonal functioning. However, change agents must take precautions to avoid invalidation of the cultural experience of others or assessing the affect, behavior, and cognitions of others without consideration of sociocultural context.

Both the American Psychological Association and the American Counseling Association have addressed the need for facilitating change while considering the sociocultural contexts in their ethics codes. American Psychological Association Ethics Code Principle A concerning Beneficence and Nonmaleficence presumes that, because clinicians' “scientific and professional judgments and actions may affect the lives of others, they are alert to and guard against personal, financial, social, organizational, or political factors that might lead to misuse of their influence.” Principle E speaks of Respect for People's Rights and Dignity and expects that clinicians “are aware of and respect cultural, individual, and role differences, including



those based on age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, language, and socioeconomic status and consider these factors when working with members of such groups.” The American Counseling Association mentions its encouragement of clinicians to “actively attempt to understand the diverse cultural backgrounds of the clients they serve” in the Introduction to Section A: The Counseling Relationship.

Social scientists and clinicians are expected to take the lead in advocating for change in relation to the consideration of these factors in theory, research, and practice. The degree to which multicultural issues receive attention in the future will depend on the willingness and effectiveness of social scientists in modeling the change that is yet to come to fruition in larger society.

*Edward A. Delgado-Romero and Jon M. Harvey*

*See also* Cross-Cultural Training (v3); Cultural Encapsulation (v3); Ethical Codes (v1); Locus of Control (v3); Multicultural Counseling (v3); Multicultural Counseling Competence (v3); Multiculturalism (v3)

### Further Readings

American Counseling Association. (2005). *ACA code of ethics*. Alexandria, VA: Author.

American Psychological Association. (2002). Ethical principles of psychologists and code of conduct. *American Psychologist*, 57, 1060–1073.

---

## CIVIL RIGHTS

---

Civil rights have been generally defined as affirmative legal promises governments make to protect the privileges and power of a specified group of people or citizens of a nation. Civil rights movements have been the way by which many marginalized groups have gained legal protection against discriminatory actions. The laws protecting the civil rights of citizens may be written or implied. Examples of such written laws in the United States are constitutional amendments such as the 13th Amendment outlawing the enslavement of peoples and the 19th Amendment protecting the right for women to vote. In a self-proclaimed democracy such as the United States, these rights have been revered as essential components of a just society. The right to “life, freedom and the pursuit of happiness,”

for example, is a phrase well known to many Americans. The United States’ own history, however, reveals the violation of these civil rights for multiple communities defined by racial, ethnic, gender, sexual orientation, social class, and religious group memberships among others.

To understand the needs and become advocates in the struggles of marginalized groups, mental health providers must first have a foundation and knowledge of the histories of these groups. The following is an outline of historical civil rights violations of marginalized groups in the United States and subsequent movements fighting for the protection of those rights.

### History of Marginalized Groups

#### *African Americans*

African Americans, more than any other group, have been at the center of civil struggles throughout U.S. history. Their struggle for liberty began with the first law passed by the Virginia Assembly in 1661 making persons of African descent slaves for the duration of their lives. The U.S. Constitution implicitly recognized the right of White landowners to hold slaves; it was not until the implementation of the 13th Amendment of 1865 that slavery and involuntary servitude were outlawed. Jim Crow laws helped circumvent these rights by allowing the virtual enslavement of poor Blacks through sharecropping and legalized segregation of schools, transportation, and public accommodations well into the 20th century. The 14th Amendment of 1868, intending to protect emancipated slaves from the physical and legal retaliation of their former masters, also failed to do so as African Americans were persecuted by organized terrorist groups such as the Ku Klux Klan. Following the Supreme Court decision of *Plessy v. Ferguson* in 1896, legal segregation and the principle of “separate but equal” were sanctioned by the law. By far the most influential civil rights organization in the African American movement, the National Association for the Advancement of Colored People (NAACP) pressed the issue of equality all the way back to the Supreme Court. Today the legacy of the *Brown v. Board of Education of Topeka* decision in 1954 demanding the desegregation of public schools helps protect the rights of people of color; women; lesbian, gay, bisexual, transgender (LGBT) persons; and persons with disabilities. The leaders of the civil rights movement of the 1950s and 1960s, including Martin Luther King, Jr.,



Malcolm X, and Rosa Parks, were the inspiration for tactics and concepts that sparked and empowered subsequent movements for women, Latinos/as, Asian Americans, Native Americans, the LGBT community, and the poor.

### **Asian Americans**

Asian Americans have not only been subject to violations of civil right liberties, but they systemically have been the direct target of such injustice. The Chinese Exclusion Act of 1882, for example, was enacted to ensure that Asians did not become naturalized citizens and could not vote. The Immigration Act of 1924 further barred all Asians ineligible for American citizenship from entering the United States. The creation of “Chinatowns” in many coastal cities is largely a result of the denial of full participation in society for early Asian immigrants. The forced relocation and internment of more than 120,000 Japanese Americans during World War II is one of the most atrocious violations of the civil rights of Asian Americans in U.S. history. Following the bombing of Pearl Harbor by the Japanese government in December 1941, Japanese Americans were forced to sacrifice their livelihoods and were imprisoned in internment camps, where living conditions risked their health and family unity. Although the Civil Liberties Act of 1988 provided an official government apology and monetary reparations for internee survivors, the wound of this violation remains open in the hearts of many Asian Americans today.

In the 1960s Asian American activists joined other groups of color in the fight for racial equality and social justice, demanding the United States take notice of what became known as the Yellow Power movement. The Asian American movement of the 1960s was led primarily by college-age students of Chinese and Japanese descent seeking to be recognized by the largely White anti-Vietnam War movement of the time. One of the most important legacies of the movement has been the implementation of Asian American studies across institutions of education. Today Asian American activists continue to struggle for political, economic, and cultural inclusion and equality.

### **Native Americans/American Indians**

The lives of Native Americans, also referred to as American Indians, and their struggle for civil rights

began with the arrival of the first Europeans on the Western Hemisphere. Stripped of the land on which they lived, Native Americans were driven by gunpoint on harsh and arduous journeys to Indian Territories. From 1838 to 1839, more than 16,000 Cherokees were driven from their homeland; more than one fourth of these people died in the march that has become known as the *Trail of Tears*. Cruel measures of forced assimilation, often led by missionaries, endorsed the removal of young Natives from their families into boarding schools, where tribal customs and use of language were subject to severe punishment. It was not until the enactment of the Indian Reorganization Act of 1934 that Native Americans were given the right to a system by which tribes could autonomously adopt representative, democratic institutions in their traditional forms of government. Although a setback of these rights occurred with the communist scare after World War II, the civil rights movement also provided opportunities for the improvement of civil rights for Native Americans. Pan-Indian organizations such as the American Indian Movement embraced the confrontation tactics practiced successfully by African Americans during the 1960s. The American Indian Civil Rights Act of 1968 further guaranteed American Indians living under tribal governments many rights and liberties of other Americans. The struggle of American Indians continues, however, as socioeconomic disparities continue to maintain poverty, poor health, and poor education among this population.

### **Latino/a Americans**

Latino/as have been the targets of violent attacks based on their race/ethnicity leading to a struggle for civil rights similar to those of other marginalized groups. The heterogeneity of this population, however, has resulted in a history often separated by struggles by nationalities. For example, Mexican Americans (also known as Chicanos/as) have a long-standing history on U.S. soil and have helped fight for the labor rights of people across racial lines. César Chávez organized and led migrant farm laborers with the United Farm Workers union movement by creating community service programs, emphasizing nonviolence, and articulating the needs and rights of farm workers. The young Brown Berets of the 1960s aimed to protect Chicano/a youth from police harassment. Although Puerto Rico was included as a U.S. territory in 1917, Puerto Ricans continue to be denied voting



rights, which is a concern for some Puerto Rican Americans. The most prominent struggle that the Latino/a community continues to face is the recognition of the rights of large numbers of Latino/a immigrants living in the United States. Basic rights such as provision of health care, fair wages, and legal protection continue to be denied this growing population.

### **Women**

The women's movements in the United States were heavily influenced by the abolitionist movement and the civil rights movements of the 1960s. The political rights of women were virtually nonexistent prior to the 19th century to the extent that wives were denied ownership of property, prohibited from leaving their husbands, and barred from custodial rights to their children. The movement for women's rights has been active since the 1700s and continues today with historical works from Mary Wollstonecraft, Susan B. Anthony, Harriet Taylor, Betty Friedan, Sara Evans, Alice Walker, Audre Lorde, and bell hooks, among others. Advocates for woman's rights have successfully demanded a wide variety of civil liberties, such as the right to vote, legalization of abortion, the right to initiate divorce, and the entrance of women to the political and labor workforce, which have had a lasting impact on issues of education, religion, sexuality, and gender identity. Feminists today continue to advocate for economic, political, and social equality and an end to oppressive conditions for women of all races.

### **Other Marginalized Groups**

The LGBT community continues to fight for equality for all regardless of sexual orientation or gender identity. Groups such as Henry Gerber's Society for Human Rights of 1924 have been fighting for "gay rights" for nearly a century. The federal and some state governments continue to resist support of LGBT civil rights legislation. In 2007, sexual and gender identity are not covered by federal civil rights codes or protected under the laws against hate crimes. Although some individual states have civil union clauses, the struggle for the legal recognition of same-sex marriages and unions continues, as does discrimination against the LGBT community legally and socially across most of the country.

In an effort to raise awareness of poverty in the United States, Martin Luther King, Jr. and colleagues

launched the Poor People's Campaign. The movement mobilized African Americans, Native Americans, Whites, and Mexican Americans to lobby Congress for social and economic equality. Large numbers of Americans continue to live below the poverty level today. The most visible members of this community are the homeless, a population disproportionately stricken with mental illness. Despite the dire needs of this marginalized group, the civil rights of the poor are often ignored by a nation still hostage to the myth of the American dream and equally blind upward mobility.

### **Mental Health Civil Rights**

Historical traumas have left members of these marginalized groups weary of the institutionalized systems that have not only failed them but have often been the perpetrators of their plights. Mental health providers are faced with the responsibility of healing remnants of these historical wounds, and they are encouraged to serve as social advocates in continuing to demand equal rights for those peoples to whom they are still denied. The call for the multicultural competence of all counselors working with marginalized groups is, in itself, a civil rights movement. It is the right of every individual living in the United States to be met with culturally competent mental health providers when seeking treatment. As researchers, practitioners, and educators, counselors at large are part of a movement whose goal is to recognize and eradicate the ways in which racism, sexism, heterosexism, classism, and other forms of discrimination continue to affect members of marginalized groups today.

Sheila V. Graham

**See also** Affirmative Action (v3); African Americans (v3); American Indians (v3); Asian Americans (v3); Classism (v3); Discrimination (v3); Diversity Issues in Career Development (v4); Latinos (v3); Multicultural Counseling Competence (v3); Organizational Diversity (v3); Prejudice (v3); Racism (v3); Sexism (v3); Social Discrimination (v4); Social Justice (v3)

### **Further Readings**

Bradley, D., & Fishkin, S. F. (1998). *The encyclopedia of civil rights in America*. Armonk, NY: Sharpe Reference.

Martin, W. E., & Sullivan, P. (Eds.). (2000). *Civil rights in the United States*. New York: Macmillan Reference USA.



Zinn, H. (2005). *A people's history of the United States: 1492 to present* (2nd ed.). New York: Harper Perennial Modern Classics.

---

## CLARK, KENNETH BANCROFT (1914–2005)

---

Kenneth Bancroft Clark was one of the most influential psychologists and social activists of his generation. Born in the Panama Canal Zone in 1914, Clark moved with his family to Harlem, New York, when he was 4 years old. After graduating from Washington High School in New York City, he enrolled in Howard University, a prominent historically Black university in Washington, D.C. It was at Howard that Clark would work with African American scholars like E. Franklin Frazier and Francis Cecil Sumner, whose ideas about racism and integration would influence his thoughts throughout his career. From Howard, he returned to New York to attend Columbia University. He would become the first African American to earn a Ph.D. in psychology in the school's history. In 1938, he married Mamie Phipps (Clark), an influential psychologist in her own right. The two had met at Howard and continued their relationship when Mamie came to New York to study psychology at Columbia. Clark would live and work in Harlem for much of the remainder of his life.

Clark was perhaps best known for his contribution to the 1954 decision of the U.S. Supreme Court in the matter of *Brown v. Board of Education of Topeka*. His research was an integral part of the case challenging the legality of segregated schools. He worked closely with his wife, Mamie, to use their research to change the way that race and prejudice are viewed in America. Over the course of his career, he would help found a community health center, chair several educational research projects, and hold several key positions within the fields of psychology and education (including the presidency of the American Psychology Association) and a seat on the New York State Board of Regents. Clark passed away in Hastings-on-Hudson, New York, in 2005.

Clark's early work focused on racial identity development in African American children. In a set of experiments known as the doll studies, African American children were presented with dolls that were identical in every way except for skin color. Some of the dolls were brown to represent African American children, and some were pinkish to represent White children.

Clark and the research team asked participants a series of questions about the dolls, such as "Which one is you?" and "Give me the doll that you like the best." The results from this series of experiments indicated that even as young as age 3, a majority of African American children were aware of the classifications of White and African American. The results also revealed that although many children identified themselves with the African American doll, a large proportion expressed a preference for the white dolls and a rejection of the brown dolls. In the eyes of many African American children, white dolls were associated with goodness and intelligence, whereas brown dolls were associated with ignorance and other negative characteristics.

Clark found these results particularly disturbing. The views of the children in the study highlighted the profound psychological conflict facing African American children in the United States at that time. Clark argued that as African American children grew, the already difficult process of identity development was further complicated for them by the cultural definitions of race. The children knew that they were African American and were also aware of the insulting value that culture had placed on this group.

Clark became preoccupied with understanding what factors created the perception of African Americans as bad and Whites as good. He theorized that these ideas were the result of pervasive cultural prejudice. The way that African Americans were treated in virtually every sphere of American life taught children that African Americans were inferior to Whites. The effect of this universal devaluing of the African American race was to confuse and discourage African American children. It has been observed that although this line of research and thinking was relevant to the state of social science knowledge and the political climate of the time, this focus on the deleterious effects of racism and racial segregation contributed to a "deficits approach" to the study of ethnic identity that it would take another generation of social scientists to offset.

Clark felt strongly that the education system had a responsibility to protect children from the dangers of prejudice. He believed that it was a school's legal and moral obligation to provide a safe learning environment in which all children could learn and develop. He criticized segregated schools because they failed to do this. In his research, he pointed out that almost universally, segregated schools for African Americans were aesthetically inferior and lacked the resources afforded to schools for Whites. Within the schools, the



biased attitude of teachers and administrators also affected students. Clark cautioned that these repeated associations of African Americans with inferior status would lead to irreversible damage to children's identity, self-esteem, and ability to function as productive members of society. He also asserted that the lessons of democracy and equality taught in schools could not be credibly proposed within a system that promoted the humiliation of a portion of its people. For African American children to have a fair educational opportunity, school segregation would have to be eliminated.

Clark continued to promote these ideas through research and activism. However, the culture of racism and prejudice in America at that time made it difficult for many to see his point of view. Despite this, he continued pressing the ideas of integration and fair educational opportunities for all students.

Perhaps no single effort illustrates Clark's desire to see change in his community more than the founding of the Northside Center for Child Development in 1946. Recognizing the need for affordable psychological care for the children of Harlem, Clark and his wife, Mamie, used their own money to fund a community center offering these services in their neighborhood. Today, Northside is still functioning in Harlem. Though it has grown beyond its humble beginnings, it still operates under the Clarks' original principles of community service and activist research.

Shortly after the founding of the Northside Center, Clark became involved in the National Association for the Advancement of Colored People (NAACP) legal battle against segregation. As a result of the papers that he and Mamie published establishing the negative effects of prejudice, Clark had gained some notoriety as one of the leading psychologists in this area. The research provided a new kind of evidence that could be used to challenge the legality of segregation. Beginning in 1951 and for several years thereafter, Clark served as a social science consultant to the NAACP. He would eventually testify as an expert witness in the 1954 *Brown v. Board of Education of Topeka* case, which called for an end to school segregation. He explained the dangers of segregation and emphasized that thorough integration was the only way to offer African American children a fair education. His testimony was cited as crucial in the Supreme Court's decision to overturn previous cases that had supported "separate but equal" educational facilities.

Though Kenneth was pleased that his and Mamie's research had been used to effect legal change, he was

troubled by the fact that schools remained illegally segregated even after the *Brown* verdict. While he and Mamie continued their research and their work at Northside, Kenneth pressed education officials at the local and national levels to make the changes that had been mandated by the court's ruling. For the remainder of his career, he worked on various advisory boards and research councils pushing for this change. In 1962, Clark served as chair of Harlem Youth Opportunities Unlimited. The organization's overall goal was to explore the reasons for the high rates of juvenile delinquency in Harlem and to devise a plan of action to reduce the problems. A few years later, Kenneth and a group of colleagues formed the Metropolitan Applied Research Center. The group of individuals, which represented a variety of professions, met with the common goal "to serve as a catalyst for change and as an advocate for the poor and powerless in American cities." Although Clark worked hard on these and many other projects, political opposition and feasibility concerns prevented many of the suggestions that he proposed from taking place as quickly as he would have liked.

Despite some setbacks, Clark remained active throughout his career. The same year that he began working with Harlem Youth Opportunities Unlimited, he began his 20-year term with the New York Board of Regents. He continued to hold several professorships, publish scores of articles and books, serve as president of the American Psychological Association, and establish several research and advisory corporations in the areas of psychology, education, and economics. For him, social justice began with an educational experience for all children that allowed them to feel respectful of themselves and their status as human beings. He worked tirelessly in his community, in the schools, and in the courts and government halls to ensure this environment of equality and respect for all children, always from his command of the knowledge and his commitment to social action.

*Kamauru R. Johnson and Edmund W. Gordon*

*See also* African Americans (v3); Black Psychology (v3); Black Racial Identity Development (v3); Civil Rights (v3); Clark, Mamie Phipps (v3); Community-Based Action Research (v1); Discrimination (v3); National Association for the Advancement of Colored People (v3); Prejudice (v3); Racial Identity (v3); Racism (v3); Social Discrimination (v4); Social Justice (v3)



### Further Readings

- Cherry, F. (2004). Kenneth Clark and social psychology's other history. In G. Philogene (Ed.), *Racial identity in context: The legacy of Kenneth B. Clark* (pp. 13–33). Washington, DC: American Psychological Association.
- Clark, K. (1955). *Prejudice and your child*. Boston: Beacon Press.
- Clark, K., & Clark, M. (1939). The development of consciousness of self and the emergence of racial identification in Negro preschool children. *Journal of Social Psychology*, 10, 591–599.
- Clark, K., & Clark, M. (1940). Skin color as a factor in racial identification of Negro preschool children. *Journal of Social Psychology*, 11, 159–169.
- Clark, K., & MARC Staff. (1972). *A possible reality: A design for the attainment of high academic achievement for inner-city students*. New York: Emerson Hall.
- Markowitz, G., & Rosner, D. (2000). *Children, race and power: Kenneth and Mamie Clark's Northside Center*. New York: Routledge.

---

## CLARK, MAMIE PHIPPS (1917–1983)

---

Mamie Phipps Clark, one of the first Black women to earn a Ph.D. in psychology, was the cofounder and director of the innovative Northside Center for Child Development in New York City. Founded in 1946, Northside is a multidisciplinary, multiracial service for children, adolescents, and parents with psychological and educational needs in the Harlem community. Clark's vision for Northside and her implementation of this vision for more than 30 years attest to her enormous contribution to strengthening and improving the lives of ethnic minority children and their families.

In addition to her professional contributions, Clark is also well known for her pioneering study of racial self-identification in African American children, conducted for her master's thesis at Howard University. Her subsequent studies on racial identification in both Black and White children, published with her husband, psychologist Kenneth B. Clark, were used to prepare the famous "Social Science Statement" supporting the racial desegregation of American schools in the 1954 United States Supreme Court case, *Brown v. Board of Education of Topeka*.

### Early Life

Clark was born in 1917 in Hot Springs, Arkansas, and, like all Black children, attended a segregated school. Her father, Harold H. Phipps, was a physician; her mother, Katie Florence Phipps, was a homemaker. Clark described her childhood as comfortable, secure, and happy despite an omnipresent awareness of racism and the personal experience of legalized discrimination. Coping with these facts of everyday life in the Jim Crow South required resilience and determination. Phipps drew on both of these qualities in her decision to pursue postsecondary education.

Upon graduating from high school, Phipps chose to attend prestigious Howard University in Washington, D.C., with a desire to major in mathematics. She enrolled in 1934 at the age of 16. At Howard she quickly discovered that the segregated public school system had ill-prepared her to meet the intellectual demands of her new environment. She realized that there were huge gaps in her education, but she acted quickly to compensate: "Well, I had to study harder. I really did. I went to summer school. I went to summer school the first two summers when I was in college, to make up the deficiencies. . . . But I was taking five courses in summer school, and that's a lot of courses" (Clark, 1976, p. 12).

### Training in Psychology

Clark's desire to pursue mathematics at Howard gave way to an interest in child development and psychology, partly because of the lack of encouragement given female students in mathematics and partly because of the influence of her future husband, Kenneth Clark. She transferred into the field with the support of Francis Cecil Sumner, the head of Howard's psychology department and the first African American to receive a doctorate in psychology. There were no Black women on the staff of the department. Clark reported retrospectively that the absence of Black women with advanced degrees in psychology itself represented a silent challenge.

Mamie Phipps married Kenneth Clark in 1937. She graduated with her bachelor's degree from Howard in 1938 and spent the summer working in the law offices of Charles Hamilton Houston, a pioneering Black civil rights attorney. She also discovered the work of psychologists Ruth and Eugene Horowitz (later Hartley) on self-identification in nursery school children. She



decided to merge her interests in race and child development in her master's research, resulting in her thesis, "The Development of Consciousness of Self in Negro Pre-school Children." In this work, she explored the development of racial identity in 300 Black children in segregated nursery schools in the Washington, D.C., area. Over the course of the next year, she published three more articles with Kenneth, looking at the effects of skin color and segregation on the racial self-identification of Black children.

In 1939, Mamie Clark was granted her M.A. degree and received a fellowship to begin doctoral work at Columbia. She chose to work with White psychologist and known racist Henry Garrett rather than with Kenneth's mentors Gardner Murphy and Otto Klineberg because, as her husband Kenneth later reported, she felt that working with Murphy or Klineberg would be too easy. In 1944 Clark received her Ph.D. Her dissertation was titled "The Development of Primary Mental Abilities with Age." During her doctoral studies she also gave birth to two children, Kate (1940) and Hilton (1943).

### **The Birth of Northside**

After graduation, Clark looked for work outside academia. Despite her husband's recent academic appointment at the City College of New York, it was very clear to Clark that full-time university appointments for doctoral-level Black psychologists were rare and those for doctoral-level Black women psychologists nonexistent. After a series of adverse experiences working in various agencies, she became convinced that there was a distinct need for more services for neglected and abandoned minority children in New York City.

With the realization that a satisfying career would ensue only if she created one for herself, Clark envisioned a psychological testing and service center for minority children. With Kenneth, she approached a number of agencies for support. None was forthcoming. Thus, with a loan from Harold Phipps, the Clarks opened a basement office in the Paul Dunbar Apartments on the north side of Harlem in February of 1946. They named it the Northside Testing and Consultation Center but, in 1947, changed the name to the Northside Center for Child Development. For the next 30 years, Mamie Clark's vision would drive Northside.

### **Treatment Philosophy**

Northside's primary and overarching objective was (and is) to provide psychological and educational services to minority children and their parents to help them cope with and overcome the pervasive impact of racism and discrimination. The Clarks' philosophy of treatment and their vision for Northside at times collided with prevailing psychiatric thought, which tended to focus exclusively on intrapsychic deficiencies. By contrast, the Clarks consistently promoted the understanding and treatment of children's emotional and behavioral difficulties holistically from a strengths-based, psychosocial, and environmental perspective. This meant that the services offered at Northside were eclectic and underwent constant revision to meet the needs of the community. For example, when it became clear early in the Center's history that minority children were overrepresented in classes for the mentally deficient, the staff at Northside retested children and showed that they did *not* meet the criteria for this designation but *were* subjected to social and educational neglect. They then developed remedial reading classes that became a core component of client services. The success of these efforts provided acceptance of the Center in the larger Harlem community.

Another critical aspect of Northside's service philosophy was that all children, regardless of race, should be served by a multiracial and multidisciplinary team of professionals and paraprofessionals. This reflected not only the Center's eclecticism but also the Clarks' unwavering belief in the pernicious effects of racial segregation on all children. Despite differences in race, class, and professional status among the staff, Mamie Clark strove to maintain a nonhierarchical atmosphere. She also believed in providing a pleasing physical environment for the children and their families. The offices at Northside, whether in the original basement or in the later multi-floor facility in Schomburg Towers, were safe, attractive, and stimulating for the children and parents served within their walls.

### **Activism in the Community**

Along with her work at Northside, Clark was active in the larger Harlem community and the greater New York City area. She worked with Kenneth on the Harlem Youth Opportunities Unlimited project, as well as serving on its advisory board. She was active



in the initiation of the national Head Start program. Beyond psychology and child development, she served on the board of directors of numerous educational and philanthropic institutions. In brief, Clark was deeply involved in her community.

Clark was the executive director of Northside until her retirement in 1979. Her death from cancer followed shortly thereafter, in 1983. As one of her staff members characterized her directorship of the Center: "When an unusual and unique person pursues a dream and realizes that dream and directs that dream, people are drawn not only to the idea of the dream, but to the uniqueness of the person themselves. I think this is what Dr. Mamie was like . . . Northside, including today's school, really revolved on her ingenuity, her dream. . . ." (Johnson, 1993, as cited in Markowitz & Rosner, 2000, p. 246).

*Alexandra Rutherford and Wade E. Pickren*

**See also** Black Psychology (v3); Black Racial Identity Development (v3); Civil Rights (v3); Clark, Kenneth Bancroft (v3); Community-Based Action Research (v1); Discrimination (v3); Ethnic Minority (v3); Prejudice (v3); Racial Identity (v3); Racism (v3); Social Discrimination (v4); Social Justice (v3)

### Further Readings

- Clark, M. P. (1976). [Interview with Ed Edwin]. Columbia University Libraries Oral History Research Office. Retrieved from <http://www.columbia.edu/cu/lweb/digital/collections/nnny/clarkm/index.html>
- Clark, M. P. (1983). Mamie Phipps Clark. In A. N. O'Connell & N. F. Russo (Eds.), *Models of achievement: Reflections of eminent women in psychology* (pp. 267–277). New York: Columbia University Press.
- Lal, S. (2002). Giving children security: Mamie Phipps Clark and the racialization of child psychology. *American Psychologist*, 57, 20–28.
- Markowitz, G., & Rosner, D. (2000). *Children, race, and power: Kenneth and Mamie Clark's Northside Center*. New York: Routledge.

on social class and the systematic oppression of subordinated groups (people without endowed or acquired economic power, social influence, and privilege) by the dominant groups (those who have access to control of the necessary resources by which other people make their living). It includes individual attitudes and behaviors, systems of policies and practices that benefit the upper classes at the expense of the lower classes, the rationale that supports these systems and this unequal valuing, and the culture that perpetuates them.

Before going on to develop this definition of *classism*, it is necessary to also define which classes are subordinate to which others. Many scholars, whether they are sociologists, economists, or psychologists, begin their attempts to define class structure by acknowledging that there is no conclusive definition. The language used to describe groups of interest varies widely, including such terminology as *poor*, *low income*, *disadvantaged*, *working class*, *blue collar*, *white collar*, *wealthy*, and *upper class*; class indicators (the criteria used to differentiate class membership) include such considerations as income, attitudes and beliefs, educational level, job prestige, power in the workplace, and differences between manual and physical labor. Each of these formulations captures some, but not all, of the truth about the lived experience of social class, but the most useful definition for a discussion of classism as a form of oppression will be one that incorporates considerations of social power and powerlessness. Along these lines, authors Betsy Leondar-Wright and Michael Zweig have offered similar formulations that include the following elements:

- *Poverty class*: Predominantly working-class people who, because of unemployment, low-wage jobs, health problems, or other crises, are without enough income to support their basic needs.
- *Working class*: People who have little power or authority in the workplace, little control over the availability or content of jobs, and little say in the decisions that affect their access to health care, education, and housing. They tend to have lower levels of income, net worth, and formal education than more powerful classes.
- *Middle class*: Professionals, managers, small business owners, often college-educated and salaried. Middle-class people have more autonomy and control in the workplace than working-class people, and more economic security; however, they rely upon earnings from work to support themselves.

---

## CLASSISM

---

According to the nonprofit resource center Class Action, *classism* can be defined as the systematic assignment of characteristics of worth and ability based



- *Owning class*: People who own enough wealth that they do not need to work to support themselves; people who own and control the resources by which other people earn a living. The owning class includes people who, as a result of their economic power, also have significant social, cultural, and political power relative to other classes.

## Conceptual Framework

To better understand classism, it is necessary to locate it within a conceptual framework that helps further clarify it. First, classism is a form of oppression and, as such, does not refer simply to prejudiced attitudes that people of one social class group might have regarding members of another class. Rather, classism, like racism, sexism, and heterosexism, is an interlocking system that involves domination and control of social ideology, institutions, and resources, resulting in a condition of privilege for one group relative to the disadvantage of another. Of course, members of both dominant and subordinated groups are capable of harboring prejudiced attitudes, but only dominant groups have the institutional and cultural power to enforce their prejudices via oppression. Making this distinction between prejudice and oppression is significant in that, in a world where the status quo is characterized by social inequities, all prejudices are not created equal; some are the expressions of real sociocultural power hierarchies.

Second, classism, like other forms of oppression, often exists within individuals at an unconscious level, so it can be perpetuated by well-intentioned people who are genuinely unaware that they are acting on learned cultural assumptions about the differences between poor people and wealthier people. Becoming aware of classism, then, does not imply that one was previously deliberately scornful of poor people or overtly lacking in concern for them. Even people who participate in charitable activities benefiting the poor, and poor people themselves, are exposed to cultural attitudes regarding the poor and incorporate them into their worldviews and self-concepts.

Finally, although isolating one form of oppression is useful for the purposes of summary and definition, the lived experience of social class is complex, and class and classism exist at intersections with other aspects of identity such as race and gender. Different forms of oppression have an interlocking nature, and their function often serves to perpetuate each other.

For example, sexism operates so that most people living in poverty are women, and racism and classism inform each other in critical ways. In the minds of many Americans, the typical poor individual is represented by a person of color, yet most welfare recipients are, in fact, White. At the same time, people of color are much more likely to live in poverty, with the 2004 poverty rates for racial groups being 25% for Blacks, 22% for Latinos/as, 10% for Asians, and 9% for Whites, according to the University of Michigan's National Poverty Center. Considering both race and gender together with regard to class reveals the very high poverty rates of about 40% for Black and Latina female-headed households.

## Examples of Classism in Everyday Life

In a nation that has long defined itself in opposition to the old-world class structures and explicit caste systems found in other societies, it is not surprising that classism would be one of the least recognized of the “-isms.” Although some are easily identifiable, many forms of classism escape the notice of the most well-intentioned people. Examples of classism include the general cultural and institutional invisibility of poor and working-class people, negative attitudes and beliefs regarding poor and working-class people, educational inequities, healthcare inequities, disparities in the judicial system, environmental injustice, social acceptance of unlivable minimum wages, and the deprecation of organizations of working people.

### *Cultural and Institutional Invisibility of Poor and Working-Class People*

Perhaps the best example of the unexamined invisibility of poor people in the mainstream U.S. cultural experience is the widespread astonishment at the depth of American poverty revealed in the aftermath of Hurricane Katrina, which struck the Gulf Coast in 2005; journalists and television reports of the time chronicled both the disaster itself and the nation's startled response to it. In her 2002 article on classism in the United States, called “Cognitive and Behavioral Distancing From the Poor,” psychologist Bernice Lott described the primary characteristic of classism as “cognitive and behavioral distancing from the poor,” a response that renders the poor invisible in many interpersonal and institutional contexts. The field of psychology is no exception; as Lott explained, a lack



of attention to issues related to poverty and classism is evident even in the consideration of multicultural issues. The result is that psychological theory, research, and practice are not particularly accessible or relevant for poor people, and middle-class psychologists who attempt to offer services in poor communities may find that their work is compromised by previously unexamined classist attitudes. Similarly, the experiences of poor and working-class people are largely without representation in art, literature, or popular culture; there are few working-class voices in the national discourse on public policy issues; and intellectualism and critical thinking are largely assumed to be the province of wealthier Americans.

### ***Negative Attitudes and Beliefs***

Writing about the time that she spent working in low-wage jobs, author Barbara Ehrenreich described her encounters with the contemptuous attitudes that are often directed toward poor and working-class people. Although most middle- and owning-class people would not consider themselves to view others unfavorably simply on the basis of their financial status, there is a considerable amount of evidence to suggest that poor people are often seen in a negative light. Television sitcoms often present poor and working-class people as narrow-minded and ignorant, even if comically so; classist attitudes are referenced in jokes about people with southern accents and people who live in trailers. Owning-class people, by contrast, can become national celebrities on the basis of the wealth they own, with the media chronicling their everyday activities. Lott's 2002 article (mentioned in the previous section) is a review of research that provides evidence of this widespread, if often unconscious, aversion. For example, study participants endorsed traits such as *crude*, *lazy*, *stupid*, *dirty*, and *immoral* more often for poor people than for middle-class people, and they listed stereotypes for poor people that included *uneducated*, *lazy*, *dirty*, *drug/alcohol user*, and *criminal*. Descriptors like these point to a tendency to locate the factors contributing to poverty within poor people themselves, effectively deflecting attention from larger societal forces that obstruct pathways out of poverty for poor families.

### ***Educational Inequities***

American cultural lore includes a belief in education as a social equalizer within a meritocratic society,

yet the reality is that the gap between the educational experiences of children from poor families and their wealthier peers continues to widen. This trend has been documented by scholars such as Jonathan Kozol, the author of several books examining the interface of class, race, and schooling in America, including *The Shame of the Nation* (2005). Students who attend public schools in poor communities are more likely to be taught by poorly paid, uncertified teachers, and their schools are more likely to have fewer computers, fewer library books, fewer classes, fewer extracurricular opportunities, and fewer teachers than schools attended by wealthier students. Correspondingly, less money overall is spent per student on behalf of children in poor neighborhoods, a gap that spans from \$8,000 per student on the low end to \$18,000 per student in wealthier neighborhoods, according to Kozol. Those poor students who do receive adequate preparation for college-level work will face financial obstacles that few can surmount. In a report called "Losing Ground," the National Center for Public Policy and Higher Education documented that the costs of a college education are escalating at a rate higher than both inflation and family income, lowering the rates of attendance by low-income students while those from middle- and owning-class families continue to attend college in record numbers. The educational equity gap, then, becomes one of the ways that "the rich get richer and the poor get poorer," as college degrees are themselves associated with increases in earning potential; the College Board estimates that over a lifetime, the gap in earnings between those with a high school diploma and a B.A. or higher exceeds \$1,000,000.

### ***Healthcare Inequities***

The annual United Nations Human Development Report usually addresses health and well-being in third-world countries, yet in 2005 it documented the widening healthcare gap in the United States, the wealthiest country on Earth. The United Nations found that, although the United States spends more money on health care than any other country, only certain groups of Americans enjoy the benefits. Among poor people and people of color, health indicators are worse in the United States than in some developing countries. Infant mortality, for example, has increased for the past 5 years and is now equal to that of Malaysia. The Kaiser Commission, which studies healthcare and insurance trends, reported that by 2004, the number of Americans



without health insurance grew to 45.5 million, with 80% of the uninsured coming from working families. Not surprisingly, people without insurance are more likely to have problems getting medical care, less able to purchase prescribed medications, more likely to let preventable conditions escalate into serious ones, and more likely to let serious problems go untreated. As more and more poor and working-class families are permitted to go without access to health care, they are increasingly vulnerable to the multiple health risks of poverty, which include elevated rates of nearly every sort of threat to survival, including heart disease, diabetes, exposure to toxins, cognitive and physical functional decline, and homicide, among many others.

### ***Disparities in the Judicial System***

Under this heading can be found one of the clearest forms of classism: bail. This overt form of discrimination hides in plain sight as the poor remain in prison cells while wealthier people accused of the same crimes go free. More generally, millions of Americans are financially without access to civil legal process, and funding for legal aid services is sufficient only to provide counsel to a small proportion of those who need it. Laura Abel at New York University's Brennan Center for Justice has explained that a scenario familiar to viewers of law-and-order television programs—that legal aid services are provided to Americans who cannot afford an attorney—never comes to pass for most poor people. For example, the Brennan Center showed in 2007 that fewer than one out of four tenants facing eviction in New York City Housing Court had legal representation; in particular, 5,000 low-income senior citizens come before New York City housing court each year with no legal representation. Overall, 67% of all potential evictees had incomes under \$25,000, making clear the linkages between poverty, lack of access to legal counsel, and homelessness.

### ***Environmental Injustice***

Classism and racism intertwine to affect the way that waste and “dirty industries” are managed in American communities. In urban areas, this means that waste dumps and pollution-producing operations are predominantly located where poor people and people of color live. In economically depressed rural areas like the Central Appalachian mountain region, poor families

contend with the effects of strip-mining and its most extreme form, mountain-top removal. Through the use of mountain-top removal, coal companies access underlying coal deposits by blasting off the tops of the Appalachian Mountains, a cost-cutting, profit-enhancing method that has already resulted in the decapitation of some 300,000 acres of mountain area in West Virginia alone; estimates are that at current rates of demolition, an area the size of Rhode Island will have been decapitated by 2012. Nearby valleys and streams are filled in with everything from the blast that is not coal—the so-called overburden—while the coal-washing process leaves behind vast slurry ponds of coal sludge, a thick mixture of soil, water, and the toxic chemicals used in coal processing. On October 11, 2000, a 72-acre, 2.3-billion-gallon impoundment near Inez, Kentucky, failed. A torrent of slurry was released into the surrounding countryside, resulting in what the U.S. Environmental Protection Agency called one of the South's worst environmental disasters. This catastrophe received little national media attention, although it ruined property, destroyed drinking water systems, and killed local animal and aquatic life in one of the poorest counties within one of the poorest regions of the United States. This dangerous situation continues to threaten the people of the Central Appalachian region, which is the location of at least 700 more slurry impoundments.

### ***Classism and the Minimum Wage***

The continuing low level of the minimum wage gives rise to inherent ethical contradictions, suggesting that attitudes toward poor and working-class people may influence public debate (or lack thereof) regarding this issue. Without people working in minimum-wage jobs to carry it along, everyday life in America would come to a standstill. Our society relies upon the labor of people who work in child care, take care of the elderly, clean offices, and serve food, yet the citizens who perform these necessary jobs cannot earn enough money to support themselves and their children. The federal minimum wage was not increased at all for a 10-year period beginning in 1996, and in terms of real purchasing power, it was allowed to fall during that time to its lowest level in 50 years, eventually representing only 64% of the poverty line. In May 2007, the U.S. Congress passed a measure to raise the minimum wage to \$7.25 per hour—yet this amount is still not sufficient to lift a



family of four above the poverty threshold. The consequences for working people who try to survive in these jobs are clear; the National Coalition for the Homeless reported in 2005 that as many as 25% of people in U.S. homeless shelters have jobs. Less obvious are the advantages that middle- and owning-class people enjoy as a result, in that they can afford to buy more products and services more cheaply when employers do not pay employees enough to live on.

An alternative perspective on the minimum wage is the living wage. As explained by the Economic Policy Institute, the living wage is a pay rate that would bring a full-time worker within 100% to 130% of the poverty line (130% being the maximum amount that a family can earn and still be eligible for food stamps). Although 58 local governments have passed living wage ordinances for their own cities or counties (beginning with Baltimore, Maryland, in 1994), this debate has yet to receive sustained attention on a national level. Different constituencies could be expected to bring different perspectives to this debate, but an attempt to understand classist attitudes must include the notion that unconscious devaluing of poor and working-class people may be at work to discourage such an examination.

### **Deprecation of Organizations of Working-Class People**

Classist attitudes can also be seen in the way that groups of poor and working-class people are regarded if they come together to advocate for themselves. Organizations such as unions comprise the sole opportunity for working-class people to have a voice in workplaces where they do not own or control resources, have no authority in the content or availability of jobs, and do not occupy roles in the corporate power structure. They have used that voice to achieve such innovations as the end of child labor and the establishment of the 8-hour (as opposed to the unlimited hour) workday. These organizations also help bring low-wage earners out of poverty; in 2005, the AFL-CIO reported that union workers earn an average of 28% more in weekly wages than their non-union counterparts. Yet, in August 2005, a Harris Poll found that a majority of U.S. adults surveyed (68%) rated labor organizations negatively—hardly a surprising finding given the increasingly unfavorable portrayal of unions in American culture. Whereas entertainment vehicles or news reports may offer sympathetic accounts of individual poor people or

families, organizations of poor and working-class people are typically portrayed unfavorably, for example, as greedy, troublesome, or corrupt. Past labor officials have indeed been found guilty of corruption—as have high-ranking members of financial, pharmaceutical, agribusiness, medical, and defense-contracting corporations, among many others. Yet, there is not an across-the-board dismissal of these organizations, nor do we begrudge their right to meet collectively to protect their interests—professional organizations, chambers of commerce, and lobbying groups are all examples of such organizing.

### **Classism in View**

An understanding of classism, then, begins with a clearer vision of poor and working-class people among us and their conspicuous absence from important cultural and institutional representations of American life. It requires a new awareness of personal attitudes and assumptions regarding the poor. Finally, it means not only recognizing the circumstances under which poor people live but also the aspects of our social system that hinder poor families in their efforts to surmount poverty.

*Laura Smith*

*See also* Deficit Hypothesis (v3); Discrimination (v3); Discrimination and Oppression (v2); Oppression (v3); Poverty (v3); Prejudice (v3); Racism (v3); Sexism (v3); Social Class (v4); Social Discrimination (v4); Social Justice; (v3) Socioeconomic Status (v3)

### **Further Readings**

- Carr, S. C., & Sloan, T. S. (Eds.). (2003). *Poverty and psychology*. New York: Kluwer Academic/Plenum.
- Correspondents of the *New York Times*. (2005). *Class matters*. New York: Henry Holt.
- Ehrenreich, B. (2001). *Nickel and dimed: On (not) getting by in America*. New York: Henry Holt.
- Hill, M., & Rothblum, E. D. (Eds.). (1996). *Classism and feminist therapy: Counting costs*. New York: Harrington Park.
- hooks, b. (2000). *Where we stand: Class matters*. New York: Routledge.
- Kozol, J. (2005). *The shame of the nation*. New York: Crown.
- Leonard-Wright, B. (2005). *Class matters*. Gabriola Island, BC: New Society.
- Lott, B. (2002). Cognitive and behavioral distancing from the poor. *American Psychologist*, 57, 100–110.



- Smith, L. (2005). Psychotherapy, classism, and the poor: Conspicuous by their absence. *American Psychologist*, 60, 687–696.
- Zweig, M. (2000). *The working class majority*. Ithaca, NY: Cornell University Press.

---

## COLLECTIVISM

---

*Collectivism* is defined as an orientation that reflects the values, attitudes, and behaviors of a person–group relationship in which family and group life is emphasized and the concept of the self is less essential. Collectivism emphasizes an interdependence among individuals in their ingroups (e.g., family, tribe, nation), with the expectation that members give priority to the goals of the group, and shapes the norms of group behavior. For example, children in collectivistic cultures are not encouraged to individuate from their parents; instead, children tend to obtain psychological well-being and a sense of security through obedience to, and dependence on, their parents. In essence, in collectivistic cultures, groups bind and mutually obligate individuals.

### Ingroup and Outgroup

An important defining feature of collectivistic cultures pertains to the dynamics of ingroups and outgroups. In collectivistic cultures, individuals usually belong to a few ingroups (e.g., family, coworkers, and friendship circles). The welfare of their ingroups is viewed as a priority, and individuals are expected to make efforts for the groups' well-being. Specifically, they are encouraged to retain connectedness among individuals, promote ingroups' goals and interests through cooperation, and avoid open conflicts. Because of the emphasis on group harmony, cooperation, and collective goals, individuals in the ingroups are perceived as interdependent and selfless. For example, individuals tend to be concerned about the impact of their behavior on members of their ingroups and tend to shape their behavior based on the norms of the groups. Moreover, individuals from a collectivistic culture tend to share resources with ingroup members and feel cared for and a sense of belongingness by being involved in the lives of other ingroup members.

Although relatedness is a defining element of collectivism among individuals in the ingroups, it does not apply to everyone else in outgroups. In collectivistic cultures, individuals' attitudes tend to be sharply

different toward others in outgroups. For example, a cooperative relationship is highly unlikely with others who belong to outgroups. Individuals tend to treat those in outgroups with distance and clear boundaries.

### Collectivism and Psychological Functioning

Scholars who have examined relations between collectivism and psychological functioning have found that collectivism contributes significantly to social, collective, and related aspects of the self-concept. For example, researchers found that collectivism was associated with decentrality of self-concept and perception of the self as part of larger social groups and endeavors; consequently, the personal needs and goals of members of collectivistic cultures should be deferred for the unity of the collective group. Moreover, personal traits that are facilitative to the maintenance of group connectedness are especially favorable in collectivistic cultures, such as being willing to sacrifice for collective benefits, being skillful in maintaining close relationships with ingroup members, and being mindful of preserving group harmony. Not surprisingly, when in conflictual situations, individuals attend to preserving relationships rather than achieving justice. Direct confrontation is usually tension provoking and undesirable in solving a conflictual situation. Studies on relationality and groups also suggest that collectivism is associated with equality. People from collectivistic cultures who showed more willingness to remain in relationships indicated ingroup preference, even in personally costly ones, and presented different forms of face-saving. Additionally, collectivism was found to have a correlation with a flexible and more ambiguous personality in that people from collectivistic cultures tend to place more focus on contexts, have less concern for consistency, and be less interested in self-enhancement as they tended to adjust themselves to their ingroups. Moreover, in organization research, collectivism was found to be associated with lower preference to work alone, lower performance in solo tasks, and more focus on work conditions and human relations. Thus, collectivism does appear to be related to psychological processes.

### Collectivism Versus Individualism

Individualism and collectivism are often conceptualized as two opposite constructs and represent very



different norms of behavior. In general, cultures of Africa, Asia, and Latin America are categorized as collectivistic, whereas cultures of Western Europe and North America are noted as individualistic. In examining the dimensional structure of collectivism, research suggested that the simple approach of viewing collectivism as the opposite of individualism does not sufficiently represent the complexities within these two constructs. Most of the recent conceptual models and empirical research support collectivism/individualism as a separate domain-specific, independent dimension depending on contextual and social cues. Moreover, it seems appropriate to view societies as simultaneously dealing with both collectivistic- and individualistic-oriented values. Consistent with the notion of separate dimensions, another model has divided collectivism into kin- and non-kin-related collectivism, as well as kin- and non-kin-related individualism. This model implies that the meaning of collectivism varies across ingroups and cultures. In other words, collectivism is associated with certain groups but not others, and it takes different forms across different cultures.

### Collectivism Across Cultures

Studies on individualism and collectivism have been using samples from countries across the world. A recent meta-analysis of the comparative research literature of individualism and collectivism found that 50 out of 83 studies examined international comparisons, and 35 examined within-U.S. comparisons. In the studies of international comparisons, 50 countries were represented, with countries in South Asia and East Asia being most represented. The findings suggest that Americans are less collectivistic oriented than other regions of the world, except for some English-speaking countries. Within-U.S. comparisons examined differences among European Americans, African Americans, Asian Americans, and Latino/a Americans. The results from these studies indicate that European Americans are significantly lower on collectivism than Asian Americans and Latinos/as, although the effects were small, but do not differ from African Americans on collectivism. However, different collectivistic cultures emphasize different elements of collectivism. For example, Asian collectivistic cultures value group harmony and modesty in one's presentation. Conversely, collectivistic cultures of the Mediterranean and Latin America construe respect/dignity as the central value; that is, individuals are expected to preserve their honor and act dependably.

### Measurement

The measurement of collectivism, as reflected in more than 2 dozen inventories, has been based primarily on Likert ratings of values and attitudes. Some of the existing scales measure individualism and collectivism as a single bipolar construct. The majority, however, measure individualism and collectivism as separate orthogonal constructs. Measuring collectivism (and individualism) has been very difficult, in part because of the many varieties of collectivism and collectivistic cultures. For example, some collectivistic cultures emphasize equality (e.g., Sweden), whereas others emphasize hierarchy (e.g., India). Nonetheless, common content components of collectivism scales are useful to depict key elements of collectivism, such as relatedness to others, a sense of belongingness to groups, a sense of duty to groups, harmony, seeking others' advice, contextual self, valuing hierarchy, and working in groups. Most of the current research literature on collectivism can be categorized into three areas: (a) the dimensional structure of collectivism and its model development, (b) the relationship between collectivism and psychological functioning domains (e.g., self-concept, self-efficacy, well-being, attribution, and relationality), and (c) international comparisons and within-U.S. comparisons.

### Counseling Implications to Collectivism

Collectivism can have a profound impact on all aspects of the counseling process. For example, individuals from collectivistic cultures are more likely to attribute the cause of an event to situational factors (e.g., environmental stressors) and less to personal characteristics. Such attributions can affect a client's perceptions of his or her presenting problems and thus are relevant for the counselor to carefully assess. Also, a counselor's choice of appropriate intervention strategies should be in line with a client's worldview (e.g., collectivism). For example, intervention strategies that promote a sense of autonomy and self-worth would be inappropriate to a client who endorses collectivism with an emphasis on interdependence. Instead, it may be more appropriate to help a client from collectivistic cultures to find ways to meet both personal needs and group expectations. In addition, traditional emphasis on direct and open communication in a counseling relationship may create uncomfortable feelings in a collectivistic-oriented client who prefers indirect and high-context communication.



In sum, collectivism represents an important culture-based psychological construct related to how the self is conceptualized relative to important ingroups and outgroups across different cultures. It is also a worldview that is related to a host of psychological processes, which underscores the utility of the construct in understanding human adjustment. A competent counselor is one who understands how collectivism and individualism influence the counseling process and takes an active approach to develop culturally appropriate intervention strategies to help his or her clients.

*P. Paul Heppner, Chia-Lin Tsai, and Yuhong He*

**See also** Allocentrism (v3); Barriers to Cross-Cultural Counseling (v3); Confucianism (v3); Cross-Cultural Psychology (v3); Cross-Cultural Training (v3); Cultural Values (v3); Filial Piety (v3); Individualism (v3); International Approaches (v4); Multicultural Career Assessment Models (v4); Multicultural Counseling (v3); Work–Family Balance (v4)

### Further Readings

- Oyserman, D., Coon, H. M., & Kemmelmeier, M. (2002). Rethinking individualism and collectivism: Evaluation of theoretical assumptions and meta-analyses. *Psychological Bulletin*, 128, 3–72.
- Rhee, E., Uleman, J. S., & Lee, H. K. (1996). Variations in collectivism and individualism by ingroup and culture: Confirmatory factor analyses. *Journal of Personality and Social Psychology*, 71, 1037–1054.
- Triandis, H. C., Bontempo, R., & Villareal, M. J. (1988). Individualism and collectivism: Cross-cultural perspectives on self-ingroup relationships. *Journal of Personality and Social Psychology*, 54, 323–338.
- Williams, B. (2003). The worldview dimensions of individualism and collectivism: Implications for counseling. *Journal of Counseling & Development*, 81, 370–374.

---

## COLONIALISM

---

Colonialism refers to a nation extending its sovereignty over territory beyond its homeland by establishing colonial settlements, dependencies, trading posts, or plantation colonies, in which native inhabitants are ruled, displaced, or extirpated. The goal of colonialism is to strengthen the homeland by controlling the natural

resources, labor, and market of the colonial territory. Usually, colonizers will impose their sociocultural mores, religion, and language on the indigenous population. The term *colonialism* also refers to a set of values, including racism, ethnocentrism, and imperialism, which aim to justify the means by which colonial settlements are established on foreign land.

### Types of Colonialism

Settlements, dependencies, trading posts, and plantation colonies are distinct ways in which colonialism has been achieved. Settlements involved people emigrating from a mother country, such as England, Spain, or France, and permanently displacing or killing indigenous populations. Dependencies occurred when colonizers did not arrive as a mass settlement but as rulers over existing native populations. Trading posts occurred primarily to engage in trade rather than to rule or settle in the larger territory. Finally, plantation colonies, used primarily in the Caribbean, involved importing slaves into colonial settlements, who eventually outnumbered the primary settlers and ruled the hinterland.

### History of Colonialism

#### *Pre-European Colonialism*

Although most world history texts cite the European Age of Exploration as the origins of colonialism, substantial evidence suggests that African and Asian colonial settlements predate European settlements by centuries. The Olmec heads found along the Mexican Gulf Coast provide the most striking evidence of African colonies in the Americas more than 3,000 years ago. North African rule over European territory is also well documented through the legacy of the Moorish societies in Spain and France and Hannibal's reign over Rome and Italy. Genghis Khan led the most notable Asian colonial establishment by conquering nations and installing the Mongol Empire across Asia, Western Europe, and North Africa. The Mongol Empire was the largest contiguous empire in world history.

#### *The First Wave of European Colonization*

European colonization, which has its roots in Portuguese and Spanish exploration of the 15th century, in many ways shaped present-day debates over colonialism. Portuguese explorers successfully established trading



posts on the Atlantic islands and along the West African coast and eventually rounded the Cape of Good Hope to reach India in 1498. In 1492, Spain financed Christopher Columbus's voyage to discover an alternate route to India by sailing west. Columbus reached the Bahamas Islands, thinking he was in Asia. He returned to Spain to obtain more resources to conquer the so-called New Land. On his second voyage, he reached Haiti, thinking he was in India, and led his army to exploit the native population. Columbus's exploits included mass murder, enslavement, torture, and rape. His human rights abuses led to some of the first debates on colonialism, which included mostly religious leaders who either condemned or justified Columbus-style atrocities against Neolithic populations.

After observing Portugal and Spain's economic boosts, Northern European nations, particularly the Netherlands, England, and France, began to stake claim to the Americas as well. Religion influenced all European colonial establishments. Spanish nations used colonialism to seek fabled Christian kingdoms, establish theocracies, and finance religious wars. Conversely, some of the largest colonial settlements from England spawn from people fleeing religious intolerance in their homeland. However, monetary gains were the cornerstone of most human rights violations. Colonizers found that harvesting crops on the hinterland reaped great profits, so they enslaved native populations and sub-Saharan Africans. Historians estimate that Western settlers enslaved more than 10 million Africans to provide the labor necessary to harvest the colonies.

### ***Independence in the Americas***

In 1776 the 13 British colonies declared their independence and became the precursor to the modern-day United States of America. Subsequently, Haiti became the second independent nation and the first Black republic in the Western Hemisphere, when Toussaint L'Ouverture led the Haitian revolution against France. The Haitian revolution also led to the first organized slavery abolition movement in a metropole, or mother country. Spanish occupation in the Americas ended with the Latin American wars.

### ***Western Expansion, New Imperialism, and the Scramble for Africa***

In the 19th and 20th centuries, new nations in the Americas formed by European colonizers focused on

conquering the western frontier. In North America, settlers subjected the Native American population to preemptive war, detention centers, and population transfers, such as in the Trail of Tears. However, the White settlers' diseases crippled the Native American population more than their prowess.

In the Eastern Hemisphere, European nations set out a new colonial agenda with *New Imperialism*, after losing most of their stake in the Americas. New Imperialism, starting with the *Scramble for Africa*, formally established a competition between the United Kingdom, the French Third Republic, and the German Empire to conquer as much territory through armed force as possible. In the Scramble for Africa, which commenced in 1880 and boiled over into World War I, European powers established dependencies in and claimed as colonial territory all of Africa except Ethiopia and Liberia (Liberia was colonized by the United States with former slaves).

Racist pseudoscientific theories and religion were used as propaganda to justify the African expansion and subsequent atrocities committed against Africans. However, major corporations, such as the De Beers Mining Company, provided the most solid platform for European exploits of Africa. During the European conquest of Africa, wars between Westerners and native Africans proliferated (e.g., the Anglo-Zulu War), and eventually European superpowers began to war with each other as they competed for territory.

The Scramble for Africa ended after World War I; however, most of Africa was still under European control. From the period immediately after World War I (1914–1918) to the mid-20th century, anticolonialism and anti-imperialism movements became powerful, spurred by communism, colonized war veterans (e.g., Senegalese sharpshooters who fought with France), and colonized elites (e.g., Algerian Franz Fanon). The French colonial empire suffered a devastating blow in the Algerian Revolution. Worldwide, sympathy increased for colonized populations, and the institution of colonialism lost popularity.

### ***Decolonialism, Neocolonialism, and Postcolonialism***

Decolonialism was most prevalent after World War II; however, cold war tensions between the two new world superpowers, the United States and the Soviet Union (USSR), spawned neocolonialism. The USSR aligned itself primarily with anti-imperial movements,



by providing training and weapons to militias planning a coup (e.g., the African National Congress and Castro's Cuban Revolution). The United States, afraid that the USSR was building dependencies, began to compete with Soviet interest by spreading democracy. U.S. and USSR competition for allies led to civil war in many third-world nations (e.g., Angola and Vietnam) and wrongful CIA- and KGB-implicated assassinations of key leaders, such as Patrice Lumumba of the Democratic Republic of the Congo and Sylvanus Olympio of Togo.

In the postcolonial era, there have been many critiques of the impact of colonialism and whether colonialism exists today. Colonialism permanently changed the social-cultural, geographical, political, and economic landscape of the world. Indigenous populations of Africa, the Americas, and Australia continue to live as second-class citizens on their native lands, whereas generations-old businesses and banks that financed acts of genocide and other atrocities reap residual benefits from the legacy of colonialism. The debate on colonialism is omnipresent and still very active to this day. Recently, the February 23, 2005, *French Law on Colonialism* contained an article that mandated high-school teachers to teach the "positive values" of colonialism to their students. French Prime Minister Jacques Chirac repealed the law in 2006.

The United States, a product of both colonialism and an independence movement, is the primary focus of the postcolonial era. Critiques allege the existence of an *American Empire*, which imposes its values on other countries to build a new style of dependency. Defenders argue that the American Empire does not exist, or they propose that the United States is a *Benevolent Empire*, which builds relationships with other nations by helping them overcome struggles, as in the Spanish-American Wars. Internally, the United States continues to grapple with its own colonial legacy. To the dismay of social advocates, history texts in the United States are replete with colonialism-related omissions (e.g., Columbus's second voyage and atrocities against Native Americans).

### Implications for Counseling

The legacy of colonialism has implications for counseling practice and research. First, the psychological impact of colonialism and survival of indigenous values among previously colonized people influences the counseling relationship. Second, cultural imperialism

is a natural by-product of colonialism, leading many counselors to make assumptions about a client's traditions and values that are shaped by the majority culture. In addition to cultural imperialism, theories of ethnocentrism, racism, White supremacy, and pseudoscience used to justify colonialism have lingered well past decolonialism and influence counseling research and practice.

Ivory A. Toldson

*See also* Acculturation (v3); Adaptation (v3); Assimilation (v3); Discrimination and Oppression (v2); Enculturation (v3); Ethnocentrism (v3); Identity (v3); Indigenous Healing (v3); Multiculturalism (v3); Oppression (v3); Racism (v3); Second Culture Acquisition (v3)

### Further Readings

- Biel, R. (2000). *The new imperialism: Crisis and contradictions in North-South relations*. London, New York: Zed Books.
- Duara, P. (2004). *Decolonization: Perspectives from now and then*. New York: Routledge.
- Fanon, F. (1980). *A dying colonialism*. London: Writers and Readers.
- Sartre, J.-P. (2001). *Colonialism and neocolonialism*. London: Routledge.

---

## COLOR-BLIND RACIAL IDEOLOGY

---

Over the past 2 decades scholars and popular authors have written about racial color-blindness as a way to characterize racial beliefs in the post-civil rights era. At its core, *racial color-blindness* refers to the belief that racism is a thing of the past and that race no longer plays a role in understanding people's lived experience. Conceptually, racial color-blindness has its roots in the law field and traditionally has been applied mainly to the Constitution. More recently, scholars have redefined the term to better capture the new social relations within the current racial climate. As early as 1997, the field of psychology questioned the underlying assumption that ignoring race and color was a desirous and appropriate approach to interracial interactions. In a pamphlet on color-blind racial attitudes, the American Psychological Association (APA) concluded that "research conducted for more than two decades strongly supports the view that we cannot be,



nor should we become, color-blind” (p. 3). The APA further provided a critique of the color-blind perspective, arguing that a color-blind approach “ignores research showing that, even among well-intentioned people, skin color . . . figures prominently in everyday attitudes and behavior” (p. 2). The APA thus argued that to get beyond racism it is essential to take into account differences between the lived experiences of people.

### Defining Racial Color-Blind Ideology

There are a number of complementary but competing definitions of *racial color-blindness*. Couching racial color-blindness as an expression of modern-day racism, sociologist Eduardo Bonilla-Silva identified four frames or types: *abstract liberalism* (i.e., emphasizing political liberalism and the availability of equal opportunities to everyone, regardless of race, and the belief that political/economic interventions only serve to create a schism between racial groups); *naturalism* (i.e., interpreting racial clustering as a natural and preferred occurrence); *cultural* (i.e., using essentialist arguments to explain racial disparities, thus rooting racial differences in cultural practices); and *minimization* of racism in today’s society. Ruth Frankenberg, also a sociologist, viewed racial color-blindness as a perspective consisting of two types: *color-evasion* (i.e., placing an emphasis on racial sameness to the detriment of seeing or acknowledging differences in experiences and political realities) and *power-evasion* (i.e., the belief that resources are fairly distributed to everyone and success is attributed to individual effort).

In the *Guidelines on Multicultural Education, Training, Research, Practice, and Organizational Change for Psychologists*, authored by the APA, the interpersonal aspects of racial color-blindness are emphasized. Based on this perspective potential racial differences are minimized in favor of universal or human experiences. There is a great deal of commonality across cultures; however, the color-blind perspective dismisses potential differences based on racial group membership and downplays how these differences may shape human experiences. This limited awareness of the manifestation of race and racism in society is the foundation for most conceptualizations of racial color-blindness. Regardless of the definition, racial color-blindness is also thought to help justify existing racial practices or policies that ultimately create and support existing racial inequalities.

Consistent with these articulations, researchers argue that racial color-blindness reflects a broader ideological stance. Racial ideology is complex, but essentially it can be conceptualized as a global term referring to the dominant views about race within a hierarchical society. Ideology in this regard consists of a shared worldview about race that helps to justify and legitimize the current racial status quo; it accounts for individual beliefs and dominant societal racial beliefs or ideas that are commonly understood and transmitted through a variety of civil society and structural mechanisms. From this perspective racial color-blind ideology is a set of commonly held beliefs that minimize and distort the existence of institutional racism. This perspective is most consistent with the minimization type of color-blind racism identified by Bonilla-Silva and the power-evasion type proffered by Frankenberg.

Recently, scholars have challenged the assumption of the emergence of a new racism. Based on the review of the interdisciplinary literature in the United States and in other English-speaking countries, Colin Wayne Leach concluded that old-fashioned racism or the endorsement of racial inferiority/superiority ideology and actions have not been supplanted by more covert forms of racial expressions. Although he did not name racial color-blindness in his critique, Leach raised questions about whether or not a shift has occurred in the manifestation of racism since the passage of civil rights laws.

In sum, racial color-blindness is premised on the persistence of racism as manifested in contemporary racial disparities across a range of indexes, including housing, health, and employment. The complex set of beliefs used to restrict awareness of the persistence of racism is part of a larger ideological stance that serves to legitimize and further perpetuate racial inequalities. There is some debate about whether racial color-blindness is a new phenomenon or whether it reflects a dimension of racism that, until relatively recently, has received attention in the social science literature.

### Measuring Racial Color-Blindness

Leslie Carr, one of the first social scientists to quantitatively examine racial color-blindness, assessed the concept with one item: “Are you color-blind when it comes to race?” He identified two types of racial color-blindness among White college students: (1) liberal (i.e., those who identified themselves as color-blind but supported affirmative action policies) and



(2) conservative (i.e., those who identified themselves as color-blind and opposed affirmative action policies), both of which were significantly related to increased racial prejudice. Later studies, however, refute the utility of using one item to capture the complexities of color-blind racial ideology.

Some researchers have created a set of survey questions to assess concepts consistent with racial color-blindness but have not explicitly adopted a color-blind racial ideology framework. For example, Samuel Sommers and Michael Norton collected statements reflective of lay theories of racism. Factor analysis of endorsement of these statements suggested a three-factor solution; one factor represented denial of the problem of racism. In their study, participants who held greater modern racism beliefs were less likely to view denial of the problem statements (e.g., “Believes that prejudice against Blacks is no longer a problem) as an expression of racism.

The Color-Blind Racial Attitudes Scale (CoBRAS), developed by Helen Neville and her colleagues, is among the first scales to assess the minimization and distortion of institutional racism most consistent with the ideological view. Sample items on the scale include “Everyone who works hard, no matter what race they are, has an equal chance to become rich” and “Racism may have been a problem in the past, but it is not an important problem today.” Emerging data on the CoBRAS have suggested an association between color-blind racial ideology and theoretically relevant constructs, including increased racial and gender intolerance, anti-affirmative action beliefs, and belief in a just world among Whites and internalized racism among racial and ethnic minorities.

### Racial Color-Blind Ideology in Counseling

When counselors ignore the influence of race and racism, they may minimize the potential influence of race and ethnocultural factors on the therapeutic process inadvertently. This, in turn, may serve to isolate racial minorities in seeking or remaining in counseling services. Several studies have assessed the association between racial color-blindness and the therapeutic process, although not always explicitly using this terminology. Findings suggest that among White psychologists and trainees, minimization of institutional racism is related to decreased multicultural competencies, including the ability to contextualize

clients’ presenting concerns and express client empathy. In fact, racial color-blindness has been found to be related to both observed and self-reported multicultural counseling competencies over and beyond that accounted for by multicultural coursework and racial group membership.

Helen A. Neville

*See also* Affirmative Action (v3); Assimilation (v3); Diversity (v3); Multicultural Counseling Competence (v3); Political Correctness (v3); Prejudice (v3); Racial Identity (v3); Racism (v3); Reversed Racism (v3); Worldview (v3)

### Further Readings

- American Psychological Association. (1997). *Can—or should—America be color-blind? Psychological research reveals fallacies in a color-blind response to racism* [Pamphlet]. Washington, DC: Author.
- American Psychological Association. (2003). Guidelines on multicultural education, training, research, practice, and organizational change for psychologists. *American Psychologists*, 58, 377–402.
- Bonilla-Silva, E. (2001). *White supremacy and racism in the post civil rights era*. Boulder, CO: Lynne Rienner.
- Carr, L. (1997). *Color-blind racism*. Thousand Oaks, CA: Sage.
- Frankenberg, R. (1993). *White women, race matters: The social construction of Whiteness*. Minneapolis: University of Minnesota Press.
- Neville, H. A., Lilly, R. L., Duran, G., Lee, R., & Browne, L. (2000). Construction and initial validation of the Color-Blind Racial Attitudes Scale (CoBRAS). *Journal of Counseling Psychology*, 47, 59–70.

---

## COMMUNICATION

---

*Communication* is difficult to define as it can be understood from a variety of perspectives. Dominic Infante, Andrew Rancer, and Deanna Womack suggest that communication occurs between humans when the meaning of symbols is manipulated to stimulate meaning. From this perspective, communication is important for promoting cooperation. Humans are social in nature and require cooperation if they are to get along and thrive. Communication also involves acquiring and sharing information through various venues such



as the 24-hour news services, newspapers, and the World Wide Web.

## Models of Communication

Ronald Adler and Neil Towne and Infante, Rancer, and Womack described several models of communication. The linear model describes communication in simple unidirectional terms—how information from a sender is communicated to a receiver. In this process, a sender encodes a message (by preparing an existing ideal for transmission) and sends the message through a channel (e.g., letter) to a receiver, who decodes (interprets) the message. The linear model proposes that noise and environment are important variables that can influence communication. Noise involves factors that can undermine the process of communication (e.g., psychological stress), and environment relates to factors such as personal experiences and physical setting that can influence communication.

The transactional model suggests that communication is not simply unidirectional (a sender transmitting a message to a receiver) but also is influenced by feedback that can include the responses of the people involved. From this perspective, individuals are referred to as communicators and not senders or receivers, as they are alternately senders and receivers throughout the communication process.

## Communication and Counseling

Communication can impact counseling in a variety of ways, such as through listening skills and multicultural issues.

### Listening Skills

Adler and Towne noted that more people spend time listening than any other form of communication. Effective communication skills are emphasized in counseling. This is especially true in marriage and family counseling where communication problems are a central focus. In this process, family members are often taught to use listening skills to obtain a phenomenological perspective (seeing others' point of view). Listening skills that promote the phenomenological perspective include open-ended statements, paraphrasing, minimal encouragers, clarifying, and reflection of feeling.

Communication of empathy is a particularly important listening skill. According to Carl Rogers,

empathy is considered a core condition in counseling and can be defined as communicating a sense of caring and understanding. According to this definition, empathy involves not just caring but being perceived as caring. In other words, a person could care about a person but not get credit for caring, unless the caring is effectively communicated to the other person.

### Multicultural Issues

In terms of multicultural communication in counseling, *multiculturalism* will be defined in an all-inclusive manner, including race, ethnicity, gender, sexual orientation, class, disability, and more. Miscommunication can occur in multicultural counseling as a result of not considering cultural issues associated with language differences and nonverbal behavior. Language differences can include counselors using standard English with bilingual clients, resulting in inaccurate assessment of clients. Nonverbal behavior can also create challenges in multicultural counseling. For example, it might be problematic for a European American counselor to misinterpret the direct eye contact of an African American client as anger.

Derald Wing Sue and David Sue examined the subtleties of nonverbal communication through various dimensions. A counselor may benefit from noting similarities and differences with comfort and emotional reactions to personal and interpersonal space (e.g., how close the counselor and client sit), physical movement (e.g., eye contact, hand gestures), and vocal cues (e.g., loudness, silence, rate). Sue and Sue emphasize the importance of recognizing these and other contextual and process modes of communicating during counseling.

Marvin Westwood and F. Ishu Ishiyama provided guidelines that could be used to address communication issues in multicultural counseling.

- Counselors should check with clients regarding the accuracy of their impressions associated with nonverbal communication.
- Counselors can help clients experience catharsis by encouraging them to use their own language to express a feeling when another language cannot adequately describe how they are feeling.
- Counselors should attempt to learn culturally appropriate responses to accurately describe clients' experiences.
- Counselors can use creative arts modalities, such as music and art, to overcome communication barriers.



## Multicultural Model for Communication in Counseling

Westwood and Ishiyama summarized a culturally embedded model for understanding communication. Unlike previous models of communication in the counseling relationship, this model assumes that cross-cultural clients enter the session with a unique language and way to relate socially. As such, it is assumed that the primary effort of initial counseling sessions is for clients to begin to understand their unique way of seeing themselves in their world (intrapersonal communication). As clients feel they are both beginning to understand themselves and are being understood by their counselors, there will be simultaneous development in being understood verbally and nonverbally (interpersonal communication), which is the unique focus of traditional models. There are three primary assumptions included in this model:

- Communication involves culturally constructed verbal and nonverbal behavior, which is often not conscious and varies between cultures.
- Individuals' perceptions of communication are at least partially determined by one's own culture, which influences both counselors and clients.
- Communicative processes are directly influenced by the situation and feelings of clients and counselors.

The multicultural model suggests that counselors are most effective when both counselor and client attempt to promote client self-understanding. In this process, the counselor can facilitate cross-cultural client communication by demonstrating an understanding of clients' unique experiences and perspectives, understanding how clients uniquely express their perspective both verbally and nonverbally, and developing multicultural competencies.

## Future Directions

When counselors emphasize multicultural communication in counseling, they increase the likelihood of validating the client, enhancing the counselor–client relationship, and improving the likelihood of reaching the counseling goals. Both beginning and veteran counselors demonstrate respect and better assist their clients by understanding their own communication style, understanding the communication style of the dominant cultures, and understanding the communication

style of each client. Future research can explore these unique dynamics.

*Michael S. Nystul and Nick Barnecllo*

*See also* Barriers to Cross-Cultural Counseling (v3); Bilingual Counseling (v3); Bilingualism (v3); Language Difficulties, Clinical Assessment of (v2); Multicultural Counseling Competence (v3)

## Further Readings

- Adler, R. B., & Towne, N. (2002). *Looking out/Looking in*. Orlando, FL: Harcourt.
- Evans, D. R., Hearn, M. T., Uhlemann, M. R., & Ivey, A. E. (2004). *Essential interviewing: A programmed approach to effective communication* (6th ed.). Belmont, CA: Thomson-Brooks/Cole.
- Infante, D. A., Rancer, A. S., & Womack, D. F. (1990). *Building communication theory*. Prospect Heights, IL: Waveland Press.
- Rogers, C. (1951). *Client-centered therapy*. Boston: Houghton Mifflin.
- Sue, D. W., & Sue, D. (2008). *Counseling the culturally diverse* (5th ed.). New York: Wiley.
- Westwood, M. J., & Ishiyama, F. L. (1990). The communication process as a critical intervention for client change in cross-cultural counseling. *Journal of Multicultural Counseling and Development*, 18(4), 163–171.

---

## CONFUCIANISM

---

*Confucianism* is an omnibus term for a set of thoughts that compose an ethos, a sentiment, that has been shaping China for many millennia. Confucianism is a group of proposals for proper socioethical ways of life, providing a foundation to the individual's commitment to sincerity, honesty, and interpersonal harmony. Its impacts are multidimensional in politics, family, interpersonal relations, and education, with deep moral and religious implications. It originated in the *Analec*s, supposedly of Confucius, and its ancient commentaries began at Mencius. Elements of Confucianism are popular in Taiwan, Hong Kong, and China and in the United States, where Confucianism is popular among Asian Americans and traditional Chinese. Asian parents emphasize education, a time-honored Confucian ideal. In Confucian ethos, Asian Americans value family; a member's decision (e.g., on house-buying)



involves other members' consultation, approval, and even financial support.

Confucianism has had to contend with other trends, such as Taoism and Buddhism. In the Sung Dynasty (960–1279), Neo-Confucianism made Confucianism the dominant philosophy among the educated, who drew from Taoism and Buddhism to formulate a new metaphysics of a sociopolitical hierarchy nonexistent in older Confucianism. This Neo-Confucian synthesis was established as dominant orthodoxy by Chu Hsi (1130–1200).

Confucianism envisions harmonious social relations in proper respectful comportment, the gentleman's way of life in polished manners, with rites and ceremonies to fulfill responsibilities of one's societal positions to promote the Five Relations: ruler–subject, father–son, elder–younger brothers, husband–wife, and friend-to-friend.

Reforming the society begins at reforming the individuals, through whom we establish loving respectful order in families and develop into orderly state and world concord. Rulers must initiate and exemplify the reform in person and in performance.

Personal desire for goodness nurtures family structural concord, to support individuals and spread to society at large. Social solidarity in various aspects is formed by people's loyalties, respect, and proper conduct.

Fulfilling the codes of conduct is a form of socialization. The codes are accepted with individual expressions. Ideally, psychological issues are considered within this goal-context of virtues as fulfillment of the ideal Five Relations.

Stressing individuals as part and parcel of families and interpersonal relationships, Confucianism is a constitutive ingredient in the Chinese value system and relevant to cross-cultural counseling. China assumes family and Five Relations (parent–child, husband–wife, etc.) as a context of living. Individual well-being depends on the harmony of family relationships. Exclusive consideration of private needs is perceived as selfish, not “independent” as in the West. Confucianism is where a good personal trait (virtue) is gentle modesty, to allow others to express their needs and help fulfill them. Seen from the West's independence, many Chinese may appear withdrawn, indecisive, and shy in self-expression.

Unwittingly, however, Western individualistic ethos does include respecting others' individual rights and laws that are communal (e.g., traffic laws, election

laws). Counselors working with clients who value Confucianism should stress community as a resource for coping, because, Confucianism would say, community *composes* individual integrity, giving birth to it, raising it. Exclusively stressing unique individuality, taking community as its auxiliary, is one major cause of mental stresses. Confucianism calls for a shift in counseling paradigm from individual-centeredness to individual–community interdependence.

*Ruth Chao and Kuang-ming Wu*

*See also* Asian Americans (v3); Career Counseling, Asian Americans (v4); Collectivism (v3); Cross-Cultural Psychology (v3); Cultural Values (v3); Filial Piety (v3); Multicultural Counseling Competence (v3); Multiculturalism (v3); Worldview (v3)

### Further Readings

- Chan, W. T. (1963). *A sourcebook in Chinese philosophy*. Princeton, NJ: Princeton University Press.
- Mair, V. (Ed.). (1994). *The Columbia anthropology of traditional Chinese literature*. New York: Columbia University Press.

---

## CONSTANTINE, MADONNA G. (1963– )

---

Madonna G. Constantine is an African American female counseling psychologist who has been described by many as an inspired researcher, prolific author, respected mentor, and leader in the exploration of multicultural and social justice issues in psychology. Her extensive record of research has blazed new trails in the exploration of multicultural counseling competence and the impact of racism on psychological practice. Moreover, as a collaborator and mentor, Constantine embodies the best of the scientist-practitioner model, conveying her dedication to research and its relevance for practice to the hundreds of students and colleagues from all over the United States that she has mentored both formally and informally.

### Career Path

Constantine was born and raised in Lafayette, Louisiana, the third of five children in her family.



With a lifelong natural curiosity about people, she realized at an early age that she wanted to become a psychologist. Constantine completed her undergraduate studies at Xavier University in New Orleans, Louisiana, where she graduated *cum laude* in 1984 with a major in psychology and a minor in English. She received an M.A. in business, industry, and social agencies counseling from Xavier in 1986 and a Ph.D. in counseling psychology from Memphis University in 1991, where she matriculated as the first student of color in the program's history.

Upon completing her predoctoral internship at the University of Notre Dame's Counseling Center, Constantine began her professional career as a practitioner, accepting a staff position at the University of Texas's Counseling and Mental Health Center in Austin. After 5 years there, Constantine sought a new career direction that would allow her to develop her research interests more fully, and in 1995 she joined the counseling psychology faculty at Temple University in Philadelphia. Three years later, in 1998, she was recruited by Teachers College, Columbia University, to their Counseling Psychology Program, where she works as a full professor as of this writing.

### National Leadership and Service

Throughout her career, Constantine has served her field as both participant and leader in a number of professional organizations and national service activities. She is a member of Divisions 17 (Society of Counseling Psychology), 35 (Psychology of Women), and 45 (Society for the Psychological Study of Ethnic Minority Issues) of the American Psychological Association (APA), and is a lifetime member of the Association of Black Psychologists. She is also a member of the American Counseling Association (ACA), the Association of Multicultural Counseling and Development, the National Career Development Association, and the Association for Counselor Education and Supervision. In particular, she has been a leader within Division 17 since the early 1990s, when she became the chair of the division's Ethnic and Racial Diversity Committee (which subsequently became the division's Section on Ethnic and Racial Diversity); she served as past chair from 1997 to 1999. On behalf of Division 17, Constantine also has served as Program Committee chair (1999–2000), Awards Committee cochair (2001–2002) and chair (2002–2003), Fellowship Committee chair (2005–present), and liaison to the

APA's Ethnic Minority Affairs Committee (1996–2003). She was the Program Committee cochair for the 2001 National Counseling Psychology Conference in Houston, Texas, and also has served as member-at-large for Division 45. In addition, Constantine has served as a grants review panel member for both the U.S. Department of Health and Human Services (2000) and the National Institute of Mental Health (2001), and she has served as a member of the Committee for the Examination for the Professional Practice of Psychology Licensing Exam (since 2002) and a member of numerous committees and task groups within APA.

Constantine's editorial experience is extensive and comprises service to some of the most important journals in the field of psychology. She is currently a consulting editor of the *Journal of the Professoriate* (since 2005) and associate editor of *Cultural Diversity & Ethnic Minority Psychology* (since 2004) and the *Journal of Counseling Psychology* (since 2007). She also served previously as associate editor of the *Journal of Black Psychology* (2002–2006) and senior and associate editor of the *Journal of Multicultural Counseling and Development* (1999–2003). Constantine has received appointments to the editorial boards of the *Journal of Counseling Psychology* (2000–2006), *Career Development Quarterly* (2005–2008), *Cultural Diversity & Ethnic Minority Psychology* (2000–2003), the *Journal of Career Assessment* (2001–2003), *Professional Psychology: Research and Practice* (2000–2003), *The Counseling Psychologist* (1999–2002), the *Journal of Psychotherapy in Independent Practice* (1997–2001), and the *Journal of Counseling & Development* (1996–1999).

### Awards and Honors

Constantine's professional accomplishments have garnered numerous national accolades, beginning with two awards that recognized the promise of her early scholarship. In 1999, she was honored by Division 45 of the APA with the Early Career Contributions to Ethnic Minority Psychology Award, and the following year she received the Fritz and Linn Kuder Early Career Scientist-Practitioner Award from Division 17 of the APA. Constantine also has been honored with Fellow status in each of these divisions, having been named a Fellow of Division 17 in 2002 and of Division 45 in 2003. She also is the recipient of five Outstanding Teaching Awards from Teachers College, Columbia University. In 2001, Constantine received



the ACA Award for Outstanding Research, and in 2005 she received the Samuel H. Johnson Award for Exemplary Service and Scholarship from the Association of Multicultural Counseling and Development as well as the Exemplary Scholarship Award from the Association of Black Psychologists. More recently, Constantine was honored with the Distinguished Scholar Award from the American Educational Research Association's Committee on Scholars of Color in Education (2006) and the Distinguished Research Award from its Division of Counseling and Human Development (2006).

### Scholarship

The proof of Constantine's commitment to psychological research lies in her astonishing productivity and the scholarly significance of her contributions. In mid-career at the time of this writing, she has authored or coauthored at least 110 journal articles and more than 40 book chapters, and she has edited or coedited four books—all in the 13 years since her first journal article in 1995. Her scholarship coheres around four interrelated themes: (1) the education, training, and supervision of counselors and psychologists; (2) vocational and psychological issues of underserved populations; (3) multicultural counseling competence; and (4) racism in psychology and education.

With regard to the education and training of psychologists, Constantine's work has illuminated everything from the internship selection process to the complexities of the clinical supervisory relationship, especially where multicultural issues are concerned. Her studies of underserved populations and corresponding vocational and psychological issues have included explorations of racial identity, Africentric cultural values and coping styles, contextual and cultural factors in vocational development and career decisions, and the cultural adjustment experiences of international students. Constantine's body of work on multicultural counseling competence is among the strongest to be found within the field of psychology. It comprises studies that systematically examine the components and effects of multicultural competence from the vantage points of clients, counselors, and supervisors, considering both self-reported and observed ratings of multicultural competence; it also includes a significant focus on the multicultural competence of school counselors.

Finally, Constantine's research on racism in psychology and education represents a major contribution to our understanding of the dynamics of oppression within these fields as well as in society as a whole. This important social justice theme bookends Constantine's work to date: Her first publication in 1995 documented the racist attitudes and behavior encountered by psychologists of color in Division 17, and her recent (2007) work on racial microaggressions has further developed this theme along several dimensions. As defined by Constantine and her colleague and collaborator Derald Wing Sue, *racial microaggressions* are the commonplace indignities and demeaning messages that are conveyed to people of color on a daily basis, often by perpetrators who are unaware of the racist connotations of their speech or behavior. Constantine's research has identified the various types of racial microaggressions experienced by Black clients, graduate students, and faculty members as perpetrated by their White counselors, supervisors, and colleagues. Utilizing primarily qualitative methodologies that allowed participants' own voices to emerge, Constantine's contributions are momentous for psychologists interested in multicultural competence and social justice. In revealing the extent to which unaware racism still pervades the field of psychology, undermines psychological practice, and produces damaging results for people of color, this research should serve to spur the field to deepen its examination of all oppression-related biases and its commitment to multicultural competence.

### Achievement in a Relational Context

In her 1994 book *Teaching to Transgress*, bell hooks described a liberatory, feminist, multicultural context for teaching and learning as "a radical space of possibility." The ability to create such spaces epitomizes Madonna Constantine as a professional and as a person. Her collaborative and feminist spirit, her reticence to showcase herself as an individual, and her avid support and mentorship of students and colleagues alike are legendary.

Laura Smith

*See also* Afrocentricity/Afrocentrism (v3); Association of Black Psychologists (v3); Counseling Skills Training (v2); Cultural Values (v3); Multicultural Counseling (v3); Multicultural Counseling Competence (v3); Oppression (v3); Racial Identity (v3); Racial Microaggressions (v3);



Racism (v3); Scientist–Practitioner Model of Training (v1); Social Justice (v3); Society for the Psychological Study of Ethnic Minority Issues (v3)

### Further Readings

- Constantine, M. G. (2001). Predictors of observer ratings of multicultural counseling competence in Black, Latino, and White American trainees. *Journal of Counseling Psychology, 48*, 456–462.
- Constantine, M. G. (2002). Predictors of satisfaction with counseling: Racial and ethnic minority clients' attitudes toward counseling and ratings of their counselors' general and multicultural counseling competence. *Journal of Counseling Psychology, 49*, 255–263.
- Constantine, M. G. (2007). Racial microaggressions against African American clients in cross-racial counseling relationships. *Journal of Counseling Psychology, 54*, 1–16.
- Constantine, M. G., Anderson, G. M., Berkel, L. A., Caldwell, L. D., & Utsey, S. O. (2005). Examining the cultural adjustment experiences of African international college students: A qualitative analysis. *Journal of Counseling Psychology, 52*, 57–66.
- Constantine, M. G., & Sue, D. W. (Eds.). (2005). *Strategies for building multicultural competence in mental health and educational settings*. Hoboken, NJ: Wiley.
- Constantine, M. G., & Sue, D. W. (Eds.). (2006). *Addressing racism: Facilitating cultural competence in mental health and educational settings*. Hoboken, NJ: Wiley.
- Constantine, M. G., & Sue, D. W. (2007). Perceptions of racial microaggressions among Black supervisees in cross-racial dyads. *Journal of Counseling Psychology, 54*, 142–153.
- Constantine, M. G., Warren, A. K., & Miville, M. L. (2005). White racial identity dyadic interactions in supervision: Implications for supervisees' multicultural counseling competence. *Journal of Counseling Psychology, 52*, 490–496.
- Miville, M. L., Constantine, M. G., Baysden, M. F., & So-Lloyd, G. (2005). Chameleon changes: An exploration of racial identity themes of multiracial people. *Journal of Counseling Psychology, 52*, 507–516.
- Perez, R. M., Constantine, M. G., & Gerard, P. A. (2000). Individual and institutional productivity or racial and ethnic minority research in the *Journal of Counseling Psychology, 47*, 223–228.
- Smith, T. B., Constantine, M. G., Dunn, T. W., Dinehart, J. M., & Montoya, J. A. (2006). Multicultural education in the mental health professions: A meta-analytic review. *Journal of Counseling Psychology, 53*, 132–145.

## CRITICAL RACE THEORY

Critical race theory (CRT), initially created as a body of legal theory, is an organizing framework useful in understanding human behavior and social processes relevant to racial group categorizations and racial stratification. Critical race theory examines the oppressive dynamics of society to inform individual, group, and social transformation. Rather than embracing a color-blind perspective, CRT places race at the center of the analysis and provides a critical perspective on how racial stratification continues to influence the lives of racial/ethnic minorities in the United States. In this context, color-blindness refers to the minimization or denial of a substantive role for race in the understanding of life outcomes for different racial groups. Critical race theory provides a framework consistent with multicultural psychology and is useful in the conceptualization and practice of counseling and psychotherapy in cross-cultural contexts. Mental health professionals working in cross-cultural contexts can use CRT to facilitate a deeper understanding of how racial stratification is manifested in everyday experience and the enduring role that race plays in the lives of individuals, families, and groups, as well as in the therapeutic process.

### Basic Tenets and Dominant Themes

Scholars across disciplines have identified several dominant and unifying themes that describe the basic tenets of CRT. Based on the core CRT literature, 10 basic tenets/dominant themes can be articulated that describe CRT's conceptual foundation.

1. Race is a social construct, not a biological phenomenon.
2. Racism is endemic to American life and should not be regarded as an aberration.
3. Racism benefits those who are privileged and serves the interests of the powerful to maintain the status quo with respect to racial stratification.
4. CRT represents a challenge to the dominant social ideology of color-blindness and meritocracy.
5. Racial identity and racial identification are influenced by the racial stratification that permeates American society.
6. Assimilation and racial integration are not always in the best interests of the subordinated group.



7. CRT considers the significance of within-group heterogeneity and the existence of simultaneous, multiple, intersecting identities.
8. CRT argues for the centrality, legitimacy, and appropriateness of the lived experience of racial/ethnic minorities in any analysis of racial stratification.
9. CRT insists on a contextual analysis by placing race and racism in a cultural and historical context, as well as a contemporary sociopolitical context.
10. Informing social justice efforts and the elimination of racial oppression are the ultimate goals of critical race theory.

The first basic tenet of CRT is that *race is a social construct, not a biological phenomenon*. It is not rooted in biology or genetics but rather is a product of social contexts and social organization. Based on the social construction thesis, CRT holds that races are categories that society creates, revises, and retires as needed. This tenet is based on scientific research demonstrating that the human phenotypic expressions used to indicate racial categorization (i.e., those physical characteristics shared by many people of a common heritage) constitute only a minute segment of people's genetic makeup and account for approximately .1% of genetic variability between races. Genetically, people are more similar than different. Furthermore, science has found no reliable link between physical traits and higher-order characteristics such as personality, intelligence, and morality. A central question that emerges from CRT is why and how pervasive social ideology continually overlooks scientific fact and attributes semipermanent characteristics to different races. CRT challenges the idea that race should be disregarded because it is not valid scientifically. Assigned racial group categorizations continue to have a strong impact on differential life outcomes, as well as on how people perceive and interact with each other. Race continues to influence the structure and functioning of a broad range of societal institutions, including education, health care, employment, media, and the legal system.

Second, *racism is endemic to American life and should not be regarded as an aberration*. Socially constructed racial categorization is currently and has historically been a fundamental organizing principle of society. Individual, cultural, and institutional expressions of racism reflect the racial stratification that is part of the fabric of the United States of America. In a CRT analysis, racism is ordinary practice and part of

the dominant cultural ideology that manifests in multiple contexts. Race and racism are central and defining factors to consider in understanding individual and group experience. Racism can express itself in very mundane, as well as quite extraordinary, ways. It affects the course and quality of life through access to valued societal resources, opportunities, and information. Thus, CRT critiques the position that racism is primarily an attitudinal or psychological problem and argues that conceptualizing it in this way hides its pervasiveness, insidiousness, and enduring nature.

A third basic tenet of CRT is that *racism benefits those who are privileged and serves the interests of the powerful to maintain the status quo with respect to racial stratification*. Those with power and influence in society have little incentive to eliminate racism. This feature is known as "interest convergence" or material determinism. Efforts to eliminate racism occur only when the change will benefit the privileged group in some way. This tenet encourages exploration of the role of societal need and power interests in the way that specific qualities are associated with particular racial groups. This idea of differential racialization examines how characteristics ascribed to a particular race change depending on the needs and interests of the majority group. Historically, these have included economic power, safety from a perceived threat, and a quest for racial or ethnic purity, among others. In addition, sentiments and stereotypes associated with a particular group change with societal conditions. For example, during World War II, Japanese Americans were in extreme disfavor, moved to internment camps, and assigned stereotypes such as "cruel" and "evil." As another example, people of Black African descent were depicted as simple-minded and childlike during slavery when justification for servitude was needed. However, more recently, African Americans are depicted as aggressive, threatening, and criminal, which serves to justify the practice of racial profiling and disproportionate rates of imprisonment, among other phenomena.

Fourth, CRT represents *a challenge to the dominant social ideology of color-blindness and meritocracy*. Race neutrality and the myth of equal opportunity ignore the reality of the deeply embedded racial stratification in the United States and the impact it has on quality of life. These dominant ideological assumptions result in a deficit analysis of differences between Whites and people of color. The traditional paradigm of equal opportunity camouflages the realities of power



asymmetry and unearned privilege afforded to dominant groups. Within this predominant paradigm of color-blindness and meritocracy, a Latina worker's failure to be promoted would be attributed exclusively to individual deficiencies with factors such as an "old boys club" ignored or discounted. A CRT analysis would illuminate the dynamics of race and differential access to opportunities for advancement that create disparities in life outcomes.

A fifth important theme relevant to CRT is that *racial identity and racial identification are influenced by the racial stratification that permeates American society*. The perceived salience of race, the significance of racial/ethnic group membership to self-concept, the degree to which racial/ethnic heritage and practices are embraced or rejected, and the affiliations and identifications that are made within and outside of one's own racial/ethnic group are all impacted by the dominant cultural narrative of White superiority. Trustworthiness, intelligence, leadership, credibility, and standards of attractiveness are among the characteristics more quickly attributed to Whites when in comparison with people of color. When there is an idealization of Whiteness by persons of color, behavior may be influenced by the need to meet the approval of Whites, and there may be collusion with attitudes of color-blindness and race neutrality to be "acceptable" to Whites. This idealization of Whiteness can be associated with the internalization of negative stereotypes and result in distancing and disidentification with respect to one's own racial/ethnic group. However, dissonance can be created when a preference for Whiteness comes face-to-face with the inescapable reality of the permanence of living as the racial/ethnic group within which one was born. Biracial and multiracial individuals and families frequently must negotiate identity and identification within a society where part of their heritage is valued as superior and is more privileged than other parts. This is most striking when one parent is White. However, this dynamic can also be present in situations where parents are members of different racial/ethnic groups of color (e.g., Japanese and African American). From a CRT perspective, positive and healthy racial identification, which does not collude with the perpetuation of racial stratification, requires exposure, familiarity, and affirming contexts that provide alternative and empowering meanings associated with one's racial/ethnic group or groups.

Sixth, within a CRT framework, *assimilation and racial integration may not always be in the best interests of the subordinated group*. In practice, racially

integrated settings occur in mainstream institutions that are majority White in composition and/or in the distribution of power. Due to the dominant ideology of White supremacy, messages of inferiority and deviance are easily available and internalized by people of color in predominantly White settings. In addition, fairness may be perceived differently by those with diverse racial experiences. For example, integration that separates children of color into different classrooms in the name of integration actually benefits White children in providing them with exposure to a "diversity" experience. Dominant cultural values and practices, sense of identity, belonging, security, and esteem are not at risk for the White children. However, the children of color face greater risk of conformity demands, encouragement to keep differences relatively invisible, alienation, disconnectedness, withdrawal, and internalized racism. This is particularly true when the institutional culture insists on a "we are all the same" value structure and silences or marginalizes voices that threaten this ideology that renders people blind to the dynamics and expressions of racism. When affirmation, validation, within-group support, and opportunities for racial and cultural socialization are missing or weak, racial integration (as it is currently practiced) can have negative effects on members of racial/ethnic minority groups.

A seventh dominant theme in CRT is *the significance of within-group heterogeneity and the existence of simultaneous, multiple, intersecting identities*. This is often referred to as anti-essentialism or intersectionality. All people have overlapping identities, and multiple lenses through which the world is experienced. CRT challenges the idea that any person has a unidimensional identity within a single category (e.g., race/ethnicity) or that racial groups are monolithic entities. There is tremendous diversity within broad racial/ethnic group categories. For example, a person of Middle Eastern descent might be a fifth-generation Lebanese man or a recently immigrated Iranian Jewish woman. Many critical race scholars recognize that poverty and race intersect in complex ways, so that the predicament of very poor racial/ethnic minority families differs in degree from that of their White counterparts. Gender, immigration status, language, and sexual orientation are among the many dimensions of diversity that exist within broad racial/ethnic group categories. It is necessary to understand the dynamics of subordination within



these dimensions of diversity and the ways that these forms of oppression (e.g., classism, sexism, heterosexism) intersect with racism.

Eighth, CRT argues for *the centrality, legitimacy, and appropriateness of the lived experience of racial/ethnic minorities in any analysis of racial stratification*. People of color have different stories to tell regarding the way that race affects their life experiences. These stories have not had as significant an influence on policies, practices, and opinions as have the dominant cultural narratives about race that permeate the media and minds of most Americans. People of color have unique perspectives on racial matters, and their voices speak of experiences involving marginalization, devaluation, and stigmatization of which their White counterparts have very little knowledge. Racial minority status grants particular expertise and competence in speaking about race and racial matters. According to CRT, this experiential knowledge is a strength and critical to analyzing the dynamics and results of racial stratification in an authentic and meaningful way. Given that storytelling is a significant aspect of human communication, CRT has advocated for marginalized people to tell their often unheard and unacknowledged stories and for these perspectives to be applied to the existing dominant narratives that influence the law. The CRT process of counter-storytelling refers to the illumination of the cultural and personal narratives, family histories, and metaphorical stories that present a contrast to dominant societal narratives about race. These stories are viewed as central sources of information necessary for an authentic and comprehensive understanding of racial stratification and subordination.

Ninth, CRT insists on a *contextual analysis by placing race and racism in a cultural and historical as well as a contemporary sociopolitical context*. CRT challenges ahistoricism and locates current manifestations of racial stratification within a broader historical landscape that has shaped the present forms and expressions of racism. Interdisciplinary perspectives and methods emerge from this contextualized approach.

Finally, a tenth dominant theme within CRT involves the recognition that *social justice and the elimination of racial oppression are the ultimate goals* of a CRT analysis and orientation. CRT provides a liberatory and transformative response to racial stratification and oppression. Research from a CRT framework should contribute to efforts that (a) facilitate the empowerment of marginalized and disenfranchised

groups, and (b) inform strategies for eliminating racism and other forms of oppression.

## Origins and Interdisciplinary Applications

The early roots of CRT lie in a variety of fields and movements including anthropology, sociology, history, philosophy, law, and politics. W. E. B. Du Bois, César Chávez, Frederick Douglass, and the Black Power and Chicano movements of the 1960s and 1970s helped inspire the development of its core ideas. CRT, as a formal idea, was first conceived in the 1970s, when a team of activists, lawyers, and legal scholars became wary that the strides made in civil rights activism and policy during the 1960s were eroding. There was clear consensus among these individuals that a different theoretical framework was needed to fight the newer, subtler forms of racism that had pervaded society. The earliest authors of CRT included civil rights lawyer Derrick Bell, legal scholar Alan Freeman, and Latino scholar Richard Delgado. Bell is arguably the most prominent source of thinking critical of traditional civil rights discourse and is considered by many as CRT's "intellectual father figure." He employed three major arguments in his analyses of racial patterns in American law: constitutional contradiction, the interest convergence principles, and the price of racial remedies. The late Alan Freeman was also instrumental in the development of CRT and wrote a number of foundational articles that critiqued racism in the U.S. Supreme Court's jurisprudence. Through scholarly dialogue and over the course of many meetings and conferences, CRT was actualized. Delgado, Kimberle Crenshaw, and Mari Matsuda have been significant contributors to CRT discourse from the 1980s to the present. During the capitalist boom of the 1980s and 1990s, critical race theorists focused primarily on the task of combating the country's racial indifference. A current focus of CRT scholars and activists is on the issue of "unmasking color-blindness."

It is noteworthy that culturally specific subdivisions have developed under the umbrella of CRT. These include Latino/a critical race studies (LatCrit), Asian American critical race studies (AsiaCrit), American Indian critical race studies (TribalCrit), critical race feminism, and a queer critical (Queer-Crit) interest group. The LatCrit contingent, as well as the AsiaCrit division, focuses its work on immigration policy and theory, language rights, assimilation, and discrimination



based on nationality, accent, or both. Scholars associated with the TribalCrit subdivision study indigenous people's rights, sovereignty, and land claims. Queer-Crit theorists focus primarily on the relationship between race and societal norms regarding sexual orientation. Some scholars have explored the interplay between feminism, sexual orientation, and CRT in their study of critical race feminism. This subgroup also examines issues such as relations between men and women of color; sterilization of Black, Latina, and Indian women; and the impact of changes in welfare, family policies, and child support laws.

The field of critical White studies has also emerged from CRT. A variety of questions have been generated that explore issues related to "Whiteness" and challenge its legitimacy as a normative standard. These questions include examining the meaning of being White, how Whiteness became established legally, how certain groups changed status in terms of their category of Whiteness, White power and White supremacy, and the unearned privileges that come with being a part of the majority culture or race.

During the first decade of the 21st century, work related to CRT is flourishing in many disciplines, and it is being applied by numerous scholars, students, and activists. Although CRT began as a movement in law, it has spread rapidly to other disciplines and has been utilized to understand the ways racial stratification operates on implicit, explicit, institutional, and individual levels to impact how those in a racialized society live and die. CRT has been continually increasing in educational scholarship, especially with regard to understanding school discipline and hierarchy, tracking, controversies over curriculum and history, and IQ and standardized testing. Within political science, CRT has been used to examine voting strategies, increasing voting power and representation and guaranteeing that the opinions and perspectives of minority groups are taken into account in the political process and major policy decisions. Critical race theorists in the legal system incorporate the ideas into their arguments to combat inequality and bias. The distribution of environmental dangers and biohazards has been analyzed from a CRT perspective, citing that sewage treatment plants are disproportionately placed in minority communities or on Indian reservations. Other issues receiving attention from "race crits" across disciplines include resolving the racism prevalent in the U.S. criminal justice system, examining racism in globalization and immigration, developing new immigration

policies, protecting language rights, combating hate speech, fighting discrimination in higher-paying jobs, rectifying disparities in the delivery of health and well-being services, demystifying the concept of race as a biological phenomenon, protecting the rights of minorities to retain their heritage and free them from the need to assimilate to advance in U.S. society, and making necessary reforms appealing to the majority group so that legislation and other appropriate measures will be approved and stand the test of time.

### **Critical Race Theory, Psychology, and Multicultural Counseling**

Although the core assumptions of CRT can be found throughout the multicultural psychology literature and underlie many of the approaches to counseling in cross-cultural contexts, there has not been a large body of work within the field of psychology that explicitly refers to CRT. However, since the end of the 20th century, there has been increased attention to the application of CRT within psychology. The primary contribution has been the work of James Jones and his 1998 proposed psychological critical race theory, in which he articulates five psychological explanations for the continuing racial disparities in the United States. These explanations, rooted in the dominant themes of CRT yet applicable to psychological research, are (1) the spontaneous and persistent influence of race, (2) the idea that fairness is derived from divergent racial experiences, (3) the asymmetrical consequences of racial policies, (4) the paradoxes of racial diversity, and (5) the salience of racial identity. Jones contends that race is both socially constructed and psychologically constructed such that racial categorizations exaggerate group differences and lead to divergent experiences for different racial groups. General CRT argues that the early civil rights era view of a disregard for race under the law will not lead to equality because of the permanence of race and racism. Similarly, utilizing psychological research, psychological CRT holds that social justice efforts must incorporate attention to race as a central dynamic in social disparities. The push and pull between commonalities and differences, belongingness and distinctiveness continues to be a tension experienced on individual, interpersonal, group, and macro-systemic levels. Jones proposes the diversity hypothesis, which holds that maintaining, valuing, and validating strong and positive group identity (e.g., racial identity) as well as a simultaneous superordinate



identity (i.e., our humanness) is necessary for both psychological well-being and movement toward social justice.

Other approaches to the application of CRT within psychology examine the ways that racial stratification (a) creates social conditions (e.g., crime, joblessness, poverty) that may be risk factors for mental health problems, and (b) generates and increases exposure to specific race-related stressful circumstances (e.g., hate crime, racial profiling). This approach also explores how a system of racial oppression has the potential to express itself through unique mental health problems that are not explicitly recognized in traditional conceptualizations of psychopathology. The focus is on understanding psychological problems that are generated by the dilemmas, dissonance, and challenges to the construction of a positive, coherent, sense of self that emerges in the societal context of a dominant ideology of White supremacy. These include concerns such as nihilistic tendencies, anti-self issues, and suppressed anger. In mainstream contexts, persons of color exhibiting behavior associated with these concerns may be positively reinforced to the extent that the behavior colludes with notions of White superiority and construes race or racism as irrelevant. Examples include being reinforced for stating that race is currently not a determinant of success in America, making disparaging remarks about members of one's own racial/ethnic group, or shedding any signs of cultural distinctiveness related to race/ethnicity so as to be indistinguishable from Whites in all ways except phenotype. However, within a CRT framework, these behaviors indicate internal conflicts that threaten self-esteem and are likely to influence interpersonal interaction and quality of life.

With respect to counseling and psychotherapy applications, CRT has been used to explore the racial experiences of marriage and family therapists in training, as well as to analyze the content of the *Journal of Marriage and Family Therapy*. These efforts reinforce the need to (a) listen to racially marginalized voices of clients, students, and supervisees about their race-related experiences, and (b) be willing to explore the meanings of race and racism with them. The ways that racial stratification has impacted status and opportunities, intersections with other social locations and multiple identities, and potential strategies for building a healthy sense of self can all be informed by CRT. Questioning dominant social ideology and exploring social justice implications are also facilitated through a

CRT analytic frame. CRT provides an interdisciplinary theoretical base that is compatible with multicultural counseling and can facilitate the development of multicultural competence among counselors and therapists.

Table 1 presents 10 basic tenets/dominant themes of CRT and an example of the application of each theme to multicultural counseling and psychotherapy. CRT can be applied to diagnosis and assessment, case conceptualization, and treatment planning, as well as the client–therapist relationship. Counselors and therapists can utilize the 10 themes to process the role of racial stratification in a client's life and the expression of CRT themes in a client's behavior and relationships. The application of CRT in counseling and psychotherapy also provides clients with resources that may be helpful in shaping their own lives in the realistic context of racism and White privilege.

## Conclusion

The future applications of CRT rely on the racial landscape of the United States in the coming decades. Although there has been some suggestion that the country will experience a transition into a more inclusive and diverse society, there is also concern that racial divisions will deepen and the gap between our language of equality and our practice of racial stratification will continue to widen. CRT provides a useful framework for generating insights into the dynamics of socially constructed racial categorizations, the racialized nature of social dynamics, and the impact of the system of racial oppression on human behavior and psychological functioning. The theory represents a paradigm shift from a traditional “we are all the same” posture, which masks power asymmetries and protects the interests of the dominant group, to an analysis that insists on the explicit identification of racial dynamics and the influence of racial stratification on life experiences and life outcomes.

Cross-cultural counseling can be further strengthened through the systematic application of CRT to facilitate more comprehensive and inclusive case conceptualizations, treatment planning, and the delivery of appropriate and responsive services to marginalized racial/ethnic populations. Furthermore, adopting a CRT perspective in counseling will require participation in social justice efforts that can have a positive impact on the psychological well-being of clients. Ultimately, a CRT perspective encourages action to eliminate the influence of the societal values of racial



**Table 1** Basic tenets of critical race theory (CRT) and applications to counseling and psychotherapy

<i>Basic CRT Tenet</i>	<i>Example of a Counseling Application</i>
1. Race is a social construct, not a biological phenomenon.	Include consideration of the subjective meaning of racial group categories to client and therapist.
2. Racism is endemic to American life and should not be regarded as an aberration.	Be aware that racism is embedded in the social structure such that how it impacts the lives and thinking of clients and therapists may not be easily articulated and can remain unquestioned, simply experienced as “normal.”
3. Racism benefits those who are privileged and serves the interests of the powerful to maintain the status quo with respect to exploring the role of racial stratification.	Assess both therapist and client resistance to naming racism as a contextual factor in the client’s life experience and to racial dynamics in the therapeutic process.
4. CRT represents a challenge to the dominant social ideology of color-blindness and meritocracy.	Ignoring race and assuming neutrality risks rendering core aspects of a client’s life experience and identity invisible communicates support of conformity to an idealized White norm and thus limits the effectiveness of psychotherapy, as important issues may be minimized or missed.
5. Racial identity and identification are influenced by the racial stratification that permeates American society.	Analysis of racial identity issues must be understood in the context of the existence of racial hierarchies such that some groups are devalued and others are idealized.
6. Assimilation and integration are not always in the best interests of the subordinated group.	Assess racial socialization and exposure to racially affirming and devaluing contexts and messages. Consider strengthening within-group social support as indicated.
7. CRT considers the significance of within-group heterogeneity and the existence of simultaneous, multiple, intersecting identities.	Socioeconomic class, gender, phenotypic expression, birthplace, sexual orientation, age, religion, and other characteristics interact with racial group to impact the nature of race-related experience. It is important to avoid assumptions of within-group homogeneity in case conceptualization and treatment planning.
8. CRT argues for the centrality, legitimacy, and appropriateness of the lived experience of racial/ethnic minorities in any analysis of social stratification.	Encourage narratives that reflect the client’s race-related experience, observations, and understandings. Engage in explicit counter-storytelling strategies when indicated. Facilitate the empowerment of clients to express, create, and reauthor both personal and cultural narratives to reflect increased understanding of racial stratification and critical consciousness.
9. CRT insists on a contextual context, as well as a sociopolitical context.	Comprehensive case conceptualization and treatment planning requires locating the client within his or her cultural, historical, developmental, and sociopolitical context.
10. Informing social justice efforts and the elimination of racial oppression are the ultimate goals of CRT.	Identify and challenge policies and practices of educational and treatment settings that reflect and perpetuate racial stratification.



superiority and racial stratification in the practice of counseling and psychotherapy.

*Shelly P. Harrell and Ani Pezeshkian*

**See also** Color-Blind Racial Ideology (v3); Cross-Cultural Psychology (v3); Discrimination and Oppression (v2); Ethnic Identity (v3); Ethnicity (v3); Multicultural Psychology (v3); Oppression (v3); Race (v3); Racial Identity (v3); Racism (v3); Social Class (v4); Social Identity Theory (v3); Worldview (v3)

### Further Readings

- Brown, T. (2003). Critical race theory speaks to the sociology of mental health: Mental health problems produced by racial stratification. *Journal of Health and Social Behavior, 44*, 292–301.
- Crenshaw, K., Gotanda, N., Peller, G., & Thomas, K. (Eds.). (1995). *Critical race theory: The key writings that formed the movement*. New York: New Press.
- Delgado, R., & Stefancic, J. (Eds.). (2000). *Critical race theory: The cutting edge* (2nd ed.). Philadelphia: Temple University Press.
- Jones, J. M. (1998). Psychological knowledge and the new American dilemma of race. *Journal of Social Issues, 54*, 641–662.

---

## CROSS, WILLIAM E., JR. (1940– )

---

William E. Cross, Jr., is an African American social psychologist who is best known for his Nigrescence model of Black racial identity. The power of Cross's original Nigrescence model, which was first articulated in 1971, is evident by its adoption in the theorizing about other cultural identities, including minority, racial, ethnic, feminist, womanist, and gay/lesbian identities. The later versions of the model (i.e., the revised and expanded models in 1991 and 2001, respectively) have not only advanced the theorizing about Black racial identity, but the 2001 revision also resulted in a psychometrically supported measurement model, the Cross Racial Identity Scale. Cross is one of the most frequently cited names in the Black racial identity literature.

### Background

Cross's interest in the identity of African Americans came, in part, out of the segregated social context of

the times in which he grew up. He was the fourth child and first son of William and Margaret Cross; his father was a Pullman porter, a job that was steady and resulted in economic security, and his mother worked at different times as a maid and a factory worker. Although both of his parents had about 2 years of college—advanced education for their time—the social context did not allow them to translate their education into related employment. Thus, although Cross's parents valued education, they did not see it as a guaranteed avenue leading to advancement.

Cross's parents encouraged their children to read broadly and to value learning, but they also communicated messages to their children that are now well documented in the research literature. Cross's father encouraged him to go to college but also pressured him to pursue a skilled trade that would enable him to support himself as an adult. He did not want his son to be educated but unemployable. Cross chose not to pursue a skilled trade, initially a source of tension between him and his father, and was the only one of his siblings (Dolores, Shirley, Charlene, Charles, and Judith) to attend college. Cross's mother communicated a different message. She insisted that Cross could do anything he wanted to do, but she also pointed out that to be successful, he needed to be much better at it than others, if he expected to succeed and be taken seriously. She also indicated that even if he were better than others, he might not be rewarded at the level that he should. Thus, there was this unstated notion of a racialized world, present in the household but never made explicit. However, until he was about 10 years old, Cross's mother actively protected him and his siblings from some of the negative events that were happening in society as they were growing up. Cross describes the notion of becoming aware of race at about age 10 as a sledgehammer that initially took all of the fun out of life.

### Origins of Cross's Nigrescence Model

Although there were many things that contributed to the development of the original Nigrescence model, three of these stand out: pursuing clinical psychology for his master's degree, the Black Power movement in the mid- to late 1960s, and the death of Martin Luther King, Jr., in 1968. After completing his bachelor's degree in psychology, Cross enrolled in a master's program in clinical psychology in 1963. In this program, with its emphasis on process, Cross developed a keen interest in identity change and became fascinated with



experiencing changes in the self without conscious awareness of the process.

Although Cross had encountered Black professionals before he had attended college, he describes these individuals as too different from his experiences to identify with as role models. However, the Black movement's emphasis on African Americans having the power to be anything they chose to be—an idea initially inculcated by his mother—led him to embrace this idea in a way that he had not done earlier. Reading books like *From Superman to Man*, with its documentation of the consanguinity of many Blacks and Whites, supported this notion. Cross concluded that what the Black movement and specific subgroups like the Black Panthers were doing was putting African Americans through a *conversion* experience that resulted in a change in African Americans' conceptualization of being Black. In keeping with his training as a psychologist and the preeminence of stage theories in the psychological literature (e.g., Freud, Piaget, Kohlberg, Erikson), Cross conceptualized this identity change in terms of five stages: pre-encounter, encounter, immersion/emersion, internalization, and internalization/commitment.

The assassination of Martin Luther King, Jr., in 1968 served to further the development of Cross's thinking. This event became his *encounter*, as described in the original Nigrescence model, leading him to immerse himself in Blackness, something that he had not yet fully done. The assassination reminded Black people in the United States of (a) the hatred and segregationist beliefs grounded in *miseducation*, (b) their existential connections to being Black, and (c) the importance of responding as a community. Going to Princeton in 1969 put Cross in a forum where he could discuss his ideas with other intellectuals; this environment supported the seminal publication of his original Nigrescence model in the journal *Black World* in 1971.

### From the Original to the Expanded Nigrescence Model

In 1991, Cross revised his model to account for greater identity variability at the pre-encounter and internalization stages. In the original formulation, everything linked to pre-encounter was thought to be negative and potentially pathological. Cross realized that the pre-encounter stage also needed to account for African Americans who do not base their identity on an attachment to Black people and Black culture (i.e.,

people with low racial salience). To capture the negative dimensions of pre-encounter, themes of racial self-hatred and miseducation were advanced. Thus, the *revised* model separates negative (miseducation and racial self-hatred) and low-salience (assimilation and other low racial salience exemplars) dimensions in the explication of pre-encounter.

This multidimensionality was also extended to internalization. All internalization identities accorded moderate to high salience to Blackness, but some were monocultural perspectives (e.g., Black Nationalist or Afrocentric perspectives), others had a dual-cultural frame (Black bicultural and biracial perspective), and others seemed to combine their sense of Blackness with two or three additional identities (multicultural perspectives). In the revised model, Cross also argued that the content of the identity stage was unrelated to individual well-being. In other words, assimilation, Afrocentricity, and multiculturalism identities may be divergent but equally efficacious pathways toward mental health.

The revised model explicates that at some point in life, a person may experience Nigrescence or Black identity change as a corrective to negative identity dynamics (miseducation or racial self-hatred). Change may also occur in a person who starts out in life with an assimilated worldview but, due to some encounter, may gravitate toward an identity that accords moderate to high salience to race. Thus, the revised model allowed researchers and therapists to better predict and explain the wide range of identity types and levels of well-being found in any large sample of African Americans.

The development of the *expanded* Nigrescence model in 2001 was due, in large part, to the development of the Cross Racial Identity Scale (CRIS), a scale that was originally conceived of as an operationalization of the revised model. In developing the CRIS, Cross and his colleagues began to describe racial identity in terms of attitudes rather than stages. The expanded model consists of four sets of attitudes (with the same names as the original four stages), each incorporating several worldviews that are relatively independent. Thus, an individual's racial identity is best described in terms of his or her racial identity attitude *profile* and not the stage that the individual is in.

### Cross's Legacy

Cross's contributions to counseling and psychology have been tremendous. First, he has made a tremendous



contribution in the theoretical realm. His initial conceptualization of Black racial identity as a stage model with movement from poor mental functioning to mental health stimulated several decades of research and theorizing on Black identity and other cultural identities and continues to have an impact on these fields to this day. The changes in the Nigrescence model over the past 3 decades (1971, 1991, 2001) have also demonstrated the important and oft-neglected relationship between theory and empirical research, and the most recent conceptualization is likely to stimulate another generation of researchers.

Second, although Cross's place as a theorist is well established, he has also had a tremendous impact on the empirical literature. There have been numerous empirical studies on the stages that he proposed in 1971 and the relationship of those stages to psychological functioning. The Racial Identity Attitude Scale, developed by Thomas Parham and Janet Helms in 1981, was based on a Q-sort that Cross had developed to examine Black racial identity stages, and was the preeminent measure of Black racial identity attitudes for more than 2 decades. Scores on the CRIS, which is the operationalization of the expanded model, have been validated for use in adolescent, emerging adult, and adult populations (a feat that has not been accomplished with any other measure of this type) and provides a context for the study of Black racial identity attitudes from a life-span perspective. Additionally, generalizable profiles of Black racial identity attitudes based on the expanded Nigrescence model have been reported for the first time in the empirical literature.

Cross's work has demonstrated that Black identity is a complex construct that is worthy of serious research scrutiny. He and his colleagues have shown that it is possible to develop a sound measure of Black racial identity attitudes that holds up under rigorous psychometric scrutiny. Finally, although Cross's focus has been on Black identity, his ideas are applicable to other cultural groups and are likely to have a continuing and profound impact on research examining cultural identity attitudes.

Frank C. Worrell

*See also* African Americans (v3);

Afrocentricity/Afrocentrism (v3); Bicultural (v3);

Black Psychology (v3); Black Racial Identity

Development (v3); Monocultural (v3); Multiculturalism

(v3); Racial Identity (v3)

## Further Readings

- Cross, W. E., Jr. (1971). The Negro-to-Black conversion experience. *Black World*, 20(9), 13–27.
- Cross, W. E., Jr. (1991). *Shades of Black: Diversity in African American identity*. Philadelphia: Temple University Press.
- Cross, W. E., Jr. (2001). Encountering Nigrescence. In J. G. Ponterotto, J. M. Casas, L. A. Suzuki, & C. M. Alexander (Eds.), *Handbook of multicultural counseling* (2nd ed., pp. 30–44). Thousand Oaks, CA: Sage.
- Cross, W. E., Jr., & Fhagen-Smith, P. E. (2001). Patterns of African American identity development: A life span perspective. In C. L. Wijeyasinghe & B. W. Jackson (Eds.), *New perspectives on racial identity development: A theoretical and practical anthology* (pp. 243–270). New York: New York University Press.
- Cross, W. E., Jr., & Vandiver, B. J. (2001). Nigrescence theory and measurement: Introducing the Cross Racial Identity Scale (CRIS). In J. G. Ponterotto, J. M. Casas, L. A. Suzuki, & C. M. Alexander (Eds.), *Handbook of multicultural counseling* (2nd ed., pp. 371–393). Thousand Oaks, CA: Sage.
- Gardner-Kitt, D. L., & Worrell, F. C. (2007). Measuring Nigrescence attitudes in school-aged adolescents. *Journal of Adolescence*, 30, 187–202.
- Vandiver, B. J., Cross, W. E., Jr., Fhagen-Smith, P. E., Worrell, F. C., Swim, J. K., & Caldwell, L. D. (2000). *The Cross Racial Identity Scale*. Unpublished scale.
- Vandiver, B. J., Cross, W. E., Jr., Worrell, F. C., & Fhagen-Smith, P. E. (2002). Validating the Cross Racial Identity Scale. *Journal of Counseling Psychology*, 49, 71–85.
- Worrell, F. C., Vandiver, B. J., Cross, W. E., Jr., & Fhagen-Smith, P. E. (2004). The reliability and validity of Cross Racial Identity Scale (CRIS) scores in a sample of African American adults. *Journal of Black Psychology*, 30, 489–505.
- Worrell, F. C., Vandiver, B. J., Schaefer, B. A., Cross, W. E., Jr., & Fhagen-Smith, P. E. (2006). Generalizing Nigrescence profiles: A cluster analysis of Cross Racial Identity Scale (CRIS) scores in three independent samples. *The Counseling Psychologist*, 34, 519–547.

---

## CROSS-CULTURAL PSYCHOLOGY

---

Cross-cultural psychology is the study of similarities and differences in individual psychological functioning in various cultural and ethnic groups, as well as the relationships between psychological variables and sociocultural, ecological, and biological variables. Cross-cultural psychology regards culture as essential



to psychological functioning, as an integral context for psychological development and behavior.

Cross-cultural psychology consists mainly of diverse forms of comparative research so as to discern various distinct cultural factors—many of which are related to ethnicity—that are relevant to forms of development and behavior. Cross-cultural research typically seeks evidence of how culture can be taken as a set of variables, independent or contextual, that affect various aspects of individual behavior.

### **Cross-Cultural Psychology Versus Ethnic Minority Psychology**

Differences in interpretation of “culture” account for the differences between cross-cultural psychology and ethnic-minority psychology. They differ in two ways, although they sometimes overlap and are taken as synonymous by some psychologists.

Ethnic minority psychology focuses on various ethnic groups such as African Americans. Cross-cultural psychology, in contrast, emphasizes differences between two or more cultures. Besides, ethnic minority psychology rooted in the United States has a briefer history than cross-cultural psychology does. Only after the civil rights movement of the 1960s was the Association of Black Psychologists founded, in 1968. The *Journal of Black Psychology* was first published in 1974 and the *Hispanic Journal of Behavioral Sciences* in 1979.

### **Historical Background**

Traditional research in psychology has understandably been carried out mostly by thinkers of Western (ultimately Hellenic) cultures. The concepts and tools of psychological research came into being in an era of industrial systems of ideas, while consideration of culture has been relegated to a secondary role in psychology, appearing, at most, as moderating or qualifying footnotes to the major theoretical propositions assumed to be universally applicable.

In the meantime, however, there slowly emerged an awareness that such psychological theories in the traditional thinking mode, being Anglo-European, may well be of quite limited relevance to non-Western communities. It was thought that consideration of cultural aspects in psychological research would render psychology more widely relevant.

The era of cross-cultural psychology commenced soon after World War II ended. Its rapid expansion can

be attributed to a shared motivation to understand the attendant horrors of war and to expand the intellectual horizons of psychology beyond parochial, nationalistic boundaries. With an emerging international perspective accompanying the cold war, the study of human behavior in cultural context evolved quite rapidly. The half decade of 1966 to 1970 saw the start of the quarterly *Cross-Cultural Psychology Bulletin* (originally called *Cross-Cultural Social Psychology Newsletter*, published periodically) and the *International Journal of Psychology*, as well as an initial *Directory of Cross-Cultural Psychological Research*.

Those years were marked also by the publication of a multisocietal study of cultural influences on cognitive conflict, a paperback volume titled *Cross-Cultural Studies*, and the flagship publication in cross-cultural psychology, *Journal of Cross-Cultural Psychology*, launched in 1970. By the late 1970 and early 1980s, enough research had been done to justify several major handbooks in cross-cultural psychology in general and in human development in particular. From the 1990s until the beginning of the 21st century, there appeared several new and updated handbooks on cross-cultural psychology. In 1998, Marshall H. Segall, Walter J. Lonner, and John W. Berry published an article, “Cross-Cultural Psychology as a Scholarly Discipline,” on the critical role of culture in psychology. Several books through the 1990s into the 21st century (e.g., *Cross-Cultural Psychology: Research and Applications*) highlight many emerging themes in cross-cultural psychology.

In addition to the literature that emerged, scholarly and professional organizations on cross-cultural psychology were founded and have continued to flourish. Since its inauguration in Hong Kong in 1972, the International Association for Cross-Cultural Psychology has been holding biennial international congresses, and it continues to play a central role in the further development of cross-cultural psychology. Other important organizations include the International Union of Psychological Sciences and the International Association of Applied Psychology, among many others. By attracting diverse participants to their conventions and disseminating the most recent research and programs, these organizations facilitate dialogues on cross-cultural psychology across the world.

In the meantime, Berry and Pierre R. Dasen proposed three goals in cross-cultural psychology: to transport and test the current psychological knowledge and perspectives by examining them in other cultures, to explore and discover new aspects of the phenomena



being studied in local cultural terms, and to integrate what has been learned from the first two points in order to generate psychology capable of addressing human basic processes and cultural variations worldwide.

### **Perspectives of Cross-Cultural Psychology**

Various approaches in cross-cultural psychology can be classified in four ways: (1) etic versus emic; (2) dichotomous versus integrative; (3) absolutistic versus relativistic versus universalistic; and (4) individualistic versus collectivistic.

#### ***Etic Versus Emic***

Following linguist Kenneth L. Pike, many cross-cultural psychologists used the contrasting terms *etic* and *emic*, to refer to etic comparative studies across cultures and emic intensive internal exploration of psychological phenomena in local cultural terms.

On the etic approach in early days, some Western psychologists used psychological notions and instruments that are designed, produced, and validated in the European American setting alone, to research psychological phenomena in other settings, cultural and national. This approach was recently criticized by Paul B. Pedersen because of its limited interpretation of the relationship between culture and psychological functioning. Emic research, on its part, focuses on culture-specific psychological phenomena and is expected to provide indigenous culture-based meanings probably missed in an overall etic approach.

After extensive use of emic approaches in cultures has produced instruments that satisfy etic criteria, comparative examination, with these instruments, of behaviors in various cultures would produce valuable information on cultural differences or similarities in psychological functioning. If superficial differences in behavior thus obtained reflect underlying shared psychological functioning, then they would support the notions of psychological universals. This possibility leads psychologists to consider another way of envisioning cross-cultural psychology today, namely, the integrative approach.

#### ***Dichotomous Versus Integrative***

An alternative to the dichotomous approach, such as emic versus etic, is integration of psychological

research. The integrative approach aids in revising and refining a theoretical understanding of human behavior, especially when theories are needed to apply to the widest audience possible. For example, cross-cultural research has helped refine understanding of child-rearing practices and attachment, and has helped modify what was considered as optimal attachment in child-rearing (based on research solely in the United States) to accommodate important child-rearing differences around the world.

Furthermore, uncovering cross-cultural differences helps render counseling more effective. Appreciation of similarities and differences in the relations between clients and mental health professionals depends much on information about people's cultural backgrounds. Cross-cultural research has helped in the development of culturally sensitive psychological assessments and treatments that have critically rendered psychotherapy effective.

Finally, cross-cultural research provides important connections among people and psychologists around the world, helping produce new modes of international intercultural cooperation among scholars, practitioners, and clients. New organizations that cut across many sorts of borders—social, economic, racial, national, as well as cultural—involve psychologists and health professionals from around the world, creating unions that would have been impossible otherwise.

#### ***Absolutism Versus Relativism Versus Universalism***

The absolutist approach assumes that human phenomena are basically and qualitatively identical throughout all cultures. Sincerity is sincere, sadness is sad, no matter how or where one observes them, and so culture has practically no meaning or displays no specific characteristics.

Assessments of such ubiquitous characteristics are likely to be made through the use of standard instruments (perhaps via linguistic translation) and simplistic interpretations, taking into account no alternative, culturally based views. This orientation resembles the imposed etic perspective that was characteristic of some early cross-cultural research.

*Cultural relativism*, a term coined by anthropologist F. Boas and expanded and disseminated by Melville J. Herskovits, was initially a warning against invalid cross-cultural comparisons with an ethnocentric perspective. Later, Berry and his colleagues took up the



term *relativism* to mean the opposite of absolutism. Thus, the relativists have no interest in intergroup similarities, in stark contrast to the absolutists, who assume and explore broad species-wide similarities.

The absolutists are prone to attempt context-free measurements with standardized psychological instruments, frequently making universal evaluative comparisons. As a result, they open themselves to errors of imposing “etics” when working in societies other than their own. In contrast, the relativists tend to lean toward emic research, considering context-free concepts and measurements as impossible, and so would try to avoid all cross-cultural comparisons; if they ever made the comparison, it would be as nonevaluative as at all feasible.

Psychologists with a universalistic perspective search for features of psychological functioning that appear common across all peoples. Berry proposed a rule of two steps: Culture comes first, comparison second. The framework begins with research in one cultural group A, firmly rooted in an indigenous tradition. Such research commences in examinations, both anthropological and psychological, of various cultural and individual behaviors and their plausible links and then draws cross-indigenous or cross-cultural research out of cultural groups B, C, D, and so forth. Thus emerges a universal psychology, rooted in both cultural-indigenous research and comparative cross-cultural analysis, achieved by gathering all indigenous psychologies and comparing them.

### ***Individualism Versus Collectivism***

Individualistic versus collectivistic approaches have been variously characterized. The approaches were said to be idiocentric-allocentric at the individual level versus idiocentric-sociocentric at the collective-cultural level; or individual and group loyalties versus culture of relatedness and separateness. In any case, the subjects in individualistic cultures have individualistic values and behaviors, and those in collectivistic cultures have collective values.

Such value dichotomy is reflected in other psychological processes and behaviors as well. Harry C. Triandis reported that even the meaning of *culture* differs in the kinds of information sampled from the culturally different environment. Such complex features in individualism versus collectivism can be conceptualized as “polythetic constructs” with the following aspects of self, goals, and the conflict between norms and attitudes.

The collectivists view the self as interdependent with others, sharing resources in a family manner. The individualists view the self as autonomously independent of groups, and whether or not to share resources is decided by individuals separately. Individuals are the units of analysis of social behavior. In contrast, the collectivists use groups. Individualists are concerned with individuals’ own successes; collectivists are concerned with group success.

Goals are envisioned differently as perspectives differ. For collectivists, individual goals are ingroup compatible; for individualists individual goals are irrelevant to the group’s goals. When individual goals and group goals collide, collectivists give priority to group goals, and individualists give priority to individual goals.

The conflict of norms versus attitudes is stressed differently. The collectivist determinants of social behavior are equally (a) norms, duties, and obligations, and (b) attitudes and personal needs. In contrast, individualist determinants are primarily attitudes, personal needs, perceived rights, and contracts. Whereas collectivists emphasize unconditional relatedness, individualists emphasize rationality in decision.

### **Areas of Research**

Cross-cultural psychology involves many areas in psychology, including cognition, values, and mental health. The major research harvested by cross-cultural psychology can be categorized into six areas: (1) values, (2) personality, (3) gender issues, (4) development, (5) mental illness and well-being, and (6) counseling.

### **Values**

Implicit in cross-cultural studies of values are guidelines on improvements in group relations, international negotiation, and globalization. Many different worldviews, conceptualizations of the world, affect what people in which society think is fair or what matters. These differences are their different views of the world to result in different manners of relating one to another.

Naturally, then, any two groups with different values (say, American students and international students) can form a community cross-culturally related, where interactions are prone to erroneous interpretations and judgments. Therefore, training in intercultural understanding is incumbent on all those



in the counseling field, deserving close attention by scholars and professionals alike.

### **Personality**

Cultural and cross-cultural analyses have thrown doubt over the existence of monolithic meanings of the key notions in psychology (e.g., personality, the self, etc.). Personality, as any other concept, is socially constructed, particularly based on Western assumptions. A high level of correspondence between higher-order personality models and everyday conceptions of personality has been found, indicating that personality is a cultural product. Some researchers (e.g., Kenneth J. Gergen) question any meaning in “personality” that exists identically in *all* contexts, seeing that some personality traits are meaningful solely in their respective specific contexts.

Despite such reports, many personality assessments (e.g., the Minnesota Multiphasic Personality Inventory or the Millon Clinical Multiaxial Inventory) were developed in Western psychology and then applied to culturally diverse populations to obtain cross-cultural validity. High degrees of cross-cultural validity, reported by some researchers such as James N. Butcher, who conducted the MMPI-2, may have prompted a proposal of the universality of personality.

### **Gender Issues**

Cross-cultural research on gender has also yielded crucial findings. The core finding is that gender-related phenomena are embedded in cultures, whether the phenomena are sex-related differences in behavior or relations between sexes. Sex-role socialization has been studied in children and adolescents. On the role gender plays in later stages of life, women in traditional societies may well gain status with age advancement, which is a situation different from that in Western societies. Such variations call for renewed explanations based on different cultural definitions of women.

A related issue is sex-role differences and their underlying dimensions as cross-cultural. The expressive-instrumental dimension assumed to underlie differential sex-role socialization has been questioned. Some scholars reported greater expressiveness of males and more androgyny in general, in traditional cultures, than in Western cultures. Thus, some societies may routinely socialize children into androgynous patterns. Socialization of both females and males for great relatedness, sensitivity to others, and expressiveness may

exist in highly collective societies, more so than in less collective communities.

Attitudes and stereotypes about gender roles have been continually popular among researchers. John E. Williams and Deborah L. Best reported that the ideals of both men and women in 14 countries were more masculine than self-ideals; in most countries, men traditionally carry an ideal image, not women. It appears universally valid to claim that breaking the stranglehold of outmoded stereotypes on sexual differences would facilitate equality between the sexes.

### **Development**

Cultural attributes seem to remain important and serve as crucial contexts for psychological development. Cross-cultural research on human development has presented a challenging corrective to knowledge and theory based on Western experience. In fact, despite increasing cross-cultural research on development, developmental psychology has remained parochial. Gustav Jahoda noticed that researchers in development commonly accept a convergence of Piagetian and Vygotskian approaches. Following Charles M. Super and Sara Harkness's developmental niche (by analogy of “ecological niche” in biology), Dasen proposed a new diagram in studying human development, to show how, in Africa, parental psychology affects social and cognitive development. Barbara Rogoff proposed a similar orientation to cognitive development to show that such development has two features: (1) Culture and behavior (or thought) are not separate variables but are mutually embedded, so culture is not an independent variable; and (2) child socialization is jointly managed by children and adults.

Fred Rothbaum and his colleagues, with an interaction model, compared Japanese and American infant-mother interactions to test whether maternal behaviors shape infant behavior or whether they mutually shape each other. The interaction model was deemed valid by significant differences between newborns in motor activity level and later changes in infant and mother behavior. Such work has brought conceptual and methodological refinements in cross-cultural research on infant-mother attachment and early stages of development.

Interest in cross-cultural studies of life-span development is emerging. Studies have been made on life satisfaction in later years and on attitudes to the elderly. Research findings on life-span development focused on later life experiences show cross-cultural



variations. For example, students in Turkey, but not in India, showed favorable attitudes to the elderly.

### ***Mental Illness and Well-Being***

Applications of cross-cultural psychology to problems of daily life are particularly evident in counseling psychology. At the same time, academic studies continue in such topics as the relationship between culture and psychopathology and between culture and diagnosis. Most psychologists now agree that the sociocultural context is a critical origin of psychological problems and that it is important to understand this cultural context. Among the issues to be researched are relationships between health and various cultural factors such as socialization, education, disability, and organizational structures of health institutions.

Depression is an example among many to this claim of culture as relevant to psychological problems. The *Diagnostic and Statistical Manual of Mental Disorders* indicates that culture can influence symptoms and experiences of depression. To reduce misdiagnosis, ethnic and cultural specificity need to be considered in diagnosis.

This raises a fundamental question, however, on how universal the notion of “depression” is. Sushrut Jadhav claims that it is questionable to indiscriminately apply *depression* or other such terms to non-Western clients, for there is insufficient evidence to detect depression as an objective entity transportable from one cultural setting to another.

From the perspective of relativist cross-cultural psychology, it is questionable that diagnostic systems and structured interviews developed in the West can ever serve as a universal framework for all cultures. These critics say the same syndromes hardly exist in the same form in other cultures, nor do individual symptoms necessarily exist in the same way across diverse cultures. For example, “fear” manifests quite differently from culture to culture; for example, among Hispanics, *ataques de nervios* are characterized by, among others, a feeling of rising heat. Counselors without such awareness will have difficulty understanding the Hispanic client’s fear, particularly if the psychologist relies on a standard interview without questions related to such a way of experiencing fear.

### ***Counseling***

It is becoming increasingly common, all over the world, for counselors to come from cultures that differ

from those of their clients, thus rendering cross-cultural counseling a challenging task. When other cultures and worldviews enter the picture, the situation can turn dauntingly complex.

Two aspects of cross-cultural research that are highly relevant to counseling are cross-cultural emphasis and intercultural focus. Pedersen specifies that cross-cultural counseling pays attention to qualitative differences across cultures and interculturally focused counseling work with ethnic and racial groups within a culture-pluralistic society. Despite different emphases, however, both aspects share many similar principles, including the necessity of cultural knowledge and sensitivity and understanding the crucial role culture plays in an individual’s life.

In cross-cultural counseling, culturally sensitive diagnosis and treatment in counseling are essential, as based on the following factors. The counselor must be aware both of what is usually done in the clients’ culture to resolve their presenting problems and of usual treatment in the counselor’s own culture. In addition, the counselor must also be aware of how well the clients are acculturated to their host culture. If the clients are fairly well acculturated, counselors can feel more comfortable in designing a treatment plan similar to their usual design for native clients. If the clients have recently arrived from other cultures, counselors may want to consider how to temper the treatment plan with supplements familiar to the clients. The clients must be willing to accommodate the proposed supplements.

*Ruth Chao*

**See also** Barriers to Cross-Cultural Counseling (v3); Career Counseling (v4); Collectivism (v3); Counseling Skills Training (v2); Cross-Cultural Training (v3); Cultural Relativism (v3); Cultural Values (v3); Ethnicity (v3); Etic–Emic Distinction (v3); Immigrants (v3); Individualism (v3); Multiculturalism (v3); Multicultural Psychology (v3); Nationalism (v3); Personality Theories (v2); Universalism (v3)

### **Further Readings**

- Berry, J. W., Poortinga, Y. H., & Pandey, J. (Eds.). (1997). *Handbook of cross-cultural psychology*. Boston: Allyn & Bacon.
- Boesch, E. E. (1996). The seven flaws of cross-cultural psychology: The story of a conversion. *Mind, Culture, and Activity*, 3, 2–10.
- Greenfield, P. M. (1997). You can't take it with you: Testing across cultures. *American Psychologist*, 52, 1115–1124.



- Herskovits, M. J. (1948). *Man and his works: The science of cultural anthropology*. New York: Knopf.
- Jahoda, G. (1986). A cross-cultural perspective on developmental psychology. *International Journal of Behavior and Development*, 9, 417–437.
- Matsumoto, D. (Ed.). (2001). *Handbook of culture and psychology*. New York: Oxford University Press.
- Pedersen, P. B. (2000). *A handbook for developing multicultural awareness*. Alexandria, VA: American Counseling Association.
- Pike, K. L. (1967). *Language in relation to a united theory of the structure of human behavior*. The Hague, the Netherlands: Mouton.
- Ratner, C. (2002). *Cultural psychology: Theory and method*. New York: Plenum.
- Rothbaum, F., Weisz, J., Pott, M., Miyake, K., & Morelli, G. (2000). Attachment and culture: Security in the United States and Japan. *American Psychologist*, 55, 1093–1104.
- Segall, M. H., Lonner, W. J., & Berry, J. W. (1998). Cross-cultural psychology as a scholarly discipline. *American Psychologist*, 53, 1101–1110.
- Shirae, E., & Levy, D. (2004). *Cross-cultural psychology: Critical thinking and contemporary applications* (2nd ed.). Boston: Pearson.

---

## CROSS-CULTURAL TRAINING

---

Cross-cultural training, also referred to as multicultural counseling competence training, denotes the process of instructing psychologists-in-training to work effectively across cultures in their practice and research activities. The term *cross-cultural* (or *multicultural*) has been defined in the counseling psychology literature in two distinct ways. One definition of *cross-cultural* is broad and inclusive of a wide variety of reference group identities (e.g., race, ethnicity, sexual orientation, social class). More traditional uses of the term, which emerged in the 1960s, were specific to different ethnicities, within and beyond the borders of the United States. On the basis of salience of race as a marker in the United States, many scholars during the 1980s and 1990s argued for a more specific definition of *cross-cultural* (*multicultural*) that focuses on domestic racial, ethnic, and linguistic minority groups. Because there has been increased attention to international issues in the field of counseling psychology during recent years (for instance, three of the five presidents of the Society for Counseling Psychology between 2003 and 2007 positioned counseling

psychology in a global sphere), *cross-cultural*, for the purposes of this entry, refers to race and ethnicity within both domestic and international contexts.

The rapidly changing demographics of the U.S. domestic population and the transnational reach of counseling psychology make cross-cultural training increasingly critical in the overall education of applied psychologists. However, despite the importance the American Psychological Association (APA) has placed on cross-cultural training and the growing percentages of people of color in the United States served by applied psychologists, clients from diverse racial and ethnic backgrounds nonetheless continue to average fewer sessions, terminate more quickly, and utilize services less often than their non-Hispanic White counterparts. Racial and ethnic minority individuals oftentimes do not view counseling as addressing their needs, or perhaps untrained, culturally insensitive therapists leave too many minority clients feeling misunderstood. If clients are not considered within their sociocultural contexts as they understand and experience them, a host of potential negative implications might ensue with regard to case conceptualization (e.g., minimizing the importance of contextual factors), diagnosis (e.g., overpathologizing clients from different cultures on the basis of their different worldviews), and treatment (e.g., difficulty establishing the therapeutic alliance, inappropriate interventions). Therapeutic services designed from a universalist framework—a theoretical approach based on White middle-class male values that assumes a set of universal laws of human functioning—may not be appropriate in contexts where diverse worldviews and cultural values prevail. On the other hand, counselors (of various ethnicities) who have received cross-cultural training and demonstrate adequate levels of multicultural competence and sensitivity generally will minimize mistakes made in cross-cultural counseling and thus provide better, more appropriate services to clients of various racial and ethnic backgrounds.

Changing demographics in the academy also call attention to the importance of cross-cultural sensitivity in university classrooms and other training settings (e.g., practica). Traditional forms of pedagogy that rely on the universalist approach are not relevant for many students of diverse racial and ethnic backgrounds. To recruit and retain graduate students from a variety of racial and ethnic backgrounds, training programs must make the curriculum relevant for these students. Although demographic trends reveal increasing



numbers of domestic students of color in undergraduate psychology programs (25% in 2000), many do not enroll in graduate study, or they withdraw before obtaining their doctorates. The teaching and training of psychology must become culturally relevant and appropriate for students from diverse racial and ethnic backgrounds so that they can (a) feel respected and validated in academic environments, thus leading to greater rates of completion; (b) bring relevant knowledge, grounded in empirical research, back to their communities; and (c) transform the ways in which psychological services are provided to a wide range of people. Based on data collected by the APA Research Office in 2000, the immediate reality remains that the majority of psychologists in the workforce (91%) and psychologists-in-training (78%) are White, and many are apathetic or resistant to cross-cultural training. With regard to internationalization, increasing numbers of international students are enrolling in applied psychology graduate programs and are being hired in academic positions in the United States or abroad in their countries of origin.

Counseling psychologists of all ethnicities, races, and nationalities are well-positioned to be leaders in the area of cross-cultural training because the variety of skills that they possess are essential in this realm. Certainly, creating environments conducive to effective cross-cultural training is challenging. Educators not only need mastery of content knowledge but also must possess excellent group facilitation skills, demonstrate appropriate self-disclosure, employ theoretical models and empirical research to guide training, and skillfully manage intense emotions that might emerge during discussions of such affectively loaded topics as racism, ethnocentrism, and White privilege.

### Historical Context

A long-standing history exists that deals with the constructs of culture and race in psychology. Initial conceptual and empirical work regarding cross-cultural psychology sought to identify equivalent individual variables across cultural groups; that is, the focus was to detect universal laws of human functioning, which perhaps only varied by context. Early attention to the notion of race in psychology often was based on models of biological inferiority and cultural deprivation paradigms, blatantly reflecting and reinforcing White supremacy. In a society as diverse as U.S. society, with a wide variety of worldviews and healing

practices among different cultures, it would seem obvious that a universalist approach would be ineffective with clients from various racial and ethnic backgrounds. However, the field of psychology was unable to transcend the universalist approach and is still struggling to do so, perhaps due to institutional racism and White privilege.

The concept of cross-cultural training in psychology gained momentum alongside grassroots activism, such as the civil rights and other liberal movements for social change. It was not until *Brown v. Board of Education of Topeka*, when psychological research was accepted as evidence in federal courts, that the stage was set for improved attention to race in therapy. The advent of minority-focused psychological associations, such as the Association of Black Psychologists (1968), Asociación Por La Raza (1970), Asian American Psychological Association (1972), and Society of Indian Psychologists (1975), provided further impetus for attention to cross-cultural training that transcended deficit paradigms. Concomitantly, the APA's evolution with regard to racial issues has facilitated the development of cross-cultural training initiatives. For example, during the National Conference on Levels and Patterns of Professional Training in Psychology (widely known as the Vail Conference of 1973), leaders decided that diversity training would be included in all APA-accredited doctoral programs; however, this was not immediately enforced. Subsequently, structural changes in the APA, such as the development of the APA Office of Ethnic Minority Affairs in 1979, the Board of Ethnic Minority Affairs in 1980, and Division 45 (Society for the Psychological Study of Ethnic Minority Issues) in 1986, compelled greater attention to culturally relevant training issues.

Since early forms of the multicultural guidelines in the 1980s and the *Guidelines for Providers of Psychological Services to Ethnic, Linguistic, and Culturally Diverse Populations* in 1993, almost 20 years had passed before the APA Council of Representatives approved as APA policy the *Guidelines on Multicultural Education, Training, Research, Practice, and Organizational Change for Psychologists* in 2002. Guideline 3 specifically encourages psychologists "to employ the constructs of multiculturalism and diversity in psychological education" and emphasizes the importance of incorporating culturally relevant practice into undergraduate and graduate instruction, including research advisement and clinical supervision.



## Key Components

During the early 1980s, Derald Wing Sue and his colleagues pioneered the development of a tripartite model of cross-cultural, or multicultural, training. Sue's model included three distinct yet interrelated areas multiculturally competent counselors should possess: (1) knowledge of the cultural values and worldviews of diverse populations, (2) awareness of one's own cultural socialization and biases, and (3) skills for interventions with diverse client populations. The domains of knowledge, awareness, and skills have become widely accepted as the components of multicultural counseling competence and continue to be the prevailing training model today. Beginning in the 1990s Patricia Arredondo and her colleagues extended the tripartite model by delineating practical and specific training strategies, objectives, and techniques in each domain.

Since Sue's early work, a growing body of research has documented the ways in which cross-cultural training is most effective. In a meta-analysis examining the findings of 30 years of published studies on multicultural training effectiveness (1973–2003), Timothy Smith and colleagues found that theoretically grounded training is twice as beneficial as training that is not based on theory. Several other key variables also were consistently predictive of higher levels of cross-cultural competence, such as advanced racial identity statuses, lower levels of racism, and greater levels of emotional empathy. These findings underscore the importance of trainee racial self-awareness as a critical aspect of cross-cultural training. Apparently, the one course method is not sufficient, and the most beneficial approach, according to Charles Ridley and colleagues, is one that integrates multicultural issues into every aspect of a training program.

P. Paul Heppner, in his 2005 Society for Counseling Psychology Presidential Address, emphasized that in an era of increasing globalization, the boundaries of counseling psychology will cross an even wider variety of countries and cultures, which further necessitates incorporating cross-cultural competence in training. He suggested a number of activities that could promote such competence: immersion experiences abroad, formal coursework, proficiency in languages other than English, cross-cultural textbooks and curricula, and learning opportunities with international students within U.S.-based training programs.

## Final Note

Greater specificity in the APA code of ethics and continued development of the *Guidelines* to explicitly

outline the ways in which psychologists can effectively work with people from a variety of backgrounds is critical. Continued research is one way to accomplish this; empirically documenting what factors make cross-cultural training work best and for whom is crucial. Although training models are needed for trainees of all racial and ethnic backgrounds (those whose socialization and education are primarily U.S. based and those from other countries who complete graduate studies in U.S. colleges and universities), specific models are needed to help White graduate students overcome apathy, resistance, and ideologies grounded in White supremacist values (e.g., the perception of the superiority or universality of their worldviews). Minimum standards must be established to ensure that graduates possess the necessary knowledge, awareness, and skills to be effective in increasingly diverse domestic and global contexts. A challenge for the field of counseling psychology is to maintain its momentum on U.S.-based social justice initiatives while also attending to transnational issues.

Lisa B. Spanierman

**See also** Barriers to Cross-Cultural Counseling (v3); Constantine, Madonna G. (v3); Counseling Skills Training (v2); Cross-Cultural Psychology (v3); International Developments, Counseling (v1); International Developments, Counseling Psychology (v1); Multicultural Counseling (v3); Multicultural Counseling Competence (v3); Sue, Derald Wing: Contributions to Multicultural Psychology and Counseling (v3); Therapist Techniques/Behaviors (v2)

## Further Readings

- Abreu, J. M., Chung, R. H. G., & Atkinson, D. R. (2000). Multicultural counseling training: Past, present, and future directions. *The Counseling Psychologist*, 28, 641–656.
- American Psychological Association. (2002). *Guidelines on multicultural education, training, research, practice, and organizational change for psychologists*. Washington, DC: Author.
- American Psychological Association Research Office. (2003). *Demographic shifts in psychology*. Retrieved from <http://research.apa.org/gen1.html>
- Arredondo, P., & Arciniega, G. M. (2001). Strategies and techniques for counselor training based on the multicultural counseling competencies. *Journal of Multicultural Counseling and Development*, 29, 263–273.
- Arredondo, P., Toporek, R., Brown, S. P., Jones, J., Locke, D. C., Sanchez, J., et al. (1996). Operationalization of the multicultural counseling competencies. *Journal of Multicultural Counseling and Development*, 24, 42–78.



- Heppner, P. P. (2006). The benefits and challenges of becoming cross-culturally competent counseling psychologists: Presidential address. *The Counseling Psychologist, 34*, 147–172.
- Leong, F. T. L., & Ponterotto, J. G. (2003). A proposal for internationalizing counseling psychology in the United States: Rationale, recommendations, and challenges. *The Counseling Psychologist, 31*, 381–395.
- Marsella, A. J., & Pedersen, P. (2004). Internationalizing the counseling psychology curriculum: Toward new values, competencies, and directions. *Counseling Psychology Quarterly, 17*, 413–423.
- Ponterotto, J. G., Casas, J. M., Suzuki, L. A., & Alexander, C. M. (Eds.). (2001). *Handbook of multicultural counseling* (2nd ed.). Thousand Oaks, CA: Sage.
- Pope-Davis, D. B., & Coleman, H. L. K. (1997). *Multicultural counseling competencies: Assessment, education and training, and supervision*. Thousand Oaks, CA: Sage.
- Ridley, C. R., Mendoza, D. W., & Kanitz, B. E. (1994). Multicultural training: Reexamination, operationalization, and integration. *The Counseling Psychologist, 22*, 227–289.
- Smith, T. B., Constantine, M. G., Dunn, T. W., Dinehart, J. M., & Montoya, J. A. (2006). Multicultural education in the mental health professions: A meta-analytic review. *Journal of Counseling Psychology, 53*, 132–145.
- Sue, D. W., & Sue, D. (2008). *Counseling the culturally diverse: Theory and practice* (5th ed.). New York: Wiley.

---

## CULTURAL ACCOMMODATION AND NEGOTIATION

---

Cultural accommodation refers to the process by which individuals may take on values and beliefs of the host culture and accommodate them in the public sphere, while maintaining the parent culture in the private sphere. *Cultural negotiation* refers to the process whereby individuals must navigate two or more cultures that have values, beliefs, and behaviors that can be perceived as conflictual or incompatible.

### Cultural Accommodation

Accommodating to culture suggests an adjustment or adaptation to a culture or a set of cultural beliefs, practices, or traditions—a construct that mirrors acculturation. When bilingual individuals speak a language (e.g., English), they may take on cultural values (e.g., individualism) and beliefs that are embedded in the

language and that are not part of their own language or culture.

Frederick T. L. Leong identified three steps to the cultural accommodation approach: (1) The client's acculturation level and the cultural biases in an extant theory or model that hinder the cultural validity of the theory are identified. (2) Culture-specific constructs, values, and concepts from the clients' cultures that accommodate the theory or model to the clients are chosen. (3) The accommodated theory is examined for its incremental validity in comparison with the unaccommodated theory to determine the efficacy of the accommodated theory with respect to relevance, utility, sensitivity, and appropriateness. For example, the acculturation level of a Chinese American female seeking counseling for career indecision should first be assessed. As a second-generation, youngest daughter with no brothers, she may have a traditional Chinese perspective on her place in the family and community but also feel bicultural (acculturated to both American and Chinese cultures) and struggle with differences in expectations (e.g., good daughter) and stressors (e.g., pressure to marry). In step 2, Chinese interdependent values of filial piety, duty, honor with attention to hierarchy, and gender roles must be considered. Finally, efficacy comparisons between the unaccommodated (e.g., independence vs. interdependence) and the accommodated theories must be made.

### Cultural Negotiation

Cultural negotiation is an adjustment process that takes place at individual, interpersonal, and systemic levels and occurs across cultural contexts. It occurs when individuals (e.g., immigrants adjusting to a new country or bicultural individuals having two cultural backgrounds) navigate diverse settings (e.g., school, home, work) and shift their identities and values depending on the norms of each environment. This allows individuals to fulfill differing expectations, obligations, and roles and to maintain relationships inside and outside their own cultural communities.

Cultural negotiation is needed to balance differing value systems, familial and community expectations, peer relationships, and identities. If conflict arises for bicultural individuals, they must negotiate between two, possibly dissimilar contexts: the culture of their family and the culture in which they live, work, and experience the world. For example, an Indian American female may weigh individualistic values with interdependent values when making a career



decision. These negotiations also manifest in behavioral differences in multiple settings, including language usage (i.e., what language to speak at home and what language to speak at school), physical manifestations (e.g., body language, manner of dress), and activities (e.g., playing soccer, ethnic folk dancing).

*Amanda L. Baden and Muninder K. Ahluwalia*

*See also* Acculturation (v3); Assimilation (v3); Cultural Values (v3); Culture (v3); Enculturation (v3); Identity Development (v3); Multiculturalism (v3); Orthogonal Cultural Identification Theory (v3); Person–Environment Fit (v4); Person–Environment Interactions (v2); Second Culture Acquisition (v3)

### Further Readings

- Leong, F. T. L. (2002). Challenges for career counseling in Asia: Variations in cultural accommodation. *Career Development Quarterly*, 50, 277–284.
- Leong, F. T. L., & Tang, M. (2002). A cultural accommodation approach to career assessment with Asian Americans (pp. 265–279). In K. S. Kurasaki, S. Okazaki, & S. Stanley (Eds.), *Asian American mental health: Assessment theories and methods*. New York: Kluwer Academic/Plenum.
- Markus, H. R., Mullally, P. R., & Kitayama, S. (1997). In U. Neisser & D. A. Jopling (Eds.), *The conceptual self in context: Culture, experience, self-understanding* (pp. 13–61). Cambridge, UK: Cambridge University Press.
- Oyserman, D., Sakamoto, I., & Lauffer, A. (1998). Cultural accommodation: Hybridity and the framing of social obligation. *Journal of Personality and Social Psychology*, 74, 1606–1618.
- Padilla, A. (Ed.). (1980). *Acculturation: Theory, models and some new findings*. Boulder, CO: Westview Press.

---

## CULTURAL ENCAPSULATION

---

Cultural encapsulation is the lack of understanding, or ignorance, of another's cultural background and the influence this background has on one's current view of the world. The purpose of this encapsulation, or "cocoon," is to allow people to protect themselves from the rapid global changes occurring in technology, families, economy, education, and social health. Cultural encapsulation can lead to a counselor applying his or her own experiences to the client's experiences despite

the reality that both developed in different worlds, cultures, and values. To define one's experience as the truth or reality may result in potentially harming the client, given the possible differences between the counselor and client.

Christopher G. Wrenn revisited the conceptualization of cultural encapsulation and classified people's reactions to global change in two ways: as either a sense of hopelessness or a denial of the reality of the change or situation. This denial of the reality of change may lead counselors to make assumptions and generalizations about people and the world based on their limited group of clients; for example, clients who choose to see a counselor have money to do so and have a situation that compels them to see a mental health professional. For example, erroneous assumptions could be made about the etiology of depression based on a limited sample of clients who verbally express their depressive symptoms, are willing to seek help through counseling, and have economic means to see a counselor for a specific amount of time. Depression may have a different developmental pathway because of one's group norms about symptom expression and help seeking (e.g., seeing a family friend, elder, or religious leader that is less expensive and more appropriate for one's age, gender, religion, or culture).

The development of a counselor's cultural encapsulation can stem from one's culturally biased assumptions about counseling and psychology. Paul Pedersen identified eight assumptions:

1. American psychology is superior to other national psychologies.
2. Theories and measurements are validated for their use in other cultures.
3. The "self-reference criterion" of evaluating one's ideas and behaviors in terms of one's own viewpoint is useful.
4. Other disciplines doing similar activities can be excluded.
5. The Western cultural bias within the literature is unintentional.
6. Engagement in international issues where advocating for victims is critical is unnecessary.
7. Indigenous psychology can be included in the universal view of psychology.
8. Empirical research supports one's cultural bias.



According to Wrenn, to avoid cultural encapsulation and these assumptions, counselors need to examine their beliefs, assumptions, and stereotypes daily and eliminate them if they are no longer present in society. Counselors must anticipate changes in the information that they hold as current truths and encourage those who think differently. Finally, counselors must avoid the tendency to be self-righteous in their beliefs about themselves and others.

*Laurie D. McCubbin and Sara Bennett*

*See also* Allocentrism (v3); Barriers to Cross-Cultural Counseling (v3); Bias (v3); Cultural Mistrust (v3); Cultural Relativism (v3); Cultural Values (v3); Culture (v3); Ethnocentrism (v3); Eurocentrism (v3); Multiculturalism (v3); Person–Environment Interactions (v2); Pluralism (v3); Worldview (v3)

### Further Readings

- Pedersen, P. (1994). *A handbook for developing multicultural awareness* (2nd ed.). Alexandria, VA: American Counseling Association.
- Wrenn, C. G. (1962). The culturally encapsulated counselor. *Harvard Educational Review*, 32, 444–449.
- Wrenn, C. G. (1985). Afterword: The culturally encapsulated counselor revisited. In P. Pedersen (Ed.), *Handbook of cross-cultural counseling and therapy* (pp. 323–329). Westport, CT: Greenwood Press.

---

## CULTURAL EQUIVALENCE

---

It is not uncommon for assessment tools to obtain unintended and unwanted sources of variance—or cultural bias—that lead to test results that are not easy to accurately interpret across cultures. Cultural equivalencies reflect a body of research methods that can be used to minimize cultural bias and measurement error in the development and/or adaptation of assessment tools. More specifically, conceptual, content, linguistic, technical, and normative equivalencies are five established dimensions of cultural equivalence that are used to minimize measurement error in cross-cultural applications.

1. *Conceptual Equivalency.* Conceptual equivalency examines the extent to which a construct has a similar

nature and meaning when applied in a different cultural context. For example, does the notion of “self” mean the same thing in British culture as it does in Ghanaian culture? Ethnosemantic procedures can be used to evaluate conceptual equivalency. This is accomplished by eliciting words that span a specific domain (i.e., self), ordering such words according to predefined dimensions (e.g., good-bad, individual-collective), utilizing word associations to understanding the meaning of such words, and employing direct observations to attach associated behaviors to these words.

2. *Content Equivalency.* Content equivalency investigates if the operationalization of the construct is relevant to the population under study. For example, are the best elements used to describe and examine the notion of “personality” the same in Chinese culture as it might be in Native American culture?

3. *Linguistic Equivalency.* Linguistic equivalency is mainly concerned with translation accuracy from language A (e.g., English) to language B (e.g., Hindi). Back translation is a commonly used method to establish linguistic equivalency. This involves having a person fluent in both languages translate the original instrument from language A to language B. Next, a second person would take the recently translated instrument in language B and translate it back into language A. A research team would then test to see if the instrument that has undergone back translation is identical to the original instrument.

4. *Technical Equivalency.* Technical equivalency is concerned about the cultural appropriateness of the measuring techniques being used with a specific population. This equivalency is concerned with the appropriateness of response formats (True vs. False, Likert Scale, etc.), reading level, cognitive complexity, and any other variables that might lead to significant over- or underreporting. Use of informants, audio/visual aids, and ethnographic methods are some ways that barriers associated with technical equivalency can be minimized.

5. *Normative Equivalency.* Norms are important in having a standard so that observations of similarities and deviations can be made for a specific sample



population in question. Thus, normative equivalency requires norms to be available for the population being studied. Indices of normative equivalency might include variables like ethnicity, gender, age, educational attainment, and socioeconomic status to name a few.

Social scientists must be aware of the importance that cultural variables can have in the acquisition of data. While much more work is needed to empirically demonstrate the nature of the aforementioned dimensions of cultural equivalence and/or the identification of new dimensions, the interpretation of results are only as good as the instruments and methodology used to obtain the raw data.

*Ezemenari M. Obasi and Sheetal Shah*

*See also* Assessment (v4); Bias (v3); Cross-Cultural Psychology (v3); Culture-Free Testing (v3); Etic–Emic Distinction (v3); Psychometric Properties (v2); Qualitative Methodologies (v1); Quantitative Methodologies (v1); Translation Methods (v3)

### Further Readings

- Canino, G., & Bravo, M. (1994). The adaptation and testing of diagnostic and outcome measures for cross-cultural research. *International Review of Psychiatry*, 6(4), 281–286.
- Marsella, A. J., & Leong, F. T. L. (1995). Cross-cultural issues in personality and career assessment. *Journal of Career Assessment*, 3(2), 202–218.

---

## CULTURAL MISTRUST

---

Cultural mistrust is an adaptive attitudinal stance in which a person of color is suspicious and guarded toward European Americans, particularly European American authority figures. It is adaptive in that if one accepts the contention that the current social paradigm is inherently racist, then a person of color cannot assume that a European American person has his or her best interests at heart. This attitudinal stance was first described in William Grier and Price Cobbs's classic book, *Black Rage*. Grier and Cobbs called this survivalistic stance *cultural paranoia*. Many writers later changed the term to *cultural mistrust* in an effort

to emphasize that it is an adaptive strategy rather than a form of psychopathology.

### Cultural Mistrust Research

A review and meta-analysis by Arthur Whaley indicates that there is a significant correlation between cultural mistrust in African Americans and their attitudes and behaviors related to mental health services use. However, the effect size for cultural mistrust was not significantly different for counseling and psychotherapy studies as compared with other types of studies, suggesting that the mental health context was neither more nor less threatening than other social situations. Younger African Americans tended to exhibit more cultural mistrust attitudes than did older African Americans.

Whaley argues that cultural mistrust is an important psychological construct for the diagnosis and treatment of African Americans. This construct, therefore, must be acknowledged by clinicians as a legitimate method of coping with racism and discrimination. In this context, discussing racism with clients, even those with severe mental illness, would be a relevant part of treatment.

### Cultural Mistrust and Counseling

A European American counselor confronting the racial and ethnic differences between the counselor and an African American client in the initial session does not, in and of itself, offset the cultural mistrust that some Black individuals have of Whites in general. Conceptualization of the client problem consistent with the client's belief system, methods of resolution compatible with the client's culture, and counseling goals consistent with that of the client are necessary to build credibility with culturally diverse clients. When an African American client who has high cultural mistrust is assigned to a European American counselor, the client may expect the counselor to be less accepting, trustworthy, and less of an expert. Clients who do not belong to the same racial or ethnic group as their counselor and who have cultural mistrust toward their counselor may terminate counseling at a high rate. Cultural paranoia also may prevent some African American clients from self-disclosing to European American therapists.

According to Whaley, African Americans with severe mental illness who report high levels of cultural mistrust are more likely to have more negative attitudes



toward White clinicians. They favor clinicians from their own racial group, although they may believe that European American clinicians receive better training. Reginald Alston and Tyronn Bell suggested that cultural mistrust may influence the way in which African Americans with disabilities approach rehabilitation counseling. Existence of cultural mistrust in a mild form could be healthy and adaptive for African Americans to sharpen their social wits and enhance their survival. However, a study by Bell and Terence Tracey indicated that among African American students, mistrust of European Americans is not always psychologically healthy. A moderate amount of trust of Whites is related to perceptions of personal well-being. It also is important to note that aspects of cultural mistrust can be mistaken for unhealthy paranoia.

*Paul E. Priester and Jose Eluvathingal*

**See also** Adaptation (v3); Barriers to Cross-Cultural Counseling (v3); Black Psychology (v3); Black Racial Identity Development (v3); Career Counseling, African Americans (v4); Coping (v2); Cultural Paranoia (v3); Defenses, Psychological (v2); Eurocentrism (v3); Healthy Paranoia (v3); Idiocentrism (v3); Relationships With Clients (v2); White Privilege (v3); Worldview (v3)

### Further Readings

- Terrell, F., & Terrell, S. L. (1981). An inventory to measure cultural mistrust among Blacks. *Western Journal of Black Studies*, 5, 180–184.
- Whaley, A. L. (2001). Cultural mistrust and mental health services for African Americans: A review and meta-analysis. *The Counseling Psychologist*, 29, 513–531.

---

## CULTURAL PARANOIA

---

The concept of “cultural paranoia” was first introduced by William H. Grier and Price M. Cobbs in their 1968 book *Black Rage*. These two Black psychiatrists explained that this condition is not a form of psychopathology, but instead is a healthy and adaptive response by African Americans to their historical and contemporary experiences of racial oppression and discrimination in the United States. Charles R. Ridley, an African American psychologist, reintroduced the concept of cultural paranoia more than a decade later to explain why Black clients do not disclose to White

psychotherapists. Ridley stated that because the encounter in counseling and psychotherapy is a microcosm of the larger American society, Black clients may not disclose personal information to White therapists for fear that they may be vulnerable to racial discrimination. Thus Black mental health professionals make a distinction between *cultural paranoia*, a form of adaptive coping, and *clinical paranoia*, a symptom of mental illness.

There have been some psychologists who questioned the use of the term *paranoia* to describe a situation that does not involve psychopathology or mental illness. Homer Ashby and Phyllis Bronstein criticized Ridley for using the term *cultural paranoia* during an exchange in the February 1986 issue of the *American Psychologist*. Arthur Whaley tried to resolve the debate by arguing that paranoia is not a simple “present-absent” symptom, falling along a continuum from mild to moderate to severe. According to Whaley, cultural aspects of paranoia in terms of lack of trust, especially among African Americans, fall on the mild, nonclinical end of the paranoia continuum. Whaley also pointed out that the term *cultural mistrust*, for which there is consensus among those on both sides of the debate, is one that is appropriate to describe African Americans’ ways of coping with racism and oppression.

The Cultural Mistrust Inventory (CMI) was developed by Francis and Sandra Terrell to assess this response style in African Americans. Using the CMI, Whaley demonstrated that what was originally labeled “healthy cultural paranoia” is indeed not a form of psychopathology. In addition, Ekta Ahluwalia used the CMI in her doctoral dissertation to study African Americans, Native Americans, Latinos/as, and Asian Americans. Ahluwalia found that Native Americans and African Americans had the highest CMI scores among the ethnic groups. Because both Native Americans and African Americans had unique histories with regard to racism and oppression in the United States, her findings provide support for the notion that the CMI is tapping these cultural experiences.

Whaley conducted qualitative and quantitative reviews of the literature on the CMI and found it to correlate positively and negatively with different measures of psychosocial functioning. The positive associations tend to involve indicators of emotional functioning, whereas the negative correlates include measures of social behavior in interracial situations. This pattern of findings may reflect the fact that the protective qualities for ethnic/racial minority mental health emanate from



lack of investment in tasks that increase the risk of exposure to racial prejudice and discrimination. A major element in addressing cultural paranoia or cultural mistrust in counseling and psychotherapy is to acknowledge racism as a reality for people of color and explore the reasons for mistrust. It is also important to recognize that the behavioral manifestations of cultural mistrust are not indicative of psychopathology. Recently, Dennis Combs and his colleagues showed the CMI to be positively associated with a measure of perceived racism and unrelated to measures of depression and clinical paranoia in African Americans. This empirical research is a direct test of the assumption, and supports it, that cultural paranoia is a healthy coping behavior in response to racial oppression and discrimination.

Arthur L. Whaley

**See also** Adaptation (v3); Barriers to Cross-Cultural Counseling (v3); Black Psychology (v3); Black Racial Identity Development (v3); Career Counseling, African Americans (v4); Coping (v2); Cultural Mistrust (v3); Defenses, Psychological (v2); Eurocentrism (v3); Healthy Paranoia (v3); Idiocentrism (v3); Relationships With Clients (v2); White Privilege (v3); Worldview (v3)

### Further Readings

- Ahluwalia, E. (1991). Parental cultural mistrust, background variables, and attitudes toward seeking mental health services for children (Doctoral dissertation, University of North Texas, 1990). *Dissertation Abstracts International*, 51(9-B), 4271.
- Ashby, H. U. (1986). Mislabeling the Black client: A reply to Ridley. *American Psychologist*, 41, 224–225.
- Bronstein, P. (1986). Self-disclosure, paranoia, and unaware racism: Another look at the Black client and the White therapist. *American Psychologist*, 41, 225–226.
- Combs, D. R., Penn, D. L., Cassisi, J., Michael, C., Wood, T., Wanner, J., et al. (2006). Perceived racism as a predictor of paranoia in African Americans. *Journal of Black Psychology*, 32, 87–104.
- Grier, W. H., & Cobbs, P. M. (1968). *Black rage*. New York: Basic Books.
- Ridley, C. R. (1984). Clinical treatment of the nondisclosing Black client: A therapeutic paradox. *American Psychologist*, 39, 1234–1244.
- Ridley, C. R. (1986). Optimum service delivery to the Black client. *American Psychologist*, 41, 226.
- Terrell, F., & Terrell, S. L. (1981). An inventory to measure cultural mistrust among Blacks. *Western Journal of Black Studies*, 5, 180–184.
- Whaley, A. L. (2001). Cultural mistrust: An important psychological construct for diagnosis and treatment of African Americans. *Professional Psychology: Research and Practice*, 32, 555–562.
- Whaley, A. L. (2001). Cultural mistrust and mental health services for African Americans: A review and meta-analysis. *Counseling Psychologist*, 29, 513–531.

---

## CULTURAL RELATIVISM

---

Cultural relativism maintains the view that all cultures are equal in value and therefore should not be judged on the basis of another cultural perspective. The cultural values and beliefs connected to religious, ethical, normative behaviors, customs, and political tenets are specific to the individuals within a given human society.

Culture is considered to be the collective knowledge and experiences of any given human society that is passed on from generation to generation. This collective knowledge often helps organize language, emotional expression, and norms of behavior within the group and thus provides members with a sense of group cohesion. Cultural relativism maintains the view that the values and beliefs of one culture have specific meaning and importance from the particular worldview of the individuals within that cultural group, community, or both. Hence, people who live outside of a particular culture may or may not perceive another cultural group's worldview acceptable and consistent with their own.

The emergence of multiculturalism within the field of psychology has raised several questions and challenges regarding the universality of the human experience. The history of psychology is rooted in Western European ideology and doctrines. Historically, theoretical constructs and concepts have developed from a Eurocentric perspective, which has permeated all aspects of psychology: diagnosis, treatment, and research of human functioning and psychological disorders. Scientific literature is replete with comparative studies using a “normative” group with a minority group. The “normative” group is often composed of cultural beliefs, customs, and values consistent with a majority-group worldview, thus leading researchers and clinicians to conclude that one group is more deficient or pathological than another group. This perspective, by definition, perpetuates a deficiency model of behavior and ignores the role and importance of cultural contexts



in the ways that people think, behave, and define their experiences.

Psychological research that employs a multicultural context has given voice to the importance of understanding human functioning and behavior from both etic (culturally universal) and emic (culturally specific) contexts. This form of research provides an awareness of the importance of internal and external validity, that is, how behavior is consistent within *and* across cultures and societies.

According to cultural relativism, patterns of behavior are not universally normal or deviant but must be understood relative to a specified cultural context. Individuals define their experiences and behave in ways that are consistent within their own cultural community. Cultural relativism supports the belief that mental health should be understood through the context of normative behavior within a specific culture. Therefore, when counselors are working with individuals from a specific culture, they should examine the worldviews of that cultural perspective, so that behaviors, attitudes, and perceptions can be viewed from within the context of that culture. For example, for many individuals within Asian cultures, filial piety defines patterns of behaviors that denote respect and devotion for one's parents. Therefore, behaviors and attitudes that fall within the confines of filial piety should be considered "normal" within that cultural frame. Counseling interventions and treatment modalities need to embrace cultural patterns that are consistent with the worldview of filial piety so that they can be more effective with the members of that cultural group. In this way, therapeutic strategies that are consistent with cultural worldviews will provide individuals within that group with sensitivity and empathy that are congruent with their cognitive, emotional, and psychological experience.

Angela D. Ferguson

**See also** Cross-Cultural Psychology (v3); Cultural Values (v3); Culture (v3); Ethnocentrism (v3); Filial Piety (v3); Multicultural Counseling Competence (v3); Multiculturalism (v3); Pluralism (v3); Worldview (v3)

### Further Readings

- Headland, T. N., Pike, K. L., & Harris, M. (Eds.). (1990). *Emics and etics: The insider/outsider debate*. Newbury Park, CA: Sage.
- Sue, D. W., & Sue, D. (2008). *Counseling the culturally diverse: Theory and practice* (5th ed.). New York: Wiley.

## CULTURAL VALUES

Culture is a pattern of responding to basic needs for food, shelter, clothing, family organization, religion, government, and social structures. Culture can be further described as discrete behaviors, traditions, habits, or customs that are shared and can be observed, as well as the sum total of ideas, beliefs, customs, knowledge, material artifacts, and values that are handed down from one generation to the next in a society. Cultural artifacts are the objects or products designed and used by people to meet reoccurring needs or to solve problems. Institutions are structures and mechanisms of social order and cooperation governing the behavior of two or more individuals. Cultural norms are rules that are socially enforced. Social sanctioning is what distinguishes norms from values.

Values are core beliefs and practices from which people operate. Each culture possesses its own particular values, traditions, and ideals. Integrity in the application of a "value" over time ensures its continuity, and this continuity separates a value from simple beliefs, opinions, and ideals. Cultural groups may endorse shared values. However, a given individual within that culture may vary in agreement with the group cultural values.

### Role of Cultural Values

Cultural universalism asserts that all human beings create culture in response to survival needs. Only humans rely on culture rather than instinct to ensure survival of their kind. What seems unique to humanity is the capacity to create culture. Cultural relativism informs us that each culture possesses its own particular traditions, values, and ideals. Judgments of what is right or wrong, good or bad, acceptable or taboo are based on particular cultural values. Values underlie preferences, guide choices, and indicate what is worthwhile in life. Values help define the character of a culture, but they usually do not provide a specific course of action. Values generally prescribe what one "should" do but not how to do it. Because values offer viewpoints about ideals, goals, and behaviors, they serve as standards for social life. All groups, regardless of size, have their own values, norms, and sanctions.

Although it may seem obvious that values are rooted in the culture from which they originate, this has not always been the way values have been operationalized.



For many years in the United States, the fundamental values of White European American males were often accepted as universal rather than culturally specific. Deviations from mainstream values were labeled as abnormal and inferior rather than merely different. Psychologist Gilbert Wrenn challenged the notion that White European American culture was universal by writing about the “culturally encapsulated counselor,” and the multicultural counseling movement has expanded the notion of culturally bound values.

### Formation of Cultural Values

Cultural values are formed through environmental adaptations, historical factors, social and economic evolution, and contact with other groups. Individuals develop cultural perceptual patterns that determine which stimuli reach their awareness. These cultural perceptual patterns also determine judgments of people, objects, and events. When the individual or society prioritizes a set of values (usually of the ethical or doctrinal categories), a value system is formed.

Values dictate what is important. They serve as a guide for the ideals and behavior of members of a culture. As guided by its values, culture can be seen as a dynamic system of symbols and meanings that involves an ongoing, dialectic process where past experience influences meanings, which in turn affects future experience, which in turn affects subsequent meaning. Cultural values provide patterns of living and prescribe rules and models for attitude and conduct.

For example, several culture-specific values have been identified for specific groups. It should be noted, however, that there is considerable within-group variability in what is valued. In traditional Hispanic and Latino/a cultures, the following have been identified as shared cultural values among many of its members: an emphasis on family unity, welfare and honor (*familismo*), a preference for close personal relationships (*personalismo*), and respect (*respeto*) for elders and authority figures.

Traditional African American values have been identified as including the following: an emphasis on collectivism, kinship, the importance of extended families, the centrality of spirituality, and holistic thinking. Commonly among African Americans, both the nuclear family (parents and children) and the extended family (relatives, friends) are important. The concept of *familismo* among African Americans generally includes both biological and nonbiological members.

Another shared cultural value of African American families is that of *role flexibility*. The head of the household may not necessarily be the father, as many African American homes are headed by the mother or grandparents.

Traditional “American” values (derived from a White European male perspective) include individualism, competition, accumulation of material possessions, nuclear families, the separation of religion from other aspects of culture, and mastery over nature. It is important to recognize that these values may not be internalized equally among all European Americans; thus, a great deal of variability exists in the adoption and expression of traditional “American” values.

Cultural values guide interactions, and these values can come into conflict with the values of a dominant cultural group and can lead to acculturative stress. Cultures are not confined to racial or ethnic groups. Cultural values can be found in diverse groups by gender, sexual identity, class, country of origin, disability, or a variety of variables. Therefore, an individual can belong to a host of cultures simultaneously, and the issue of navigating cultures with incompatible value systems (e.g., religion and sexual identity) may lead to a fragmented sense of identity or self-hatred.

### Categories of Cultural Values

Some researchers suggest that cultural values can be divided into six main categories: (1) ethics (notions of right and wrong, good and evil, and responsibility); (2) aesthetics (notions of beauty and attractiveness); (3) doctrinal (political, ideological, religious, or social beliefs and values); (4) innate/inborn (values such as reproduction and survival; this is a controversial category); (5) non-use/passive (includes the value based on something never used or seen, or something left for the next generation); and (6) potential (the value of something that is known to be only potentially valuable, such as a plant that might be found to have medicinal value in the future).

In multicultural societies, cultures may come into conflict. *Parochialism* occurs when members of a given culture believe their way is the “only” way. They do not recognize other ways of living, working, or doing things as being valid. *Equifinality* has been suggested as a more appropriate assumption to make in a multicultural world. This assumption asserts that the way of any given culture is not the only way.



Instead, there are many culturally distinct ways of reaching the same goal or living one's life. Another conflict may involve *ethnocentrism*. This occurs when members of a culture recognize the existence of other cultures and yet believe their way is the "best" way and all other cultural valuations are inferior. The notion of *cultural contingency* may be a more appropriate response in a multicultural world; that is, cultural values are seen as choices that are equally valid for the individuals involved.

### Role of Psychologists

Psychologists are charged with dealing with cultural values in several ways. First, they are compelled to understand their own cultural values and how these values affect their work and worldview. Therefore, psychologists should be aware of their own cultural values, and in cases where their cultural values may lead to harm with culturally different clients, psychologists must refer these clients to culturally competent practitioners. In addition, psychologists should actively learn about the cultural values of their clients and, where possible, work with these cultural values as strengths rather than as liabilities or pathological beliefs. For example, psychologists might involve cultural spiritual leaders in the treatment of culturally different clients. The notion of cultural competence extends to all other professional arenas of psychologists, including education, teaching, research, and consultation.

*Edward A. Delgado-Romero and Billy Yarbrough*

**See also** Barriers to Cross-Cultural Counseling (v3); Cross-Cultural Psychology (v3); Culture (v3); Ethnic Identity (v3); Ethnicity (v3); Multicultural Counseling Competence (v3); Multiculturalism (v3); Pluralism (v3); Race (v3); Racial Identity (v3); Worldview (v3)

### Further Readings

- American Psychological Association. (2003). Guidelines on multicultural education, training, research, practice and organizational change for psychologists. *American Psychologist*, 58, 377–402.
- Paniagua, F. A. (2005). *Assessing and treating culturally diverse clients: A practical guide*. Thousand Oaks, CA: Sage.
- Pedersen, P. B., Draguns, J. G., Lonner, W. J., & Trimble, J. E. (Eds.). (2002). *Counseling across cultures* (5th ed.). Thousand Oaks, CA: Sage.

## CULTURE

Culture consists of implicit and explicit patterns of behavior acquired and transmitted by symbols and their embodiments in artifacts. The essential core of culture consists of traditional (i.e., historically derived and selected) ideas and their attached values. Culture systems may be considered as products of action and conditioning elements of further action. A. L. Kroeber and Clyde Kluckhohn collected and analyzed several hundred definitions of culture and arrived at this definition, which the authors believed would be acceptable by most social scientists: *Culture* is one of the most important concepts in 20th-century social sciences. A reflective look at the way the concept of culture is used would be enlightening because different disciplines and schools of thoughts have their own definitions and there is no common understanding. In addition, understanding the issues of cultural unity and diversity has increasingly become relevant in our daily lives.

### Historical Perspective

Kroeber and Kluckhohn's definition represents a summary of what American anthropologists and social scientists would call culture in the 1940s and 1950s. In contrast with this definition, in the 1920s and 1930s, culture was simply defined as "the learned behavior." However, Kroeber and Kluckhohn argued that although the concept of culture is based on the study of behavior and behavioral products, culture cannot be conceptualized as only the behavior or the investigation of behavior. Instead, part of culture consists of norms for or standards of behavior, and another part consists of ideologies justifying or rationalizing certain ways of behavior. Finally, every culture includes broad general principles of selectivity and ordering ("highest common factors") about behavior.

### Definitions of Culture

The word *culture* originates in Middle English ("a cultivated piece of land") from the French word *culture* and from the Latin verb *culturare* ("to cultivate"). All versions of the word ultimately come from the early Latin *colere* ("to till or cultivate the ground"). A review of overarching themes and patterns in definitions of culture in various disciplines might be beneficial to our understanding of culture. Each theme has its own



strengths and weaknesses, and there are inevitable overlapping and interpenetrating relationships between and among themes.

Seven types or themes of definitions of culture can be listed:

1. *Structure/pattern*: Definitions that look at culture in terms of a system or framework of elements (e.g., ideas, behavior, symbols, or any combination of these or other elements)
2. *Function*: Definitions that see culture as a tool for achieving some end
3. *Process*: Definitions that focus on the ongoing social construction of culture
4. *Product*: Definitions of culture in terms of artifacts (with or without deliberate symbolic intent)
5. *Refinement*: Definitions that frame culture as a sense of individual or group cultivation to higher intellect or morality
6. *Power or ideology*: Definitions that focus on group-based power (including postmodern and postcolonial definitions)
7. *Group membership*: Definitions that speak of culture in terms of a place or group of people, or that focus on belonging to such a place or group

## Culture and Psychological Processes

Theories explaining culture from a perspective of psychological processes contribute to the understanding of the processes through which specific individuals' actions and behaviors influence the actions and behaviors of others and become norms, customs, and rituals. They help to explain how the specific clusters of thoughts and action can become commonly shared among some populations but not others. Biological foundations, motivational systems, affective/emotional systems, cognitive/communication systems, and linguistic perspective will be presented as five of the examples of psychological theories.

According to the *biological foundations approach*, biological foundations of the cognitive mechanisms give rise to the aspects of culture. There are two perspectives that could be reviewed under the biological foundations approach: evolutionary and neurological. The evolutionary perspective suggests that human beings may be especially likely to communicate

information that has affective content relevant to survival and reproduction. Consequently, knowledge structures that are suggestive of these affective states may be likely to become culturally shared.

The neurological foundation tradition emphasizes the coevolution of psychological and cultural phenomena. The main idea of coevolution is that human beings evolved to be cultural. Human beings are evolutionarily shaped and genetically predisposed to seize and make use of cultural resources available in their local environments. Another neurological foundation of culture is "plasticity." Completely preprogrammed development is neither adaptive nor efficient. Instead, human ontogeny entails a built-in reliance on environmental patterns for species-typical development. This plasticity, or reliance on environmental patterns, provides a window for the cultural shaping of the human development. Another neurological foundation of culture, the notion of sensitive period, is defined as the ability to experience certain cultural patterns (e.g., tendencies of phoneme discrimination, visual perception, and culture-specific emotions) during a sensitive period of development. In other words, human beings are exposed to certain cultural patterns during a sensitive period of their development, and this early shaping of experience may make later shaping by other cultures more difficult.

According to the *motivational systems approach*, there is an existential need to make sense of big questions such as the meaning of life. Another motivational foundation is an epistemic need to make sense of day-to-day reality. Reality is often multiple and ambiguous, and people require culture, social influence with a historical and material dimension, to help define reality. A specific case of this need is observed in interpersonal communication, where people are motivated to engage in a micro-level form of cultural process, the production of common ground.

Terror management theory, an example of the motivational systems approach, proposes that culture emerged to serve as a psychological buffer against the existential anxiety that results from the awareness of our own mortality. Culture minimizes existential anxiety by providing a conception of the universe (cultural worldview) that fills the world with order, meaning, and permanence. Culture also provides a set of standards of valued behavior that, if satisfied, provides self-esteem to individuals. Culture acts as a buffer because many cultural beliefs and behaviors offer symbolic immortality (e.g., life after death, naming children after



grandparents). In addition, culture provides a set of rules, standards, and principles according to which a person can be judged to be a socially acceptable or good person. One of the broad hypotheses that the terror management theory makes is that awareness of one's own mortality leads to enhanced attempts to defend one's own cultural worldview. For example, one study indicated that mortality salience increases derogation of alternative cultural worldviews and punishment of individuals who violate cultural rules.

The *affective/emotional systems* approach uses the affect/emotions as the foundation of culture. An affective foundation of culture is the concept of affective primacy, which is defined as direct, automatic shaping of moods, feelings, and preferences by everyday worlds. People are often likely to acquire affective charge of practices or artifacts unwittingly, in the process of engaging cultural worlds. For example, immersed in cultures where it is taboo to eat pork, people are likely to feel disgusted at the thought or scent of cooking pork products.

The *cognitive/communication systems* approach can be represented by Bibb Latané's dynamic social impact theory (DSIT). This theory adopts a theory of social influence to explain how cultures develop and change over time. It assumes that people influence and are influenced by others through the process of communication, which is defined as any type of social exchange of information. DSIT posits that influence will occur whenever groups of people interact on social attributes. Three factors—strength, immediacy, and number—are the basis of social influence. Strength is defined as individual differences in supportiveness or persuasiveness. Some people are more attractive, richer, or more educated than others; consequently, these characteristics may lead them to have a stronger influence on others around them. Immediacy includes proximity in physical or social space. Finally, social impact depends on the number of other individuals who share a particular attitude. The more people who agree with our opinions, the less likely we will be able to change them. In short, people are more influenced by persuasive, close, and numerous others.

To explain the creation and continuation of culture, DSIT uses concepts of clustering and correlation to explain how cultures are formed and consolidation and continuing diversity to address temporal change in cultures. Clustering represents the fact that as people are influenced by those in their local area, pockets of shared opinions will form, leading to regional differences.

DSIT posits that communication will lead to spatial clustering of attributes. In other words, over time, people will be increasingly likely to share similar attitudes with those living close to them. A second prediction of DSIT is that attitudes that are originally unrelated across individuals within a group will become increasingly correlated over time. Finally, DSIT predicts that attributes will consolidate or decrease in diversity, as people influence each other over time. Although consolidation leads to majority influence and majority sizes will tend to increase, the diversity will continue to exist.

Finally, *linguistic perspective* links culture to static features of languages. Language determines each culture by representing reality in a particular manner. Thus, every language is a vast pattern system with culturally ordained forms and categories. Through language, human beings communicate, analyze nature, notice or neglect types of relationships and things, channel their reasoning, and build consciousness. This theory posits that use of language in human interaction may play an important role in the evolution and maintenance of cultural representations. The theory has four main assumptions:

1. Language is a carrier of cultural meanings.
2. Cultural meanings are evoked when language is used in interpersonal communication.
3. The use of language in communication will increase the accessibility of existing shared representations in the culture. In addition, through communication, private idiosyncratic representations will be transformed into publicly shared representations, which in turn form the cognitive foundations of culture.
4. Evolved and shared representations will then be encoded into the language and the cycle continues.

In sum, biological, motivational, affective/emotional, cognitive, and linguistic theories contribute to the understanding of culture and help explain how specific clusters of thoughts and action can become commonly shared among some populations but not others. Next, concepts of cultural worldview and cultural values of several groups are discussed.

## Cultural Values

Cultural values are characterized by dimensions considered important to members of a cultural group and which may subsequently guide their norms and



behavior. Researchers have stated that the cultural values of a given cultural group guide the members of that group to find solutions to common human problems. Accordingly, it has been argued that an analysis of cultural values is necessary if the uniqueness of any cultural group is to be fully understood.

### **Differences in Cultural Values Among Cultural Groups**

Overall, many studies examining racial/ethnic groups compared with White culture in the United States report differences. In general, it has been found that racial/ethnic and immigrant groups are characterized by activity that places an emphasis on spontaneous self-expression of emotions, desires, and impulses; collateral social relationships or relationships whose individual goals are subordinate to group goals; and subjugation to nature and present time. In contrast, research demonstrates that White cultural groups are characterized by social relationships that are individualistic, view action and spontaneity as more important than self-control, strive for mastery over nature, and have a time orientation that is focused on the future.

Although racial/ethnic and immigrant groups may endorse similar value orientations, they attach different meanings to the same value orientations and may differ in why these value orientations are important to their particular cultural group. Researchers have begun to investigate the specific cultural values of racial/ethnic groups to gain a clearer understanding of the meanings of these values for different groups.

#### ***Asians***

Among Asians there exist significant differences due to ethnicity, migration or generational status, assimilation, acculturation, religion, socioeconomic status, educational level, and political climate in their country of origin. Nonetheless, values common to many Asian cultural groups include an emphasis on harmony in relationships, emotional restraint, precedence of group interests over individual interests, importance of extended family, deference to authority, obedience to and respect for parents, emphasis on hard work, importance of fulfilling obligations, and a high value placed on education. In addition, families are often patriarchal, relationships among family members may be well defined, elders are often respected and cared for, and an individual's behavior may reflect upon the entire family.

Researchers have identified six Asian cultural values: collectivism, conformity to norms, emotional self-control, family recognition through achievement, filial piety, and humility. Saving face is another cultural value, which is reflected in indirect communication styles being more desirable.

#### ***African Americans***

African Americans' sense of self and cultural traditions have been derived from various cultural and philosophical principles shared with West African tribes. Researchers also state that people of African ancestry continue to maintain cultural connections to these traditions. In addition, an African-centered worldview provides important information around which African Americans build their beliefs. These include the beliefs that there is a spiritual essence that permeates everything, everything in the world is interconnected with the principle of consubstantiation or the sense that everything within the universe is connected as a part of a whole, and that the collective is the most important element of existence. In addition, Afrocentricity also includes the beliefs that self-knowledge is assumed to be the foundation of all knowledge.

Moreover, African Americans value family, which includes not only blood relatives but also extended family and fictive kin. Other values include a spirit of coexistence, maintaining a strong connection to the church, education as a means of self-help, a present time orientation with less emphasis on particulars, harmony with nature, collateral relations with others, and communication patterns that include body movement, postures, gestures, and facial expressions in addition to verbal communication. Despite having experienced hardship, African Americans also demonstrate persistence, forgiveness, and resilience.

#### ***European Americans***

European Americans consist of various cultural groups that descend from European countries. Among the cultural values that have been identified for European Americans is individualism, which stresses independence and autonomy. Additionally, researchers have identified an importance on productivity, rigid time orientation, and a focus on the nuclear family. For the most part, these cultural values differentiate this cultural group from others in that importance is placed on the individual rather than the group.



## Latinos/as

Diversity among Latino/a groups exists across geography, country of origin, race, class, traditions, acculturation, and historical and sociopolitical circumstances. However, some shared cultural values have been identified for Latinos/as; these include *familismo*, *personalismo*, *simpatia*, *respeto*, and the expression *si Dios quiere* (if it is God's will). *Familismo* refers to strong family orientation in that Latinos/as value close relationships, cohesiveness and interdependence, and cooperation among family members.

The value of *personalismo* refers to valuing and building interpersonal relationships and the importance of warm, friendly, and personal relationships. This describes the orientation that Latinos/as have toward people rather than toward impersonal relationships. *Simpatia* also demonstrates this orientation that emphasizes harmonious interpersonal interactions. *Respeto* demonstrates the importance of interpersonal harmony, which governs all positive interpersonal relationships and dictates the appropriate deferential behavior toward others on the basis of age, socioeconomic position, sex, and authority status.

The expression *si Dios quiere* (if it is God's will) describes the value of fatalism, which is an indication or form of acceptance that Latinos/as have no control over what God has willed. This value makes sense given that Latinos/as often make reference to their belief in higher powers as a way of making meaning.

Further, among Latinos/as cooperation is important, cultural pride is significant, family structure is hierarchical with deference to elders and males, and adherence to family roles is important. Latinos/as also believe in a holistic connection between the mind and body that permeates their health and illness beliefs. In addition, the church and faith play a significant role and shape Latino/a core beliefs such as the importance of sacrifice, service to others, and long suffering even in the face of adversity.

## Native Americans

Despite the vast diversity among Native Americans, researchers have identified specific values among this cultural group. Among these values, a collectivist cultural value has been identified. Specifically, personal accomplishments are honored and supported if these accomplishments benefit the group. Similarly, it is believed that all things are connected and have purpose. In addition, the importance of spirituality is among the

cultural values of Native Americans. In particular, Native Americans believe in a creator that is considered male and female and is in command of all the elements. Additionally, Native American cultural values come from a spirituality that emphasizes coexisting in harmony with nature. From this comes the cultural value of sharing, as all things belong to the Earth.

Native Americans also value elders because of the wisdom they have acquired. In addition, there is a respect for the past and the contributions of the ancestral spirits. Other cultural values include a focus on nonverbal communication, reciprocal relationships that emphasize cooperation, a preference for a fluid time orientation, and respect for tribal rituals.

Given that these cultural values are central for a particular cultural group, it offers many implications for their worldviews, how they interpret and perceive environments and situations, and how they make decisions. With the understanding of cultural values, the understanding of culture may become more advanced. Thus, in clarifying and defining cultural values we may have a better understanding of what culture means to specific groups.

Elif Celebi and Rocio Rosales

**See also** Acculturation (v3); Barriers to Cross-Cultural Counseling (v3); Collectivism (v3); Communication (v3); Cross-Cultural Psychology (v3); Cross-Cultural Training (v3); Cultural Values (v3); Enculturation (v3); Ethnic Identity (v3); Ethnicity (v3); Individualism (v3); Multicultural Counseling Competence (v3); Multiculturalism (v3); Person–Environment Interactions (v2); Race (v3); Racial Identity (v3); Worldview (v3)

## Further Readings

- Carroll, J. B. (Ed.). (1956). *Language, thought and reality: Selected writings of Benjamin Lee Whorf*. Cambridge: MIT Press.
- Carter, R. T. (1991). Cultural values: A review of empirical research and implications for counseling. *Journal of College & Development*, 70, 164–173.
- Faulkner, S. L., Baldwin, J. R., Lindsley, S. L., & Hecht, M. L. (2006). Layers of meaning: An analysis of definitions of culture. In J. R. Baldwin, S. L. Faulkner, M. L. Hecht, & S. L. Lindsley (Eds.), *Redefining culture: Perspectives across the disciplines* (pp. 27–52). Mahwah, NJ: Lawrence Erlbaum.
- Greenberg, J., Simon, L., Pyszczynski, T., Solomon, S., & Chatel, D. (1992). Terror management and tolerance: Does



- mortality salience always intensify negative reactions to others who threaten one's worldview? *Journal of Personality and Social Psychology*, 63, 212–220.
- Herring, R. D. (1992). Understanding Native American values: Process and content concerns for counselors. *Counseling and Values*, 34, 134–137.
- Kenrick, D. T., Maner, J. K., Butner, J., Li, N. P., Becker, D. V., & Schaller, M. (2002). Dynamic evolutionary psychology: Mapping the domains of the new interactionist paradigm. *Personality and Social Psychology Review*, 6, 347–356.
- Krebs, D., & Janicki, M. (2004). Biological foundations of moral norms. In M. Schaller & C. S. Crandall (Eds.), *The psychological foundations of culture*. Mahwah, NJ: Lawrence Erlbaum.
- Kroeber, A. L., & Kluckhohn, F. R. (1952). *Culture: A critical review of concepts and definitions*. New York: Random House.
- Latané, B. (1996). Dynamic social impact: The creation of culture by communication. *Journal of Communication*, 46, 13–25.
- Paniagua, F. (1998). *Assessing and treating culturally diverse clients*. Thousand Oaks, CA: Sage.
- Parham, T. A. (2002). *Counseling persons of African descent*. Thousand Oaks, CA: Sage.
- Peregory, J. J. (1993). Transcultural counseling with American Indians and Alaskan Natives: Contemporary issues for consideration. In J. McFadden (Ed.), *Transcultural counseling: Bilateral and international perspectives* (pp. 163–191). Alexandria, VA: American Counseling Association.
- Sandhu, D. S. (1997). Psychocultural profiles of Asian and Pacific Islander Americans: Implications for counseling and psychotherapy. *Journal of Multicultural Counseling & Development*, 25, 7–22.
- Santiago-Rivera, A. L., Arredondo, P., & Gallardo-Cooper, M. (2002). *Counseling Latinos and la familia: A practical guide*. Thousand Oaks, CA: Sage.
- Sue, D. W. (1978). World views and counseling. *The Personnel and Guidance Journal*, 56, 458–462.
- Sue, D. W., & Sue, D. (2008). *Counseling the culturally diverse: Theory and practice* (5th ed.). New York: Wiley.
- and somatic symptoms and do not necessarily fit into contemporary diagnostic and classification systems of Western nosology.
- Although there is no consensus among mental health professionals about the extent and ways in which cultural factors influence the manifestation and diagnosis of mental disorders, the American Psychiatric Association's inclusion of a *Glossary of Culture-Bound Syndromes* within the most recent *Diagnostic and Statistical Manual of Mental Disorders (DSM)* constitutes a significant step toward addressing the difficulties encountered in the application of *DSM* criteria across cultural boundaries and suggests a concerted effort to increase universal utility of diagnostic and classification systems of Western nosology by integrating a group of mental disorders long marginalized as culture-specific. The inclusion of these categories also reflects an increasing recognition of the important role of culture in assessment and treatment as well as a growing acceptance of cultural differences in the diagnostic process. It should be noted that these syndromes were compiled on the basis of decades of interdisciplinary research (i.e., anthropology, psychiatry, and psychology).
- According to the *DSM*, culture-bound syndromes refer to “recurrent, locality-specific patterns of aberrant behavior and troubling experience that may not be linked to a particular *DSM* diagnostic category. Many of these patterns are indigenously considered to be ‘illness,’ or at least afflictions, and most have local names” (p. 898). The glossary included in the *DSM* lists more than 20 culture-specific diagnoses along with descriptive features.
- These syndromes can be categorized into the following major definitional iterations:

1. A mental illness that is not attributable to an identifiable organic cause, is often recognized locally as an illness, and does not correspond to a recognized Western medical category
2. An illness that is not attributable to an identifiable organic cause, is recognized within local culture as an illness, and resembles a Western disease category but may lack some symptoms considered as salient in Western culture
3. A discrete disease entity not yet recognized in Western culture
4. A nondescript illness that may or may not have an organic cause and may correspond to a subset of a Western disease category

---

## CULTURE-BOUND SYNDROMES

---

The term *culture-bound syndromes* was first coined in 1951 to describe mental disorders unique to certain societies or culture areas. The syndromes may include dissociative, psychotic, anxiety, depressive,



5. Illnesses in the idiomatic rhetoric category that represent culturally accepted explanatory mechanisms but may not correspond with Western idioms and, in Western culture, may suggest culturally inappropriate thinking and perhaps delusions or hallucinations
6. Illnesses in the category of generalized culture-bound syndromes that are characterized by behaviors such as trance, hearing, seeing, or communicating with the dead or spirits, which may or may not be seen as pathological within local culture but could indicate psychosis, delusions, or hallucinations in Western culture
7. Unreal syndromes that allegedly occur in a given cultural setting, which, in fact, does not exist

As an example, *shenjing shaijo* (“weakened nerves” or “neurasthenia”) is on the list of culture-specific diagnoses in the *DSM* and also is included in the *Chinese Classification of Mental Disorders, Second Edition*. It is characterized by a set of symptoms, including fatigue, headaches, concentration difficulties, sleep disturbance, and memory loss, and, in many cases, the symptoms would meet the criteria for *DSM* Mood or Anxiety Disorder. An apparent psychiatric illness with no identifiable organic cause, *shenjing shaijo* is recognized in the Chinese culture but has locally salient features different from Western diseases and does not typically have symptoms considered critical in Western psychiatry.

Another example is *rootwork*. In the southern United States and in Caribbean societies, *rootwork* is a set of cultural interpretations that explain illnesses such as generalized anxiety, fear, and dizziness, in terms of hexing, witchcraft, voodoo, or the influence of an evil person. It is not so much an actual illness as a locally accepted explanatory mechanism of “illnesses.”

### Points of Tension

Defined as a network of domain-specific knowledge structures shaped by members of a given cultural group, culture is internalized into each individual’s self-concept and functions as a template to guide one’s expectations, perceptions, and interpretations. Culture exerts its influence over individuals through regulating notions of self, reality, social behaviors, and patterns of emotional expression. As such, culture shapes the experience, expression, and meaning of illness by offering specific contents to thoughts and feelings, which, in turn, manifest as psychological discomfort.

Developing a universally applicable set of descriptive criteria of mental disorders thus remains a daunting task, resulting in much dispute about the utility of the concept.

The focus on the debate over the term *culture-bound syndromes* often centers on confusions or conflation among the various culture-bound syndrome categories. Given the heterogeneity of these syndromes in the *DSM*, they are loosely connected at best. Questions remain about the elusive nature of the concept and, in particular, about the lack of clarity regarding the inclusion and exclusion criteria. More specifically, for example, to what extent are the defining features based on peculiarities of the diagnostic process used? Some argue that because the criteria for culture-bound syndromes are socially constructed, every diagnosis, however appropriate, occurs in a broad sociocultural context. The principles of diagnostic systems, therefore, need to be flexibly structured so that the inclusion and exclusion criteria can be applied more directly in the context of the local culture. Questions are raised about how essential characteristics of culture-bound syndromes should be understood within the cultural context. Moreover, given that how individuals perceive, interpret, and respond to mental illness is different from the actual symptoms of the disorder, how much emphasis should be placed on subjective complaint as opposed to symptom manifestation?

Another issue concerns the relationship of culture-bound syndromes to standard diagnostic systems, such as the *DSM*. It has been argued that many mental disorders do not necessarily conform to the categories in the *DSM*, and significant differences are noted across cultures, in part, because of differing beliefs about self and reality as well as different ways of conceptualizing and displaying mental experiences. In this view, mental disorders are believed to be socially and culturally construed. Although the *DSM* has some utility across differing cultural boundaries, the reliability and validity of these classificatory systems are inevitably reduced as a result of the nonuniversality of cultural experiences in relation to mental illnesses.

### Counseling Implications

With the influx of immigrants from various cultural groups, U.S. society has become more diverse, and greater demands are being placed on counselors in all types of agencies to provide services that are culturally responsive and effective. Because culture is such a rich



vein of information, counseling practice is inevitably embedded in multiple sociocultural realities and contexts. As such, the concept of culture-bound syndromes is important for counselors because minority clients, particularly those who are recent immigrants, may bring with them their own indigenous patterns and conceptions of mental illness into the counseling process and relationship. That is, counseling in general, and mental illness in particular, are likely perceived, experienced, and interpreted differently by the client than by counselors. Counselors thus face the challenge of negotiating with their client a diagnosis in the assessment process, which may occur in a number of ways. Some may, for example, share with the client's view of the illness as a culture-bound syndrome and offer interventions that are consistent with the folk medicine treatment. Others may empathize with the client's subjective complaint but decide to educate the client about the causes and nature of the illness as they perceive it. Still others may discount the client's experience of illness as merely exotic, given the imprecise nature of the concept of culture-bound syndrome. The assessment process, the final diagnosis, as well as the interventions are thus dependent, to a considerable extent, upon the multicultural awareness, knowledge, and skills of counselors.

In relation to culture-bound syndromes, multiculturally competent counselors endeavor to become aware of, and knowledgeable about, the location of culture-bound syndromes in their sociocultural context by raising questions such as the following: Who are those who experience the culture-bound syndromes? What contextual factors may affect the manifestation of these syndromes? To what extent do members of some cultural groups complain of somatic discomforts that are, in fact, psychological in origin because their discomfort is locally recognized as an illness? What is the role of culture in the healthcare system? How has Eurocentrism been reflected in the history of the psychiatric diagnostic system most commonly used today?

In an effort to further improve their skills in the assessment of cultural influences on experiences, counselors may need to use the *DSM* guidelines for assessing cultural context by considering (a) the client's cultural identity; (b) cultural expressions and explanations of the illness; (c) cultural factors in relation to psychosocial environment and levels of functioning, such as cultural perceptions of social and situational stressors, social support, level of functioning, and

disability; (d) cultural similarities and differences (e.g., social status, language preference) between the client and counselors that may affect the development of a collaborative working alliance; and (e) a summary statement that describes how cultural factors and issues influence comprehensive diagnosis and care.

Counselors may also benefit from a holistic approach when formulating and classifying the culture-bound syndromes, particularly in making distinctions between subjective complaints and symptom manifestation. In doing so, counselors will likely reduce diagnostic and interpretational biases during the assessment process.

Eric C. Chen

**See also** Cross-Cultural Psychology (v3); Cultural Values (v3); Culture (v3); *Diagnostic and Statistical Manual of Mental Disorders (DSM)* (v2); Ethnicity (v3); Help-Seeking Behavior (v3); Multicultural Psychology (v3); Psychopathology, Assessment of (v2); Spirituality/Religion (v2)

### Further Readings

- American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed., Text rev.). Arlington, VA: Author.
- Guarnaccia, P. J., & Rogler, L. H. (1999). Research on culture-bound syndromes: New directions. *American Journal of Psychiatry*, 156, 1322–1326.
- Hughes, C. C. (1996). The culture-bound syndrome and psychiatric diagnosis. In J. E. Mezzich, A. Klienman, H. Fabrega, & D. L. Parron (Eds.), *Culture and psychiatric diagnosis: A DSM-IV perspective* (pp. 289–305). Washington, DC: American Psychiatric Press.
- Tseng, W. (2001). *Handbook of cultural psychiatry*. San Diego, CA: Academic Press.

---

## CULTURE-FREE TESTING

---

Culture-free testing is far more hypothetical than real. It assumes, if not requires, there are no cultural influences in any measurement and assessment of an individual or group on some trait. This further suggests that measurement and assessment can be designed to only tap into true individual or group traits and not draw on any culture-related error variances that may and do occur. Historically, culture-free measurement



was seen as merely error-reduced measurement. Error here means unintended and undefined variance thought of as being unavoidable yet reducible through solid methodology.

### Culture-Free Testing in Two Test Paradigms or Models

However, the artifact of culture-free testing is easily recognizable in current research paradigms that presume with big enough samples that researchers can control and even eliminate cultural influences or patterns in the data through either matrix algebra or calculus-based statistical methods: classic test theory (Observed Score = True Score + Error) and modern test theory with its Raschian, function-based calculus, respectively.

As such, culture-free testing may be the psychometric equivalent of a myth, or perhaps better stated as a cipher, at present. Namely, in the absence of any quantity or example of a bona fide culture-free test, scientific opinion cannot confirm culture-free testing as a reality, at present. Thus, it may be tempting to summarily dismiss culture-free testing without fully knowing why.

However, its guiding principles have been useful in discouraging, let alone discontinuing, the use and creation of “separate yet equal” versions of tests for men, women, and various ethno-cultural groups.

### Historical Backdrop

Seminal works in the 1950s on the role of values in constructing a valid theory of human action and the need to improve the accuracy of what psychological tests measured have influenced the field to consider that culture serves as a context for understanding an individual. The subsequent waning of an inclusive theory of action and the booming growth of trait-factor testing and measurement meant that “culture as context” became supplanted by the notion of “culture as barrier.” Therefore, a standardized test was presumed to be largely culture free through the 1950s and into the 1960s. By the 1970s, culture-free testing was made an explicit assessment goal from both positivist and civil rights perspectives. As culture-free testing could not be validated by its own data, it did not last long, giving way to the notion of culture-fair testing in the late 1970s and into the early 1980s. Not surprisingly, culture-fair testing, in turn, was not supported by its data, despite the rigors of classic test theory test validation.

It should be noted, however, that the culture-free testing movement still affected testing significantly. For example, a single Strong Interest Inventory with overall, male, female, and other group norms exists instead of separately developed Strong Campbell instruments for each, as was the case in the not too distant past. Thus, the now nonremarkable modern testing practice of using the same instrument yet with different norms was a direct result of this notable psychometric evolution before it dead-ended in classic test theory.

### Implications in Modern Test Theory

Culture-free testing may seem a noble, if not odd, idea that cannot be realized in classic test theory and its matrix algebra assumptions, but what about modern test theory with its calculus-based functions? These equations allow for group differences to be “smoothed out” by an algorithm made up of hundreds, if not thousands, of responses. Thus, modern test theory statistics are not presumably influenced by culture because they are “non-norm norms” or “not group yet group-based comparisons.” Hence, though methodologically debatable, key assumptions of culture-free testing can and do “live on” because of their modern test theory mathematics.

In practice, as might also be expected, cultural and other group effects can and do affect some item characteristic curves or other modern test theory-based data indices. Indeed, cultural data nonuniformly impact an item or a test’s accuracy and consistency. Thus, item/test function shape “morphs” or changes when “true,” nonuniform group differences occur, of which culture is one. In short, modern test theory’s inferred assumptions about being culture free or culture fair do not prevail, despite some mathematical support that it should.

True to postmodern and constructivist assumptions, tests generally work best with those resembling the norming, or even non-norm, group. This too may extend to test developers and test users. Similar to the ciphered culture-free test, confirming data supporting culture-free testing appears to be wanting, and though theoretically plausible in places, it does not now appear to be forthcoming in practice any time soon.

*Jesus (Jesse) R. Aros*

*See also* Bias (v3); Career Counseling, Immigrants (v4); Cross-Cultural Psychology (v3); Cultural Equivalence



(v3); Culture (v3); International Test Commission (v1); Psychometric Properties (v2); Test Interpretation (v2)

### Further Readings

- Anastasi, A. (1982). *Psychological testing* (5th ed.). New York: Macmillan.
- Biggs, D., & Porter, G. (1994). *Dictionary of counseling*. Westport, CT: Greenwood Press.
- Braun, H., Jackson, D., & Wiley, D. (2002). *The role of constructs in psychological and educational measurement*. Mahwah, NJ: Lawrence Erlbaum.
- Cronbach, L., & Meehl, P. (1955). Construct validity in psychological tests. *Psychological Bulletin*, 52, 281–302.
- Hansen, J. I. C. (1992). Does enough evidence exist to modify Holland's theory to accommodate for individual differences of diverse populations? *Journal of Vocational Behavior*, 40, 188–193.
- Hansen, J. I. C. (1992). A note of thanks to the women's movement. *Journal of Counseling & Development*, 70, 520–521.
- Kluckhohn, C. (1951). Values and values orientation in the theory of action. In T. Parsons & E. A. Shils (Eds.), *Toward a general theory of action* (pp. 288–443). Cambridge, MA: Harvard University Press.
- McArthur, C. (1992). Rumbblings of a distant drum. *Journal of Counseling & Development*, 70, 517–519.
- Murphy, G. (1955). The cultural context of guidance. *Personnel and Guidance Journal*, 34, 4–9.

---

## CULTURE SHOCK

---

Culture shock is a complex set of symptoms associated with the experience of migration to or contact with a new environment and the process of adjusting to this new environment. Historically, culture shock was conceptualized as a consequence of stress caused by contact with a new culture, resulting in feelings of anxiety, sadness, and confusion related to the loss of social rules and accustomed cultural cues. Contemporary definitions tend to characterize culture shock as a state of emotional and physical discomfort one experiences when coming into contact with a new culture and the opportunity for adaptation, acculturation, and integration into the host culture. As the population of the United States continues to become more diverse and multicultural, it is important that mental health professionals identify the physical and emotional elements of

culture shock and how to develop appropriate interventions when working with clients experiencing such issues.

### Historical Perspective

The term *culture shock* first came into existence in the mid-1950s when K. Oberg conceptualized culture shock as an experience of strain and anxiety resulting from living in a new culture accompanied by feelings of sadness and loss. In the late 1970s, the concept of culture shock evolved into a more cognitive reaction, which was manifested as feelings of impotence or inability to deal with an environment because of unfamiliarity with the dominant culture. In the 1980s, a more comprehensive definition of *culture shock* was put forth by S. Rhinesmith, who asserted that culture shock occurs when an individual experiences concurrently the challenges associated with living in a new environment and the loss of a familiar cultural environment.

### Contemporary Views

Existing research and literature today focus on diverse aspects of culture shock, such as its symptoms and manifestations. Culture shock typically includes symptoms or feelings of anxiety, isolation, frustration, disorientation, sadness, helplessness, powerlessness, vulnerability, and extreme homesickness. When individuals migrate to a foreign country, their separation from a familiar environment, which includes friends and family members, could result in a sense of personal loss and, thus, a loss of intimacy that was once accessible to them. All of these feelings affect the mental health of individuals experiencing culture shock. As a result, they can isolate themselves from contact with others in the new culture, thus precipitating symptoms such as changes in sleep patterns and appetite and extreme feelings of sadness and worthlessness. Such symptoms, coupled with feeling overwhelmed by new cultural norms, may cause some immigrants to become depressed or to engage in obsessive and/or compulsive behaviors in an attempt to gain control of the foreign situation. All of these symptoms can have a detrimental effect on individuals' sense of self-efficacy, as they may find it difficult to complete the tasks that were once routine for them.

Somatic reactions to culture shock also can be manifested in the lives of individuals who have migrated to a new culture. Because individuals are



constantly (both consciously and unconsciously) processing new information (i.e., language, cultural values, and daily customs) about the host culture, they can experience cognitive fatigue, which can contribute to headaches or migraines. Furthermore, internalized feelings of anxiety about residing in a new country and adapting to a new culture can precipitate panic attacks, extreme sweating, irregular heart beats, high blood pressure, and gastrointestinal disturbances. In addition, marked feelings of homesickness can result in other somatic reactions, such as severe back pain and muscle pain.

### Implications for Counseling

With the changing demographics of the United States and the influx of immigrants to nations around the world, it is important that mental health professionals acquire the knowledge and skills to work effectively with people experiencing culture shock. Ways that mental health counselors can be cognizant of potential culture shock symptoms include assessing immigration status and generational status of individuals, assessing their length of stay in the country, and evaluating their experiences of adjustment to the new culture. Finally, physical manifestations of culture shock must be taken into account when counseling individuals who have recently immigrated. Mental health interventions that work with clients' adjustment to and sense of efficacy living in a culture different from

their own will be beneficial to their physical and mental well-being.

*Cristina Dorazio and Madonna G. Constantine*

**See also** Acculturation (v3); Acculturative Stress (v3); Adaptation (v3); Assimilation (v3); Enculturation (v3); Cultural Values (v3); Culture (v3); International Developments, Counseling (v1); Person–Environment Fit (v4); Person–Environment Interactions (v2); Psychological Well-Being, Dimensions of (v2); Stress (v2)

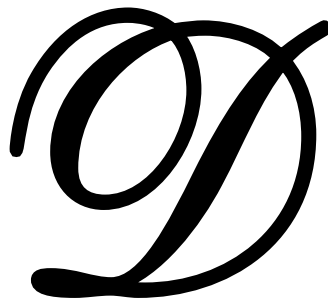
### Further Readings

- Constantine, M. G., Anderson, G. M., Berkel, L. A., Caldwell, L. D., & Utsey, S. O. (2005). Examining the cultural adjustment experiences of African international college students: A qualitative analysis. *Journal of Counseling Psychology, 52*, 57–66.
- Merta, R. J., Stringham, E. M., & Ponterotto, J. G. (1988). Simulating culture shock in counselor trainees: An experiential exercise for cross-cultural training. *Journal of Counseling & Development, 66*, 242–245.
- Misra, R., & Castillo, L. G. (2004). Academic stress among college students: Comparison of American and international students. *International Journal of Stress Management, 11*(2), 132–148.
- Oberg, K. (1960). Culture shock: Adjustments to new cultural environments. *Practical Anthropology, 4*, 177–182.
- Winkelman, M. (1994). Culture shock and adaptation. *Journal of Counseling & Development, 73*, 121–126.









---

## DEFICIT HYPOTHESIS

---

Social science and medical literature, including research on mental health and counseling, has frequently been based on presuppositions that all individuals who differ from members of the sociopolitically dominant cultural group in the United States (i.e., male, heterosexual, Caucasian, Western European Americans of middle-class socioeconomic status and Christian religious affiliation) are deficient by comparison. This *deficit hypothesis* is particularly apparent in scientific literature presumptions that attribute psychological differences from Caucasians to deviance and pathology.

### Inferiority Premise

Regarding members of U.S. racial and ethnic minority groups (or people of color)—African American, Hispanic/Latino/a American, Asian American, and American Indian people—the inferiority model is one example of a deficit hypothesis. The inferiority model assumes that the dominant Caucasian group represents the standard for normal or ideal behavior and that cultural groups who differ from these norms are biologically limited and genetically inferior by comparison. In contrast, psychology literature includes critiques that cite how data have been distorted or fabricated to support the inferiority model.

For example, based on the belief that smaller skull size and underdeveloped brains were biologically determined measures of the inferior intelligence of people of color, Samuel George Morton, in the 19th century, published research findings that supported

the prevailing inferiority view. Subsequent scholars (e.g., Stephen Jay Gould) disputed these findings by examining Morton's data and reporting errors of calculation and omission. Nevertheless, the inferiority deficit hypothesis persisted in the mental health and social science literature and practices of the 20th century. Eminent leaders in early American and British psychology perpetuated the inferiority belief of their times.

In 1904 G. Stanley Hall, the first president of the American Psychological Association, published his belief that Africans, American Indians, and Chinese people were in an adolescent or immature stage of biological evolution compared with the more advanced and civilized development of Caucasian people. Cyril Burt, an influential British psychologist whom many consider the father of educational psychology, published fabricated data to support his contention that Negroes inherit inferior brains and lower intelligence compared with Caucasians. In 1976, Robert Guthrie presented a critique of the flawed scientific evidence offered by several researchers who had claimed to verify the inferior intelligence of American Indians and Mexican Americans. In part due to the conclusions drawn from an inferiority deficit hypothesis, people of color who exhibited symptoms of psychological distress were considered unworthy or incapable of benefiting from most psychological or educational interventions. Thus, they were ignored, jailed, or confined to segregated mental hospitals.

The inferiority premise has resurfaced in current times, for example, in the 1994 publication of Richard Herrnstein and Charles Murray's *The Bell Curve: Intelligence and Class Structure in American Life*.



Similar to previous investigations based on an inferiority hypothesis, the research of these authors concluded that intelligence is largely inherited and correlated with race; that those who have inferior intelligence (i.e., people of color) should serve those who have superior intelligence (i.e., Caucasians); and that programs purported to promote the intellectual functioning of people of color (e.g., Head Start) are useless, and thus their resources and funding should be reallocated to serve people who are capable of benefiting (i.e., Caucasians of superior intelligence). Subsequently, scholars (e.g., Ronald Samuda, Franz Samelson, Alan Reifman) have refuted these findings and presented empirical evidence that challenges and rejects these conclusions.

### Cultural Deprivation Premise

In the context of the social activism of the 1950s and 1960s in the United States, the genetic inferiority premise of the deficit hypothesis shifted to a cultural deprivation premise. Similar to the inferiority model, the cultural deprivation model assumes that the dominant Caucasian group represents the standard for normal or ideal behavior. However, this model attributes psychological differences from Caucasians to the various ways in which people of color are socially oppressed, deprived, underprivileged, or deficient in comparison.

The term *cultural deprivation* emerged from scholars' writing about poverty in the United States during the 1950s and 1960s (e.g., Frank Riessman's 1962 book, *The Culturally Deprived Child*). The deficit hypothesis of cultural deprivation posits that poverty-stricken racial/ethnic minority groups perform poorly in psychological and educational testing and exhibit psychologically unhealthy characteristics because they lack the advantages of Caucasian middle-class culture (e.g., in presumably superior education, books, toys, and formal language). Not only does this premise mistakenly imply that people of color have no valuable cultures of their own, but it also infers that the destructive influences of poverty and racial/ethnic discrimination cause irreparable negative psychosocial differences in their personality characteristics, behavior, and achievement compared with more favorable middle-class Caucasian standards.

In rebuttal, scholars have criticized the scientific merit of the research design and interpretations of findings from studies claiming to support the cultural deprivation model. For example, Abram Kardiner and

Lionel Ovesey published a book in 1951, titled *The Mark of Oppression*, in which they concluded that the basic Negro personality, compared with the general Caucasian personality, is a manifestation of permanent damage, in response to the stigma and obstacles of the social conditions faced by Negroes in U.S. society, which prevents them from developing healthy self-esteem and promotes self-hatred. Scholarly critiques have noted that the authors made these generalizations on the basis of 25 psychoanalytic interviews with African American participants, all of whom but one had identified psychological disturbances, in comparison to a so-called control group of one Caucasian man. Furthermore, Kardiner and Ovesey's conclusions were disputed for failing to recognize that individuals may respond in a variety of ways (including healthy and unhealthy responses) to stress, hardships, and oppression.

One useful purpose served by studies based on the cultural deprivation premise was the attention paid to the psychosocial and environmental barriers facing people of color and their families. On the other hand, most studies focused only on abnormal and negative aspects in the lives of people of color (e.g., crime and juvenile delinquency). One detrimental implication for cross-cultural counseling is that counselors may similarly attend to and focus on only negative aspects in their assessment and interventions with clients of color. Thus (as noted by scholars such as Elaine Pinderhughes), counselors may misattribute as pathological these clients' responses to oppression instead of recognizing aspects that may be positive, healthy, and resilient.

### Applications to Other Nondominant Groups

In addition to applications with people of color, the deficit hypothesis may form the basis for some counseling research and practice with other nondominant groups (e.g., by gender, sexual orientation, or religious affiliation). In other words, the deficit hypothesis may be apparent in presumptions that attribute psychological differences from the dominant group in U.S. society (e.g., male, heterosexual, or Christian) to deficiency or pathology. For example, Carol Gilligan's research findings have disputed an underlying deficit hypothesis regarding gender differences in moral development (i.e., that female participants are deficient in moral reasoning compared with males).



Her research has demonstrated that the moral reasoning of girls and women is different from, instead of inferior to, that of boys and men.

### Alternative Premises

Two alternative premises to those that use only one standard of comparison (e.g., Caucasians) are models of counseling and psychotherapy based on cultural differences or diversity. Another alternative perspective to the deficit hypothesis is that of optimal human functioning. In contrast to presuming mental health deficiency in cultural group members who differ from the dominant group, the basic premise of optimal human functioning is that there are many ways to be human and promote healthy development in response to different cultural contexts and human conditions. One implication for cross-cultural counseling research and practice is that this model for conceptualizing healthy development includes both emic (culturally specific) and etic (universal) considerations. These alternative models of personality and human development offer propositions to explore beyond the ethnocentric limitations of the deficit hypothesis.

*Margo A. Jackson and Jaya Mathew*

**See also** Barriers to Cross-Cultural Counseling (v3); Bias (v3); Discrimination (v3); Ethnocentrism (v3); Eurocentrism (v3); Monocultural (v3); Oppression (v3); Prejudice (v3); Racism (v3); Sexism (v3); Social Discrimination (v4); Universalism (v3); Visible Racial/Ethnic Groups (v3); White Privilege (v3)

### Further Readings

- Gilligan, C. (1982). *In a different voice: Psychological theory and women's development*. Cambridge, MA: Harvard University Press.
- Guthrie, R. V. (2004). *Even the rat was White: A historical view of psychology* (2nd ed.). Upper Saddle River, NJ: Pearson.
- Walsh, W. B. (Ed.). (2003). *Counseling psychology and optimal human functioning*. Mahwah, NJ: Lawrence Erlbaum.

percentage terms, reflect an unprecedented demographic complexity in the history of the nation. Thirty-one percent of the total U.S. population is composed of ethnic and racial minorities. In addition, 11% of the total U.S. population is foreign born; of these, 51.7% are from Latin America and 26.4% are from Asia. For the first time in history, the United States is experiencing a large proportion of children and young adults who are not of European ancestry and do not speak either a Germanic language (including English) or a Slavic language as their first language.

### Demographic Changes

Changes in the information collected in the most recent U.S. Census, such as mixed-race status, same-sex couples, and grandparental caregiving, have provided a rich, albeit complex, demographic landscape. Some of the demographic changes influencing the research, teaching, and practice of counseling psychology are summarized in this section.

### Race and Ethnicity

The ratio of persons of color to Whites increased from 1 out of every 8 persons in 1900 to approximately 1 out of every 3 in 2000. Most of the increase in racial and ethnic diversity occurred in the latter part of the 20th century, with an increase of 88% from 1980 to 2000 in the combined non-White and Latino/a population. The Asian and Pacific Islander population tripled while the White population dropped 12 percentage points between 1970 and 2000. In addition, the option to select more than one racial group in the 2000 census identified 6.8 million (2.4%) multiracial individuals. The increase in racial and ethnic diversity in the United States has been attributed mainly to unprecedented international migration rates from Latin America and Asia/Pacific Islands and higher birth rates for these groups. Latinos/as, an ethnic category that includes any race, is the fastest-growing segment of the population with an increase from 6.4% in 1980 to 12.5% of the total population in 2000.

### Age

The proportion of older people is increasing and that of younger people is decreasing, particularly for White groups. The number of people age 65 years and older increased 10 times since 1900, with a total of

---

## DEMOGRAPHICS, UNITED STATES

---

Considerable changes in the population characteristics of the United States, both in numerical and in



35 million, or 12.4% of the population, in 2000. This number is expected to increase again substantially in the 2010s when baby boomers begin approaching conventional retirement age. The proportion of the population of children under 15 years of age has declined since 1900, dropping from 1 out of every 3 (35.5%) individuals to 1 out of every 5 (21.4%) in 2000. The increase in racial diversity in immigration has also influenced the age composition of the United States, with younger age cohorts having a greater percentage of individuals of color than older age cohorts. Latinos/as have the youngest median age and have the highest percentage of children under 15 (32%), while non-Latino Whites have the oldest median age and lowest percentage of children under 15 years of age.

### ***Households and Family Structure***

The U.S. Census 2000 reflected a growing complexity in household composition. Fifty-two percent of all households were composed of married couples while 9% of coupled households were composed of unmarried couples, a figure that increased 63% from 1990 to 2000. The number of unmarried couples is likely larger because the census restricted responses to only heads of households and their partners. African Americans and Native Americans/Alaskan Indians had the largest percentages of unmarried couples with 16.9% and 17.4%, respectively, while Asians had the lowest reported rates with 4.7%. The one-person household experienced the greatest growth and was 26% of all households in 2000. In addition, 1 out of every 9 households described as composed of unmarried partner couples were same-sex unions in the 2000 census. Approximately 1 out of 4 same-sex couples are parenting children under 18 years old.

About 5.8 million grandparents were identified as living with their grandchildren in the U.S. Census 2000, and 2.4 million were identified as the primary caregivers of these children. Grandparents residing with their grandchildren and serving as caregivers were more common with non-Whites and Latinos/as. However, Latino (35%) and Asian (20%) grandparents living in multigenerational households are less likely to be caregivers than African Americans (52%) and Native Americans/Alaskan Natives (56%).

### **Mental Health Care Need and Use**

Findings from different studies converge to highlight high prevalence of unmet mental health care needs.

Forty-six percent of adults in the United States are predicted to meet diagnostic criteria for a mental health disorder in their lifetime, according to findings from the National Comorbidity Survey Replication. The Survey also found that only 41% of adults in need of mental health services received treatment with rates of unmet need greater for ethnic and racial minority groups, the elderly, and the poor. Data on mental health service use for children and adolescents are even more disheartening, with 79% of those with mental health needs going unmet. Similar to the adult population, ethnic/racial minority children and adolescents have higher rates of unmet mental health needs (African Americans 76.5%, Latinos/as 88.4%, Other 89.7%) than Whites (76%).

Ethnic/racial minority status, low educational level, and low income have been found to be associated with premature termination of mental health services. For example, once services are initiated, African American families have been found to have attrition rates greater than 50%. African Americans have also been found more likely to receive low-quality psychiatric care, which may partially explain the high attrition rates. Being Latino/a, particularly of Mexican descent, has been associated with low use of mental health services. Only 15% of Mexican immigrants and 37% of U.S.-born Mexican Americans with psychiatric disorders have been found to receive care from a general practitioner, mental health professional, other professionals, or informal helpers to address their mental health needs.

In addition, findings from the McArthur Foundation National Survey of Midlife Development in the U.S. suggest that individuals with minority sexual orientation (e.g., lesbian, gay, bisexual) have higher prevalence rates of major depression, panic attacks, psychological distress, and generalized anxiety disorder than do heterosexual men and women. Lesbians, gay men, and bisexual individuals have been found to use mental health services more than their heterosexual counterparts and account for 7% of adults between the ages of 25 and 74 receiving mental health services.

### **Implications for Counseling Psychology**

The demographic characteristics of counseling psychologists in the United States, as reflected in the membership to American Psychological Association's Society of Counseling Psychology, suggest that approximately 11% of counseling psychologists at the



doctoral level self-identify as non-White or Latino/a, falling short of reflecting Census 2000 data by two thirds. The average age of counseling psychologists (57 years) reflects the fact that 78% of members are White, which is the oldest racial group in the United States. This high number of older members also suggests that the number of younger people entering the field is relatively low and that fewer counseling psychologists will be available to address the needs of Latinos/as, Asians, and Blacks, who are the youngest groups, and of individuals with minority sexual orientations in the near future.

Recent research suggests that ethnic match between therapist/counselor and client is not a strong predictor of mental health service use or premature termination of treatment, suggesting that culturally competent and responsive care may be more predictive of use and continuation of services than the ethnic or racial status of the counselor. This emphasis on cultural competence and culturally responsive care has two major implications for both practicing and counseling psychologists in training. First, it suggests a focus on ethnic-specific or minority group-specific (e.g., individuals with minority sexual orientations) mental health needs and program development. Second, it emphasizes the increasing importance that counseling psychology training programs include in their curricula ethnic-specific engagement and treatment retention strategies and minority group-specific concerns. Moreover, the increasing ethnic and racial diversity of the United States and the greater visibility of lesbians, gay men, and bisexual individuals point to the need to recruit more young individuals to join the profession.

Ané M. Maríñez-Lora and Stephen M. Quintana

*See also* African Americans (v3); Alaska Natives (v3); Asian Americans (v3); Cross-Cultural Training (v3); Diversity (v3); Diversity Issues in Career Development (v4); Ethnic Minority (v3); Immigrants (v3); Latinos (v3); Multicultural Counseling Competence (v3); Pacific Islanders (v3); Socioeconomic Status (v3); Visible Racial/Ethnic Groups (v3); White Americans (v3)

### Further Readings

Cochran, S. D., Sullivan, J. G., & Mays, V. M. (2003). Prevalence of mental disorders, psychological distress, and mental services use among lesbian, gay, and bisexual adults in the United States. *Journal of Consulting and Clinical Psychology, 71*, 53–61.

- Gates, G. J., & Ost, J. (2004). *The gay and lesbian atlas*. Washington, DC: Urban Institute Press.
- Hobbs, F., & Stoops, N. (2002, November). *Demographic trends in the 20th century* [U.S. Census Bureau, Census 2000 Special Reports, Series CENSR-4]. Washington, DC: Government Printing Office.
- Kataoka, S. H., Zhang, L., & Wells, K. B. (2002). Unmet need for mental health care among U.S. children: Variation by ethnicity and insurance status. *American Journal of Psychiatry, 159*, 1548–1555.
- Kazdin, A. (1996). Dropping out of child psychotherapy: Issues for research and implications for practice. *Clinical Child Psychology and Psychiatry, 1*, 133–156.
- Kessler, R. C., Berglund, P. A., Demler, O., Jin, R., Merikangas, K. R., & Walters, E. E. (2005). Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication (NCS-R). *Archives of General Psychiatry, 62*(6), 593–602.
- Maramba, G. G., & Hall, G. C. N. (2002). Meta-analyses of ethnic match as a predictor of dropout, utilization and level of functioning. *Cultural Diversity & Ethnic Minority Psychology, 8*, 290–297.
- Vega, W. A., Kolody, B., Aguilar-Gaxiola, S., & Catalano, R. (1999). Gaps in services utilization by Mexican Americans with mental health problems. *American Journal of Psychiatry, 156*, 928–934.
- Wang, P. S., Lane, M., Kessler, R. C., Olfson, M., Pincus, H. A., & Wells, K. B. (2005). Twelve-month use of mental health services in the U.S.: Results from the National Comorbidity Survey Replication (NCS-R). *Archives of General Psychiatry, 62*(6), 629–640.
- Wierzbicki, M., & Pekarik, G. (1993). A meta-analysis of psychotherapy dropout. *Professional Psychology: Research and Practice, 24*, 190–195.

---

## DISCRIMINATION

---

To discriminate is to make distinctions or to acknowledge that differences exist. Therefore, discrimination is an act or practice of making distinctions based on perceived or actual differences. Although the word *discriminate* has neither a negative nor a positive connotation, the term *discrimination* often carries a negative undertone. Because these two terminologies do not carry the same meaning, Carl Friedrich Graumann and Margaret Wintermantel termed the latter *social discrimination*. This entry is concerned with social discrimination, which is defined as any behavior made by a person toward another that is based exclusively on the other's innate characteristics or group



membership. Social discrimination involves denying people fair treatment because of their group membership or personal attributes without considering their individual merit or ability.

Discrimination is not the same as stereotypes or prejudice. Unlike these two constructs, which involve primarily cognitive elements, discrimination involves *actions* that are often dependent on people's motivation level and ability to discriminate. It may manifest itself in more than one form (i.e., subtle and direct) and on two different levels (i.e., individual and institutional). Discrimination may be further classified into numerous types, the most common ones being race, ethnicity, gender, age, religion, class, sexual orientation, ability, and mental illness. Existing theories on discrimination suggest that it may be caused by both individual (e.g., personality) and structural factors (e.g., intergroup conflict).

### Discrimination Versus Stereotypes and Prejudice

While the construct of discrimination is conceptually related to prejudice and stereotypes, several important distinctions merit consideration. Stereotyping involves placing things or people into categories in an oversimplified manner. Hence, stereotypes are overgeneralized mental representations that may carry a positive or a negative meaning. Because stereotypes are frequently acquired through hearsay, it is difficult to know if they are true or false. A number of social cognitive theorists, including Gordon Allport, believe that humans naturally place things and people in categories to create a sense of coherence in our world and to increase personal comfort. For Henri Tajfel, the exaggerations of group attributes often associated with stereotypes stem from the inability of humans to process excess information. Whereas stereotypes involve a person's positive or negative belief or opinion about the characteristics of a certain group and its members, prejudice is an individual's negative attitude toward, or tendency to make negative attributions of, a particular group. For instance, if a person perceives Asians as competitive and frugal (stereotypes), and if these attributes are viewed negatively, then this person will likely have negative attitudes (prejudice) toward Asians.

Unlike prejudice and stereotypes, which involve cognitive and affective components, discrimination entails observable behaviors, which can be blatant or subtle. Although it may be logical to assume that

negative attitudes can lead to discriminatory actions, the relationship between discrimination and prejudice is not straightforward. In fact, studies that document inconsistencies between attitudes and behaviors have been in existence since the 1930s. Nonetheless, some scholars argue that these observed discrepancies may be due to measurement error rather than to actual inconsistencies between the two constructs: Whereas attitudes are usually assessed using global scales, behaviors are often measured specifically.

### Ability and Motivation to Discriminate

Two factors have been proposed to help explain the lack of consistency between attitudes and behaviors: ability and motivation to discriminate. Because discrimination involves actions that are intended to disadvantage certain people, it would require the person discriminating to have the ability to do so. Jennifer L. Eberhardt and Susan T. Fiske relate one's ability to discriminate to the concept of power. They assert that discrimination occurs when people in power make important choices that ultimately restrict the opportunities of individuals from certain groups. For instance, an individual may hold negative beliefs about a certain group yet may be unable to cause harm. Thus, according to this definition, if the consequences of the person's actions do not lead to disparities in the way groups are treated, discrimination may not occur.

One's motivation to discriminate is another important factor when considering the connection between attitudes and behaviors. In general, strong, negative attitudes and feelings (e.g., anger and hatred) toward certain groups increase people's level of motivation to discriminate against members of such groups. Some believe that tension between groups and perceived threat, which intensifies existing negative attitudes, further stimulate people's tendency to act on their beliefs and desires. Attitudes with less intensity, on the other hand, are less likely to be transformed into action. Although there has been much scholarly interest in examining how prejudice leads to discrimination, researchers are becoming increasingly interested in examining the factors that allow people to resist acting on their negative attitudes.

### Forms and Levels of Discrimination

Discrimination takes on several forms. According to David Schneider, *straight-line discrimination* (i.e.,



direct) involves deliberate and conscious negative behaviors that target individuals from certain groups. On the other hand, *subtle discrimination* (i.e., indirect) is characterized by a range of different behaviors, which may involve a decision not to help and other nonverbal actions.

Discrimination occurs on two levels. On the individual level, discrimination is described as the unequal treatment of an individual based on group membership. Unfair hiring practices that base eligibility on an applicant's group affiliation (i.e., racial, religious, etc.) is one of the most common examples of discrimination. Individual-level discrimination can be deliberate or subtle in form. On the societal level, *institutional discrimination* is characterized by a pattern of unequal treatment of individuals based on their group membership. Such patterns are sewn into the fabric of the society or institutions and are often perpetuated unconsciously by prejudice. Institutional discrimination occurs when prejudice permeates the public domain and becomes part of public policy, thus limiting opportunities for certain groups. Like individual-level discrimination, institutional discrimination can be either deliberate (e.g., the decision of lawmakers not to allow certain groups to vote) or subtle (e.g., requiring both male and female police recruits to pass a strength test normed on men before becoming an officer).

## Theoretical Background

### *Social Identity*

Humans naturally organize their lives into structures and develop habits to feel comfortable and secure. Identity facilitates the creation of meaning and structure in people's lives. Theorists believe that having the security of knowing one's self according to one's own history and one's social group membership is vital to people's mental health. Furthermore, individuals frequently derive meaning from their lives by comparing themselves to those who belong to other groups. For instance, masculinity is meaningful only when a person contrasts it with femininity. Although the process of making comparisons extends beyond just physical characteristics, external attributes are what people often use to differentiate themselves from others.

Two theories are widely recognized with regard to social identity. In social identity theory, social groups are seen as an important source of identity. The theory posits that, in general, people like to view themselves positively

and they want to feel positive about themselves. To achieve this, people join groups that will either improve their positive identity or enhance the worthiness of the group to which they already belong. To achieve positive self-regard, people often feel motivated to make distinctions between their own group and other groups. Not surprisingly, they are more likely to favor their own group. Some scholars assert that although hostility toward members of the other group is not central to social identity theory, it is a natural corollary. Social identity theory maintains that conflict develops not only from limited physical resources, which is a realistic threat, but also from scarce social resources, which form a symbolic threat. Social resources include norms, moral principles, and beliefs that people hold. When a minority group advances norms that are different from those of the majority, members of the majority group may feel threatened by the new value system.

Self-categorization theory, which was derived from social identity theory, underscores the relevance of the cognitive aspect of group identity. This theory purports that group identity is not always salient to an individual's identity and that it may become relevant only when certain environmental cues trigger the individual's identification with certain groups. For instance, being the only White man in a room full of Asian women may trigger certain feelings that one has about being male and being White.

### *Ingroup-Outgroup Bias*

William G. Sumner coined the terms *ingroup* (relating to members of one's own group) and *outgroup* (relating to members of other groups) in 1907. Sumner argued that it is natural for humans to derogate members of the outgroup because it promotes devotion to the ingroup and its accepted norms. Two codes that govern group behavior according to Herbert Spencer are the codes of "amity" and "enmity." The code of amity is characterized by positive feelings toward members of the ingroup, while the code of enmity involves negative feelings and behaviors toward those of the outgroup. Sumner later termed this phenomenon of favoring the ingroup and derogating the outgroup *ethnocentrism*. For Sumner, devotion to one's group is necessary for the survival of its members; this notion is rooted in the evolutionary theory and in social Darwinism.

Ingroup bias occurs when people give preferential treatment to members of their group or when individuals evaluate a member of their group more favorably



than they do nonmembers. For instance, students in one university are likely to evaluate their sports team, regardless of their performance, more favorably than teams from other universities. In fact, findings from a number of studies suggest that individuals are more likely to show positive behaviors toward members of their own ingroup than members of the outgroup even if there are no direct benefits to showing favoritism to members of one's own group. Accordingly, this also means that people are likely to discriminate against members of the outgroup even if doing so presents no perceived value to them or their group.

### **Social Dominance**

Another influential theory that has been proposed recently to explain the basis of social discrimination and inequality is social dominance theory. Social dominance theory states that human societies naturally organize themselves into groups. These groups reflect social hierarchies wherein groups in power enjoy substantial privilege and social value while subordinate groups suffer negative consequences and stigma. There are three distinct group systems within this theory: the age system (which privileges adults and middle-age people over the young), the patriarchal system (favoring males over females), and the arbitrary set system (which is made up of socially constructed group distinctions based on situational and historical factors, including race, social class, religion, etc.).

Social dominance theorists believe that the systematic nature of group discrimination results from people's shared knowledge and beliefs that serve to legitimize and uphold discriminatory practices. These scholars suggest that these shared ideologies influence how resources are allocated, which in turn serve to perpetuate existing prejudice and discriminatory behaviors. According to James Sidanius, the acceptance of principles that legitimize discrimination is due, in part, to people's desire to be in power, a psychological orientation known as the *social dominance orientation*. This orientation is viewed to be influenced not only by individual factors (e.g., personality), but also by contextual factors (e.g., power differential).

Sidanius and his colleagues also assert that focusing solely on the individual's psychological motivation and social construals (as in the case of social identity theory) to explain the nature of discrimination ignores the important social consequences of the actions (i.e., systematic oppression or structural inequality) or the

structural causes of the behaviors. On the other hand, they maintain that focusing mainly on structural theories fails to explain individual differences in behaviors. Several theorists argue that social dominance theory addresses the limitations of the two approaches by focusing on both structural and psychological aspects of discrimination, its universal and subtle forms, and the interaction between different systems (e.g., individual predispositions, social contexts, and cultural ideologies).

## **Common Types of Social Discrimination**

### **Race and Ethnicity**

Racial discrimination refers to the unequal treatment of people on the basis of race. Although the definition of race is often disputed, racial discrimination usually references unequal treatment of people based on widely shared notions of race that are based largely but not exclusively on physical attributes (including the color of their skin, the shape of their eyes, etc.) and cultural heritage. Rich accounts of racial discrimination and oppression exist in the histories of the United States and other countries.

Although the United States has made improvements to reduce discriminatory behaviors through public policy, several historical factors continue to perpetuate racism, which has been present since the time of slavery. Inequalities in job opportunities and educational access with regard to racial differences are still prevalent, and minority groups continue to have lower income and higher unemployment rates compared with their White counterparts. Though overt racial discrimination decreased over the years, modern institutional discrimination has taken its place. Racial discrimination emphasizes the inferiority of the minority groups, which can invoke different emotions for members of the subjugated group, such as feelings of humiliation, shame, frustration, anger, and even hatred toward members of other groups. Hence, discrimination has important psychological implications for its victims. The development of various psychological symptoms, such as depression and anxiety, has been linked with the stressful experiences of those who have been the targets of discrimination.

The continued arrival of immigrants, including refugees, in the United States, reinforces the concept of ethnic and racial difference (the idea of "us vs. them"). Xenophobia (the irrational fear of strangers)



brings about feelings of distrust of and discomfort around immigrants. These feelings may activate people's prejudice, which in turn increases their motivation to discriminate. Discrimination toward immigrant groups is well documented throughout history and has been associated with competition over limited employment opportunities. For instance, one of the underlying causes of the 1992 Los Angeles riots was the high rate of unemployment and the changing ethnic makeup of the city. As Hispanic immigrants began to populate historically African American neighborhoods, Koreans took over businesses that were formerly owned by Blacks. As a result, a number of riot victims experienced substantial distress and trauma characteristic of post-traumatic stress disorder. Although there are larger institutional issues linked with the L.A. riots, this incident also serves as an example that prejudice and discrimination may occur even between members of various minority groups.

Access to education is another issue relevant to discrimination that continues to stimulate public debate. Affirmative action is a policy that began as a measure to correct institutional discrimination against traditionally underrepresented groups. Whereas some people believe that affirmative action can promote the advancement of historically disadvantaged groups, others argue that it is an act of reverse discrimination that discriminates against poor Whites and Asians. Certain psychological outcomes have been associated with affirmative action. It has been found that affirmative action sometimes decreases the recipients' level of motivation and self-efficacy, and that individuals who believe that they were hired because of their minority status suffer the stigma of incompetence. Furthermore, they may be subjected to prejudice and further discrimination, especially by those who feel that they are undeserving. The pressure of performing to expectations adds to the stress that these individuals face.

## **Gender**

Gender discrimination refers to behaviors that deny individuals opportunities and privileges on the basis of their gender. Unlike the category of sex, which classifies people according to their biological or phenotypic differences (i.e., male or female), gender encompasses both biological and social components. When people talk about gender, they are usually referring to the social or cultural attributes of being male or female (i.e., masculinity and femininity).

The treatment of men and women has varied significantly by country throughout history. Nonetheless, some scholars claim that the existing body of evidence suggests that women in most societies are perceived as subordinate to men. In the United States, women were not afforded the same employment opportunities as men, who were more likely to receive better educational opportunities. Women have historically accepted roles ascribed to them by their male-dominated society. It was not until after the Seneca Falls Convention of 1848 that more women began to play a more active role in advocating for their rights. Moreover, Title VII and Title IX of the Civil Rights Act (which removed employment and educational barriers for women, respectively) were designed to help improve the opportunities of women in the educational and occupational arenas. However, the current state of inequality between men and women suggests that these policies, which are intended to protect women, are not implemented effectively. Women continue to work in low-status jobs and are paid less than men who hold the same position.

Some theorists argue that benevolent prejudice, not hostile sexism, is the main cause of ongoing gender discrimination. Paternalism, which allows men to assert their privilege as the dominant gender, can be used to argue that men use their position of power to women's benefit, an idea that seems favorable to women. Men in male-dominated societies reason that they carry a great deal of responsibility to protect and provide for women. This paternalistic idea, however, has hurt women more than it helped them because it supports patriarchy. Research on affirmative action, which also promotes the preferential hiring of women, suggests that women who believe that they get hired because of their gender are less likely to be motivated, interested, and committed to their occupations. They are also more likely to negatively evaluate their ability and performance on a task.

Finally, women have frequently been viewed as sex objects throughout history. Research found that women are more likely than men to be the target of sexually derogatory comments and to be perceived as sexual objects. These sexist incidents were found to be associated with depression, anger, and decrease in self-esteem.

## **Sexual Orientation, Ability, and Mental Illness**

People who are discriminated against because of their sexual orientation, ability, or mental illness share



one thing in common: They possess characteristics that many people would consider to lie outside a socially constructed idea of normality. Hence, they can be easily seen as members of the outgroup. Discrimination based on sexual orientation refers to behaviors that deny people opportunities and rights because of their sexual orientation (e.g., homosexuality and bisexuality). Because it is often perceived that attraction to a person from the opposite sex is normal and natural, anything that deviates from this biological norm is seen as “abnormal.” A large majority of gays, lesbians, and bisexuals report experiencing discrimination because of their sexual orientation, and their rate of victimization (due to hate crimes) is higher than that of the national population, especially for gay males. Furthermore, many gays and lesbians also report being denied employment because of their sexual identity, while those employed but treated unfairly in their work environment are more likely to have negative attitudes about work. Population-based studies also indicate that lesbian and gay youth have higher rates of major depression, generalized anxiety disorder, and substance abuse and dependence compared with the general population. Epidemiologists associate these observed rates to perceived discrimination (stigma) felt by gay men and lesbians. Gay men also face the stigma of being perceived as having AIDS or HIV. The fear of the AIDS epidemic may further motivate heterosexual people with homophobia to discriminate against gay men.

Like homosexuality, a person’s disability has been seen as a deviation from what is considered normal. Discrimination due to one’s disability occurs when a competent person with a disability (i.e., physical or mental impairment that limits the execution of certain activities) is denied the same opportunities as those who do not have disabilities. Historically, individuals with disabilities were institutionalized and separated from people who were considered “normal.” Ability-based discrimination can be traced back to the eugenics movement and to the idea of natural selection. Supporters of the movement feared that human civilization would be bound to failure if the “inferior” classes multiplied to produce more “defective” children. People with visible disabilities, in particular, face the stigma of being seen as different. They have also experienced hate crimes, which have been associated with post-traumatic stress, depression, anxiety, and anger. People with disabilities make up the largest minority group in the United States. They have a very

high unemployment rate, which many argue is the result of the failure of the larger society to accommodate people of different abilities. For instance, many establishments do not offer Braille for individuals with visual impairment or an interpreter for those who are deaf or hard of hearing.

Since the United Nations broadened the definition of disability to include mental illness, many have referred to mental illness as a form of disability. Supporters of the eugenics movement were not only concerned with people with physical disabilities; they were also worried about people with mental illness, regarding the mentally ill as “feeble-minded.” Today, many people with mental illness are still stigmatized and seen as abnormal. Despite efforts to educate people about the etiology of mental illness, many still attribute mental illness to physical or moral weakness, resulting in a number of individuals with mental illness suffering humiliation for their conditions. In some cultures (e.g., South Asians) that value close-knit relationships with community members, mental illness brings shame to the family because it carries a stigma. Accordingly, they may delay seeking treatment because they fear degradation and the stigma that comes with the illness.

### ***Other Types of Discrimination***

Discrimination has many types. Certain types may be more controversial than others, depending on the current state of affairs. Moreover, some people may be more likely than others to fall victim to discrimination because they belong to more than one discriminated group. Gay Black men, for example, may be more likely to suffer from hate crimes than heterosexual Black men or gay White men. Understanding how the interactions between the different types of discrimination affect both the risk for becoming a victim of discrimination and the possibility of subsequent mental health problems is an important issue to consider.

*Noriel E. Lim and Sumie Okazaki*

**See also** Affirmative Action (v3); Antisemitism (v3); Bias (v3); Classism (v3); Deficit Hypothesis (v3); Discrimination and Oppression (v2); Diversity Issues in Career Development (v4); Ethnocentrism (v3); Prejudice (v3); Racism (v3); Sexism (v3); Social Class (v4); Social Discrimination (v4); Social Identity Theory (v3); Stereotype (v3); Tokenism (v3)



## Further Readings

- Allport, G. (1954). *The nature of prejudice*. Garden City, NY: Addison-Wesley.
- Crosby, F., Bromley, S., & Saxe, L. (1980). Recent unobtrusive studies of Black and White discrimination and prejudice: A literature review. *Psychological Bulletin*, 87, 546–563.
- Eberhardt, J. L., & Fiske, S. T. (1996). Motivating individuals to change: What is a target to do? In C. N. Macrae, C. Stangor, & M. Hewstone (Eds.), *Stereotypes and stereotyping* (pp. 369–415). New York: Guilford Press.
- Graumann, C. F., & Wintermantel, M. (1989). Discriminatory speech acts: A functional approach. In D. Bar-Tal, C. F. Graumann, A. W. Kruglanski, & W. Stroebe (Eds.), *Stereotyping and prejudice: Changing conceptions* (pp. 183–204). New York: Springer.
- Healey, J. F. (2004). *Diversity and society: Race, ethnicity, and gender*. Thousand Oaks, CA: Pine Forge Press.
- Hogg, M. A., & Abrams, D. (1990). Social motivation, self-esteem, and social identity. In D. Abrams & M. A. Hogg (Eds.), *Social identity and social cognition* (pp. 28–47). Oxford, UK: Blackwell.
- Marshall, S. (2004). *Difference and discrimination in psychotherapy and counselling*. London: Sage.
- Monteith, M. J., Ashburn-Nardo, L., Voils, C. I., & Czopp, A. M. (2002). Putting the brakes on prejudice: On the development and operation of cues for control. *Journal of Personality and Social Psychology*, 83, 1029–1050.
- Mullen, B., Brown, R., & Smith, C. (1992). Ingroup bias as a function of salience, relevance, and status: An integration. *European Journal of Social Psychology*, 22, 103–122.
- Operario, D., & Fiske, S. T. (1998). Racism equals power plus prejudice: A social psychological equation for racial oppression. In J. L. Eberhardt & S. T. Fiske (Eds.), *Confronting racism: The problem and the response* (pp. 33–53). Thousand Oaks, CA: Sage.
- Schneider, D. (2004). *The psychology of stereotyping*. New York: Guilford Press.
- Sidanius, J., Pratto, F., van Laar, C., & Levin, S. (2004). Social dominance theory: Its agenda and methods. *Political Psychology*, 25, 845–880.
- Sidanius, J., & Veniegas, R. C. (2000). Gender and race discrimination: The interactive nature of disadvantage. In S. Oskamp (Ed.), *Reducing prejudice and discrimination: The Claremont symposium on applied social psychology* (pp. 47–69). Mahwah, NJ: Lawrence Erlbaum.
- Tajfel, H., & Turner, J. C. (1979). An integrative theory of intergroup conflict. In W. Austin & S. Worchel (Eds.), *The social psychology of intergroup conflict* (pp. 33–47). Pacific Grove, CA: Brooks/Cole.

- Turner, J. C., Oakes, P. J., Haslam, S. A., & McGarty, C. (1994). Self and collective: Cognition and social context. *Personality and Social Psychology Bulletin*, 20, 454–463.

---

## DIVERSITY

---

As a response to the shifting population demographics in the United States, issues related to diversity have received increased attention in recent years. The word *diversity* simply means difference, but the term is most commonly used to refer to differences among people. The ways in which individuals may differ from one another are considerable. Some perspectives argue for a narrow diversity focus, whereas others believe that diversity should encompass the myriad ways that people may differ from one another.

### Defining Diversity

Some scholars adopt definitions of *diversity* that focus on particular demographic differences among individuals. Specifically, differences in ethnicity, race, and gender have been the most emphasized dimensions of diversity. The focus on these particular identity elements stems from the sociopolitical history of prejudice and discrimination toward women and minorities. Furthermore, focusing on differences based in ethnicity, race, and gender draws attention to the differential distribution of power in the United States. Traditionally, women and individuals of color have not had the power allotted to men and Whites. Therefore, some scholars argue that certain elements of diversity, such as ethnicity, race, and gender, have more serious social ramifications than other elements and, as a result, should receive primary focus. Proponents of this view believe that treating all elements of diversity equivalently would mask and invalidate the history of discrimination and marginalization suffered by groups that are not near the top of the power hierarchy. More recently, others have argued that additional demographic characteristics, such as sexual orientation, age, and religion, should also be included in definitions of diversity given the emerging evidence of discrimination based on these social categories. Those who focus on power differentials and resulting discrimination tend to concentrate on demographic elements of diversity.



Other scholars contend that focusing on demographic aspects of diversity is limiting, and therefore they adopt broader definitions where other differences between people may be recognized. In addition to less-accentuated aspects of demographic diversity, such as age, sexual orientation, and religion, others contend that differences in personality, ability, work styles, and ideology are also important dimensions of diversity that have been underemphasized. Advocates of broader definitions of diversity argue that no one group benefits from diversity over others. They contend that by expanding the definition, one may be more likely to gain the support of White men and others who may feel marginalized by more narrow conceptualizations of diversity. It is argued that the emphasis should be on improving the educational and working environment for everyone, not just individuals from traditionally marginalized groups. Therefore, it is argued that a more inclusive definition of diversity benefits everyone.

The approach to diversity that one adopts has implications for counseling practice and research. For example, a therapist who adopts a narrow approach to diversity while working with an older Latina lesbian may overlook critical issues related to age, gender, or sexual orientation by focusing only on ethnic aspects of the client's experience. On the other hand, a therapist who adheres to a broad diversity perspective may fail to attend to pertinent issues in the therapeutic relationship by downplaying the importance of ethnicity or race in an African American client's experience. Sometimes the adoption of a broad perspective of diversity is symptomatic of an unacknowledged discomfort with more provocative aspects of diversity (e.g., race or sexual orientation) on the part of the therapist. For example, a White therapist who is uncomfortable with people of color may always avoid issues of race by emphasizing other broader aspects of diversity, allowing the therapist to avoid acknowledging or working through his or her prejudices. Both broad and narrow definitions of diversity offer their own sets of strengths and weaknesses. In the end, individuals should weigh the costs, benefits, and implications of adhering to either approach.

### **Ideological Perspectives of Diversity**

The two most prominent ideological perspectives that influence how individuals conceptualize and view diversity are the melting pot and multiculturalism.

### ***Melting Pot***

The *melting pot* refers to the idea that individuals of different cultural backgrounds in the United States assimilate to share one common national identity. This conceptualization of diversity presumes that differences among individuals can be harmoniously blended into one cohesive social product. In this view, differences among people are thought to help facilitate the achievement of a common goal. One criticism of the melting pot perspective is the implicit expectation that ethnic minorities and others should shed their native cultural norms and values and assimilate to dominant U.S. culture (e.g., White, middle-class culture). Furthermore, there is an assumption that individuals who attempt to shed their cultural traits and assimilate to dominant U.S. culture will be accepted as one of the majority. As many have noted, groups that exhibit physical differences from those of the majority often have great difficulty being accepted into the majority culture. For example, it is a common experience for Asian Americans to be asked what country they are from when, in fact, they were born in the United States. Furthermore, individuals who have a strong cultural and ethnic identity may see assimilation as something to avoid at all costs. The idea of losing or shedding cultural norms, behaviors, and identity is highly undesirable to individuals who value their cultural background and heritage.

### ***Multiculturalism***

*Multiculturalism* refers to the idea that social differences should be acknowledged, celebrated, encouraged, and preserved. Within the context of multiculturalism, diversity is affirmed and considered a valuable asset. One of the myths surrounding multiculturalism is that it is inherently divisive given the emphasis on cultural difference. Contrary to the melting pot ideal, the goal of multiculturalism is not to blend cultural differences but to maintain and take advantage of social differences. Research has found that multiculturalism can help achieve unifying superordinate goals, such as democracy, freedom, and justice, by fostering an open dialogue and facilitating contact for individuals from different backgrounds.

Counseling psychologists were among the first to address multicultural issues within psychology. The changing demographics of the United States served as a clarion call to counseling psychologists to develop



culturally relevant skills for working with diverse populations. As a result of the multicultural movement within counseling psychology, practitioners and educators began to emphasize the importance of building cultural expertise and increasing multicultural competence. Some counseling psychologists contend that awareness or acknowledgment of cultural differences is not a desirable end goal because it does not lead to effective outcomes in therapy or society. Instead, they argue that mutual enrichment for all parties is necessary to achieve the true goals of multiculturalism. One component necessary for achieving mutual enrichment is the acknowledgment of power differences through open and honest dialogue about equity and opportunity in society.

Some counseling psychologists argue that several components are necessary if a therapist wishes to increase his or her level of cultural competence. First, therapists need to acknowledge their own privilege as well as the biases that may be present in a given social situation. Second, therapists who aim for cultural competence value others' feedback, listen carefully, and diligently work to reduce their own prejudiced attitudes. Finally, a multiculturally competent therapist aims to increase awareness of his or her own biases and assumptions, gain knowledge about the cultural context in which clients are embedded, and become adept in advancing positive change.

Similar to the controversy surrounding the conceptualization of diversity, there has also been debate within the field of counseling psychology about adopted definitions of multiculturalism. Some argue that multiculturalism should be defined broadly and include differences based on race, ethnicity, gender, sexual orientation, disability, and socioeconomic status, among other elements of social difference, whereas others contend that conceptualizations should be more limited and focused. Proponents of the more focused view contend that the adoption of broad definitions of multiculturalism allows individuals to treat all differences equally, therefore obfuscating the deeper level issues related to race, ethnicity, and gender. By adopting a broad conceptualization of multiculturalism, individuals from dominant groups (e.g., Whites) may treat all human difference equally, thereby avoiding issues related to their role in the oppression of women and minorities. The espousal of a more focused multicultural definition allows individuals to delve deeper and explore the values, beliefs, and norms of different

cultural groups as well as their role in prejudice and discrimination.

## Diversity in the Workplace

Several scholars have noted the benefits of increasing diversity in organizations. In addition to the social justice-oriented goals of increasing equality and reducing discrimination in organizations for individuals of diverse backgrounds, organizations also increase overall organizational effectiveness when they successfully include and manage diverse employees. One benefit of diversity for organizations is that they increase overall profits when they can successfully retain and acquire employees from diverse backgrounds. Not only does successful retention of diverse employees reduce turnover costs, but it also aids in the acquisition of highly talented minorities and women to the organization. Individuals from underrepresented backgrounds have a tendency to seek employment in organizations that have successfully retained other individuals from diverse backgrounds. The inclusion of individuals from diverse backgrounds in an organization aids in creating a work environment that fosters creativity, which results in broader market perspective. For example, people of different cultural groups tend to want to buy a product that is supported or created by a person from their group. The presence of a multiculturally diverse staff also may help clients from diverse backgrounds feel more comfortable when seeking services from a counseling center or practice. If they perceive the environment to be open to their interests and experience, they may be more likely to seek and remain in therapy. It may be quite overwhelming for a person of color, for example, to walk into a counseling center where there are no people of color and discuss issues related to their experiences as a minority. When organizations take into account viewpoints of women and men of different cultural, ethnic, and social backgrounds, they increase their client base.

Another aspect of an organization that is improved with diversity is problem solving. Diverse groups bring a broader range of experiences that can help in problem solving because heterogeneous groups produce solutions of better quality than those produced by homogenous groups. The mere presence of people with diverse opinions improves the quality of the decision processes regardless of whether or not the minority view was used. Overall, diverse groups provide an



organization with a competitive advantage because efficiency in problem solving increases and results in better decisions.

As diversity increases in an organization, the organization members become more flexible and able to adapt to problems and issues that arise. Organizational flexibility is increased if diversity and its successful management result in broadened procedures and less-standardized management methods. The organization becomes more fluid and adaptable because it must adjust to the increase of women and men of different cultural and social backgrounds. Successfully managing diversity within an organization leads to system flexibility that results in a better and more efficient working environment.

Although the benefits of diversity in the workplace have been documented, arguments against increasing diversity in the workplace persist. Opponents of diversity in organizations argue that the increase of minorities and women in the workplace weakens organizational effectiveness by increasing conflict among employees and, in turn, reducing their productivity. Therefore, some organizations aim to keep their organizations as homogeneous as possible to avoid the perceived conflict that would be produced if they increased the level of diversity in their organizations.

Furthermore, detractors of diversity argue that increasing diversity in the workplace also results in a greater number of ill-equipped and unqualified employees. This view stems from negative stereotypes about beneficiaries of affirmative action who are usually perceived to be minorities and women. Unfortunately, one of the prevailing myths surrounding affirmative action is that unqualified persons obtain positions over more-qualified individuals. Affirmative action programs that utilize quotas to increase the number of minorities and women in the workplace have been deemed illegal and very rarely exist in organizations. When they are detected, they are usually quickly dismantled. Furthermore, studies have shown that beneficiaries and nonbeneficiaries of affirmative action in organizations yield similar productivity levels and outcomes.

Scholars argue that the consequences of increased diversity in an organization are related to the perceived commitment to diversity from the upper echelons of an organization. Organizations that lack strong vision and leadership in terms of how to address diversity issues have the most conflict in their organizations. The organizations that are most successful in managing diversity are the ones that encourage

fairness at all levels and attempt to utilize all the skills and benefits that diverse employees bring to an organization.

## Diversity in Higher Education

In recent years, greater attention has been given to the role of diversity in higher education. The widely publicized affirmative action cases at the University of Michigan (i.e., *Grutter v. Bollinger*, *Gratz v. Bollinger*) reinvigorated the debate surrounding the role of diversity and affirmative action in institutions of higher education across the United States. Proponents of diversity in higher education cited the benefits to students and society, while opponents referred to the perceived cost associated with diversifying an institution.

Colleges and universities are charged with the task of preparing students for their future as citizens. Students receive not only education that is pertinent to their career goals but also informal training on how to function in a democratic and diverse society. Their daily interactions in college help prepare them for the adult world outside the college context. Arguably, the time spent in the college environment is among the only chances in life where people may acquire skills designed to aid them in becoming competent workers and citizens in a culturally diverse society.

Scholars have argued that diverse environments help facilitate psychological and intellectual growth needed for college students to lead fulfilling lives after college. First and foremost, diverse environments help students become more active learners. Most people engage in automatic thought processes that require little effort. The goal of most professors in the classroom is to help stimulate critical and effortful thinking. Students must engage in controlled or effortful thinking when they learn something new because they have no prior experience with the content and therefore must think carefully about how to accommodate the new information.

Novel situations also promote effortful thinking. Students on a college campus who grew up in racially homogenous environments may experience a set of novel situations when they set foot on a diverse college campus. In addition to formal situations such as the classroom, informal interactions that may occur in residence halls, public dining areas, and other places provide students with opportunities to interact with individuals from backgrounds different from their own. Other elements that promote critical thinking include instability, discontinuity, and discrepancy.



These elements stem from cognitive-developmental theories that suggest that there needs to be some level of discomfort and uncertainty to promote critical and effortful thinking. Novelty, instability, discontinuity, and discrepancy all help aid the effortful processing of new information. Diverse college campuses provide an environment for these processes to work so that students can grow intellectually.

Social science research has documented the ways in which students are enriched in a learning environment. A student's quality of thinking depends, in part, on his or her social environment. One mechanism that further enriches the learning environment, by fostering critical thinking, is disequilibrium. Disequilibrium is achieved when an idea is presented that causes students to rethink notions they may have regarding a given idea. This may occur when a student from a different background asks a question from a different perspective and, as a result, challenges others to rethink their notions regarding the subject.

### Affirmative Action

Affirmative action has had a long and controversial history since it was first mentioned in President John Kennedy's Executive Order 10925 of 1961. The order required federal contractors to take "affirmative action" to end discrimination against minorities. In 1964, Title VII of the Civil Right Act prohibited discrimination in employment. Title VII allowed individuals who were discriminated against to sue their employers. In 1967 President Lyndon Johnson extended the policy to include women into the protected category. Employers were required to submit reports about their recruitment and hiring efforts and to explain how they would counteract inequality in their organization. Employers at some institutions of higher education started to keep careful records of the demographic characteristics of their applicant pools.

The topic of affirmative action often incites strong emotional responses either in favor of or against the policy. Individuals launch into heated debates without actually defining what they mean by *affirmative action*. Some social science scholars define affirmative action as any effort undertaken by organizations and institutions that are designed to ensure equality of opportunity and outcome for everyone. Federal employers are required by law to implement affirmative action programs in their organizations and institutions. Private institutions, although not required by law, also often put

into practice affirmative action programs as a means to increase diversity in their institutions.

The mechanism by which diversity in the workplace and higher education is increased is through affirmative action. Affirmative action programs in the workplace may vary in their goals. Some emphasize recruitment of qualified minorities and women, whereas others implement additional programs designed to ensure retention of their diverse employees. Other programs may focus on the promotion of minorities and women within the workplace. Most often, affirmative action programs are designed to recruit and hire individuals in the organization, and diversity management programs manage the diversity within the organization after the employees have been hired.

In higher education, affirmative action programs are implemented to increase racial and ethnic diversity on college campuses. The goal of most higher education institutions that value diversity is to admit enough individuals to develop a critical mass of minority students. These policies aim not only to increase the numbers of diverse students but also to admit those who are capable of withstanding the demands of college work. Furthermore, some social scientists argue that affirmative action policies are necessary to guarantee fairness in institutions of higher education because affirmative action programs emphasize outcomes. It is not enough to increase opportunity for underrepresented groups; one must implement procedures to ensure that opportunity translates into results.

The importance of effectively managing diversity will become more vital as the United States becomes more diverse. Individuals of European descent who can be categorized as Caucasian are projected to be less than 50% of the population by the year 2050, thereby making people of color the majority. Attention to issues of diversity is especially crucial in the workplace and in higher education given the role these institutions have in helping individuals lead successful and fulfilling lives. Multiculturally competent counseling professionals who are trained in areas of diversity may be called upon to provide training services to organizations and institutions of higher learning. The training that counseling psychologists receive may help organizations and institutions communicate effectively by encouraging open dialogue and aiding in the deconstruction of biases and prejudices. The shifting population demographics in the United States necessitates further investigation of all aspects of diversity to



ensure that individuals have a chance to live in an equitable, just, and democratic society.

Germiné H. Awad

**See also** Affirmative Action (v3); Assimilation (v3); Career Counseling (v4); Culture (v3); Demographics, United States (v3); Diversity Issues in Career Development (v4); Identity (v3); Interracial Comfort (v3); Multiculturalism (v3); Organizational Diversity (v3); Political Correctness (v3); Racial Identity (v3); School Counseling (v1)

### Further Readings

- Blaine, B. E. (2000). *The psychology of diversity: Perceiving and experiencing social difference*. Mountain View, CA: Mayfield.
- Cox, T. H., & Blake, S. (1991). Managing cultural diversity: Implications for organizational competitiveness. *Academy of Management Executive*, 5, 45–58.
- Crosby, F. J. (2004). *Affirmative action is dead: Long live affirmative action*. New Haven, CT: Yale University Press.
- Gurin, P., Lehman, J. S., & Lewis, E. (2004). *Defending diversity: Affirmative action at the University of Michigan*. Ann Arbor: University of Michigan Press.
- Locke, D. C. (1990). A not so provincial view of multicultural counseling. *Counselor Education & Supervision*, 30, 18–25.
- Smith, T. B. (2004). *Practicing multiculturalism: Affirming diversity in counseling and psychology*. Boston: Allyn & Bacon.
- Stockdale, M. S., & Crosby, F. J. (2004). *The psychology and management of workplace diversity*. Malden, MA: Blackwell.

---

## DRAPETOMANIA

---

Drapetomania was an alleged disease afflicting enslaved Africans in the antebellum southern United States, causing them to attempt to escape their servile societal station. The term combined the Greek words *drapetes* (“a runaway slave”) and *mania* (“madness”). Most contemporary references to this “disease” treat it as a prototypical historical example of racism masquerading as psychological science in clinical practice. Some, however, have cited drapetomania in broader indictments of the entire mental health field.

## Resisting Enslavement as Symptomatic of Mental Disease

In an 1851 report commissioned by the Louisiana State Medical Association, physician Samuel Adolphus Cartwright summarized putative physical characteristics and health conditions of those of African descent in the state. He identified drapetomania as a unique, though vaguely defined, condition, with the key symptom of fleeing from enslavement.

Citing supposed physiological differences and the Christian Old Testament as evidence that people of African descent were destined to obey and serve, Cartwright concluded that drapetomania was a risk whenever masters either treated the enslaved as equals or treated them with cruelty.

Drapetomania could be prevented by beatings, administered if enslaved Africans showed sulkiness or dissatisfaction without obvious cause. Forbidding alcohol, eliminating visits to neighbors at night, and withholding adequate food, shelter, and clothing also were measures taken to prevent drapetomania. According to Cartwright, treating people of African descent like children, using this combination of controls, would reaffirm and support Africans’ basically docile and submissive nature and thus effectively cure them from running away. Failure to treat drapetomania adequately might yield another novel disorder identified by Cartwright—*dysaesthesia aethiopis*—characterized by intellectual dullness, refusal to work, proneness to mischief, and unresponsiveness to punishment from overseers.

Although many rationalized African enslavement with similar arguments, there is no evidence that this proposed diagnosis particularly affected mental health theory or practice of the time. In fact, W. A. Sawyer reports that Cartwright’s report generated published skepticism from medical colleagues, who rejected his arguments as being informed more by his politics than by science.

## Contemporary Views

Twentieth-century social scientists typically cite drapetomania as a classic example of racist pseudoscience. Alexander Thomas and Samuel Sillen notably discussed drapetomania as an early point in a long line of medical justifications of dehumanizing treatment of African Americans through genetic deficiency theories and faulty, self-serving epidemiology.



Thomas Szasz, often credited with drawing modern professional attention to drapetomania, argued that Cartwright's racist nosology highlights the general inappropriateness of applying medical analyses to so-called mental problems. Szasz saw psychiatric labels as simply stigmatizing objectionable behavior of socially marginalized people and justifying societal interventions disguised as medical care. While drapetomania is not a widespread view, some recently have used its example to question the validity of diagnoses like oppositional defiant disorder and attention deficit/hyperactivity disorder.

*David Rollock*

*See also* African Americans (v3); Attention Deficit/Hyperactivity Disorder (v1); Deficit Hypothesis (v3);

Discrimination (v3); Discrimination and Oppression (v2); Oppositional Defiant Disorder (v1); Oppression (v3); Prejudice (v3); Racism (v3)

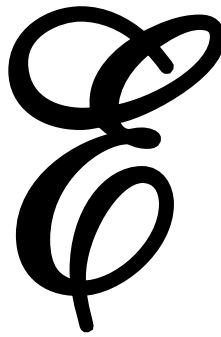
### Further Readings

- Cartwright, S. A. (1851, May). Report on the diseases and physical peculiarities of the Negro race. *New Orleans Medical and Surgical Journal*, pp. 691–715.
- Sawyer, W. A. (1988). Brickell vs. Cartwright: Confrontations in the antebellum medical literature. *Southern Medical Journal*, 81(6), 774–780.
- Szasz, T. S. (1971). The sane slave. *American Journal of Psychotherapy*, 25, 228–239.
- Thomas, A., & Sillen, S. (1972). *Racism and psychiatry*. New York: Brunner/Mazel.









---

## EMPOWERMENT

---

The term *empowerment* was first used in the mid-17th century. Historically, it has been described as the process of giving power to, or empowering, others. In other words, empowerment may be understood as a way of assisting others to help themselves. In contemporary descriptions of empowerment, the term has become mainstream and well-known, and it is a frequently used term in society. Modern definitions are similar to historical definitions, but modern definitions are broader and include the process of enabling others to gain control and power. Empowerment involves the practice of increasing power—from individuals to large communities—so that individuals and collective groups can take action to improve their situations. This description explains empowerment as a way of enabling people to possess or to delegate power. Empowerment may derive from outside influences, but it is also something that can be generated within a person, which is called *self-empowerment*.

### Explanation

#### **History**

There are various settings in which empowerment may take place, including in vocational settings. In vocational settings, empowerment may be defined as the process of encouraging and allowing employees to take the initiative to improve the quality and conditions within their work environment. Empowerment also allows workers to improve the operation or the service

of the organization with which they are employed. Several forms of empowerment exist, such as individual empowerment, social empowerment, and political empowerment. The commonly referenced examples of empowerment include the civil rights movement in the 1950s and 1960s and the women's movement, which began in the mid-1800s, both of which sought after political empowerment for supporters. Some of the well-known leaders in political empowerment include César Chávez, Mahatma Gandhi, Malcolm X, Nelson Mandela, and Martin Luther King, Jr.

#### **Multicultural Issues**

Issues of empowerment are important with regard to multiculturalism, and in particular to oppressed groups and marginalized populations. Empowerment is related to cultural competence as both focus on how groups have experienced issues such as racism and discrimination. Empowerment contributes to change and improvement in the quality of people's lives and also to the improvement of societies. From a social justice perspective, empowerment involves giving people the right to make their own decisions and choices and allowing people to act on those decisions and choices. Empowerment can be generated within individuals to address inequalities in their lives, or it can be generated across communities to help larger groups gain control over their life situations. Empowerment may bring about more choice and freedom for individuals and groups and may lead them to be more involved in organizations and advocacy efforts. Furthermore, empowerment can facilitate gained respect, strong



relationships with others, and the sense of connection to a larger community.

### ***Conceptualization of Empowerment***

The process of becoming empowered involves more than just gaining access to power. Becoming empowered also involves a change in the way that people think, such that awareness and critical thought occur. Additionally, empowerment is not something that can be forced upon others. If an individual or group attempts to generate empowerment within others, the conditions should be created that facilitate its development; it should not be forced. Empowerment theory explains that empowerment involves the process of changing beliefs and attitudes within the self or among others, which subsequently leads to social change. Empowerment has been described as ecologically embedded and operating within intricate connections among individuals, groups, and community settings. Thus, empowerment is a concept that changes over time and takes on different forms depending on the individual.

### ***Critical Consciousness***

An underlying aspect of empowerment theory discusses the development of critical consciousness within those who are attempting to create change in their thinking. Critical consciousness is the process of recognizing oppression and taking action against this recognized oppression. Theories of empowerment explain the development of critical consciousness as involving three psychological processes: group identification, group consciousness, and efficacy. These psychological processes usually occur one after the other, either independently or in conjunction with each other. The first process involves group identification procedures. Group identification is described as the identification of common experiences and concerns, a preference for one's own group, and culture and norms. The second psychological process of critical consciousness involves what is called group consciousness. Group consciousness is the understanding of the discrepancy in status and power among different groups. The third process of critical consciousness is self-efficacy and/or collective efficacy, which refers to the belief in the ability to perform a given task or responsibility. For example, empowerment with regard to efficacy refers to people's perceptions of

their capability to generate social change. Critical consciousness is a significant contributor to the development of empowerment because groups and individuals believe in their abilities to create change and will be more likely to be empowered.

### **Counseling**

In counseling, empowerment is viewed as a way in which to concentrate on issues of lack of power, which is also referred to as powerlessness, and to mediate the role that lack of power plays in the formation and maintenance of social problems. Issues of empowerment are often present in counseling, with an emphasis on the clients' beliefs about themselves. This emphasis can generate clients to contribute to change—both the change they want for themselves and the change they want to see in others. This contribution to change is often referred to as community and social change. The role of empowerment in counseling suggests a new way of viewing counseling, as empowerment may also lead to the development of programs and policies that create empowered environments.

In counseling, empowerment is most often conceptualized at the individual level. Individual empowerment may also be known and described as psychological empowerment. Empowerment in counseling settings involves working with clients to make changes that they want to make in their lives. Zimmerman describes three aspects of individual, or psychological, empowerment: intrapersonal, interactional, and behavioral. Intrapersonal is described as how people think about themselves and includes concepts such as self-efficacy and motivation. The interactional component refers to social environments and how people think about and relate to their social environment. The final component, behavioral, relates to the actions that people take to put into effect their influence on the social and political environment. This is accomplished through participation in community organizations and activities. Understanding of these three components is important in counseling relationships because strength in all three components is necessary for people to become empowered.

*Terri L. Jashinsky*

**See also** Adventure Therapy (v1); Civil Rights (v3); Counseling Skills Training (v2); Cultural Accommodation and Negotiation (v3); Discrimination (v3); Ethnic Pride (v3); Learned Helplessness (v3); Multicultural Counseling



(v3); Multiculturalism (v3); National Association for the Advancement of Colored People (v3); Oppression (v3); Power and Powerlessness (v3); Racial Pride (v3); Social Justice (v3)

### Further Readings

- Bemak, F., Chi-Ying, R., & Siroskey-Sabdo, L. A. (2005). Empowerment groups for academic success: An innovative approach to prevent high school failure for at-risk, urban African American girls. *Professional School Counseling, 8*(5), 377–389.
- Gutierrez, L. M. (1995). Understanding the empowerment process: Does consciousness make a difference? *Social Work Research, 19*(4), 229–237.
- Peterson, N. A., Lowe, J. B., Aquilino, M. L., & Schneider, J. E. (2005). Linking social cohesion and gender to intrapersonal and interactional empowerment: Support and new implications for theory. *Journal of Community Psychology, 33*(2), 233–244.

---

## ENCULTURATION

---

Given the ongoing dramatic racial/ethnic diversification of the United States, the need for counselors to understand the unique cultural backgrounds of their clients presents an important challenge. A useful construct in this effort is enculturation.

### Construct Definition and Clarification

In 1948 Melville J. Herskovits first described enculturation as the process of socialization into, and maintenance of, the norms of one's indigenous culture, such as the salient values, ideas, and concepts. It includes learning the cultural characteristics, such as language and traditions and customs, which distinguish the members of one group of people from another.

A term that often is confounded with enculturation is acculturation. The term *acculturation* has been used to describe the process of contact between members of two cultural groups, particularly when groups of people migrate from their countries of origin to other countries. John W. Berry and his colleagues described acculturation as consisting of (a) contact and participation and (b) cultural maintenance. The process of contact and participation is reflected in the extent to which people become involved in other cultural groups or

remain primarily among themselves. On the other hand, the process of cultural maintenance is represented in the extent to which cultural identity and characteristics are considered important and maintained.

However, the latter part of the acculturation definition is problematic because it largely overlaps with the definition of *enculturation*. Although the characterization of acculturation in terms of cultural maintenance may work well for migrants who have been socialized into their indigenous cultural norms before arriving in a new country, it may not accurately describe the experiences of all racial/ethnic minority individuals, particularly those who were born in the new country. These persons, particularly individuals who are several generations removed from migration, may never have been fully enculturated into their ethnic group's cultural norms by their parents and family, who also may have been born in the new country. For these persons, the application of cultural maintenance process may be inappropriate because they might never have been completely socialized into their indigenous cultural norms in the first place. In addition, these persons may be socialized to their indigenous cultural heritage more fully later in life and, hence, engage in the process of enculturation during this time. For these reasons, the term *enculturation* better captures the diversity of racial/ethnic minority persons in the United States in terms of their generations since migration and the resultant variability in levels of adherence to the norms of their ancestral cultures, in comparison to the cultural maintenance concept within the acculturation construct.

Hence, *enculturation* is now used to describe the process of (re)socializing into and maintaining the norms of the indigenous culture, whereas *acculturation* is used to describe the process of adapting to the norms of the dominant culture. Within the field of counseling, enculturation (and acculturation) has been used to study clients' help-seeking attitudes and behaviors and their participation in the counseling process.

### Construct Dimensions

In describing enculturation, it is also important to consider the dimensions on which the construct can be observed and assessed. Originally, enculturation (and acculturation) had been characterized as involving changes in two personal dimensions: behaviors and values. The behavioral dimension of enculturation includes language use and participation in various cultural activities (e.g., food consumption), whereas the values



dimension reflects relational style, person–nature relationships, beliefs about human nature, and time orientation. Definitions of enculturation (and acculturation) have continued to grow progressively more comprehensive and integrative. Currently, enculturation is described in terms of changes at three levels of functioning: behavioral, affective, and cognitive.

In 2001 Bryan S. K. Kim and Jose M. Abreu reviewed the item contents of 33 instruments designed to measure enculturation (and acculturation) and proposed a set of dimensions along the conceptual framework described earlier. Kim and Abreu proposed that enculturation (and acculturation) consists of the following four dimensions: behavior, values, knowledge, and identity. Behavior refers to friendship choice, preferences for television programs and reading, participation in cultural activities, contact with ancestral culture, language use, food choice, and music preference. Along the cognitive level of functioning, Kim and Abreu proposed two dimensions: values and knowledge. The value dimension refers to attitudes and beliefs about social relations, cultural customs, and cultural traditions. The knowledge dimension refers to culturally specific information, such as names of historical leaders in the culture of origin and significance of culturally specific activities. Along the affective level of functioning, Kim and Abreu proposed the inclusion of identity, which refers to attitudes toward one's cultural identification, attitudes toward ancestral groups, and level of comfort toward people of ancestral groups.

### Psychological Implications

To understand the psychological experiences of racial/ethnic minority individuals as they engage in the process of enculturation within the context of acculturation to the dominant U.S. cultural norms, it is helpful to consider a model proposed by Berry and his colleagues. These scholars theorized the following four acculturation “attitudes” based on combining either high or low levels of enculturation and acculturation: integration, assimilation, separation, and marginalization. Integration occurs when individuals are proficient in the cultures of both their indigenous group and the dominant group. Hence, people in this status are both highly enculturated and strongly acculturated. Separation occurs when an individual maintains and perpetuates the culture of origin (high enculturation) and does not absorb the culture of the dominant group (low acculturation). Assimilation

occurs when an individual absorbs the culture of the dominant group (high acculturation) while rejecting the indigenous culture (low enculturation). Finally, marginalization represents the attitude of an individual with no interest in maintaining or acquiring proficiency in any culture, dominant or indigenous (low acculturation and low enculturation). Marginalization is perhaps the most problematic of the four statuses because marginalized individuals will lack sense of belongingness in either culture.

On the other hand, the integration (or biculturalism) status may be the healthiest status for individuals. The literature on biculturalism suggests that people who can effectively function in both indigenous and dominant cultures may exhibit increased cognitive functioning and better mental health. Described as having bicultural competence, these individuals tend to have high degrees of (a) knowledge of cultural beliefs and values of both cultures, (b) positive attitudes toward both groups, (c) bicultural efficacy, or belief that one can live in a satisfying manner within both cultures without sacrificing one's cultural identity, (d) communication ability in both cultures, (e) role repertoire, or the range of culturally appropriate behaviors, and (f) a sense of being grounded in both cultures.

### Future Directions

In the late 1980s a Delphi study was conducted to examine the future prospects for enculturation (and acculturation) as a construct of interest among scholars in counseling. The results revealed a consensus among these experts in predicting that the construct of enculturation (and acculturation) would play an increasingly important role in counseling theory, research, and practice during the 1990s, as the numbers of racial/ethnic minorities in the United States continue to rise rapidly. At the time of this writing, a search of the PsycINFO database using “enculturation” as the keyword yielded 290 citations, with 236 references having the publication date of 1990 or later. Hence, it appears that there is a trend toward an increased focus on enculturation. However, more research work in counseling seems needed for this prediction to be fully realized.

*Bryan S. K. Kim and Yong S. Park*

*See also* Acculturation (v3); Assimilation (v3); Barriers to Cross-Cultural Counseling (v3); Bicultural (v3); Cultural



Accommodation and Negotiation (v3); Cultural Values (v3); Culture (v3); Ethnic Identity (v3); Multiculturalism (v3); Orthogonal Cultural Identification Theory (v3); Person–Environment Interactions (v2); Pluralism (v3); Racial Identity (v3); Second Culture Acquisition (v3)

### Further Readings

- Chun, K. M., Organista, P. B., & Marin, G. (Eds.). (2003). *Acculturation: Advances in theory, measurement, and applied research*. Washington, DC: American Psychological Association.
- Hofstede, G. (2001). *Culture's consequences: Comparing values, behaviors, institutions, and organizations across nations* (2nd ed.). Thousand Oaks, CA: Sage.
- Kim, B. S. K., & Abreu, J. M. (2001). Acculturation measurement: Theory, current instruments, and future directions. In J. G. Ponterotto, J. M. Casas, L. A. Suzuki, & C. M. Alexander (Eds.), *Handbook of multicultural counseling* (2nd ed., pp. 394–424). Thousand Oaks, CA: Sage.
- LaFromboise, T., Coleman, H. L. K., & Gerton, J. (1993). Psychological impact of biculturalism: Evidence and theory. *Psychological Bulletin*, 114, 395–412.
- Segall, M. H., Dasen, P. R., Berry, J. W., & Poortinga, Y. H. (1999). *Human behavior in global perspective: An introduction to cross-cultural psychology* (2nd ed.). Boston: Allyn & Bacon.

---

## ESPIRITISMO

---

*Espiritismo* is the belief that problems, conceptualized by Western psychologists as being related to mental health issues, are caused by spirits. These spirits can be forced away from the person through interventions offered by a folk healer, the *espiritista*. After the spirits leave, the person returns to mental health.

The core beliefs of *espiritismo* were developed by Frenchman Allan Kardec. He wrote a book of orations, *Le Livre des Esprits* (The Spirits' Book) that attracted European and Latin American intellectuals. His work was available in Cuba and Puerto Rico by the 1860s. By the 1870s it had had a marked effect on religious practices in the Spanish- and French-speaking Caribbean and Latin America. In Cuba, *espiritismo* was used as a foundation for the African-derived religious system known as Santería. According to Kardec, *espiritismo* consists of an invisible world populated by spirits that surround the visible world. The spirits can

enter the visible world and attach themselves to human beings. Some of these spirits are presently incarnated as human beings and others are not. In other words, it is the belief that the soul is immortal and that the spirits of dead persons can communicate with incarnated persons or that they may intervene directly in the lives of people.

Spirit mediums, or *espiritistas*, serve the purpose of communicating between the incarnated spirits and the spirits of the dead. Healing by the *espiritistas* consists primarily of removing harmful spiritual influences from the person and strengthening positive ones. This is done through a number of interventions: lighting special blessed candles, saying specific prayers, or donating a specified amount of money to a charity.

Similar beliefs and practices are seen in other cultures. An example of a related phenomenon is Arab culture's belief in the *jinn*. *Jinn* are creatures who are similar to angels but are under the dominion of Satan. Problems described as mental health issues in Western psychology are seen as being caused by *jinn*. An individual is placed under possession of the *jinn* either through the black magic incantations of another or by visiting locations where the *jinn* dwell and failing to ask for God's protection while there.

The diagnostic process for *jinn* possession is to visit a *sheik*, the cultural equivalent of an *espiritista*. The *sheik* reads passages from the Qur'an and closely observes the individual to differentiate between wholesale possession and temporary *jinn* visitation. Possession is marked by seizure activity during the Qur'an reading and requires a formal exorcism. On the other hand, a temporary visitation by the *jinn*, marked by twitching fingers during the Holy reading, requires the incantation-specific prayers or drinking a glass of water into which a Qur'anic verse has been placed.

While *espiritismo* and *jinn* possession are similar, there are distinct differences. In *espiritismo*, it is the souls of the departed who are vexing the victim, whereas *jinn* are supernatural creatures separate from humans. The main similarity lies in conceptualizing mental health concerns on a metaphysical plane and requiring treatment that includes forms of exorcism, prayer, or theistic ritual activity. It is useful for counselors to be familiar with these concepts when engaging in cross-cultural counseling, as these beliefs may impact the clients' expectations toward the counseling process. It is not recommended that counselors



naively attempt to include such practices within their counseling practice.

*Paul E. Priester, Gregory Benson,  
and Asma Jana-Masri*

*See also* Barriers to Cross-Cultural Counseling (v3); Cross-Cultural Training (v3); Indigenous Healing (v3); Religion/Religious Belief Systems (v3); Santería (v3); Spirituality (v3); Spirituality and Career Development (v4); Spirituality/Religion (v2)

### Further Readings

- Al-Ashqar, U. S., & Zarabozo, J. A. (1998). *The world of jinn and devils*. Boulder, CO: Al-Basheer.
- Comas-Díaz, L. (1981). Puerto Rican espiritismo and psychotherapy. *American Journal of Orthopsychiatry*, 51, 636–645.
- Kardec, A. (2005). *The spirits' book*. New York: Cosimo.

---

## ETHNIC CLEANSING

---

Ethnic cleansing refers to the implementation of a well-defined policy that aims to establish an ethnically homogenous group in a specific territory or society through the expulsion of an unwanted minority group in a systematic manner. Such a policy may be carried out directly through deportation, forced emigration, or violence, or it may involve the use of more passive forms of coercive action such as harassment or discriminatory legislation. A broader definition of *ethnic cleansing* includes the discrimination of one group against another civilian group, delineated by a demographic variable that extends beyond ethnicity to include other sociocultural divides such as race, religion, national origin, or ideological considerations. Ethnic cleansing of minorities is often motivated by a desire of a particular group to consolidate its power by eliminating the conditions for potential and actual opposition in order to create a political stronghold throughout a region. That is, although causes of ethnic cleansing are mainly rooted in political gain for a particular group, ethnic cleansing is embellished by, and inseparable from, prejudiced attitudes and discriminatory practices on the basis of ethnicity, race, or religion. Each of these forms of discrimination reflects the general tendency for human beings to fear dissimilarity.

Concerted efforts also may be made to remove all physical traces of the expelled group in the territory (e.g., the destruction of civilian infrastructure and cultural sites), thereby effecting radical demographic changes. Because ethnic cleansing is such a brutal tactic intended specifically to create a hostile, if not life-threatening, environment for members of the target group, it is characterized by widespread and flagrant human rights violations.

Included in the broad definition of ethnic cleansing is genocide. Among the most active and aggressive forms of ethnic cleansing, genocide is used to eradicate entire segments of a population, with the implicit or explicit aim of creating cultural, racial, and ethnic homogeneity. In an effort to prevent atrocities similar to the Holocaust of Nazi Germany during World War II, when an estimated 6 million European Jews were tortured and executed, the United Nations passed a resolution in 1948 that recognized genocide as a crime against humanity. This resolution, *The Convention on the Prevention and Punishment of the Crime of Genocide*, defined genocide as any criminal act committed by an individual, group, or government, in time of peace or in time of war, with intent to destroy a national, racial, ethnic, or religious group. These punishable acts include killing members of the target group, causing them serious bodily or mental harm, deliberately inflicting conditions that will bring about the group's physical destruction in whole or in part, imposing measures to prevent births within the group, and forcefully transferring children of the group to other groups.

Examples of ethnic cleansing include the forced displacement of Native Americans by White settlers in North America in the 18th and 19th centuries, the Armenian massacres by the Turks in 1915–1916, the Nazi Holocaust, and the Soviet Union's deportation of certain ethnic minorities from the Caucasus and Crimea during the 1940s. Precipitating events among the recent cases of ethnic cleansing in the late 20th century often include complex regional struggles between different political constituencies that have pushed minorities to the edge of extinction. When ethnic clashes among factions occur, mass rape, sexual torture, and psychological trauma are common. Women and children are particularly vulnerable because many men leave their families and communities to join resistance groups. During the armed conflicts in the former Yugoslavia in the 1990s, for example, the vicious treatment and massacre of ethnic groups was the consequence of belligerent mobs



targeting civilians to expel ethnic minorities in the population and hasten military surrender.

Another recent example of ethnic cleansing is the Rwandan genocide in 1994. This example is of particular importance because of the scale of fighting and the rapid speed of the massacre. Within a few months of the start of political and ethnic fighting in Rwanda, waves of violence claimed between 500,000 and 1 million lives, most of them ethnic Tutsis. Another 2 million civilians were forced to abandon their homes.

The violence associated with ethnic hatred in Rwanda has threatened the stability of the region in Africa, with the potential to ignite a wide conflagration throughout the continent. This ripple effect destabilizing the region is most recently evident in the Darfur crisis of ethnic cleansing in western Sudan at the start of the 21st century. Some 200,000 innocent civilians of Darfur have died, and 2.5 million have been displaced since fighting among rebels, the Sudanese army, and a militia of Arab nomads began in early 2003. Many civilians died in refugee camps because they were subject to further attacks. Lack of food, water, and medicine has also led to mass starvation and disease epidemics. Although the Darfur atrocities have drawn widespread condemnation, the international community remains slow or ineffective in stopping the violence that continues at the time of this writing. As in the past, the degree and pace of responses to ethnic cleansing in Darfur at the international level hinge largely on the calculation of perceived interest and the actual costs of intervention and enforcement within the diversity of the international society. Although the long-term effects of such destructive atrocities are not known, it is evident that practices of ethnic cleansing are comprehensively toxic.

### **Experiences and Needs of Ethnic Cleansing Survivors**

Survivors of ethnic cleansing may be at heightened risk for developing physical and mental health problems. They may experience psychological traumatization subsequent to the violence committed against them through the development of symptom patterns that are subsumed under the diagnosis of post-traumatic stress disorder (PTSD) in the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders*. Symptoms of PTSD are common among refugees when they have been the victims of, or have witnessed, torture, rape, and other horrific events.

The severity of these symptoms, however, differs widely from individual to individual and also depends on the type, duration, and nature of the trauma experienced. Although the concept of PTSD may serve as a useful tool for understanding victims of psychological traumatization, PTSD is not necessarily a universal response to traumatic stress. That is, trauma as experienced by refugee youth and families may be moderated by personal, contextual, and cultural factors.

When ethnic cleansing occurs, the prolonged armed conflict displaces many civilians, and many of them seek refuge outside their countries to escape political turmoil as well as religious, racial, or political persecution. During the internal political upheavals in their countries in the 1970s and 1980s, for example, large scales of refugees from Latin America slipped across the international border into the United States.

When ethnic cleansing survivors are forced to abandon their homelands, the horror they endured may end when they successfully take shelter outside their country, but the stress they experience may not subside; rather, it may manifest in a different form. As war refugees, they have been uprooted from their familiar social and cultural milieu, which, combined with their exposure to violence, can have severe negative impacts on their health and well-being. Similar to other groups of immigrants, war refugees in a foreign country also face obstacles, such as linguistic constraints and cultural differences, in their adjustment process. The process is further complicated by the cumulative effects of resettlement, familial separation, and previous exposure to the violent, abusive, and dehumanizing world of war. These myriad potential counseling issues, combined with clinical manifestations characteristic of PTSD, create a unique challenge for counseling professionals working with survivors of ethnic cleansing. War refugees may suffer the psychological impact of separation from family and friends. The psychosocial impact of relocation and the disruption of a social support system may lead to loss of self-identification, social isolation, and loss of the sense of security. Such family disintegration disrupts the protective function of a social network that can mitigate the psychological effects of trauma and distress among individuals—children in particular. When children experience the violent death of, or separation from, parents during a war, severe grief, sleep disorders, depression, intense fears, feelings of vulnerability, and other emotional problems are common. Such difficulties faced by refugee children may be exacerbated by



the inability of their surviving family members, who may suffer psychological distress themselves as well, to respond to the emotional and psychological needs of the children.

For refugee youth, their ability to cope with traumatic life events is further complicated by stress in relation to relocation, educational pursuits, and their identity development. In the United States, for example, it is the age, rather than academic background, of refugee children that determines their grade placement in schools. Young refugee children may thus be apt to quickly learn the new language and adjust to the new culture, whereas refugee adolescents may find resettlement a more daunting task due, in part, to inadequate education, lack of family support and community resources, and significant linguistic and cultural differences. Some may eventually develop behavior problems (e.g., aggression, vandalism), drop out of school, or run away from home.

### Counseling Implications

Counseling professionals working with ethnic cleansing survivors need to design interventions that achieve a high level of social and cultural specificity. Effective interventions assist refugee youth and families as they negotiate profound social, cultural, economic, familial, and psychological transitions. These considerations underscore the importance of a systemic approach that examines the interplay between trauma and distress as related to political violence and forced migration, as well as the transitions associated with life in a foreign country. This perspective also necessitates the need to locate the refugee's experiences within multiple social spaces, including that of life before war, wartime, and within multiple systems, including families, neighborhoods, schools, villages, and service institutions.

Specifically, in designing intervention strategies, counseling professionals must keep in mind a number of overarching principles. First, attention needs to be given to the importance of cultural variables, as well as individual resilience, that moderate the effects of traumatic experiences. Because the severity of symptoms of ethnic cleansing survivors differs widely from individual to individual and from time to time, many survivors experience mild or occasional symptoms that do not interfere with their daily functioning. Second, consistent with the hierarchy of human needs, any intervention should address basic human needs (e.g., food, water, shelter, and security) first, followed by

psychological needs (e.g., belongingness and personal identity). Creation of a stable structure, physical and psychological, proves advantageous for survivors because of the lack-of-control and general disruption characteristics of experiencing such comprehensive physical and psychological displacement. Third, survivors of ethnic cleansing may experience survivor's guilt, that is, the guilt of being one of the few who successfully escape from dangerous situations. They may have no information about the whereabouts of their family, relatives, and friends left behind. As they struggle to rebuild their life, the feeling of survivor's guilt may interfere with a survivor's process of recovery from psychological trauma. Counseling professionals must strike a balance between helping their clients reconstruct their traumatic story and supporting them to go through the grieving process at their own pace. Group counseling as a treatment modality may be particularly effective in providing the therapeutic power of universality and instillation of hope necessary for ethnic cleansing survivors to restore their social bonds with others and their connections with ordinary life.

Eric C. Chen

**See also** American Indians (v3); Antisemitism (v3); Bias (v3); Cross-Cultural Psychology (v2); Cultural Encapsulation (v3); Cultural Mistrust (v3); Discrimination (v3); Discrimination and Oppression (v2); Ethnicity (v3); Ethnocentrism (v3); Nationalism (v3); Oppression (v3); Posttraumatic Stress Disorder (v2); Prejudice (v3); Racism (v3); Refugees (v3); Secondary Trauma (v2); Stereotype (v3); Xenophobia (v3)

### Further Readings

- American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed., Text rev.). Washington, DC: Author.
- Chen, E. C., & Park-Taylor, J. (2006). Intersection of racism and immigration: Implications for educational and counseling practice. In M. G. Constantine & D. W. Sue (Eds.), *Addressing racism: Facilitating cultural competence in mental health and educational settings* (pp. 43–64). New York: Wiley.
- Ehrenreich, J. H. (2003). Understanding PTSD: Forgetting "trauma." *Journal of Social Issues*, 3, 15–28.
- Herman, J. L. (1992). *Trauma and recovery*. New York: Basic Books.
- Nicholl, C., & Thompson, A. (2004). The psychological treatment of post-traumatic stress disorder (PTSD) in



- adult refugees: A review of the current state of psychological therapies. *Journal of Mental Health*, 13, 351–362.
- Shannon, V. P. (2005). Judge and executioner: The politics of responding to ethnic cleansing in the Balkans. *Journal of Genocide Research*, 7, 47–66.
- United Nations. (1999, September). *Reports of the Secretary-General to the security council on the protection of civilians in armed conflict*. New York: Author.
- United Nations. (2001, March). *Reports of the Secretary-General to the security council on the protection of civilians in armed conflict*. New York: Author.
- Weine, S. M., Becker, D. F., Vojvoda, D., Hodzic, E., Sawyer, M., Hyman, L., et al. (1998). Individual change after genocide in Bosnian survivors of “ethnic cleansing”: Assessing personality dysfunction. *Journal of Traumatic Stress*, 11, 147–152.

---

## ETHNIC IDENTITY

---

Ethnic identity, broadly defined, is a dynamic and multidimensional construct that represents the part of one's self-concept that is derived from a sense of belonging and commitment to a particular ethnic group. Other key components of ethnic identity include self-identification, the importance of ethnicity in one's life, ethnic group affiliation, positive feelings and attitudes toward one's ethnic group, and the belief that others view one's ethnic group favorably. Ethnic identity also is manifest in a shared sense of identity, values, attitudes, heritage, and lineage with other members of the ethnic group, as well as in individual and collective engagement in the language, customs, and traditions of the ethnic group.

### Historical Perspectives

The conceptualization and operationalization of ethnic identity have undergone numerous changes over the years. Historically, ethnic identity was defined according to membership in a given ethnic group, whether ascribed by the individual or by others. Early definitions also focused heavily on ethnic group preferences and attitudes. For example, the famous doll studies by Kenneth B. Clark and Mamie P. Clark in the late 1940s revealed that African American girls were more likely to assign positive attributes to white dolls, not black dolls. However, early methods of

studying ethnic identity often conflated notions of ethnicity and ethnic identity, privileged the opinion of others over the individual, and conceptualized ethnic identity as a relatively static construct. The dynamic process of ethnic identity development and its multidimensional nature were largely overlooked.

Ethnic identity is now conceptualized within the framework of Henri Tajfel's social identity theory, which postulates that people have an innate need to belong, and identification with a group contributes to a positive overall self-concept and sense of well-being. But, as the Clark and Clark doll studies revealed, membership in a devalued ethnic group can lead people to distance themselves from their ethnic group or to report a greater preference for the dominant group. An alternative strategy when excluded or threatened by another group is for people to identify more strongly with their ethnic group, develop a sense of ethnic pride, and emphasize the distinctiveness of their own group. This perspective of ethnic identity places a greater emphasis on personal agency and a subjective sense of self, as well as psychological and emotional affiliation with an ethnic group.

There remains an ongoing debate over the similarities and differences between ethnic identity and racial identity. Although the two constructs share much in common (e.g., both ethnic identity and racial identity are types of social identities), racial identity is believed to emerge based on experiences with racism and oppression due to phenotypic differences, such as skin color or facial features. Ethnic identity, by contrast, is believed to develop from a more basic need to belong and identify with similar others. Although prejudices and cultural pressures are significant in understanding ethnic identity, the primary emphasis is not on oppression and sociopolitical stratification as it is in the case of racial identity.

Various developmental models have emerged to explain the formation of ethnic identity. In general, these models propose that one's ethnic identity initially starts as an unexamined aspect of one's self that eventually becomes examined. The individual subsequently goes through a period of exploration of and immersion into the group's beliefs, traditions, and behaviors until the process concludes with ethnic identity achievement and clarity. One problem with these stage models, however, is that they imply that individuals go through a fairly predictable trajectory of ethnic identity development. It is more likely the case that people cycle through these different aspects



of identity negotiation depending on personal circumstances and the social context.

More recently, a multidimensional perspective of ethnic identity has emerged, which challenges the idea of ethnic identity as a single, unitary construct. Most scholars agree that ethnic identity includes cognitive, affective, and behavioral components, including self-identification, salience and centrality of ethnicity in one's life, a sense of belonging and affiliation, private regard (e.g., positive affect toward one's group), public regard (e.g., perceived favorability of one's group), and interest and participation in ethnic-specific activities. It is thought that these different aspects of ethnic identity are accessible, salient, or central to the individual based on the moment or situation. Thus, the nature and manifestation of ethnic identity can be viewed as context dependent. For example, a person may suddenly develop strong ethnic group pride with the public success of another ethnic group member. Furthermore, specific aspects of ethnic identity may have unique or differential effects on the psychological functioning of individuals, depending on the circumstances. Pride in one's ethnic group, for instance, tends to be related to self-esteem, but it may be associated with lower self-esteem when a person experiences greater discrimination because of individual sensitivity to rejection.

### Influences on Ethnic Identity

Prominent variables influencing ethnic identity include ethnic socialization, acculturation, and discrimination. Parents play a particularly important role in children's ethnic identity development through engaging in ethnic socialization—a process of teaching children about their ethnicity and the experiences they may have with the broader society because of their ethnic group membership. For example, immigrant parents may speak to children in their native language, eat ethnic-specific foods, celebrate cultural holidays and traditions, and socialize with other ethnic group members. Moreover, parents may make an earnest effort to teach the history and to instill the values of their culture to their children. These direct and indirect ethnic socialization experiences gradually become internalized by children and help to shape their ethnic identities.

For those individuals who belong to an ethnic group within a larger, ethnically diverse society, acculturation processes also impact ethnic identity. Acculturation refers to a process of change in one's

cultural attitudes, values, and behaviors that result from contact with another culture or society. Level of acculturation, in turn, is believed to affect how individuals relate to their own group as a subgroup of the larger society, thereby influencing quality and degree of ethnic identification. A unidimensional model of acculturation proposes that ethnic group identification is inversely related to adaptation to the mainstream culture. To illustrate, a Mexican immigrant to the United States who retains a strong sense of ethnic identity as a Mexican would have weak ties to American culture in this model; on the other hand, high levels of acculturation to American culture would be associated with a weakened ethnic identity as a Mexican. By contrast, a bidimensional model of acculturation proposes that identification with one's traditional or ethnic culture is independent of one's identification with the other culture, allowing for biculturalism—identification and awareness of oneself as a member of multiple ethnic or cultural groups. Both models have received empirical support, although there is increasing evidence in support of the bidimensional model. The implication of each model is that the development of ethnic identity does not necessarily occur in cultural isolation.

The association between ethnic identity and discrimination or bias against one's ethnic group is a complex one. On the one hand, when confronted with discrimination, people may increase or decrease their level of ethnic identification to maintain a positive self-concept and well-being. On the other hand, ethnic identity affects perceptions of discrimination or victimization as well. Some scholars have found that a stronger ethnic identity heightens sensitivity to personal discrimination, whereas others have found that individuals are motivated to minimize perceptions of bias against one's ethnic group, possibly to preserve a positive self-concept and well-being. This bidirectional association between ethnic identity and discrimination highlights the dynamic social processes that underlie issues of ethnicity and race.

### Future Directions

The concept of ethnic identity has been of increasing interest to counseling research and theory, particularly for how it relates to psychological functioning and interpersonal relationships. The different perspectives of ethnic identity (e.g., ethnic identity as a unitary vs. multidimensional construct, or as a static state vs. a



multistage developmental process) lend to the challenge of understanding how ethnic identity relates to such issues of psychological functioning as self-esteem, well-being, or mental illness. Future efforts to uncover the exact mechanisms through which ethnic identity affects psychological adjustment will allow for the better integration and utilization of ethnic identity in clinical interventions and in prevention strategies promoting optimal development.

*Alisia G. T. T. Tran and Richard M. Lee*

**See also** Acculturation (v3); Bias (v3); Black Racial Identity Development (v3); Clark, Kenneth Bancroft (v3); Discrimination (v3); Enculturation (v3); Ethnicity (v3); Ethnic Pride (v3); Identity (v3); Identity Development (v3); Racial Identity (v3); Self-Esteem (v2); Social Identity Theory (v3); White Racial Identity Development (v3)

### Further Readings

- Ashmore, R. D., Deaux, K., & McLaughlin-Volpe, T. (2004). An organizing framework for collective identity: Articulation and significance of multidimensionality. *Psychological Bulletin*, 30(1), 80–114.
- Clark, K. P., & Clark, M. P. (1947). Racial identification and preference in Negro children. In T. M. Newcomb & E. L. Hartley (Eds.), *Readings in social psychology* (pp. 169–178). New York: Henry Holt.
- Helms, J. E. (1995). An update of Helms' White and people of color racial identity models. In J. G. Ponterotto, J. M. Casas, & L. A. Suzuki (Eds.), *Handbook of multicultural counseling* (pp. 181–191). Thousand Oaks, CA: Sage.
- Phinney, J. S. (1990). Ethnic identity in adolescents and adults: Review of research. *Psychological Bulletin*, 108(3), 499–514.
- Tajfel, H. (1978). *Social identity and intergroup relations*. Cambridge, UK: Cambridge University Press.

---

## ETHNICITY

---

Ethnicity refers to a social group category defined by the shared historical, national, social, political, and cultural heritage of a people. Ethnicity includes a reference to shared ancestry, language, customs, traditions, and similar physical characteristics among a group of people. In addition, ethnicity tends to be informed by the social group's particular geographic area. For example, in the United States, an individual

may be racially classified as Black because he or she is associated with the social, political, and economic experiences, in addition to similar physical characteristics, of that social group, but be ethnically classified as Jamaican because he or she shares the historical, national, social, political, and cultural heritage with others from the Caribbean country of Jamaica. Ethnicity is assumed to have broad implications for how individuals understand themselves and experience the world around them. Therefore, ethnicity is thought to shape individuals' experiences of psychological well-being.

Given the connection between ethnicity, culture, and psychological well-being, ethnicity is a significant variable to explore in cross-cultural counseling situations. Social group categories provide reservoirs for meaning and context for individual and shared group experiences. Therefore, knowing an individual's ethnicity can provide a counselor with a framework for understanding the individual from a particular cultural perspective.

### Race Versus Ethnicity

Race and ethnicity are often, erroneously, used interchangeably in public discourse and in scholarly and research literature. Oftentimes in the United States, ethnicity is used as a euphemism for race because the former tends to connote a more positive conception than race, which tends to be a politically charged construct. However, to be precise, race and ethnicity, though interrelated, are distinct constructs. Ethnicity is informed by an individual's race but represents a specific aspect of his or her cultural experience. Whereas race represents a limited number of social groups (e.g., Black, White, or Asian) based upon the varying social, political, and economic needs of society, ethnicity represents a larger number of specific and unique social groups (e.g., Haitian, Irish, or Japanese) based upon the historical culture of a people.

When considering culture, one must take into account the values, customs, traditions, attitudes, social norms, and patterns of interaction of a people. Given the complexity and array of the components of culture, considering broad racial categories only restricts the nuanced experiences of said culture. Therefore, ethnicity allows for greater distinction within broad racial categories such that significant but subtle differences between various subgroups are recognized. Consider the racial group Asian, which encompasses individuals



representing more than 25 different ethnic groups with distinct social, political, and economic histories. With this vast array of ethnicities, knowing that someone is Asian provides very little information when compared with knowing that someone is Vietnamese, Cambodian, Chinese, or Pakistani.

## Identity

Even though ethnicity allows for greater distinction among groups of people, counselors must also remain aware of within-group differences among members of ethnicities. Counselors consider how the individual understands his or her own ethnicity in relation to his or her sense of self. Ethnic identity is one way to think about those within-group differences. Whereas *ethnicity* refers to the social group category, *ethnic identity* refers to an individual's sense of belongingness or connection to his or her ethnic group. In this sense, ethnic identity includes the degree to which an individual adheres to the attitudes and values, upholds the customs and traditions, and perceives the world from a perspective that is consistent with his or her ethnicity. This means that a Jamaican person who espouses attitudes and values, participates in cultural activities, and experiences the world in a manner that is consistent with other Jamaicans is said to have a positive ethnic identity as Jamaican. This may be contrasted against a Jamaican individual who does not participate in Jamaican cultural activities, perhaps espouses attitudes and values that differ from those of other Jamaicans, and experiences the world in a manner that is inconsistent with other Jamaicans—this individual can be described as having a less positive ethnic identity.

Furthermore, it is assumed that ethnic identity has implications for self-esteem in that an individual's affiliation with a particular group influences the degree to which he or she may incorporate aspects of that group identity into his or her self-concept. Consequently, if an individual has a strong sense of connection with a social group he or she is more likely to incorporate the positive and negative characteristics associated with that group into his or her personal identity. Using the Jamaican example, if the individual has a strong Jamaican identity, then it is highly likely that the group concept and esteem of that ethnicity will have an influence on his or her personal concept and esteem.

In the context of the United States, considering an individual's specific ethnicity, the social and political

history and current status of that group, and the individual's immigration status has implications for the relevance of ethnicity for a person. It also has influence on the sense of esteem associated with an ethnicity. For example, the social status of an individual's ethnicity may be different in the United States than in his or her home culture, which may have implications for the individual's ethnic identity. Therefore, in addition to being aware of a client's ethnicity, counselors should also consider the individual's level of ethnic identity. The processes of enculturation and acculturation are useful concepts to explore when considering ethnicity in the counseling relationship.

## Enculturation and Acculturation

No culture exists in isolation from others. This is most evident in the United States for racial and ethnic groups where multiple groups live parallel in a broader societal context. The constructs of enculturation and acculturation describe the processes that allow cultures to remain distinct while simultaneously existing in the context of other cultures.

Enculturation and acculturation are processes that explain the degree to which ethnicities retain, or relinquish, aspects of their culture when they are located in the context of a broader culture. Specifically, *enculturation* refers to the process through which members of an ethnicity learn about, and come to appreciate, the various aspects of their culture, including values, customs, traditions, attitudes, social norms, and patterns of interaction. *Acculturation* refers to the process through which members of an ethnicity learn about the differences between, and boundaries around, aspects of their culture and those of the broader, host culture.

Enculturation and acculturation are dynamic, adaptive processes that have a profound influence on ethnic groups and their individual members. This is to say that the degree of enculturation and acculturation for different ethnicities may be different depending on several factors, including (a) immigration status (i.e., personal choice or refugee status), (b) intensity of cultural exposure (i.e., degree/type of ethnic socialization to home or host culture), (c) experiences with prejudice and discrimination, and (d) the numerical balance between the home culture and the host culture. Counselors are encouraged to consider each of these factors as an influence on an individual's ethnic identity. This is to say that there are likely many within-group differences for individual members of an



ethnicity based upon these factors that may be masked if one were to only look at the ethnic group broadly.

### Implications for Counseling

There is an extensive literature in the counseling field examining ethnicity and (a) individual psychological health, (b) its influence on the counseling relationship, (c) processes affecting identity development, (d) an individual's experience with discrimination, (e) relevant counseling issues for specific ethnicities, and (f) relevant counseling interventions for specific ethnicities. Generally speaking, researchers and counselors agree that knowledge of a client's ethnicity, among other aspects of his or her cultural background, is critical in providing effective and ethical counseling services. Competent and effective counselors should always consider these aspects of their own and their clients' backgrounds. Ethnicity and, subsequently, ethnic identity are integral aspects of individuals' life experiences and their psychological well-being. In providing counseling services, counselors must strive to find a balance between knowledge of a client's ethnicity, understanding the relevance of his or her ethnicity, and considering other important individual aspects of the client.

*M. Nicole Coleman*

**See also** Acculturation (v3); Bicultural (v3); Cross-Cultural Psychology (v3); Cultural Values (v3); Culture (v3); Demographics, United States (v3); Ethnic Identity (v3); Ethnic Pride (v3); Identity (v3); Orthogonal Cultural Identification Theory (v3); Race (v3); Racial Identity (v3); Racial Pride (v3)

### Further Readings

- Berry, J. W. (1993). Ethnic identity in plural societies. In M. E. Bernal & G. P. Knight (Eds.), *Ethnic identity: Formation and transmission among Hispanics and other minorities* (pp. 271–296). Albany: State University of New York Press.
- Helms, J. E., & Talleyrand, R. (1997). Race is not ethnicity. *American Psychologist*, 52, 1246–1247.
- McGoldrick, M., Giordano, J., & Garcia-Preto, N. (2005). *Ethnicity and family therapy* (3rd ed.). New York: Guilford Press.
- Phinney, J. S. (1996). When we talk about American ethnic groups, what do we mean? *American Psychologist*, 51, 918–927.

- Ponterotto, J. G., Casas, J. M., Suzuki, L. A., & Alexander, C. M. (Eds.). (1999). *Handbook of multicultural counseling*. Thousand Oaks, CA: Sage.
- Sue, D. W., & Sue, D. (2002). *Counseling the culturally diverse* (4th ed.). New York: Wiley.
- Tajfel, H., & Turner, J. C. (1986). The social identity theory of intergroup behavior. In S. Worchel & W. Austin (Eds.), *Psychology of intergroup relations* (pp. 7–24). Chicago: Nelson-Hall.

---

## ETHNIC MINORITY

---

The term *ethnic minority* is used to describe an individual who belongs to an ethnic group that is marginalized by society because of social and cultural characteristics that are different from, or devalued by, the dominant ethnic or cultural group. In the United States in 2007, Americans of European descent are considered the dominant ethnic group, or ethnic majority, and all others are considered ethnic minority groups. Examples of the major ethnic minority groups in the United States include African Americans, Hispanic/Latino/a Americans, Asian Americans, Pacific Islanders, American Indians, Alaska Natives, and Arab Americans. Ethnic minority groups in the United States can be further defined by country of origin, with individuals identifying solely as a member of their country of origin (e.g., someone who identifies as “Mexican” or “Chinese”) or individuals identifying with both the country of origin and the United States (i.e., someone who identifies as “Filipino American” or “Jamaican American”). Members of immigrant countries may also identify solely as “American” and dissociate with their country of origin altogether.

To fully understand who is an ethnic minority, it is necessary to elaborate on the terms *ethnic* and *minority*. An ethnic group includes people who share common characteristics, which may include race, country of origin, language, religion, customs, beliefs, and values. These common characteristics are typically transferred through successive generations, and ethnic characteristics take on different meanings through and within each generation. Although ethnic categorizations exist, it is virtually impossible to correctly label every ethnic group present in the United States. This is due primarily to the great heterogeneity within and among ethnic groups, such as differences in regions, customs, generations, and languages/dialects. For



example, although Korean American persons may identify as part of the same group, they may differ based on regions (e.g., those whose heritage is from North Korea may differ from those from South Korea), customs (e.g., subgroups may participate in different traditions or practices), generations (e.g., immigrants may hold different values than second-generation Korean Americans), and language (e.g., some members may speak Korean only, others may speak English only, and others may speak both).

The meaning of ethnicity has evolved since the founding of the United States. In line with the voluntary and involuntary immigration of people to the United States, the term *ethnic* was used primarily as a descriptor to identify people who were of non-Anglo-Saxon Protestant descent. In this regard, ethnic was used to describe racial, religious, country-of-origin, and language differences. At different points in the history of the United States, the term *ethnic minority* was attributed to religious minorities (e.g., Catholics and Jews), as well as non-Anglo-Saxon Americans (e.g., Irish and Italians). Throughout time, these European American immigrant groups, which previously may have been considered “ethnic minorities,” assimilated to the dominant culture’s way of life. These groups may have assimilated primarily because they recognized that belonging to the White racial group afforded them power and privileges. Additionally, with the immigration of Hispanic/Latinos/as and Asians, as well as with civil rights for African Americans, it became evident that Americans of European descent held the power and privilege, and all others were less valued and oppressed.

The word *minority* is taken from the Latin term *minor*, meaning “smaller.” When used literally, within the context of a societal or social setting, the term *minority* means “the smaller group as compared to a larger group.” In its current usage, the term *minority* is commonly understood as a descriptor of social status assigned to the subordinate groups in a given society or culture, without necessarily connoting smaller population sizes. Majority groups are those that hold the power and have privileges in a given society, and minority groups are those that are negatively affected by an unequal power distribution. Minority groups can be based on race, gender, sexual orientation, ability, religion, and ethnicity, among other group membership characteristics. For example, women would be considered the gender minority group, gays/lesbians/bisexuals would be considered sexual minority groups, and

non-Christians (e.g., Jews, Muslims, and atheists) would be considered religious minority groups.

In the present-day United States, *ethnic minority* is used primarily as a label for people who self-identify or are identified as belonging to an ethnic group of non-European descent. Although not necessarily a numerical minority in many areas of the country, a defining characteristic of an ethnic minority is the prejudice, discrimination, and ethnic injustices to which these groups are subject. These ethnic injustices are pervasive and include historical, institutional, and individual discrimination that is based on one’s ethnicity (e.g., Japanese American internment during World War II, poor working conditions and wages for Mexican and Filipino farmworkers in California, discriminatory treatment toward Caribbean domestic workers). Ethnic injustices should not be confused with racial injustices, which include historical, institutional, and individual discrimination that is based on race (e.g., slavery, racial segregation, racial microaggressions or hate crimes against Asians or Blacks). Although laws have been enacted to protect American citizens against discrimination based on ethnicity, ethnic minorities are presently not proportionately represented in most spheres of American society. The power structure of the United States favors ethnic groups of European descent, as exemplified through media, education, government, politics, and economics.

The term *ethnic minority* may have both positive and negative implications. Some scholars have rejected the term because the word *minority* may have a connotation of being “minor,” less than, or objectified, whereas *majority* has the connotation of being “major,” superior, or most important. By identifying in this way, ethnic minority individuals may indicate that they subconsciously or unconsciously view themselves as inferior or subordinate to the European American majority group, while European American majority individuals may confer that they are of the superior, dominant group.

Some scholars prefer the term *ethnic minority* because it is inclusive of all racial and cultural minorities. For example, in the U.S. Census, Hispanic/Latinos/as are not considered a racial group. Instead, they are identified as an ethnic group and are divided racially into two groups: White Hispanics and non-White Hispanics. However, because Latinos/as (both White and Black) have experienced histories of oppression and discrimination, their experiences would parallel other ethnic minority groups. So although not all



Latinos/as would be considered racial minorities, all may be defined as ethnic minorities. Accordingly, the term *ethnic minority* is an inclusive term to accept people of all marginalized ethnicities, regardless of their racial group.

Because of these implications, there are substitute terms that might be used alternatively with *ethnic minority*. *People of color* is a term that was used to differentiate from the subordinate implications of *minority*. Individuals may also use this term as an empowering way to take back the racially charged term *colored people* that was used to segregate African Americans before the civil rights movement. Because *people of color* was a term that was coined by individuals of ethnic minority groups, it is a term that ethnic minority individuals may feel more connected to, in comparison with most racial and ethnic identifiers (e.g., American Indian, Hispanic, Filipino) that were given by the groups' oppressors or colonizers. Using *people of color* would be similar to how some groups empower themselves by using identifiers that were created by members of their own groups (e.g., Native, Latino/a, or Filipino).

Some negative implications of the term *people of color* include that it pits these people of color against Whites, acknowledging implicitly that Whites are the standard and that people of color are the "other." Additionally, individuals of ethnic minority groups with light skin color (e.g., some Hispanic/Latinos/as and some Asians) may not feel comfortable or connected with identifying as a person of color, because of physical skin color differences. *Racial minority* is a term that is used in the same manner as *ethnic minority*, to signify those racial groups that have been oppressed by the dominant group. However, the term may still hold an undertone of subjugation or inferiority and may not be inclusive to all ethnic groups. Finally, sometimes the term *racial/ethnic minority* is used to be inclusive of oppressed racial and ethnic groups.

Identity and terminology may have several implications in counseling. First, a counselor should be aware of the various ways that a client may identify both racially and ethnically. A person's racial identity includes the ways that a person identifies with his or her racial group (e.g., Black, Asian), and a person's ethnic identity includes the way that a person identifies with his or her ethnic group (e.g., Haitian American, Vietnamese American). An ethnic minority client may identify as both a racial and ethnic minority or may not identify as either. Accordingly, a counselor must take

into consideration that a client's racial and ethnic identities may affect her or his worldview, which may influence a counseling relationship.

Counselors should also be knowledgeable of both visible and invisible ethnic minority groups. Some ethnic minority groups are "visible," or identifiable, in that upon first look a counselor may be able to identify their racial group; these groups may include African Americans, Asian Americans, and darker-skinned Hispanic/Latino/a groups. Yet there may be other ethnic minority groups that may not be easily visible or identifiable; these groups include light-skinned Hispanic/Latino/a groups, multiracial persons, and Native Americans. Individuals from these invisible minority groups may identify strongly as an ethnic minority, but their ethnic identity may be ignored because of their physical appearances.

Kevin L. Nadal and David P. Rivera

*See also* Affirmative Action (v3); African Americans (v3); Alaska Natives (v3); American Indians (v3); Arab Americans (v3); Asian Americans (v3); Classism (v3); Diversity Issues in Career Development (v4); Ethnic Identity (v3); Eurocentrism (v3); Identity (v3); Latinos (v3); Multiracial Families (v3); Pacific Islanders (v3); Racial Identity (v3); Social Class (v4); Society for the Psychological Study of Ethnic Minority Issues (v3); Visible Racial/Ethnic Groups (v3)

### Further Readings

- Franklin, J. H. (1971). Ethnicity in American life: The historical perspective. In J. H. Franklin, T. F. Pettigrew, & R. W. Mack (Eds.), *Ethnicity in American life* (pp. 9–21). New York: Anti-Defamation League of B'nai B'rith.
- Phinney, J. S. (1996). When we talk about American ethnic groups, what do we mean? *American Psychologist*, 51(9), 918–927.
- Sue, S. (1991). Ethnicity and culture in psychological research and practice. In J. Goodchilds (Ed.), *Psychological perspectives on human diversity in America* (pp. 51–85). Washington, DC: American Psychological Association.

---

## ETHNIC PRIDE

---

Ethnic pride is a positive feeling of being a member of one or more ethnic groups. As a component of ethnic



identity, ethnic pride includes an appreciation and understanding of one's culture and history. Ethnic pride does not involve being arrogant, racist, or ethnocentric. Instead, ethnic pride, or pride in general, can be considered a source of self-respect and dignity. Ethnocentrism and racism, on the other hand, refer to discriminating against people because of their ethnicity and believing in the superiority of one ethnic group over another ethnic group.

For some individuals and cultures, having a high degree of ethnic pride is discouraged, and acculturation and assimilation are instead emphasized. However, ethnic pride and acculturation (or assimilation) are not mutually exclusive concepts. For example, it is possible for someone to have a high (or low) level of ethnic pride and also be more (or less) acculturated to mainstream American society. In some cultures, such as the Latino/a, African American, and Native Hawaiian cultures, there is a growing movement to embrace and be proud of one's ethnicity and culture.

Ethnic pride can be increased through activities that promote empowerment and a positive feeling toward one's ethnic group. This may be accomplished through exposure to ethnic role models, reading books, watching movies, traveling, eating ethnic foods, listening to music, and dancing.

Ethnic pride has been examined in relation to various health and academic outcomes. In general, however, there is a relative dearth of information in this area, and additional research is needed. Overall, these studies have found that high levels of ethnic pride are associated with a greater knowledge of health risks and less favorable attitudes toward smoking; among African American fourth graders, high levels of ethnic pride are associated with high academic achievement scores in school and standardized tests. Other research has found that high levels of ethnic pride are associated with less drug use and exposure among African American, Mexican American, and mixed ethnicity students, while high levels of ethnic pride are associated with more drug use among White students. In sum, these studies point to the important role of ethnic pride in physical, psychological, and academic outcomes.

*Lisa A. P. Sanchez-Johnsen*

**See also** Acculturation (v3); Afrocentricity/Afrocentrism (v3); Assimilation (v3); Enculturation (v3); Ethnic Identity (v3); Ethnocentrism (v3); Identity (v3); Psychological Well-Being, Dimensions of (v2); Racial Identity (v3); Racial Pride (v3); Racism (v3)

## Further Readings

- Ma, G. X., Shive, S. E., Tan, Y., Toubbeh, J. I., Fang, C. Y., & Edwards, R. L. (2005). Tobacco use, secondhand smoke exposure and their related knowledge, attitudes and behaviors among Asian Americans. *Addictive Behaviors*, 30(4), 725–740.
- Marsiglia, F. F., Kulis, S., & Hecht, M. L. (2001). Ethnic label and ethnic identity as predictors of drug use among middle school students in the southwest. *Journal of Research on Adolescence*, 11(1), 21–48.
- Phinney, J. (1992). The Multi-Group Ethnic Identity Measure: A new scale for use with adolescents and young adults from diverse groups. *Journal of Adolescent Research*, 7, 156–176.
- Smith, E. P., Atkins, J., & Connell, C. M. (2003). Family, school and community factors and relationships to racial-ethnic attitudes and academic achievement. *American Journal of Community Psychology*, 32(1/2), 159–173.
- Vazquez, C. I. (2004). *Parenting with pride—Latino style*. New York: Rayo.

---

## ETHNOCENTRISM

---

The revolutionary climate of the 1960s within U.S. society challenged the existing boundaries of civil rights to include racial/ethnic minorities. Concurrently, an emergence of leading racial/ethnic minority scholars in counseling and psychology set the stage for the extensive examination of the influence of individuals' cultural backgrounds (i.e., values, attitudes, shared history, customs, race, habits, social rules of behavior, social status, perceptions of locus of control and responsibility) on psychological development and treatment process and outcomes in counseling relationships.

Culture was perceived as the lens through which individuals viewed and interpreted the world, and a growing number of professionals explained differential patterns in diagnoses, treatment, and counseling outcomes by highlighting practitioners' inattentiveness to differences between clients' cultural backgrounds and the primarily Eurocentric norms promoted by many practitioners. In addition, the predominance of White Americans within the profession seemed to perpetuate the legacy of racist attitudes, which assumed superiority based on differences in phenotype and culture. The term that describes this characteristic of seeing one's own community norms and group identity as the models against which all



others should be judged as aberrant, strange, and inferior is *ethnocentrism*. Although, much of the literature highlights attention to White majority group members' ethnocentrism, it is important that readers note that all individuals who have strong cultural group identity or who have little awareness of a group identity have the capacity to assume an ethnocentric stance in day-to-day activities.

### Positive Versus Negative Effects

The ethnocentric perspective can have both affirming and detrimental implications for self-concept and interactions with others. Social identity theory purports that as individuals understand themselves, the following personality qualities are enhanced: personal identity, affiliation with others within group, confidence, understanding of self, psychological well-being, and self-esteem. However, the sole or primary culture-specific focus can negatively affect individuals' ability to accept the relativism of their and others' cultural identity.

However, in spite of this mix of both positive and negative characteristics associated with a strong positive group identity (one aspect of being ethnocentric), many individuals assume that such is automatically equated with only negative implications. Empirical evidence supports the notion that one can simultaneously have a strong positive group identity and accept the legitimacy of the culturally different. Nevertheless, the most effective strategy to balance the effective expression of respect for both self and other, when the two value systems collide, remains somewhat unclear.

Because empirical evidence supports the notion that individuals can simultaneously have a strong positive group identity and respect those of other groups, it is imperative that practitioners are sufficiently multiculturally competent to effectively bridge any differences existing between themselves and all clients. However, in spite of the mandate for multicultural counseling training in all accredited programs, this competence varies significantly among practitioners.

### Counselors' Ethnocentrism in Counseling

Practitioners' ethnocentric responses to clients are spontaneous and, too often, sources of unconscious, psychological harm to clients who persist in the relationship. Clients with strong positive self-concepts

will prematurely terminate the counseling relationship. The following are examples of common errors made in counseling relationships, when ethnocentrism is not monitored: use of negative judgment words to describe the clients' experience, behavior, or primary support network; pathologizing differences and using assessments without considering population-demographic characteristics on which the measures are normed; engaging clients based solely on perceptions of phenotype or stated group identity; responses that indicate unawareness of one's own identity; unwillingness to examine transference or countertransference (i.e., consistently defining clients' responses in counseling as resistant to intervention); expressed insensitivity or lack of respect for clients' perception of experience associated with their unique group membership; premature problem-solving and advice-giving based on what the counselor believes the client ought to be or do; generating alternatives without considering the negative implications for ingroup and outgroup membership or preparing the client for potential shifts related to proposed changes; distancing oneself from the client by expressing no understanding of the client's experience; not specifically addressing stark differences between self and client that might influence the client's perception of the relationship and of the counselor as a person (i.e., sex, race, ethnicity, age); disaffiliating from one's group or client's perceptions of one's group when client expresses concern about counselor's group membership (i.e., I'm not racist; I'm not sexist; I'm not like all of the others like me, I'm different); not inviting the client to share perceptions whenever there is any indication of counselor's insensitivity. As a result, the client's culture is not respected, and the counselor's culture is not used in a manner that enhances the therapeutic working alliance. The increased probability of inaccurate assessment results, unstable rapport, insufficient collection of important information, inappropriate diagnoses, and negative outcomes are results from such interactions. Sensitivity is warranted particularly with clients who are ethnocentric in their own identity.

### Presenting Concerns of the Ethnocentric Client

Ethnocentric clients might exhibit various presenting concerns: difficulty with interactions across groups, including difficulty finding and maintaining bonds, understanding commonalities, and accepting



differences; higher levels of insecure self-identity, which could have a direct impact on individual self-esteem and self-concept; issues regarding acculturation; and issues associated with limited awareness of their own ethnocentrism. These concerns require counselors' intervention to enhance ethnorelativism versus ethnocentrism so as to not deculturate clients. For optimal outcomes in counseling to occur, it is imperative that practitioners effectively monitor their own ethnocentrism.

### Effects of Ethnocentrism in the Counseling Relationship

The counseling profession has attempted to monitor the phenomenon of ethnocentrism within the counseling relationship through multicultural counseling, which refers to a process in which a trained professional from one cultural/racial/ethnic background interacts with a client of a different cultural/racial/ethnic background for the purpose of promoting the client's cognitive, emotional, psychological, and/or spiritual development. The acquisition of culture-specific knowledge has become the norm as diversity increases within the general populace. Some scholars have developed counseling models that provide a guide for practitioners to self-monitor ethnocentrism within sessions. All are efforts to minimize harm to clients because of unmonitored ethnocentrism. However, key questions remain unanswered: Is cultural relativism a real or ideal training objective? Can practitioners who maintain ethnocentric attitudes and beliefs effectively counsel culturally different clients? Can practitioners effectively and strategically self-monitor ethnocentrism during the counseling session in a manner that benefits the client? With increasing diversity within both the general populace and graduate student cohorts in counseling programs, what are ways in which training programs could strategically maximize the degrees of multicultural competence among all graduates? Finding answers to these questions will facilitate a clearer understanding of how ethnocentrism might be addressed more effectively in both training and service delivery.

*Robbie J. Steward and Chandra M. Donnell*

**See also** Acculturation (v3); Barriers to Cross-Cultural Counseling (v3); Civil Rights (v3); Classism (v3); Cross-Cultural Training (v3); Cultural Encapsulation (v3); Cultural Relativism (v3); Discrimination (v3); Diversity

Issues in Career Development (v4); Enculturation (v3); Eurocentrism (v3); Identity (v3); Multicultural Counseling (v3); Multiculturalism (v3); Prejudice (v3); Racism (v3); Social Discrimination (v4); White Privilege (v3); Worldview (v3)

### Further Readings

- DeCremer, D. (2001). Relations of self-esteem concerns, group identification, and self-stereotyping to in-group favoritism. *Journal of Social Psychology, 141*(3), 389–400.
- Fish, J. M. (2000). What anthropology can do for psychology: Facing physics envy, ethnocentrism, and a belief in "race." *American Anthropologist, 102*(3), 552–563.
- Gaertner, L., Iuzzini, J., Witt, M. G., & Orina, M. M. (2006). Us without them: Evidence for an intragroup origin of positive in-group regard. *Journal of Personality and Social Psychology, 90*, 426–439.
- Phinney, J. S., Lochner, B., & Murphy, R. (1990). Ethnic identity development and psychological adjustment in adolescence. In A. Stiffman & L. Davis (Eds.), *Ethnic issues in adolescent mental health* (pp. 53–72). Newbury Park, CA: Sage.
- Roysircar, G. (2004). Cultural self-awareness assessment practice examples from psychology training. *Professional Psychology: Research and Practice, 38*, 658–666.
- Steward, R. J. (1998, March–April). *PAR—A theoretic model for self-assessment and practice toward multicultural counseling competence*. Paper presented at the American Counseling Association World Conference, Indianapolis, IN. (ERIC Document Reproduction Service No. ED419185)
- Sue, D. W. (2004). Whiteness and ethnocentric monoculturalism. Making the "invisible" visible. *American Psychologist, 59*, 761–769.
- Verkuyten, M. (2005). Ethnic group identification and group evaluation among minority and majority groups: Testing the multiculturalism hypothesis. *Journal of Personality and Social Psychology, 88*, 121–138.

---

## ETIC–EMIC DISTINCTION

---

For centuries, the field of psychology has been interested in understanding behavior and cultures. In effect, social and behavioral scientists have identified two critical approaches in understanding human behavior and cultures: an *etic perspective* and an *emic perspective*. Based on universal comparisons of behaviors that can be generalized across cultures, the *etic* approach is



consistent with the use of quantitative hypothetical-deductive methods wherein researchers or outsiders are the primary judges of the validity of an experience. Conversely, based in a belief that unique values and norms of a given culture are key to understanding behaviors meaningful to indigenous members of a given society, the *emic* approach is consistent with qualitative research methodologies wherein members of the society or insiders become the primary sources of validity of a particular experience. With the increasing knowledge that behavior or phenomena can be universal and yet be culturally bound, the etic–emic distinction and how these two perspectives are negotiated in theory, research, assessment, and practice have become germane to the field of counseling psychology.

Originally coined in 1954 by the linguist Kenneth L. Pike, the etic–emic distinction was first referenced in psychology by David French in 1963 when he examined the relationship between anthropology and studies of perception and cognition. In 1969, John W. Berry adapted its use to cross-cultural psychology. Since this period, scholars engaged in multicultural psychological research have employed these two epistemologies to conceptualize and operationalize both comparative and indigenous research.

Interestingly, although well established and widely used in different fields—linguistics, anthropology, education, medicine, philosophy, psychiatry, social work, sociology, public health, psychology, folklore, semiotics, and management—these terms have been viewed in opposition to each other, resulting in a long-standing controversy over the efficacy of the two perspectives. In fact, there have been several shifts in the debate on its dichotomous versus symbiotic nature. In essence, the controversy over the definitions and applications of the approaches has continued to fuel the etic–emic debate.

### **Etics and Emics: A Dichotomous Perspective**

The tension over whether etic–emic approaches are contrasting or complementary seems to come from researchers who have different assumptions about concepts, behaviors to be assessed, and methods of analysis. For instance, etic researchers examine more than one culture or language at a single moment in time. Because of this brief intervention, etic approaches are an effective means of providing a broader perspective on behavior while meeting practical demands (e.g., financial constraints, time pressures). Within this approach, concepts or classifications are known in

advance (as based on prior research) rather than determined during analysis. Etic concepts are judged against criteria that are external to the system, absolute, and directly measurable. Furthermore, the etic view does not perceive all aspects of a situation to be part of a larger setting. Instead, etic data can be obtained through analysis of partial information.

Conversely, the emic approach tends to be culture-specific and applied to one culture or language at a time or over a sustained period of time. Within this approach, concepts are discovered rather than predicted and viewed against criteria that are relevant to the internal functioning of the system. The emic view thus perceives each component as interconnected and functioning within a larger structural setting. This allows for the understanding of the culture as a whole rather than a series of disconnected parts.

These dichotomous polarities inherent in the defining characteristics have led scholars to equate etic and emic with descriptors such as scientific versus subjective, cross-comparative versus ethnographic, and formal versus informal methodologies. In effect, it has led etic researchers to question emic perspectives and emic researchers to question etic perspectives for conceptual and methodological weaknesses. Etic perspectives have been dismissed for their assumption of cultural universality wherein all behaviors are perceived as equally present in all cultures with minimal modifications required when examining issues. Within this focus, cultural or contextual factors are minimized. On the other hand, emic perspectives are criticized for being overly culturally specific with limited generalizability to a larger population. These criticisms have tended to keep the two approaches somewhat separate.

### **Etics and Emics: An Integrated-Symbiotic Perspective**

However, not all researchers ascribe to this separation, and many have argued for examining the complementary nature of the two approaches. For instance, Pike perceived the relationship to be symbiotic with the two perspectives being equally valuable because they examine the same data from two different standpoints. Similarly, Patricia Greenfield argued that the two approaches are complementary in that emic approaches serve well within an exploratory context while etic approaches work well when testing hypotheses. Other scholars, such as French, have ascribed to Pike's view of etics as an entry point to emics. Within this context, one approaches the



phenomena across cultures from a common ground perspective, leading up to studying specific aspects of the phenomena within a culture.

In attempting to address the forced dichotomization between etic and emic approaches, Berry expanded on Pike's ideas about the symbiotic nature of the two perspectives. Berry noted that researchers' choice of orientation (etic/emc) has consequences in the way (method) research may be conducted. In attempting to compare behaviors across cultures (etic) while at the same time understanding behavior that is meaningful to a particular culture (emic), Berry proposed a framework that highlights the essential and interconnected nature of the two perspectives.

In initiating cross-comparative research, Berry cautioned against what he termed *imposed etics* or what Harry C. Triandis later called *pseudoetics*, or false etics. Both authors believed that although the intentionality is that of an etic orientation, researchers typically begin with a concept or instruments based in their own culture, in essence, coming from their own emics. Because the "emics" of researchers might be categorically different from those of participants, false assumptions can be made about the validity of concepts or instruments within or across cultures. Furthermore, entering a system with what "appears" to be an etic concept can provide only a preliminary approximation of the phenomena.

Thus, both advocate for a convergence of the two approaches through engaging in what Berry refers to as *parallel emics*, wherein modifications are made to the external criteria or categories (imposed etics) to develop instruments within each culture independently. Once indigenous assessments are created for each culture, cross-cultural comparisons can be made. Concepts that appear as universal across cultures are then referred to as *derived etics*, whereas concepts that vary across cultures are considered to be culture-specific and hence truly "*emic*."

### Contemporary Perspectives

Understanding etic and emic distinctions is critical to understanding behaviors within and across cultures. Although the concept of etics is commonly associated with an outsider standpoint and emics with an insider viewpoint, scholars in the field of multicultural and cross-cultural psychology argue that concepts can have both a universal and a culture-specific base. In light of this, contemporary views highlight the importance of

an integrated etic–emic perspective that can help examine phenomena through a functional, conceptual, and contextual equivalence.

Arpana G. Inman

**See also** Cross-Cultural Psychology (v3); Cross-Cultural Training (v3); Cultural Encapsulation (v3); Multicultural Psychology (v3); Pedersen, Paul Bodholdt (v3); Qualitative Methodologies (v1); Quantitative Methodologies (v1); Sue, Derald Wing: Contributions to Multicultural Psychology and Counseling (v3); Worldview (v3)

### Further Readings

- Berry, J. W. (1969). On cross-cultural comparability. *International Journal of Psychology*, 4, 119–128.
- Berry, J. W. (1989). Imposed etics-emics-derived etics: The operationalization of a compelling idea. *International Journal of Psychology*, 24, 721–735.
- Berry, J. W. (1999). Emics and etics: A symbiotic conception. *Culture and Psychology*, 52, 165–171.
- Berry, J. W., & Kim, U. (1993). The way ahead: From indigenous psychologies to a universal psychology. In U. Kim & J. W. Berry (Eds.), *Indigenous psychologies: Research and experience in cultural context* (pp. 277–280). Newbury Park, CA: Sage.
- Feleppa, R. (1986). Emics, etics, and social objectivity. *Current Anthropology*, 27, 243–255.
- Fischer, A. R., LaRae, M. J., & Atkinson, D. R. (1998). Reconceptualizing multicultural counseling: Universal healing conditions in a culturally specific context. *The Counseling Psychologist*, 26, 525–588.
- French, D. (1963). The relationship of anthropology to studies in perception and cognition. In S. Koch (Ed.), *Psychology: A study of a science: Vol. 6. Investigations of man as socius: Their place in psychology and the social sciences* (pp. 388–428). New York: McGraw-Hill.
- Greenfield, P. M. (1997). Culture as process. Empirical methodology for cultural psychology. In J. W. Berry, Y. H. Poortinga, & J. Pandey (Eds.), *Handbook of cross-cultural psychology: Vol. 1. Theory and method* (2nd ed., pp. 301–346). Needham Heights, MA: Allyn & Bacon.
- Harris, M. (1976). History and significance of the emic/etic distinction. *Annual Review Anthropology*, 3, 329–350.
- Headland, T. N., Pike, K. L., & Harris, M. (Eds.). (1990). *Emics and etics: The insider/outsider debate*. Newbury Park: Sage.
- Mead Niblo, D., & Jackson, M. S. (2004). Model for combining the qualitative emic approach with the quantitative derived etic approach. *Australian Psychologist*, 39, 127–133.



- Pike, K. L. (1967). *Language in relation to a unified theory of the structure of human behavior*. The Hague: Mouton.
- Triandis, H. C. (1972). *Culture and social behavior*. New York: McGraw-Hill.
- Triandis, H. C. (2000). Dialectics between cultural and cross-cultural psychology. *Asian Journal of Social Psychology*, 3, 185–195.

---

## EUROCENTRISM

---

Eurocentrism is defined as judging the experiences of non-European-descended individuals (i.e., African Americans, Latinos/as) against a European American standard. Eurocentrism often leads to negative attitudes and beliefs about groups of people and can confirm mainstream stereotypes about non-European group members. In essence, a Eurocentric belief system assumes that European American culture (i.e., Western culture) is the norm and should be viewed as the standard against which other cultures are judged. Both implicit and explicit Eurocentrism serve as a basis for prejudice. Though Eurocentrism has significant implications for mental health and psychology, little research exists on the subject.

The Eurocentric worldview is based on Western values and characteristics such as individualism, competitiveness, dualistic thinking, a belief in control over nature, hierarchical decision-making processes, standard English, a rigid time orientation, Judeo-Christian beliefs, patriarchy, the Protestant work ethic, future orientation, “objective/rational” thought, property ownership, and nuclear family structure. When one expects others, regardless of their cultural background, to behave in ways that reflect these values, deviations are pathologized and often serve as the basis of some form of group-based oppression. Eurocentrism, in the context of U.S. society, as well as other multicultural societies, is harmful in that non-Western cultural values (e.g., collectivism, living within an extended family system) are viewed, at best, as novel and, at worst, “deficient” in relation to European American cultural values. Viewing the experiences of others from a Eurocentric perspective may lead to exclusion, marginalization, and discrimination when individuals do not possess and display traits valued within European American culture. Eurocentrism can occur at individual, cultural, and institutional levels and can be manifested in overt and covert ways.

## Everyday Eurocentrism

When immigrants come to the United States, there is often an underlying expectation that they will ultimately assimilate into mainstream American (i.e., Eurocentric) cultural lifestyles. For example, in many work and educational settings, employees or students might be expected to wear Western-style clothing or speak standard English despite the fact that many individuals may prefer non-Western, traditional, indigenous dress, or prefer to communicate in their native languages, even if they are capable of speaking English. The pressure to “fit in” and become Americanized may challenge non-Western individuals to assimilate and abandon their own personal and cultural preferences. This expectation may be tacit as well as explicit. Students who come to school dressed in non-Western, traditional clothing may be ostracized from peers or, in extreme cases, may be told that they must modify their dress (e.g., banning the practice of wearing head coverings or religious artifacts).

Eurocentrism can also result in life-changing consequences for those who do not fit the standard. Employment research has found that employers are much less likely to call back job applicants with African- versus European-sounding names and to make actual job offers. This type of preference may suggest a Eurocentric bias as well as a pattern of discrimination with regard to interview selection practices. This type of biased behavior and assumptions about what type of behavior is preferred are also relevant to the field of psychology.

## Eurocentrism in Psychology

Manifestations of Eurocentrism can also be found within the practice of psychology. For example, although the *Diagnostic and Statistical Manual of Mental Disorders (DSM)* has been used to diagnose various forms of mental illness for decades, many of the *DSM* diagnostic categories are vulnerable to racial disparities. For example, there is an overrepresentation of African American boys who have diagnoses of conduct disorder, attention deficit/hyperactivity disorder, and other behavioral disorders than what one would expect given their statistical representation in the population. It has been argued that African American boys are given these diagnoses in greater proportions than their White counterparts because teachers, physicians, and mental health professionals use Eurocentric standards of conduct to judge these



children and are faster to diagnose them with “disorders.” Furthermore, mental health professionals have also been accused of minimizing the impact of racism and other forms of discrimination on the mental health of non-White individuals. The lack of inclusion of such factors in the assessment process may contribute to inaccurate diagnoses and a tendency to conceptualize pathology in the individual rather than interpreting the situation as being rooted in social problems. For instance, recent longitudinal research has found that African American youth who perceive discrimination are more likely to manifest symptoms of depression and conduct problems than their counterparts who do not perceive such discrimination. Other research with Asian American youth has found that experiences of cultural marginalization contribute to depression. Thus, in addition to the problems that Eurocentrism can influence in educational or workplace settings, Eurocentrism and its potential consequences (e.g., racism, discrimination) can affect non-Western individuals’ mental health and the way that mental health professionals perceive them.

It is also important to recognize that the process of counseling has been accused of being Eurocentric. Historically, counseling theories and techniques were developed by White counselors and therapists of European American descent, who worked exclusively with White clients. Scholars have noted that although many therapeutic techniques have been developed and empirically validated as being effective, limited research has been conducted with respect to the effectiveness of such interventions with people of color and clients who are not of European descent. The lack of available research on evidence-based treatment for people of color could be seen as an outcome of Eurocentrism within the field of psychology. As a result, the field of psychology has a less-developed knowledge base about the most effective ways to intervene with non-Western clients.

Within psychology and other mental health professions, Eurocentrism can have adverse effects on individuals and institutions because of the societal power and authority scientific professions like psychology have in the United States.

On the other hand, psychology has also played an important role in efforts to change social policy that has facilitated discrimination. For instance, Mamie P. Clark and Kenneth B. Clark conducted psychological research that helped convince the U.S. Supreme Court

that educational segregation resulted in prejudice and discrimination that harmed African American youth. It is important that psychologists remain vigilant against the historical and contemporary effects of Eurocentrism in relation to research, policy development, organizational behavior, and clinical practice.

*Sha’kema M. Blackmon and Elizabeth M. Vera*

**See also** Allocentrism (v3); Barriers to Cross-Cultural Counseling (v3); Bias (v3); Cross-Cultural Psychology (v3); Cultural Encapsulation (v3); Cultural Relativism (v3); Cultural Values (v3); Discrimination (v3); Discrimination and Oppression (v2); Ethnic Pride (v3); Ethnocentrism (v3); Idiocentrism (v3); Monocultural (v3); Racial Pride (v3); Social Discrimination (v4); Universalism (v3); White Americans (v3); White Privilege (v3); Worldview (v3)

### Further Readings

- Bertrand, M., & Mullainathan, S. (2003). *Are Emily and Greg more employable than Lakisha and Jamal? A field experiment on labor market discrimination*. Retrieved March 15, 2006, from [http://povertyactionlab.org/papers/bertrand\\_mullainathan.pdf](http://povertyactionlab.org/papers/bertrand_mullainathan.pdf)
- Brody, G. F., Chen, Y. F., Murry, V. M., Ge, X., Simmons, R. L., Gibbons, F. X., et al. (2006). Perceived discrimination and the adjustment of African American youths: A five-year longitudinal analysis with contextual moderation effects. *Child Development*, 77(5), 1170–1189.
- Cunningham, W. A., Nezlek, J. B., & Bananji, M. (2004). Implicit and explicit ethnocentrism: Revisiting the ideologies of prejudice. *Personality and Social Psychology Bulletin*, 30(10), 1332–1346.
- Hwang, W. C. (2006). The psychotherapy adaptation and modification framework: Application to Asian Americans. *American Psychologist*, 61(7), 702–715.
- Katz, J. H. (1985). The sociopolitical nature of counseling. *The Counseling Psychologist*, 13(4), 615–624.
- Kim, S. Y., Gonzales, N. A., Stroh, K., & Wang, J. L. (2006). Parent-child cultural marginalization and depressive symptoms in Asian American family members. *Journal of Community Psychology*, 34(2), 167–182.
- Kress, V. V. W., Eriksen, K. P., Rayle, A. D., & Ford, S. J. W. (2005). The *DSM-IV-TR* and culture: Consideration for counselors. *Journal of Counseling & Development*, 83, 97–104.
- Stewart, E. C., & Bennett, M. J. (1991). *American cultural patterns: A cross-cultural perspective*. Yarmouth, MN: Intercultural Press.





---

## FAMILISMO

---

Familismo refers to a strong sense of identification with, and loyalty to, nuclear and extended family. It also includes a sense of protection of familial honor, respect, and cooperation among family members. Through these values, individuals place their family's needs over their own personal desires and choices. Researchers indicate that familismo-related values foster the creation or facilitation of the whole, rather than that of the individual. Scholars further define familismo as the most important cultural aspect defining the beliefs and attitudes of Latinos/as. Thus, it becomes fundamental that therapists working with Latino/a populations understand the concept of familismo and its impact on the well-being of Latinos/as.

Familismo is best understood from a multidimensional perspective, which includes three dimensions: structural, behavioral, and attitudinal. The structural dimension defines the spatial and social boundaries in which behaviors and attitudes within the family acquire meaning. The inclusion or exclusion of nuclear and extended family members defines these boundaries. The behavioral dimension refers to the support shared among family members. Visiting and calling family members reflect this dimension. The attitudinal component of familismo refers to the commitment to family relationships, including individual's identification with the nuclear and extended family. Like most constructs, familismo should be examined from a dialectical perspective where both positive and negative aspects are highlighted.

Traditional views on family dynamics have facilitated the misinterpretation of familismo. Some therapists may perceive strong family bonds among Latinos/as as signs of codependency, enmeshment, or pathology, leaving many Latinos/as feeling misunderstood and inaccurately diagnosed. Because strong family relationships among Latinos/as can cause confusion in the interpretation of symptoms, familismo should first be interpreted as a cultural variable that may also serve as a therapeutic and individual strength.

Research indicates that factors underlying the concept of familismo may positively influence Latinos/as' treatment adherence and their psychological well-being. Encouraging and strengthening family cooperation and support could be a way through which mental health providers use familismo to promote treatment adherence. They may encourage family members to set goals and make decisions that may benefit the clients' well-being. In turn, this may reinforce the clients' self-esteem and positively affect their decision-making process.

Further studies show that a strong sense of familismo may decrease cultural and intergenerational problems within the family. These studies hypothesize that the concept of familismo would lower adolescents' feelings of depression, anxiety, alcohol use, and conduct problems and increase involvement with school activities. Thus, reinforcing familismo may serve as a useful tool for therapists fostering the well-being of Latino/a adolescents.

Given that familismo is a key cultural dynamic present in Latino/a communities, it becomes crucial to understand how its function may affect the well-being



of Latinos/as. Therapists are encouraged to examine their personal and professional values of family structure and interdependence as they work with Latino/a clients.

*Miguel E. Gallardo and Yanina Paoliello*

**See also** Barriers to Cross-Cultural Counseling (v3); Career Counseling, Latinos (v4); Cross-Cultural Psychology (v3); Cultural Values (v3); Culture (v3); Diversity (v3); Ethnic Identity (v3); Ethnic Pride (v3); Latinos (v3); Multicultural Counseling (v3); Multiculturalism (v3); Multicultural Psychology (v3); National Latina/o Psychological Association (v3); Work–Family Balance (v4)

### Further Readings

- Antshel, K. M. (2002). Integrating culture as a means of improving treatment adherence in the Latino population. *Psychology, Health & Medicine*, 7(4), 435–449.
- Bacallao, M. L., & Smokowski, P. R. (2005). “Entre dos mundos”: Bicultural skills training with Latino immigrant families. *The Journal of Primary Prevention*, 26(6), 485–509.
- Santiago-Rivera, A. L., Arredondo, P., & Gallardo-Cooper, M. (2002). *Counseling Latinos and la familia*. Thousand Oaks, CA: Sage.

---

## FATALISM

---

Mental health scholars have long been interested in fatalism. In 1959 Bruce P. Dohrenwend, in an extension of the sociologist Émile Durkheim’s late-19th-century writings, posited that fatalism was a common cause of mental disorder and suicide. Fatalism was thought of as a societal response to excessive regulation and oppressive discipline, in the extreme like that experienced by prisoners. In psychological paradigms, fatalism has most frequently been grounded in the generalized expectancies framework, for example, internal–external locus of control. In this perspective fatalistic persons believe they have little or no influence on events that will happen to them. Other common prominent characterizations of fatalistic beliefs include a stable future orientation and malleable attributions of the causes of previous events.

Many scholars have thought individuals’ overall fatalism would lead to poor adaptation, lack of behavioral control, and, in turn, poor health and well-being;

results have been mixed, however. One approach to derive more consistent findings has been to define situation-specific fatalistic beliefs that may inhibit specific protective actions, such as those related to coping with disease, unemployment, or natural disasters. The way global fatalism has typically been constructed also has limitations when applied to more collectivist groups. One major challenge has been to discriminate what reflects spirituality or faith, which may be adaptive in many circumstances, from that of a negative expectation about outcomes where persons do have agency. An example of this problem appears in the literature of fatalismo in Latinos/as, the extent to which a person believes his or her destiny is not under his or her control. Although fatalism was thought to be parallel to fatalismo, fatalismo, when described by Latinos/as, includes components of spirituality as well as external locus of control, but neither fully encompasses it. It would be inappropriate to assume fatalismo is broadly associated with poor mental health, maladaptive behaviors, or passivity toward one’s life. When extended to populations of Asian descent, fatalism may include beliefs of a higher order, a characteristic not inherent in typical Western conceptualizations.

Given multiple definitions of fatalism and questions about its comparability and meanings across cultural groups, scholars and practitioners should not assume all fatalistic-type beliefs are maladaptive. Promising approaches for intervention and therapy may focus on negative expectations toward future outcomes for which the respondent does have substantial agency and incorrect negative attributions for past events.

*Scott C. Carvajal*

**See also** Barriers to Cross-Cultural Counseling (v3); Collectivism (v3); Cross-Cultural Psychology (v3); Cultural Values (v3); Discrimination and Oppression (v2); Learned Helplessness (v3); Locus of Control (v3); Meaning, Creation of (v2); Multicultural Psychology (v3); Optimism and Pessimism (v2); Positive Psychology (v2); Power and Powerlessness (v3); Worldview (v3)

### Further Readings

- Guzmán, M., Santiago-Rivera, A., & Hasse, R. (2005). Understanding academic attitudes and achievement in Mexican-origin youths: Ethnic identity, other-group orientation, and fatalism. *Cultural Diversity & Ethnic Minority Psychology*, 11(1), 3–15.



- Neff, J., & Hoppe, S. (1993). Race/ethnicity, acculturation, and psychological distress: Fatalism and religiosity as cultural resources. *Journal of Community Psychology*, 21(1), 3–20.
- Yeh, C., Inman, A., Kim, A., & Okubo, Y. (2006). Asian American families' collectivistic coping strategies in response to 9/11. *Cultural Diversity & Ethnic Minority Psychology*, 12(1), 134–148.

## FILIAL PIETY

Filial piety is the cultural value and responsibility to treat one's parents with the highest respect. *Filial* refers to anything related to a son or daughter, and *piety* refers to the virtue of being reverent and compliant. The value includes the notion of taking care of one's parents, while showing love, respect, courtesy, and support. It includes the importance of avoiding rebellion, disgrace, or loss of face of one's family and ancestors. It is a collectivist value, in that an individual respects the worth, beliefs, and standards of a collective (i.e., one's family, tribe, ethnic group, or community) rather than of the individual. An individual is often expected to put her or his parents' needs before her or his own. This may include making decisions that best benefit one's parents and family, while making self-sacrifices for one's parents.

The term derives from Chinese and Confucian traditions, which have been passed down to subsequent generations through storytelling. The most notable written work is *The Twenty-Four Examples of Filial Piety*, a collection of stories chosen and compiled by Guo Jujing during the Yuan Dynasty (1280–1368 C.E.) while he was mourning his father's death. In this collection are stories of exemplary actions of filial children from the times of primordial Emperor Shun down to the 12th century. For example, in "Wu Meng Attracts Mosquitoes to Drink His Blood," the title character takes off his shirt at night to allow mosquitoes to bite him instead of his ailing parents. In these stories, the child's actions are praised by the community, and she or he is revered for being an ideal respectful child.

Although *filial piety* was first coined as a Chinese term, it is a value that takes similar forms in other

Asian and Latino/a cultures. Other East Asian cultures (namely, Japanese and Korean) subscribe to the aforementioned values of filial piety, whereas other Asian groups may have similar values with slight differences. Asian Indians may uphold *dharma*, which includes individual ethics, duties, and obligations to one's family, while Filipinos may maintain *utang ng loob* (debt of gratitude), which embraces selfless obligations to one's parents, with an expectation of reciprocity from other family members. In Latino/a culture, filial piety is most similar to *familismo*, which is a strong identification and attachment of individuals with their nuclear and extended families.

Because many Asian cultures tend to maintain specific gender roles (i.e., men as authority figures, women as caretakers), acts of filial piety may differ for men and women. Examples of filial piety for men may include holding provider roles (i.e., paying for parents' expenses, making family decisions), whereas examples of filial piety for women may include more homemaking roles (i.e., cleaning and cooking for the parents/family). Examples of filial piety for both genders include individuals choosing colleges that would be most convenient for their parents (both geographically and financially) or an individual living at home as an adult to take care of her or his aging parents.

Kevin L. Nadal

*See also* Asian Americans (v3); Career Counseling, Asian Americans (v4); Career Counseling, Latinos (v4); Collectivism (v3); Confucianism (v3); Cross-Cultural Psychology (v3); Cultural Values (v3); Familismo (v3); Family Counseling (v1); Identity Development (v3); Latinos (v3); Loss of Face (v3); Parent–Adolescent Relations (v1); Parenting (v1); Worldview (v3)

## Further Readings

- Ikels, C. (Ed.). (2004). *Filial piety: Practice and discourse in contemporary East Asia*. Stanford, CA: Stanford University Press.
- Yeh, K.-H. (2003). The beneficial and harmful effects of filial piety: An integrative analysis. In K. Yang, K. Hwang, P. B. Pedersen, & I. Daibo (Eds.), *Progress in Asian social psychology: Conceptual and empirical contributions*. Westport, CT: Praeger/Greenwood.









---

## HEALTHY PARANOIA

---

Healthy paranoia is a healthy, normative, and adaptive response to racism perceived by Black Americans. The term was first used by Grier and Cobbs to describe the inclination they observed among Blacks to mistrust Caucasians in the areas of education, business, law, work, interpersonal relations, politics, and counseling. They suggested that cultural mistrust, in a mild form, was healthy and adaptive and fostered the development of healthy paranoia. This cultural response style, based on experiences of racism or oppression, helped Blacks to function effectively in a predominantly European American society. For example, concerns about being unfairly treated or judged may lead some Black Americans to exercise caution or engage carefully in tasks evaluated by Caucasians. Many mental health professionals assert that cultural aspects of paranoia, associated with a history of racism and discrimination in American society, must be distinguished from psychopathology. Healthy paranoia is a defense against an oppressive environment that has been hostile to the interests of Blacks. This protection limits trust, facilitates understanding of social situations, and enhances survival. Misinterpretation of healthy paranoia as pathological delusion is one cause of the misdiagnosis of Black clients.

Healthy paranoia research has focused on the effects on diagnosis (e.g., overdiagnosis of paranoid schizophrenia in Black patients), counseling process (e.g., help-seeking attitudes of Black students), counseling outcomes (e.g., premature termination), and educational and occupational expectations. Healthy

paranoia can have significant effects on the personal lives of Black individuals because it inhibits personal expression, an experience that is often undesirable and painful. It also can affect a wide range of situations, such as preference for counselors and other helping professionals.

### Implications for Counseling

Counselors in today's society need to develop race-specific expertise in addition to general counseling skills. Awareness of their own cultural identity and personal biases, along with knowledge and skills specific to the experiences of culturally diverse clients, is essential to conducting effective psychotherapy with populations of color. In particular, understanding and attending to issues of healthy paranoia can facilitate the provision of culturally sensitive and effective counseling services to Black clients. Knowing the history of a Black client who has experienced prejudice and discrimination can help therapists evaluate whether mistrust of a particular therapist is attributable to healthy paranoia or pathological paranoia. Counselors' recognition of healthy paranoia as an adaptive coping response to an oppressive situation or context can prevent overdiagnosis or misdiagnosis of clients of color and can enhance the delivery of culturally competent services to clients of color.

*Carlos P. Zalaquett*

*See also* African Americans (v3); Barriers to Cross-Cultural Counseling (v3); Black Racial Identity Development (v3); Career Counseling, African Americans (v4); Cross-Cultural



Psychology (v3); Cultural Mistrust (v3); Cultural Paranoia (v3); Discrimination and Oppression (v2); Eurocentrism (v3); Multicultural Counseling Competence (v3); Racial Identity (v3); Underdiagnosis/Overdiagnosis (v2); White Privilege (v3)

### Further Readings

- Grier, W. H., & Cobbs, P. M. (1968). *Black rage*. New York: Basic Books.
- Sue, S. (2006). Cultural competency: From philosophy to research and practice. *Journal of Community Psychology*, 34, 237–245.
- Whaley, A. L. (1998). Cross-cultural perspective on paranoia: A focus on the Black American experience. *Psychiatric Quarterly*, 69, 325–343.
- Whaley, A. L. (2001). Cultural mistrust and the clinical diagnosis of paranoid schizophrenia in African American patients. *Journal of Psychopathology and Behavioral Assessment*, 23, 93–100.

---

## HELMS, JANET E. (1947– )

---

Janet E. Helms, born in Kansas City, Missouri, is a scholar and educator best known for her work on the theory and measurement of racial identity development and her active involvement in psychological organizations. Over a period of approximately 25 years, Helms's theory of racial identity development has emerged as a set of highly interrelated conceptualizations that describes a process through which people of varying races cope and, invariably, *fail* to cope with societal racism. Helms's more recent scholarship has focused on test bias. In this body of work, she and her collaborators strive to address the questions of *why* racial disparities exist in cognitive abilities tests and *how* test constructors, practitioners, and policymakers can diminish this bias. As theoretician, researcher, mentor, educator, and advocate, Helms represents a positive force in the field of psychology. Her contributions have been applied not only to counseling and psychotherapy training and practice but also to education, law, organizational studies and practice, research methodology and ethics, and public policy. The reach of her work extends outside of the United States to countries such as Brazil, South Africa, Ghana, and Uganda.

### Racial Identity Theory

With regard to her theory on racial identity development, Helms contends that a study of race and racism needs to take into account the manner in which people are cognitively, affectively, and conatively affected by the appraisals that people make about them and, recursively, by the appraisals they make about themselves and others. *Racial* appraisals are but one aspect of this process that becomes internalized and highly integrated with other aspects of identity. In the early statuses of racial identity development and in the absence of deliberate efforts to illuminate and correct distortions about people based on race, many people adopt information processing strategies that accept a status quo perspective about racism. In other words, people may fail to question the negative or negligible treatment of non-Whites, the heralding of White people and White culture, or the seeming inevitability of Blacks and Latinos/as, as examples, to occupy positions of low prominence in education relative to Whites. Crucial to the status quo perspective are mechanisms that exist at all levels in the sociopolitical ecology that upholds a tolerance for *not* questioning or that encourages the deflection of these aspects of reality. People adopt information processing strategies of obliviousness, selective attention to reality, and denial to cope with these racial stimuli. However, even though these strategies can help release some of the discomfort or pain associated with the stimuli, they may not be effective. With increased exposure to history, accuracy about people from all backgrounds, and so forth, comes the opportunity for growth in racial identity development. Moreover, as people transcend the different statuses of racial identity, they can gradually replace inchoate information processing strategies (obliviousness, denial, selective attention) with strategies that are more consistent with mental health qualities, like complexity in thinking, flexibility, a willingness to approach rather than avoid situations, and so forth.

Built upon the formulations of W. E. Cross, Jr., Helms's research and theoretical writings on racial identity development began in the early 1980s. With T. A. Parham, Helms created a scale to assess Blacks' racial identity attitudes, one aspect of racial identity. This scale was used in subsequent studies to explore the relationship of racial identity attitudes of Blacks to an array of psychological variables, such as Black college students' preference for counselors based on counselor race. The scale also spawned a proliferation



of measures and theories by others, setting a precedent in identity development model and assessment development. Significantly, in addition to reformulating Cross's identity development model for Blacks, Helms developed three other models that completed her overarching theory of racial identity, the White identity model, the people of color model, and the racial interaction model.

In her racial interaction model, Helms demonstrated how counselors can effect meaningful change in counseling when racial stimuli are presented. Helms proposed that when counselors developed advanced status racial identity schemata, they were in better positions to help their clients in counseling. By contrast, in parallel relationships, in which the counselor and client share similar racial identity schemata, and in regressive relationships, where the counselor's schemata are less sophisticated than the client's, little or no change is likely. These formulations were later elaborated to apply to other situations that involved an influential or expert person who is expected to teach, guide, or lead others (e.g., teachers with students, organizational leaders with employees, group leaders with subordinate or nonexpert members).

### Impact of Race and Racism

What is apparent throughout Helms's research and theoretical writings is her strong insistence that race and racism need to be understood as phenomena that have an ostensible impact on socialization. Indeed, she urges researchers to strive to achieve a full understanding of these phenomena in order to know when and how to attend to these influences on personality development, interpersonal and group dynamics, and mental health functioning. In Helms's lectures, writings, and life stories are lessons about the vicissitudes of racism. When listening or reading carefully, one can learn that racism is not merely an act of negative bias or maltreatment (discrimination), nor is it something that evenly maligns one group against another (bigotry) with little regard for a history that entitles one group, Whites, and subordinates others (e.g., African Americans and Asian Americans). Her contributions are often woven tales of what life is like from someone who resides in two "warring" worlds, as drawing from the words of W. E. B. Du Bois: a dominant or "received view" perspective and the nondominant group perspective.

Importantly, as a consummate educator, Helms repeatedly makes a case for studying racism's impact

on psychological functioning and development by encouraging researchers and practitioners alike to break from convention. To learn about race and racism, one must use direct assessments, not the skillful avoidance or codified wording that characterizes social norms. *Direct* assessments involve querying participants about their perceptions of themselves and others as racial beings and of the relevance of race, as they see it, within their sociopolitical contexts. Direct assessments are challenging. Racial discourse can provoke anxiety and suspicions, even create alarm about how one will be judged. But in its place, what can be seen as the norm in conventional research are studies in which participants are asked merely to report a racial designation. When conducting these indirect assessments, researchers restrict themselves in gleaning meaningful information about the potential relevance of race to their focus of study. Instead, they rely on speculations on how the participants' reported designations configure into their findings, leaving the scientific world with little knowledge about race or the possible relevance of race to their findings. Helms's work *and* words can be used as exemplars for how we can learn a great deal about the psychology of race and racism.

### Education, Career, and Awards

Helms received her B.A. and M.A. degrees in psychology at the University of Missouri in Kansas City. She earned her doctorate in psychology, with a specialization in counseling psychology, in 1975 from Iowa State University of Science and Technology. Her first job was as an assistant professor at Washington State University in Pullman, Washington in 1975, and she followed this with an academic position at Southern Illinois University from 1977 to 1981. From 1981 to 1999, she worked at the University of Maryland, College Park, beginning as an assistant professor and later promoted to full professor. While at the University of Maryland, she served for a short period as codirector of the Counseling Psychology Program and as an affiliate of the Women's Studies Program. She maintained a private practice for many years while working in the suburban Maryland/Washington, D.C., area.

In 2000, Helms began her academic post at Boston College and was eventually named Augustus Long Professor of Counseling Psychology a short time later. Helms is the founding director of the Institute for the Study and Promotion of Race and Culture at Boston College. She has published more than 60 articles and



four groundbreaking books, including *Black and White Racial Identity: Theory, Research, and Practice*; *A Race Is a Nice Thing to Have: A Guide to Being a White Person or Understanding the White Persons in Your Life*; and (with Donelda Cook) *Using Race and Culture in Counseling and Psychotherapy: Theory and Practice*. She is associate editor of the *Assessment Journal* and is on the editorial board of the *Journal of Multicultural Counseling and Development*. She is Fellow of the American Psychological Association (APA) in Division 17 (Counseling Psychology) and Division 45 (Study of Ethnic Minority Issues). She is a Division 17 representative on the APA Council of Representatives and the APA's representative on the Joint Committee on Testing. She also is a member of the Association of Black Psychologists. She is the recipient of numerous awards, including the first Janet E. Helms Award for Mentoring and Scholarship in Professional Psychology at Columbia University, Teachers College. She also won the APA Division 17 Leona Tyler Award. In 2006 she was the recipient of the APA Distinguished Award for Education and Training in Psychology.

Chalmer E. Thompson

**See also** Black Racial Identity Development (v3); Cross, William E., Jr. (v3); Deficit Hypothesis (v3); Identity (v3); Identity Development (v3); Race (v3); Racial Identity (v3); Racism (v3); White Racial Identity Development (v3)

### Further Readings

- Helms, J. E. (1984). Toward a theoretical explanation of the effects of race on counseling: A Black and White model. *The Counseling Psychologist*, 12(4), 153–165.
- Helms, J. E. (Ed.). (1990). *Black and White racial identity: Theory, research, and practice*. New York: Greenwood Press.
- Helms, J. E. (1992). *A race is a nice thing to have: A guide to being a White person or understanding the White persons in your life*. Topeka, KS: Content Communications.
- Helms, J. E. (1995). An update of Helms's White and people of color racial identity models. In J. G. Ponterotto, J. M. Casas, L. A. Suzuki, & C. M. Alexander (Eds.), *Handbook of multicultural counseling* (pp. 181–198). Thousand Oaks, CA: Sage.
- Helms, J. E., & Cook, D. A. (1999). *Using race and culture in counseling and psychotherapy: Theory and process*. Needham Heights, MA: Allyn & Bacon.

## HELP-SEEKING BEHAVIOR

Help-seeking behavior can be understood as the steps an individual, a couple, or a family takes to enter into a relationship with a counseling professional. There seems to be a gap between those who need counseling services and those who utilize them, which can be attributed to multiple factors across several dimensions. The understanding of help-seeking behavior needs to include an exploration of clients' race, ethnicity, social class, gender, and geographic origin, among other variables. Additionally, it is important to examine the availability, cost, and access to services, previous utilization experience in counseling, clients' level of belief in the helpfulness of the counseling process, and whether counseling is sought voluntarily or is imposed. Help seeking by the client cannot be viewed apart from the relationship between the clients and the counselors offering the help, or apart from the organization with which the provider is affiliated. In the process of examining the variables that affect help-seeking behavior, it is important to consider that no variable can be understood alone, independent from other variables, or isolated from contextual dimensions. Understanding the complexity and variety of help-seeking behavior of clients has implications for the successful or unsuccessful outcome of the counseling process.

### Historical Background

Healing practices across cultures to relieve emotional or relational distress are not new. The act of engaging in a relationship, however, whereby one person, a couple, or a family relate to another person in a professional setting for behavioral or cognitive change and emotional or relational relief, is a relatively new, 20th-century, Western phenomenon. This development is due, in part, to sociopolitical changes the century brought to individuals and families in the West as a result of the Industrial Revolution, including the decline of extended family proximity in urban centers, the decline of authority over the life of the family, and the adjustments needed as a result of shifts in gender roles. In the first five decades of the 20th century, clients sought relief from emotional or psychological distress with the only professionals available at the time, that is, psychoanalysts or psychiatrists. Mentally ill patients were often hospitalized, sometimes for the rest of their lives, without their consent. Outpatient



treatments existed but were limited to individuals who could afford the private practice fees of psychoanalysts and psychiatrists.

Increases in client demand for counseling professionals started to occur in the United States in the 1960s and 1970s as a result of important legislative initiatives. The Community Mental Health Act of 1963, for example, funded the establishment of mental health centers across the country. This law and others that followed, including the deinstitutionalization of state mental hospital patients that took place in 1975, initiated an increase in demand for outpatient services, substance abuse services, family counseling, and other clinical services.

In the latter half of the 20th century, three historical shifts affected help-seeking behavior. The feminist movement spearheaded feminist counseling in the 1970s and resulted in women's demand for counseling that would help them to challenge assumptions related to the nature of their mental health, their suffering, and their position in the family. Systemic ideas influenced the development of couple and family counseling, in responding to couples or families seeking help on a variety of clinical issues. Changing immigration patterns in the last three decades of the 20th century resulted in an increased demand for counseling on the part of immigrant communities.

## Race and Ethnicity

The expansion of the traditional provision of counseling services to low-income ethnic minorities and immigrants has not been met without challenges. Dropout rates are high for ethnic and racial minorities and immigrants, particularly if they are in lower socioeconomic strata.

There is an important relationship between an individual's racial or ethnic background and his or her social class, level of education, minority or majority status, level of identity development, exposure to racism and discrimination, or religious affiliation in terms of how they affect help-seeking behavior. African Americans, Latinos/as, Asian Americans, and other ethnic minority groups tend to underutilize counseling services and are less likely than Caucasians to access outpatient mental health services. African Americans drop out after the first counseling encounter at much higher rates than do other minority and nonminority groups. Exposure to racism and discrimination may make a prospective African American client distrustful of providers of a different

race or ethnicity. Asian Americans may underutilize counseling services because they may lack knowledge regarding services, either because of continued stigma associated with formal help seeking or because of cultural prescriptions against self-focus. Latinos/as' help-seeking behavior may reflect cultural prescriptions that include an unwillingness to seek help for psychological, nonmedical reasons and a degree of fatalism that precludes perceptions of self-agency. Once racial and ethnic minority clients seek the help of a counseling professional, the encounter is likely to involve a provider rooted in the cultural middle-class values of individuality, self-disclosure, self-awareness, self-improvement, rationalism, and future planning. A growing body of literature suggests that conventional services do not seem to respond adequately to the values, needs, and cultural characteristics and preferences of racial and ethnic minorities.

The religious affiliation of racial and ethnic minorities may impact the help-seeking behavior. Individuals, couples, or families who rely on clergy and a religious community for their spiritual needs may find it difficult to seek the help of secular social services, that is, services not affiliated with a religious group.

Low-income racial and ethnic minority clients can often be other-referred (as opposed to self-referred) to receive counseling by legal, medical, or school systems. Frequently, counseling is mandated as a means of social control of racial and ethnic minority clients of low socioeconomic status as an alternative to jail or termination of parental rights. Other-referred and mandated clients drop out of services at higher rates than self-referred or voluntary clients because of lack of knowledge about, lack of preparation for, or distrust regarding the counseling process.

## Immigration Status

Help-seeking behavior also varies according to immigrant status (i.e., first or second generation) and acculturative processes. For immigrant groups who belong to racial, ethnic, or language minorities, lower levels of acculturation are associated with lower levels of utilization of counseling services, higher dropout rates, and higher rates of mandated referrals or referrals from other sources. For example, cultural or language incongruence is strongly related to utilization of services, as when the collectivistic orientation of certain groups clashes with the individualistic worldview of the service providers or when linguistic



barriers between providers and clients affect utilization rates and outcomes.

### Social Class

Help-seeking behavior varies across social class in terms of access to resources, continuity with services, and whether or not individuals with emotional, psychological, or relational distress choose the help of a counselor for their problems. Social class cannot be understood in isolation but in context with other variables, for example, immigration status and race or ethnicity. As counseling is an activity that involves the belief that speaking to a stranger about intimate matters is helpful, the outcome of counseling needs to be understood in terms of the relationship to a client of any social class background who seeks help within a middle-class, Western counseling cultural system.

### Gender

There are gender differences in help-seeking behavior. As with social class, race, and ethnicity, gender cannot be viewed in isolation from other variables. Research data show that a large percentage of counseling relationships are initiated at the request of women, and women constitute by far the largest percentage of clients in counseling. This is due to a variety of reasons, including different cultural patterns of expression of psychological distress in men and women, roles traditionally held by women as family caretakers, and women's tendency to view themselves as needing to take more responsibility for the relational needs of the family, among others. From this point of view, counseling can be considered a female cultural behavior, in addition to a middle-class cultural value, because it involves the acceptance of the free expression of emotional content and openness to vulnerability. Some men, particularly in patriarchal or hierarchical family structures, might consider talking to a stranger about intimate family matters a sign of weakness, incompetence, or lack of control.

### Implications

Once clients seek help, it appears that a major factor that contributes to positive outcomes is a perceived congruence between the values of the provider of counseling services and of the client seeking help. How providers of counseling services react to the

different variables involved in help-seeking behaviors, attitudes, and expectations can greatly affect the outcome of the counseling relationship. Providers who accept the differences rather than fight against them, who prepare their clients for the services they are about to engage in, and who provide culturally and linguistically relevant services have a better chance of retaining the clients who seek their help.

Sara Schwarzbaum

**See also** Acculturation (v3); Barriers to Cross-Cultural Counseling (v3); Collectivism (v3); Cultural Mistrust (v3); Ethnic Minority (v3); Immigrants (v3); Outcomes of Counseling and Psychotherapy (v2); Self-Disclosure (v2); Social Class (v4); Race (v3); Worldview (v3)

### Further Readings

- Evans, K. M., Kincade, E. A., Marbley, A. F., & Seem, S. R. (2005). Feminism and feminist therapy: Lessons from the past and hopes for the future. *Journal of Counseling & Development, 83*(3), 269–277.
- Falicov, C. J. (1998). *Latinos and family therapy*. New York: W. W. Norton.
- Hays, P. (2001). *Addressing cultural complexities in practice*. Washington, DC: American Psychological Association.
- Kliman, J. (1998). Social class as a relationship: Implications for family therapy. In M. McGoldrick (Ed.), *Re-visioning family therapy: Race, culture, and gender in clinical practice* (pp. 50–61). New York: Guilford Press.
- McCarthy, J., & Holliday, E. I. (2004). Help seeking and counseling within a traditional male gender role: An examination from a multicultural perspective. *Journal of Counseling & Development, 82*(1), 25–30.
- Sanchez-Hucles, J. (2000). *The first session with African Americans: A step-by-step guide*. San Francisco: Jossey-Bass.

---

## HIGH-CONTEXT COMMUNICATION

---

Anthropologist Edward T. Hall introduced the construct of high-context (HC) communication to describe the degree to which people rely on contextual factors rather than the explicit and transmitted part of the message to derive meaning in communication. In HC communication, people derive meaning from mutually shared information of the context that is associated with a communication event. HC communicators pay less



attention to the explicit, communicated speech to gather information. HC communication involves indirect messages, less emphasis on verbal content, and heightened sensitivity to others. HC communicators gather meaning by inferring meaning from the person's circumstances.

Hall proposed that the nervous system has developed an information-processing mechanism that can effectively cope with information overload through a culturally determined process called *contexting*. This process posits that individuals need to select only a portion of the total information available in an event to create meaning. The information that is not selected for processing but needed to create meaning is filled in by context. According to Hall, as contexting increases in a communication event, less information is needed from the explicit code to create meaning. While contexting requires time to develop, when it is accomplished, HC communication tends to be predictable, stable, and efficient.

Culture shapes the contexting process by socializing individuals to organize their past experiences according to a prescribed system of symbolic representations. This pattern of symbolic representations determines the cultural norms, rules, and expectations that guide how people communicate with one another. HC predominance is found in Japanese, Korean, Chinese, Latin American, African, Arabic, and Mediterranean cultures. Individuals within these cultures tend to be well-informed about others in their ingroup.

When a client says to the counselor, "You've been really helpful, but I don't think I will need any more counseling," a HC communicator would not interpret

the statement at face value. The counselor may have observed that the client did not make eye contact while verbalizing his or her intent to end counseling and that the client identifies with a culture that discourages interpersonal confrontations. Based on HC communication, the counselor may hypothesize that the client is not satisfied with counseling and may ask the client questions about how therapy can be more helpful.

*Yong S. Park and Bryan S. K. Kim*

**See also** Allocentrism (v3); Collectivism (v3); Communication (v3); Counseling Skills Training (v2); Cultural Values (v3); Culture (v3); Low-Context Communication (v3); Relationships With Clients (v2); Self-Disclosure (v2)

### Further Readings

- Gudykunst, W. B., & Ting-Toomey, S. (1988). *Culture and interpersonal communication*. Newbury Park, CA: Sage.
- Hall, E. T. (1976). *Beyond culture*. Garden City, NY: Anchor Press.
- Hall, E. T., & Hall, M. R. (1990). *Understanding cultural differences*. Yarmouth, ME: Intercultural Press.

---

## HISPANICS, HISPANIC AMERICANS

---

**See** LATINOS









---

## IDENTITY

---

The concept of identity has been defined as an internalized psychic system that integrates an individual's inner self and the outer social world into a congruent whole. The integration of a personal self and social outer world has been viewed as a developmental process and one that, according to Erik Erikson, requires the individual to synthesize fragments of childhood identifications into a single structure during late adolescence and early adulthood. Identity formation has long been viewed in this way; however, the notion that individuals synthesize fragments of childhood identifications into a single structure during adolescence may no longer be an adequate model in which to fully understand the development of identity. Many researchers and theorists now contend that traditional theories of identity development do not fully explain the development of an individual's group or social identity such as gender, ethnicity, class, and sexual orientation. A prominent criticism of foundational theories of identity development is that they were constructed based on traditional Eurocentric individualistic culture. Consequently, traditional theories may not aptly apply to women, non-White European racial/ethnic groups, and collectivistic cultures whose family systems, cultural norms, and developmental milestones may be different from traditional Eurocentric cultural patterns. It is at this point that psychologists began looking at elements of personal identity and the sociopolitical and cultural forces that affect identity.

Much of the research examining identity has focused on traits or dynamics that are considered

universal for all human beings (e.g., self-esteem, introversion–extraversion, and levels of anxiety) regardless of race, culture, gender, sexual orientation, or class. At this level, researchers and clinicians treat human experiences as being similar, for example, the experiences of aging, coping with life stress, and interpersonal relationships. However, the extent to which any one of these traits and dynamics may be high or low, prominent, amplified, or muted differs as a result of sociodemographic categories such as culture, class, gender, ethnicity, or sexual orientation.

All individuals must merge cognitive, emotional, and social factors to construct one's sense of self. Although the process of integration is similar for many people, Erikson's theory does not account for differences people may experience while integrating multiple identities based on demographic categories (e.g., gender, race, sexual orientation, physical ability). An individual's unique traits and characteristics, family dynamics, cultural and ethnic norms, beliefs and attitudes, and experiences of oppression significantly contribute to the development of one's inner self and social outer world. These factors may either inhibit or facilitate the developmental process of exploration, resolution, and commitment needed for the expression and saliency of one's identity. As the field of psychology has incorporated a broader understanding of identity, many researchers and theorists have come to recognize that individuals are cultural beings and are affected differently by various dimensions of personal identity and contextual factors. The relationship between psychological and socio-cultural forces in individuals' lives has expanded



conceptualizations of the manner in which individuals develop awareness and acceptance of themselves in relation to self, others, their place and definition in society, and membership(s) in social groups.

### **Social and Group Identity**

Henri Tajfel's social identity theory is an integration of social psychological theories that describe the process by which individuals identify with respective social groups. People categorize themselves and are categorized by others in terms of social reference groups, which often serve to maintain shared attitudes, beliefs, and values common to insider members. A feeling of "belonging" is an important aspect of every person's sense of self. Social groups help create a frame of reference that contributes to an individual's place and definition in society. Personal identity development addresses the question "Who am I?" whereas social identity addresses the question "Who am I, relative to others?" The latter question is rather poignant for non-dominant group members, who often experience issues of societal oppression, discrimination, and marginalization that are connected with their group identity. When taking these factors into account, exploration of identity may include the need to be aware of, evaluate, and self-identify with respective social groups (e.g., gender, race/ethnicity, sexual orientation, class, religion), while experiencing oppression and marginalization associated with membership in those respective groups. Identification with a social group that is viewed negatively by society is filled with cognitive and affective challenges that must be negotiated and integrated with the self. Consequently, integrating inner and outer perceptions of oneself becomes a complex process, potentially involving positive perceptions of oneself on a personal level, but also having to negotiate negative perceptions of oneself as a member of a respective social group. Commitment and resolution toward an integrated "self," as proposed by traditional identity theorists, can therefore become more challenging and difficult.

### **Identity Development Models**

During the past 20 years, identity development models have emerged primarily because of the interest in multicultural counseling. Several models have been developed to describe racial identity, feminist and womanist identity, gay and lesbian identity, biracial

identity, and social class worldview. Identity models provide a conceptual framework to describe the psychological and sociocultural affiliation and connectedness to respective social groups. Typically each model describes a progression through a series of stages or ego statuses of nonacceptance/unawareness to self-acceptance/awareness of a specific social group. Each ego status involves distinct developmental tasks, which must be resolved for successful progression to the next status. Some models focus on the impact of "isms" (e.g., racism, sexism, heterosexism) as contributing factors to acceptance or nonacceptance of a respective social identity. For example, Janet Helms's models of racial identity describe the process of development by which members in respective social groups must overcome internalized racism in order to achieve a self-affirming racial group identity. The general assumption of Helms's and other social identity development theories is that if an individual can embrace the attitudes, behaviors, and beliefs relative to his or her social identity, his or her psychological well-being will be positive.

This description regarding the process of identity development is a very general theme found in many identity development models and should not be interpreted as a uniform process for all members within a respective social group or across social groups. Experiences of "isms" are internalized differently from person to person and from group to group and should be explored from both an etic and an emic perspective. Identity development involves the process of integrating an individual's cognitive, emotional, and social experiences with aspects of his or her inner self (e.g., personality traits, anxiety, self-esteem, introversion–extroversion).

Until the recent past, models of identity have focused on single social identities. Researchers and theorists have argued that single-identity models are inadequate to describe and understand individuals' multiple social identities from this perspective. Many people are members of more than one social group. For example, women of color identify as women and as racial group members. Additionally, both memberships place these individuals in marginalized, non-dominant groups. Given that most identity models and identity theories focus on one identity, they often omit experiences related to the convergence of multiple identities within one individual. Membership in overlapping social identities may also extend to experiencing and internalizing multiple forms and layers of



oppression. Psychological and sociocultural factors influence the development of one's social identities and thus affect the way in which an individual integrates those identities to construct a congruent whole.

Individuals are cultural beings, and all aspects of an individual's identity are interconnected (including race, gender, class, sexual orientation). The development of an individual's identity involves integrating the cognitive, emotional, and social experiences related to his or her social identity with aspects of his or her inner self (e.g., personality traits, anxiety, self-esteem, introversion–extroversion). An individual's sociocultural context serves as a filter through which the cognitive, emotional, and social experiences of his or her social outer world are integrated with aspects of his or her personal self to construct a congruent whole. This complex process of integration is particularly salient for individuals who are members of non-dominant groups. They often have the challenging task of integrating multiple, sometimes conflicting, aspects of themselves to form a single structure of identity. Counseling strategies need to embrace the idea that identity development for nonmajority members includes sociocultural factors, as well as personal aspects of the self. In this way, the individual is better able to integrate all facets of his or her multiple selves and develop a more congruent, whole sense of self.

*Angela D. Ferguson*

*See also* Adult Development (v1); Black Racial Identity Development (v3); Ethnic Identity (v3); Identity Development (v3); Orthogonal Cultural Identification Theory (v3); Racial Identity (v3); Social Identity Theory (v3); White Racial Identity Development (v3)

### Further Readings

- Erikson, E. H. (1968). *Identity, youth, and crisis*. New York: W. W. Norton.
- Helms, J. E. (1994). *Black and White racial identity: Theory, research, and practice*. Westport, CT: Greenwood Press.
- Triandis, H. C. (1989). The self and social behavior in differing cultural contexts. *Psychological Review*, 96, 506–620.

themselves within the context of cultural demands and social norms. Identity development has been seen historically as a primary developmental task of adolescence—the transition from dependency in childhood to increasing responsibility for one's own needs, interests, drives, aspirations, and desires in adulthood. This transition involves a cognitive reorganization in how youth think about themselves in relation to others as they gain physical, social, and psychological maturity. However, societal and historical shifts have complicated the developmental markers for adolescence, causing the demarcation of adolescence to become difficult to define. Additionally, despite being associated with adolescence, identity development is an ongoing process that continues throughout adulthood where one forms an identity within a larger and transitional cultural context. For example, changes in the body due to puberty, shifts in sociocultural context due to war or the civil rights movement, changes in individual role responsibility due to parenthood or divorce, and changes in cognitive processing due to aging support a life-span view of identity formation. Moreover, cultural factors such as race, ethnicity, gender, class, and sexual orientation also affect the identity formation that take place on the way to and through adulthood.

Historically, psychological theories of identity development date back to Sigmund Freud's psychosexual stages of development, which describe underlying motivations and impulses that shape the sense of self. However, Erich Fromm suggests that identity is more fluid than characterized by Freud and involves an awareness of oneself as a separate individual, in addition to a sense of agency and self-efficacy in one's own actions in the context of social group norms. Fromm's view also supports a view where identity formation begins prior to adolescence, when the development of a sense of self that is separate from parental figures begins and extends into adulthood, when agency and a sense of self-efficacy may be challenged with new life roles. These differences between Freud's and Fromm's seminal theories have led to two divergent views of identity formation in contemporary theories: the structural stage models of identity development and the more fluid and nonlinear sociocultural models of identity development.

---

## IDENTITY DEVELOPMENT

---

Identity development is the complex process by which people come to develop a sense and understanding of

### Stage Models of Identity Development

Erik H. Erikson is the seminal figure in the area of identity development, having formulated a compelling



conceptualization of development across the life span. Extending Freud's psychosexual model, Erikson introduced a psychosocial model of identity development drawing from disciplines such as anthropology and social ecology. He was one of the first theorists to consider the development of personality as a lifelong process and identified eight developmental stages beginning at birth and extending throughout the life span. Each of the stages presents new "tasks," or conflicts, that influence the ongoing process of identity development. The ability to negotiate conflicts successfully during each of the stages results in the development of psychological resources, which serve as the foundation for a fully integrated sense of self.

Although identity developmental tasks are encountered across the life span, identity development has been considered the primary psychosocial task of adolescence or, as characterized by Erikson, identity versus identity confusion. Adolescence is a time when, according to Erikson, individuals begin to integrate their childhood experiences, inner drives, opportunities, abilities, and social values into a sense of who they are as individuals. Within this framework, the central task of this stage is to develop a stable and authentic personal identity. Identity formation is stimulated by adolescents accelerating their psychological, physical, and social individuation from the family. Through investment in peer groups and observations of role models, adolescents learn to develop a sense of self that can be valued and shared with others.

The process of establishing an identity is not, however, easy. Adolescents, faced with many important adult and life-changing responsibilities, can become confused about their role both personally and professionally and may become unable to resolve their identity conflicts. Consequently, doubt may begin to develop about the adolescent's ability to find a valued place in society. If pervasive, these doubts may lead to some form of identity confusion. According to Erikson, a phenomenon that reduces identity confusion is called identity commitment.

Commitment is a form of allegiance to values and ideologies. Adolescents explore alternative viewpoints and select principles that best fit their moral standards, values, and ideals. The adolescent's fidelity to his or her ideals helps forge important bonds that help create a sense of security and stability to navigate through the doubts associated with identity confusion and progress toward identity achievement. Research has shown that being high on commitment makes for

greater sense of stability, or adjustment. For example, research in vocational development confirms that commitment to career goals is associated with identity development.

One criticism of this stage and most other stage models is that the terms are vague and difficult to operationalize, making the models difficult to measure empirically. However, researchers such as Anne Constantinople and Allen Waterman, among others, have extensively examined identity development and have found some empirical evidence supporting the validity of Erikson's model. Another criticism is that the stage model does not account for individual or cross-cultural differences; thus, it may not be applicable across different sociocultural contexts. Additionally, the model does not account for the sometimes nonlinear or cyclical movement among the various stages, which has been found to occur.

James E. Marcia, in 1966, expanded Erikson's conceptualization by including the concept of status regression, which allowed for the movement of identity to shift from a higher-order status to a lower-order status. Status regression is supported in the developmental research as being part of the normative and continuous process of identity development. Marcia also extended Erikson's model by delineating an ego identity status paradigm, which suggests that individuals experience identity crises involving a process of questioning, reflecting, and working through individual stages of conflict. Resolving these identity crises facilitates higher-order development, whereas not resolving them may lead to regression or becoming stuck in a particular status. The four components of Marcia's status model are identity diffusion, moratorium, foreclosure, and identity achievement.

### ***Identity Diffusion***

This status classifies people who are not committed to a set of values, ideals, and so forth, and are not actively searching for an identity, which leads to an identity that is poorly defined and rather diffuse, as the name suggests. These individuals may seem to drift aimlessly. Research has demonstrated that people who have fulfilled the exploration-commitment process tend to be more interpersonally competent and mature than those who are diffused. Diffusion is considered to be the least advanced of the statuses followed by foreclosure, moratorium, and identity achievement. It is also generally considered that individuals will develop



greater identity achievement with age and that relatively few in later adolescence will be diffused.

### **Moratorium**

This status is marked by individuals who are actively searching identity alternatives and have not yet committed to an identity. These individuals tend to be ambivalent about achieving an identity and may oscillate between rebellion and conformity. Furthermore, these individuals struggle to find answers and explore various roles. Consequently, they may try different roles in a temporary and uncommitted fashion and have difficulty firmly deciding on a given set of beliefs, values, or aspirations. Because these individuals are actively exploring new ways of being, they are on the path to identity achievement. However, because moratorium involves much ambiguity—particularly in cultures and societies that value decisiveness, commitment, and goal-directed behavior—these individuals tend to score high on measures of anxiety.

### **Foreclosure**

This is the status most commonly endorsed during early adolescence and typically declines with age. Foreclosed individuals have committed to an identity without having explored other options. These individuals tend not to be anxious and appear goal directed, yet tend to be inflexible and defensive. They are strongly committed, though their commitments are not intrinsic. Rather, their sense of self is often based on the desires or values of family, peers, teachers, religious figures, or media personalities. Consequently, their identity commitment does not reflect an authentic expression of self but of conformity to others' values. Consequently, they may not progress to the identity-achieved status.

### **Identity Achievement**

Individuals in this status have explored various alternative identities and have committed to an identity. These individuals are thought to have successfully negotiated the psychosocial task of adolescence, negotiated the challenges of moratorium, and coped with identity crises. As a result, they have made a firm commitment to a given identity and are able to articulate how and why they have decided upon their particular choices. Individuals develop a comfort with themselves and their life direction. Furthermore,

individuals are able to accept their limitations and appreciate their individual strengths. Identity-achieved individuals tend to score high on measures of moral development, autonomy, and creativity and perform well under stress.

Marcia identified another factor essential for the development of a mature identity in addition to commitment: exploration. Exploration refers to an individual's active questioning of various alternatives for their identity. Exploration also involves the concept of self-efficacy, which suggests, according to Nancy Betz and Gail Hackett, that individuals who approach specific tasks with a sense of competence and confidence tend to be more engaged in the task and have more positive outcomes.

## **Nonlinear Identity Development Models**

Departing from the clearly delineated stage models, nonlinear models are more integrative in nature and may more accurately reflect cross-cultural identity shifts. Michael D. Berzonsky's social cognitive model of identity emphasized the differences in the sociocultural processes used by individuals to construct, conserve, and accommodate their identities. Berzonsky described three identity orientations: informational, normative, and diffuse/avoidant. Information-oriented individuals actively seek out and process information that is relevant to their identity transition. The normative identity orientation describes those who conform to the expectations and desires of authority figures. These individuals tend to disregard information that conflicts with their beliefs or values and thus appear unreceptive to differing views. Finally, diffuse/avoidant individuals tend to display an unwillingness to confront the problems and challenges associated with identity development.

Berzonsky also described the context of the attributes one uses to define one's own identity development. As a result, he identified three identity orientations: (1) social identity, which is rooted in public self-image and includes factors such as reputation, popularity, and the impressions one manages for others; (2) personal identity, which includes private self-attributes such as values, goals, and psychological makeup; and (3) collective identity, which is grounded in extended social groups such as family, community, nation, and racial and ethnic groups. Berzonsky's view of social, personal, and collective group identification



as three layers of one's identity that are negotiated in the process of identity formation highlights the importance of models that take into account diverse cross-cultural experiences. Particularly important are the racial identity and ethnic identity development models, in addition to emerging models of social identity and social class.

William Cross's 1991 theory of Nigrescence, Janet Helms's 1990 theory of racial identity development, and Jean S. Phinney's 1996 theory of ethnic identity development have all expanded and redefined the meaning of identity development within the context of a cross-cultural society. These models of sociocultural identity development all can be integrated into Berzonsky's three identity orientations of social, personal, and collective identity. The social layer involves the racial and ethnic perceptions and behaviors of others, the personal layer involves the racial perception of self, and the collective layer involves the larger societal view of one's own racial and ethnic group. The racial identity and ethnic identity models also allow for fluid progression and regression within the delineated stages and are shaped by exposure to, and internalization of, various cross-cultural interactions. These interactions may include oppressive experiences and positive cross-cultural experiences during the life span.

Additionally, Henri Tajfel and John Turner proposed the social identity theory perspective, which suggests that cross-cultural identity is affected by the psychological processes that take place when one identifies with a group. Social identity theory posits that when someone identifies with a group, the person develops bias in favor of the ingroup and bias against other groups that may be seen as in competition with the ingroup. Identification with a group has been linked with an increased level of self-esteem and sense of positive ingroup racial attitudes. Social identity theory has been successfully applied to the study of racial identity and has been empirically supported for separate groups, including Latinos/as, Asians, and African Americans.

Another layer of identity that is often salient within an individual is social class status, which may also affect one's identity development in a cross-cultural society. Social class identity development as described by Lee Nelson and colleagues occurs as one has experiences within the context of the particular social class in which the individual begins to identify. Over time these experiences become internalized and lead to identity shifts throughout adulthood that occur so that

new experiences confirm the internalized beliefs the individual has developed about himself or herself. Ultimately, an individual learns to conform to the behavioral, attitudinal, and value-based expectations of his or her internalized class. Nelson and colleagues found that nearly all of the participants in their study described experiences of social isolation and deprivation when trying to move up in social class through higher education, which may have a large impact on the identity that is developed.

### **New Advances in Identity Development**

A criticism of the models of identity development that articulate linear forms of development is that they reflect a conflict-based model where an individual (particularly an adolescent or an individual not exposed to other groups) navigates between stages of either identifying or not identifying with others' views to arrive at a stage in which there is no longer this internal conflict and one has actualized his or her own identity. The new models of identity development conceptualize identity development as multidimensional and transitional given the context. These new models depart from conflict-based models and involve acceptance of the transitional and fluid nature of identity at any given moment.

In 1998 Robert M. Sellers and colleagues introduced the multidimensional model of racial identity, which is a multidimensional and integrated model of identity development and includes the fluid concept of saliency in identity development. More specifically, the extent to which one's own racial or ethnic group becomes an integral part of one's identity depends on the saliency of the attribute to the individual. The multidimensional model of racial identity takes into consideration the multitude of salient groups that an individual may identify with (e.g., gender, age, race, occupation). This integrative theory is an important departure from the stage models of identity development. It allows for flexibility across different particular cultural contexts for the individual to choose which aspect of identity becomes salient.

In 2001 Daniel P. McAdams added an important component to the area through his narrative view of identity development. McAdams's life story model of identity states that individuals create stories about themselves and weave their own stories as they selectively remember and recount episodes that are salient



to them. McAdams posited that people tell and retell their own life stories in social contexts, and these stories can be seen as a way of negotiating how they have thought of themselves throughout time.

Specifically, according to McAdams, the *I* is the narrator that creates the story and the *me* is the self-concept that is created as a result. This narrative approach model, steeped in cross-cultural and societal processes, facilitates an integrative view using the individual as the source and context for his or her own identity development given the various stages and happenings that have been most salient to them. In McAdams's model, identity is formed not through resolving conflicts, as suggested by Erikson, or choices, as suggested by Marcia, but through creating authentic narratives about the self. Overall, McAdams's and Erikson's approaches suggest that identity development is fluid and influenced by both intrapersonal psychological processes and interpersonal societal experiences throughout the life span.

### Implications for Counseling

With the multiple theoretical approaches to identity development and the multiplicity of cultural factors that impact identity development, shifts inherent throughout the process of identity formation have important implications for counselors. Counselors can facilitate clients' identity searching and committing to identity alternatives as well as recognize the normative stress involved in identity exploration. By encouraging identity development, clients can develop an authentic sense of self that is able to accommodate the different experiences clients have had and will have throughout their lives. Thus, by gaining an understanding of clients' identity development, counselors learn how the clients' cultural worldview and view of self impacts the framework through which the client understands his or her presenting concerns, which may serve to facilitate the therapeutic alliance and the growth and healing of the client.

### Future Directions

The view of identity development as being multidimensional has been supported in the racial and ethnic identity development research, yet identity development differences between those in an individualistic society and those in a collectivistic society have not been sufficiently investigated. It has been suggested

that the psychosocial process of individuation occurs differently for men and women and perhaps differently across different cultural contexts. For example, those from individualistic societies are typically taught to value autonomy and independence from an early age. Yet those from collectivistic cultures learn to value relationships and connectedness, indicating potential variances within the identity development processes of those with both cultures. Future identity research could explore the vicissitudes of identity development across contexts as well as the consistencies across contexts.

Additionally, the process of sexual identity development warrants more study. There have been extensive studies on sexual body development in adolescence; however, the psychological processes that take place as relationships with same- and opposite-sex friends and partners are forged have not been fully studied. Furthermore, the stigmatization and negotiation within a social network where one's sexual orientation may not be readily distinguishable, and the effect this may have on an individual's identity, warrant further study.

*Ruth Montero, Nicholas C. Scull,  
and Stephen M. Quintana*

*See also* Adult Development (v1); Black Racial Identity Development (v3); Cross, William E., Jr. (v3); Ethnic Identity (v3); Helms, Janet E. (v3); Identity (v3); Orthogonal Cultural Identification Theory (v3); Racial Identity (v3); Social Identity Theory (v3); White Racial Identity Development (v3)

### Further Readings

- Berzonsky, M. D. (2004). Identity processing style, self-construction, and personal epistemic assumptions: A social-cognitive perspective. *European Journal of Developmental Psychology, 1*(4), 303–315.
- Berzonsky, M. D., & Neimyer, G. J. (1994). Ego identity status and identity processing orientation: The moderating role of commitment. *Journal of Research in Personality, 28*, 425–435.
- Betz, N. E., & Hackett, G. (1986). Applications of self-efficacy theory to understanding career choice behavior. *Journal of Social & Clinical Psychology, 4*(3), 279–289.
- Blustein, D. L., Devenis, L. E., & Kidney, B. A. (1989). Relationship between the identity formation process and career development. *Journal of Counseling Psychology, 36*(2), 196–202.



- Constantinople, A. (1969). An Eriksonian measure of personality development in college students. *Developmental Psychology*, 1(4), 357–372.
- Cross, W. (1991). *Shades of Black: Diversity in African American identity*. Philadelphia: Temple University Press.
- Erikson, E. H. (1963). *Childhood and society*. New York: W. W. Norton.
- Erikson, E. H. (1968). *Identity: Youth and crisis*. New York: W. W. Norton.
- Fromm, E. (1941). *Escape from freedom*. New York: Farrar & Rinehart.
- Helms, J. (1990). *Black and White racial identity theory, research, and practice*. Westport, CT: Praeger.
- Marcia, J. E. (1966). Development and validation of ego identity status. *Journal of Personality and Social Psychology*, 3, 551–558.
- Marcia, J. E. (1967). Ego identity status: Relationship to change in self-esteem, “general maladjustment,” and authoritarianism. *Journal of Personality*, 35, 118–133.
- McAdams, D. P. (2001). The psychology of life stories. *Review of General Psychology*, 5(2), 100–122.
- Nelson, M. L., Englar-Carlson, M., & Tierney, S. C. (2006). Class jumping into academia: Multiple identities for counseling academics. *Journal of Counseling Psychology*, 53(1), 1–14.
- Phinney, J. (1996). When we talk about American ethnic groups, what do we mean? *American Psychologist*, 51, 918–927.
- Phinney, J. S., & Kohatsu, E. L. (1997). Ethnic and racial identity development and mental health. In J. Schulenberg, J. L. Maggs, & K. Hurrelmann (Eds.), *Health risks and developmental transitions during adolescence* (pp. 420–443). New York: Cambridge University Press.
- Sellers, R. M., Smith, M. A., & Shelton, J. N. (1998). Multidimensional model of racial identity: A reconceptualization of African American racial identity. *Personality and Social Psychology Review*, 2(1), 18–39.
- Tajfel, H., & Turner, J. (2001). An integrative theory of intergroup conflict. In M. A. Hogg & D. Abrams (Eds.), *Intergroup relations: Essential readings* (pp. 94–109). New York: Psychology Press.
- Waterman, A. S. (1982). Identity development from adolescence to adulthood: An extension of theory and a review of research. *Developmental Psychology*, 18(3), 341–358.

---

## IDIOCENTRISM

---

The word *idio* means own, personal, private, peculiar, and distinct. The word *centrism* refers to adopting the middle position between two extreme viewpoints. The

combination of these words, *idiocentrism*, should be used when measuring individual-level orientations reflecting individualistic cultures. Individualistic cultures are common in countries in North America and Western and Northern Europe, and the term *individualism* represents general attributes of such cultures. Individualistic cultures often are described in contrast to collectivistic cultures, which are more common in Asia and Africa. The term *allocentrism* should be used when measuring individual-level orientation in collectivistic cultures. Separating the terms *idiocentrism* from *individualism*, and *allocentrism* from *collectivism*, helps eliminate confusion concerning across-versus within-culture analyses. However, the term *individualism* continues to be used as a substitute for *idiocentrism* in the literature.

Idiocentrism is reflected in attitudes, beliefs, norms, roles, and values. Several personality characteristics, such as competition, emotional distance from ingroups, self-reliance, and hedonism, are associated with idiocentrism. Further, idiocentrism is a situation-specific disposition that can be measured along a normal distribution and, as such, allows for examination of idiocentric dispositions in both individualistic and collectivistic cultures. Thus, individuals vary in the degree they value individualism, and a person can be more or less idiocentric within either an individualistic or a collectivistic culture. Idiocentrics in a collectivistic culture will tend to strive for their individual goals and may feel repressed by the culture and desire to break away from it. Allocentrics in individualistic cultures will seek for something communal to belong to, such as organizations, gangs, and other types of groups.

## Characteristics of Idiocentrism

Harry C. Triandis proposed that there are four main elements of difference between individualism and collectivism: (1) the self (independent vs. interdependent), (2) goals (goal priority based on self vs. group), (3) relationships (rationality vs. relatedness); and (4) social behaviors (determined by attitudes vs. norms). In individualistic cultures, the self is viewed as stable and internally located, and the surrounding environment is changeable. For allocentrics, the environment is stable and the self is changeable, adjusting to the environment.

Idiocentrics focus on individual ability, unique characteristics, personal freedom, expression, independence, self-enhancement, and actualization; the self is



the vehicle for such enhancement and actualization. Being achievement oriented, idiocentrists tend to have higher levels of academic motivation and place more importance on social competition and recognition than do allocentrists. Further, idiocentrists' personal likes and dislikes determine their behavior, and they are likely to attribute events or behaviors to internal dispositional factors. Their communication style is associated with content rather than context, focusing on what is said rather than how it is said.

Similarly to allocentrists, idiocentrists have ingroups (e.g., family, tribe, and nation), but their ingroups are often small, for example, consisting of first-degree relatives or a few friends. In addition, idiocentrists do not behave differently toward their ingroups compared with other groups (outgroups), which is a pattern of allocentrists. Idiocentrists also tend to be emotionally disconnected from larger ingroups and value their own personal goals over the goals of their ingroups. For example, when there is a conflict between idiocentrists and their ingroups, the goal or need of the individual is given priority over that of the group. Basically, idiocentrists' social experiences are structured and arranged in relation to the self. Allocentrists, on the other hand, have internalized the values of their ingroups, and following these values and expectations becomes a normal and expected activity.

Because idiocentrists tend to be focused more on themselves than others, there is a tendency for them to be lonelier and have less of a social support system compared with allocentrists. They also tend to be more emotionally unstable, experience higher rates of depression and suicide, and be less adjusted in intimate, romantic relationships. They also show less preference for seeking professional help for their problems.

## Empirical Findings

Since the 1980s, individualism and collectivism have been of growing interest to scholars and researchers. Empirical data have shown consistently that there is substantial variation among cultures regarding behavior and psychological processes. The first empirical study that identified the factors of individualism and collectivism was published in 1980 by Geerte Hofstede. In 2002, the first meta-analytic study on individualism and collectivism was published by Daphna Oyserman, Heather M. Coon, and Markus Kemmelmeier. These authors identified over 170 articles on the topic. In terms of personal constructs and individualism, Oyserman and

colleagues found support for relationships between higher scores on individualism and optimism, inflated sense of self, dispositional attribution style, goal orientation, and direct communication. In addition, for individuals who scored high on individualism, self-esteem was associated with more personal success than family life, and more personal control was associated with less depression. In counseling, individualism has been associated with a lesser ability to conceptualize clients from a multicultural perspective, and many scholars have pointed out the importance for mental health professionals to be aware of possible cultural (individualistic) bias when working with clients from other cultures.

Future research on idiocentrism should examine the conflict that children from collectivistic cultures may experience when living and growing up in Westernized, individualistic cultures. However, concerns have been raised regarding the low number of adequate and reliable measures of idiocentrism and how difficult it is to measure this construct as well as the related constructs of idiocentrism, collectivism, and allocentrism. Thus, additional scale development studies are needed as well as studies that would help clarify within- and between-group differences in terms of idiocentrism.

*Johanna Nilsson and Ashley Heintzelman*

**See also** Acculturation (v3); Acculturative Stress (v3); Allocentrism (v3); Collectivism (v3); Cross-Cultural Psychology (v3); Cross-Cultural Training (v3); Cultural Encapsulation (v3); Cultural Values (v3); Culture (v3); Enculturation (v3); Familismo (v3); Individualism (v3); Locus of Control (v3); Worldview (v3)

## Further Readings

- Constantine, M. G. (2001). Predictors of observer ratings of multicultural counseling competence in Black, Latino, and White American trainees. *Journal of Counseling Psychology, 48*, 456–462.
- Hofstede, G. (1980). *Culture's consequences: International differences in work-related values*. Beverly Hills, CA: Sage.
- Kim, U., Triandis, H. C., Kagitcibasi, C., Choi, S., & Yoon, G. (1994). *Individualism and collectivism: Theory, method, and applications*. Thousand Oaks, CA: Sage.
- Oyserman, D., Coon, H. M., & Kemmelmeier, M. (2002). Rethinking individualism and collectivism: Evaluation of theoretical assumptions and meta-analyses. *Psychological Bulletin, 128*, 3–72.



- Triandis, H. C. (1995). *Individualism and collectivism*. Boulder, CO: Westview Press.
- Triandis, H. C. (2001). Individualism-collectivism and personality. *Journal of Personality*, 69, 907–924.
- Triandis, H. C., & Gelfand, M. J. (1998). Converging measurement of horizontal and vertical individualism and collectivism. *Journal of Personality and Social Psychology*, 74, 118–128.

---

## IMMIGRANTS

---

Immigrants are people who leave their country of birth to live in a different country, most often on a permanent basis. Currently, people are immigrating to the United States by the thousands, hoping to find work and a better or safer life. The Office of Immigration Statistics reports that, in the United States, in 2005 alone, 1,122,373 people became legal permanent residents, which was a significant increase from 957,883 in 2004. Countries that are frequent contributors of immigrants are Mexico, India, and China. In light of this information, mental health professionals must be prepared to work with the increasing immigrant population of color in the United States.

### Brief History of Immigration

Up until 1875, the United States did not restrict immigration. However, later the exclusionary sections of the Immigration Acts of 1875, 1882, and 1891 barred people from entering the United States who were deemed unsavory, including convicts, prostitutes, the mentally insane, those who could not provide for themselves, polygamists, and those who suffered from contagious diseases. The Chinese Exclusion Act of 1882 singled out people from China, preventing their immigration. To enforce these acts, stations, as on Ellis Island, were set up for the purpose of checking, rejecting, or accepting immigrants and processing their papers.

There was a lag in immigration during World War I, but after the war was over, immigration increased to the point where a national origins quota system was developed to limit the number of people from each country who were eligible to immigrate, as instituted by the Johnson–Reed Act of 1924. Passports, which were used in World War I for security reasons, became the norm and were necessary to enter the country.

During this time, eugenicists, who believed that intelligence and morality are determined by race, were influential and were asked to speak at congressional hearings. Eugenicists advocated that the races should not be mixed because they felt that other races were less intelligent, inferior, and degenerate. This line of thinking in the social sciences bled into the immigration policies, and people who were considered “White” had an easier time of getting into the country.

In 1924, Mexico was exempt from the quotas, and states like California and Texas welcomed Mexican immigrants into the labor force. Another factor that increased Mexican immigration was that Mexicans were considered “White” because of their ancestry and not because of their actual skin color. In 1929, the State Department made the decision to restrict Mexican immigration, but illegal immigration at the U.S.–Mexico border was not strictly monitored, and immigrants continued to cross the border at unofficial points. To enforce the quota system, Congress implemented the U.S. Border Patrol to apprehend illegal immigrants, and the Immigration and Naturalization service was born in 1933 to deal with immigration processing demands and sanctions.

As time went on, Congress became more lenient in its immigration policy. For example, in 1943, Congress repealed the Chinese Exclusion Act. Also, due to the Displaced Persons Act of 1948 and the Refugee Relief Act of 1953, many refugees displaced by World War II, who would otherwise be unable to immigrate under the national origins quota system, were able to enter the United States. During the 1950s and 1960s, Presidents Dwight Eisenhower, John Kennedy, and Lyndon Johnson used their executive powers to relax existing U.S. immigration laws. Consequently, political refugees such as Hungarians and Yugoslavians (Hungarian Refugee Act of 1956), Hong Kong Chinese (the Refugee-Escapee Act of 1957), and Cubans (the Cuban Adjustment Program of the 1960s) were also granted political asylum and, later, immigrant status.

With the aid of the U.S. Congress, President Johnson enacted President Kennedy’s proposal to abolish the national origins quota system, which appeared to be based on ethnic discrimination. Congress instituted a preference system in the Immigration Act of 1965, which admitted immigrants on a first-come, first-served basis. Unification of families was the goal of the major preferences, which covered 74% of the preference slots. For example, the largest single preference (24%) was for brothers and



sisters of naturalized citizens. Encompassed in the third preference (10%) were professionals or persons of exceptional ability in the arts and sciences. The sixth preference consisted of skilled or unskilled labor for which a shortage of employable and willing persons exists in the United States. Although the national origins quota system was removed, in 1978 a worldwide ceiling of legal immigrants annually allowed was implemented.

While Congress encouraged immigration by instituting programs to help refugees, illegal immigration was vigorously deterred. The Immigration Reform and Control Act of 1986 instituted sanctions against employers who hired undocumented workers, and individuals found to be working illegally were deported. To further discourage illegal immigration, under a 1996 welfare bill, illegal immigrants became ineligible for most federal and state benefits, such as food stamps and Supplemental Social Security Income, with the exception of emergency medical care, immunizations, and help with disaster relief. On the other hand, refugees and asylum seekers are able to become legal residents after 1 year of living in the United States. Legal immigrants, who are permanent residents and green card holders, are eligible to apply for citizenship after they have lived in the United States for 5 years and have completed English language and civic tests.

The dramatic rise in immigration to the United States in the past 30 years has resulted in about 3 million non-native-born children and 10.8 million children who were born in the United States and have non-native-born parents. These new immigrant families are more ethnically, linguistically, and socio-economically diverse than previous immigrant populations, who were mainly from Western Europe. These immigrant populations have resulted in schools in many cities across the United States serving a growing number of immigrant students of color. To fail to address the counseling needs of immigrant students is to ignore the social, psychological, linguistic, and academic difficulties these students encounter in their acculturation process.

Therapists must be aware of the history of immigration in the United States and the current immigration policy when working with immigrant clients. For example, an immigrant who is living here illegally will have a different set of concerns than a legal immigrant with a green card. The acculturation adaptation process of immigrants holding green cards differs

from that of political refugees who enter because of circumstances such as fleeing war, ethnic cleansing, political oppression, or religious persecution in their countries of origin.

## Challenges Immigrants Face

### *Financial Stress*

Rubén G. Rumbaut reported that immigrants may be more likely than natives to be poor and to work in low-status jobs. This finding is not necessarily indicative of immigrants' lack of skills; rather, it illustrates the societal factors that bar immigrants from obtaining ideal employment. Francisco L. Rivera-Batiz talked about how many immigrants (86.8%) were employed in blue-collar occupations, and few (25.45%) had schooling beyond 10 years, which makes it difficult for illegal immigrants to succeed economically. It can be difficult, even for educated immigrants, to obtain desired jobs, as the training they received in their native country might not be accepted in the United States and they may not seek respecialization to obtain U.S. licenses and certifications. Immigrants who enter the United States illegally are vulnerable to exploitation by employers who pay lower wages because illegal immigrants are not protected by the government and if they complain, they risk revealing their illegal status and deportation. To illustrate the payment gap, men who are legal immigrants are reported to receive 41.8% more for pay than illegal immigrants. Illegal immigrants also do not receive many of the benefits that legal immigrants do, and they may experience stress from being unable to access services for themselves and their families.

### *Prejudice*

Upon entering the United States, many immigrants face prejudice and discrimination based on both their immigrant status and ethnicity. U.S. citizens have expressed a fear that immigrants will take jobs away from citizens because they are willing to work for less money, and there are pervasive negative stereotypes about immigrants being lazy and criminal in their conduct. In an effort to curb illegal immigration, certain states have passed propositions that severely limit illegal immigrants' access to services such as health care, welfare, and education (i.e., Proposition 187 in California, which was directed mostly toward illegal



Mexican immigrants). There is evidence that people who were in favor of these legislations exhibited more prejudice toward immigrants and were concerned about the economic implications of immigration. Prejudicial attitudes like these create an uncomfortable and unwelcoming environment for immigrants, both legal and illegal, and add to their acculturation adaptation difficulties and psychological distress.

### ***Psychological Distress***

Many immigrants experience psychological distress, but are less likely to seek treatment, due to cultural attitudes as well as a lack of health insurance. Even if immigrants are in treatment, there is a chance that they will be incorrectly diagnosed. Somatization as a symptom of psychological distress is relatively common and unlikely to be detected by Western mental health professionals, which may result in underdiagnosis of disorders in immigrants. Somatization is particularly prevalent in collectivistic, context-dependent cultures in which the expression of emotional distress is inhibited or when individuals from these societies have an acute sense of the mind–body connection at times of stress. Thus, identifying individuals as suffering from somatization may be difficult, particularly because immigrants often seek medical help from doctors as opposed to mental health professionals, and they frequently reject psychiatric consultation.

### ***Family Difficulties and Conflicts Due to Immigration***

#### **Parent–Child Acculturation Differences**

Immigration is a stressful process for the family partially because the members may each adapt differently to the host or new society. For example, young elementary school children adapt more easily than adults as they are not yet set in their cultural customs and are more easily influenced by new customs and values learned in school. As a result, conflict may arise when children's American values clash with their parents' more traditional ones. However, it is not always the parents who adhere to traditional values. Immigrant families sometimes do not immigrate together; sometimes, one or both of the parents go to the United States first to secure jobs, leaving the children with relatives in their native country. It may be years before the parents are able to bring the children over to live with them. As a result, some

children may be more traditional than their parents and may be offended by their parents' behavior. They also may be reluctant to obey their parents when they have lived apart from them for so long. All these dynamics of age and time of entry can threaten the family structure and cause stress for immigrant families. Thus, the therapist needs to be aware of the many different immigrant family dynamics.

### **Difficulties of Immigrant Children**

Gargi Roysircar delineated difficulties that many immigrant students face, including lack of family and social supports, trauma from war or refugee camp experiences, poverty, and health concerns. One major stress experienced by immigrant students is the language barrier. However, children may gain more English skills than their parents, thus making the students responsible for interpretation and helping their parents understand the American educational system. Not only does language “brokering” by children present awkward role reversals within families, it also makes immigrant students solely responsible for their own learning within the education system, a heavy burden for any student to bear, not to mention one who is transitioning across cultures. These difficulties can cause many different conduct problems and confusion in immigrant children, such as acting out or being silent, having somatic complaints, showing poor attendance at school, and experiencing difficulty making friends. The immigrant students' native-born counterparts and teachers are most often completely unknowing and unsuspecting of these difficulties and their effects on the immigrant students. The consequent sense of isolation, loneliness, and harassment from other students becomes a common barrier that impedes immigrant students' successful transition to a new school environment.

### **Increasing Help-Seeking Behaviors in Immigrants**

Help-seeking behavior is a major barrier to immigrants receiving support. Often, the cultures from which many immigrants originated do not have the same formal help structures (such as counselors and social workers) and rely mostly on informal structures (such as family, friends, and spiritual leaders). More than simply teaching immigrants how to utilize the resources available in school and the community,



counselors (especially those in the school system) can help students and teachers appreciate the cultural differences in help-seeking preferences and potential stigmas and taboos about seeking help. Teachers, who are in frequent contact with immigrant students, become allies in helping direct students to appropriate resources in the school. Along with teachers, school counselors can serve immigrant students through small group work on transitioning and bicultural issues or through a buddy or mentor system. The purpose is to provide information and ease the inhibition of seeking help. Surrounding immigrants with a support network builds a protective system that enables them to develop and broaden their cultural, linguistic, and emotional hardiness so that they can be successful in school and in their personal lives.

### Counseling Immigrants

When counseling immigrants, there are many factors to consider. Family structure, experience of prejudice, legal status, and reasons for immigrating are only a few of the facets of the immigrant experience. It is helpful for counselors to be familiar with these factors when counseling a client, as they will affect how the client adapts to the new culture and how he or she responds to counseling and other available help resources. Because of the rapidly changing face of U.S. communities and schools, counselors must consider seriously the societal dynamics created when new immigrants enter educational, employment, and neighborhood environments. The introduction of greater plurality in U.S. communities and schools can be seen as an opportunity to broaden the educational experience of all members of a community rather than forcing the re-education and assimilation of immigrants.

*Gargi Roysircar and Emily Pimpinella*

*See also* Acculturation (v3); Acculturative Stress (v3); Adaptation (v3); Assimilation (v3); Bicultural (v3); Bilingual Counseling (v3); Career Counseling, Immigrants (v4); Cultural Accommodation and Negotiation (v3); Demographics, United States (v3); Multicultural Counseling (v3); Multiculturalism (v3); Refugees (v3); Second Culture Acquisition (v3)

### Further Readings

Bemak, F., & Chung, R. C. (2003). Multicultural counseling with immigrant students in schools. In P. B. Pedersen &

- J. C. Carey (Eds.), *Multicultural counseling in schools: A practical handbook* (pp. 190–210). Boston: Pearson Education.
- Marsella, A. J., Friedman, M. J., Gerrity, E. T., & Scurfield, R. M. (1996). *Ethnocultural aspects of posttraumatic stress disorder: Issues, research, and clinical applications*. Washington, DC: American Psychological Association.
- Ngai, M. M. (2004). *Impossible subjects: Illegal aliens and the making of modern America*. Princeton, NJ: Princeton University Press.
- Office of Immigration Statistics. (2006). *Yearbook of immigration statistics: U.S. legal permanent residents: 2005*. Retrieved May 13, 2006, from <http://www.uscis.gov/graphics/shared/statistics/yearbook/index.htm>
- Portes, A., & Rumbaut, R. G. (1996). *Immigrant America: A portrait* (2nd ed.). Berkeley: University of California Press.
- Rivera-Batiz, F. L. (1999). Undocumented workers in the labor market: An analysis of the earnings of legal and illegal Mexican immigrants in the United States. *Journal of Population Economics*, 12, 91–116.
- Roysircar, G. (2004). Child survivor of war: A case study. *Journal of Multicultural Counseling and Development*, 32(3), 168–180.
- Roysircar, G. (2006). A theoretical and practice framework for universal school-based prevention. In R. Toporek, L. H. Gerstein, N. A. Fouad, G. Roysircar, & T. Israel (Eds.), *Handbook for social justice in counseling psychology* (pp. 130–145). Thousand Oaks, CA: Sage.
- Roysircar-Sodowsky, G., & Frey, L. L. (2003). Children of immigrants: Their worldviews value conflicts. In P. B. Pedersen & J. C. Carey (Eds.), *Multicultural counseling in schools: A practical handbook* (pp. 190–210). Boston: Pearson Education.
- Rumbaut, R. G. (1997). Ties that bind: Immigration and immigrant families in the United States. In A. Booth, A. C. Crouter, & N. Landale (Eds.), *Immigration and the family: Research and policy on U.S. immigrants* (pp. 3–46). Mahwah, NJ: Lawrence Erlbaum.
- Sodowsky, G. R., Lai, E. W. M., & Plake, B. (1991). Moderating effects of sociocultural variables on acculturation attitudes of Hispanics and Asian Americans. *Journal of Counseling & Development*, 70, 194–204.
- Smith, M. L. (1998). *Overview of INS history*. Retrieved May 13, 2006, from <http://www.uscis.gov/graphics/aboutus/history/articles/oview.htm>
- Waters, M. C. (1997). Immigrant families at risk: Factors that undermine chances for success. In A. Booth, A. C. Crouter, & N. Landale (Eds.), *Immigration and the family: Research and policy on U.S. immigrants* (pp. 79–87). Mahwah, NJ: Lawrence Erlbaum.



---

## INDIAN HEALTH SERVICE

---

The Indian Health Service (IHS) is the agency within the U.S. Department of Health and Human Services responsible, since 1955, for providing federal health services to American Indian and Alaska Native (AI/AN) people. Its charge as the principal healthcare provider and health advocate for AI/ANs is to collaborate with federal entitlement programs, state or local healthcare programs, and private insurance providers to mobilize the necessary funding and adequate healthcare provision for the AI/AN population. This includes approximately 1.8 million of the nation's estimated 3.3 million AI/ANs who belong to more than 562 federally recognized tribes. Most IHS services are designated for AI/ANs who live on or near reservations/villages located in 35 states, primarily in the western United States. However, some AI/ANs who live in urban areas are served by this agency.

The provision of health services to members of federally recognized tribes grew out of a special government-to-government relationship between the federal government and Indian tribes established in 1787. This unique relationship is based on Article I, Section 8 of the U.S. Constitution and has been given substance through numerous Supreme Court decisions, treaties, legislation, and executive orders that acknowledge the federal government's obligation to provide free health care to AI/AN people in exchange for their cessation of over 400 million acres of tribal land.

In 1975, the U.S. Congress passed the Indian Self-Determination and Education Assistance Act (Public Law 93-638) to provide tribes the option of either assuming from the IHS the administration and operation of health services and programs in their communities or remaining within the IHS direct healthcare system. Congress consequently passed the Indian Health Care Improvement Act (IHCIA; Public Law 94-437) in 1976. The IHCIA is a health-specific law that provides appropriate authority for the delivery of health services to AI/ANs and supports the options of P.L. 93-638. The goal of this legislation is to provide comprehensive directives to the federal government regarding the delivery of services to AI/ANs and to encourage the maximum participation of tribes in the planning and management of those services.

The stated mission of the IHS, in partnership with AI/AN people, is to raise their physical, mental, social, and spiritual health through comprehensive

and culturally acceptable personal and public health services. To that end, it assists tribes in developing their health programs through activities such as health management training, technical assistance, and human resource development. It provides hospital and ambulatory medical care and preventive and rehabilitative services. The agency also helps develop community sanitation facilities for Indian homes that have neither a safe water supply nor an adequate sewage system. Preventive measures involving environmental, educational, and outreach activities are combined with therapeutic measures. Within these broad categories are special initiatives in areas such as injury control, alcoholism, diabetes, and mental health.

The operation of IHS programs is overseen by 12 regional administrative units called area offices. Each area office provides administrative support in the forms of distributing funds, monitoring programs, evaluating activities, and providing technical support to the hospitals, clinics, and other facilities within its region. IHS-funded services are delivered through three mechanisms: direct IHS services, tribal services, and Urban Indian Health Programs. These services are provided to those qualified AN/ANs who meet IHS eligibility criteria. For those qualifying, health services are delivered directly at IHS facilities, through tribally contracted and operated health programs or at IHS contract health service facilities. The federal system consists of 49 hospitals in 12 states, 180 health centers in 12 states, 273 health stations in 18 states, and 8 school health centers. In addition, 34 Urban Indian Health Programs provide limited health and referral services to approximately 150,000 AI/ANs living in cities throughout the country.

As of 2003, the IHS staff was 64% non-Indian and 36% Indian. The IHS clinical staff consists of approximately 840 physicians, 380 dentists, 100 physician assistants, and 2,580 nurses. The mental health government employees with the IHS include 71 psychologists, 33 psychiatrists, and 127 social workers, not including tribal psychologists and social workers. The agency also employs allied health professionals, such as nutritionists, health administrators, engineers, and medical records administrators. There is approximately a 10% vacancy rate for health professional positions in the IHS.

AI/ANs are at higher risk for mental health disorders than any other racial or ethnic group in the United States. Their overrepresentation might be due to the high rates of homelessness, incarceration,



alcohol and drug abuse, and stress and trauma. More than one third of the demands made on health facilities in Indian country are related to mental health, alcoholism, and substance abuse concerns. The IHS is limited to basic psychiatric emergency care and does not provide ongoing, quality mental health care. Instead, the approach adopted by the IHS is one of responding to immediate mental health crises and stabilizing patients until the next episode (J. Perez, personal communication, July 21, 2003). Select examples of other AI/AN health disparities include the following: Their life expectancy is 6 years less than that of other U.S. citizens; their tuberculosis rate is 4 times the national average; complications due to diabetes are almost 3 times the national average; and their infant mortality rate is 1.7 times greater than the rate for European American infants.

In 2004 the U.S. Commission on Civil Rights censured the federal government for not living up to its treaty obligations through proper funding and effective administration of the IHS in a report based upon their fact-finding mission in New Mexico in 2003. The report, titled *Broken Promises: Evaluating the Native American Health Care System*, noted great disparities in the health and medical care of AI/ANs in general and even greater disparities for urban AI/ANs. The major contributor to health disparities in Indian country has been the chronic underfunding of the IHS. It is currently operating at an estimated 57% of the budget it requires. It received an appropriation of approximately \$3.1 billion for fiscal year 2006. This amount rendered a per capita IHS personal healthcare expenditure of \$2,133 as compared with \$5,518 for the total U.S. population (the federal government spends \$3,803 on average for prison inmates). Funding for urban programs, which serve 25% of the AI/AN population, is only 1% of the total IHS appropriation. In fiscal year 2005, the budget for the IHS mental health program was \$55 million; for the Alcohol and Substance Abuse Program it was \$139.1 million. In addition to this fiscal barrier, the U.S. Commission on Civil Rights report cited cultural, social, and structural barriers within the IHS that limit access to health care. For example, many AI/ANs are persistently dissatisfied with the IHS because of the constant turnover of care providers, remote and inadequate facilities, extensive wait time for services, lack of continuity of care, and misdiagnosis or late diagnosis of diseases. Furthermore, the IHS does not provide formal language assistance to its patients and relies on staff or family members to act as translators.

Nevertheless, despite having inadequate funds, the IHS has helped to reduce some health disparities. For example, the life expectancy for AI/ANs is now 71 years of age, up from 65 years in 1976. In many cases the agency has identified solutions to the health problems common in AI/AN communities, yet Congress has failed to provide the necessary resources to implement those solutions. The AI/AN professional staff within the IHS has increased 125% since the inception of the agency scholarship and loan repayment programs, established in 1981 to help reduce the shortage of health professionals within the IHS. Many of the recipients of these scholarships and loans are AI/ANs. The IHS is currently applying technology to distance education and service delivery to bring primary care and specialty medicine to remote areas through telemedicine programs and partnerships.

It appears as if the *de jure* response of the federal government to overcome the shortcomings of the IHS is to encourage increased local community control through tribal P.L. 93-638 self-determination contracts and compacting. The government also appears to rely *de facto* upon supplemental funding from tribes with gaming revenues from casinos for health care, human resource development, and health disparity research. Certain tribes have demonstrated the efficacy of economic development and community collaboration for the enhancement of the emotional, physical, spiritual, and social health of AI/AN people. However, many rail against these measures on the grounds that they facilitate the government's continued neglect of its treaty obligations and rely on a means of economic development that may not be robust.

Teresa LaFromboise

*See also* Alaska Natives (v3); American Indians (v3); Bureau of Indian Affairs (v3); Career Counseling, Native Americans (v4); Community-Based Health Promotion (v1); Depression (v2); Indigenous Healing (v3); Society of Indian Psychologists (v3); Substance Abuse and Dependence (v2); Suicide Potential (v2)

### Further Readings

- Indian Health Service. (2002). *Facts on Indian health disparities*. Washington, DC: Author.
- Roubideaux, Y. (2002). Perspectives on American Indian health. *American Journal of Public Health*, 92, 1401-1403.



- Snyder, A. (2005). Reforming American Indian/Alaska Native health care functioning: The role of Medicaid. *American Journal of Public Health, 95*, 766–768.
- U.S. Commission on Civil Rights. (2004). *Broken promises: Evaluating the Native American health care system*. Washington, DC: Author.
- Zuckerman, S., Haley, J. M., Roubideaux, Y., & Lillie-Blanton, M. (2004). Access, use, and insurance coverage among American Indians/Alaska Natives and Whites: What role does the Indian Health Service play? *American Journal of Public Health, 94*, 53–59.

---

## INDIGENOUS HEALING

---

The term *indigenous* has been used primarily in anthropology and social sciences to refer to customs or people who are native to a specific region. In this context, *indigenous* implies a cultural referent that is non-native; this perspective has been characterized traditionally as Western European to the extent that most early anthropologists were European. Thus, people and ways of life that were characterized as indigenous were markedly different from those of the Western European orientation. Furthermore, in the context of anthropology, designation as “native” or “indigenous” implied deficiency, a premise that served to reinforce colonialism and oppression.

Recently, mental health researchers have applied *indigenous* to various forms of emotional, spiritual, and physical healing practices. *Indigenous healing* can be defined as beliefs and practices that originate within a culture and are designed specifically for the needs of cultural ingroup members. The notion of healing may imply specific roles and expectations of the helper, including the use of intuition, inspiration, or both; being chosen, gifted, or called to be a healer; manipulating higher energies through applying specific knowledge; and being a conduit between tangible and spiritual worlds.

Characteristics of indigenous healing and healers have been offered in the literature. Some theorists have described the “universal shamanic tradition” to outline intrinsic qualities of indigenous healing: reliance on use of community, group, and family networks to protect and reconnect individuals and/or problem solve to address pressing concerns; community participation in spiritual and religious traditions intended for healing; and a consideration of healers as keepers of spiritual

wisdom, empowered with transcendent skills. Other characteristics of indigenous healing include metaphysical etiology of illness (e.g., influence of deities, figures, or energies), harmony between universal contrasts (e.g., male–female or good–evil), energy and motion (e.g., laying on of hands), and the involvement of the collective (e.g., families, tribe, or community). Lastly, indigenous healing practices tend to define wellness as the homeostasis of physical, social, personal, and spiritual dimensions of the human experience and the holism of mind, body, and spirit. Thus, unlike counseling and psychotherapy, healing methods that have been steeped in the cultural worldviews of Western Europe and reflect consonant values (e.g., individualism, linear thinking, internal locus of responsibility, and separation of mind and body), indigenous healing methods are thought to originate outside of Western frameworks and operate from contrasting values (e.g., collectivism, circular thinking, external locus of responsibility, and the essential interconnection of mind, body, spirit, and the universe).

Examples of indigenous healing practices salient for specific cultural groups have been presented in the mental health literature; within-group differences, such as acculturation level, ethnicity, and adoption of diverse worldviews, are to be addressed with clients when mental health practitioners consider integrating indigenous practices in the context of counseling and therapy. For example, indigenous Native American healing practices include the Vision Quest, which is a rite of passage that serves to elevate the individual to a different plane of consciousness through the concentration of life energy in the sweat lodge and herbal treatment from a medicine man. Healing practices that can be considered indigenous for people of African descent can include practices endemic to the Black church, such as prayer, collective readings, and unique relationships between a higher power, the community, and the self.

Among Latino/a populations, the practices of *yerberos* (i.e., herbalism) and *Santería* (i.e., a religion in which Christian deities have been ascribed unique powers and which is characteristic of native African and Caribbean belief systems) may be applied to restore balance through the application or ingestion of liniments and/or herbs, lighting candles or burning herbs, or prayer. Indigenous healing practices of East Asian and Indian cultures (e.g., *kampyo* or Chinese herbal medicine in Japan, or *ayurveda* in India) similarly apply herbs and dietary considerations to restore balance between the energy counterparts.



Manipulation of energies through acupuncture, physical movement (e.g., yoga, tai-chi, qi-gong, and reiki), or diet are other methods of restoring balance and regularity to the flow of universal energies in the body.

Counseling professionals are encouraged to build their familiarity with indigenous healing practices relevant to diverse cultural groups in an effort to promote their multicultural counseling competence. Donald R. Atkinson and his colleagues presented a three-dimensional model, in which counselors are advised to consider liaising with indigenous healers when clients indicate that such methods of healing are salient to them. Furthermore, counselors can familiarize themselves with diverse indigenous healing methods through building connections with local healers.

Mai M. Kindaichi

*See also* Barriers to Cross-Cultural Counseling (v3); Cross-Cultural Psychology (v3); Cultural Values (v3); Espiritismo (v3); Etic–Emic Distinction (v3); Health Belief Model (v1); Multicultural Counseling Competence (v3); Religion/Religious Belief Systems (v3); Santería (v3)

### Further Readings

- Atkinson, D. R., Thompson, C. E., & Grant, S. K. (1993). A three-dimensional model for counseling racial/ethnic minorities. *The Counseling Psychologist*, 21, 257–277.
- Frame, M. W., Williams, C. B., & Green, E. L. (1999). Balm in Gilead: Spiritual dimensions in counseling African American women. *Journal of Multicultural Counseling and Development*, 27, 182–192.
- Garrett, M. T., & Wilbur, M. P. (1999). Does the worm live in the ground? Reflections on Native American spirituality. *Journal of Multicultural Counseling and Development*, 27, 193–206.
- Lee, C. C., Oh, M. Y., & Mountcastle, A. R. (1992). Indigenous models of helping in non-Western countries: Implications for multicultural counseling. *Journal of Multicultural Counseling and Development*, 20, 1–10.

---

## INDIVIDUALISM

---

*Individualism* is a common term in the counseling and psychological literature used to describe certain cultures and specific individual attributes valued in these cultures. The term *individualism* is often used in contrast to *collectivism*. Both terms describe a cultural

syndrome that reflects shared attitudes, beliefs, norms, and values that are found among individuals who live in specific geographical regions and speak a particular language during a specific historical period. Individualistic cultures, such as the mainstream European and North American cultures, place a high value on individuals being independent and self-sufficient. In contrast, collectivistic cultures, more often found in Asia and South America, focus on relational harmony and collective values. Of all the variations that exist among cultures, the individualistic–collectivistic cultural syndrome appears to be the underlying structure of such difference and thus may be the most important. These differences do not only impact the individual but also have a broader impact on, for example, economic, historical, and political systems and structures.

### Historical Foundations

European political philosophers of the 18th and 19th centuries, including John Locke, Jean-Jacques Rousseau, and Alexis Tocqueville, provided some of the foundation for the contemporary conceptions of individualism and collectivism by debating ideas about individual freedom versus the collective right within the state. Significant historical events such as the 1775 American and 1789 French Revolutions, both emphasizing equality and liberty, brought attention to the idea of individual freedom. Additionally, many of the early U.S. citizens who had fled Europe because of religious and political oppression were influenced by ideals expressed in the French Revolution. These ideals also came to shape the U.S. Constitution and its focus on protecting individual rights and also the U.S. culture at large.

In many parts of the world, there appears to be a movement toward individualism from collectivism, with prosperity playing a key role. As individuals become more financially well off, they become increasingly independent from their ingroup (e.g., family, tribe, nation), which is a sign of individualism. It is further argued that the more complex a culture is, the more likely it is to be individualistic. Indices of complexity include product per capita, personal computers per capita, the size of cities, and percentage of the population that is urban. Additionally, increased social and geographic mobility, exposure to mass media from individualistic countries, small families (small families tend to raise their children with a more



individualistic mind-set) are all believed to contribute to individualism. Raising children to be self-reliant and independent, in turn, supports individualism at a cultural level.

### Variations and Types

Whereas some suggest that individualism and collectivism are dichotomous variables representing opposites on a bipolar continuum, others argue that they can coexist and that individuals can present with aspects of both individualism and collectivism. Harry C. Triandis suggested that there may be different dimensions of individualism and collectivism, such as that American individualism differs from Swedish individualism, and the collectivism of Israeli kibbutzim is different from that of Korean collectivism.

Trying to uncover variations among the individualism–collectivism construct, Triandis and Michele Gelfand identified four types of individualist–collectivist patterns (horizontal individualism, vertical individualism, horizontal collectivism, and vertical collectivism). Horizontal patterns entail the self being different from others, emphasizing hierarchy, whereas vertical patterns assume that the self is similar to others, emphasizing equality. Countries such as Australia value equality, and others, such as the United States and India, value hierarchy. More specifically, horizontal individualists are characterized by self-reliance with a desire to be unique but not distinguished. Vertical individualists are also self-reliant but with a desire to be distinguished, and they do this through individual competition with others. On the other hand, vertical collectivists are willing to sacrifice their own goals for those of the group, and they only value competition when it is between their ingroup and other groups.

### Characteristics

Whereas the term *individualism* is proposed to represent the general attributes of a given culture, the term *idiocentrism* is to be used when describing or measuring individual-level orientations of individualism. Such use of terminology helps clarify the differences between the individual and the cultural level of analysis and allows for examination of idiocentric individuals in a collectivist culture (and for allocentric individuals in an individualistic culture). At this point, however, the literature has not been consistent in its use of the terms *individualism* and *idiocentrism*.

According to Triandis, individualism and collectivism vary in four main areas: (1) self (independent vs. interdependent), (2) goals (goal priority based on self vs. group), (3) relationships (rationality vs. relatedness), and (4) social behaviors (determined by attitudes vs. norms). Specifically, in cultures that emphasize individualism, people tend to be independent and autonomous from their ingroups. In these cultures, there is value placed on the development of the self and on individuals' abilities and skills. Internal attributes, including thoughts and emotions, help organize persons' behaviors and meaning making. In these cultures, individuals' goals are prioritized over those of the group, and their behavior is guided based on individual attitudes rather than on the norms of the ingroup. Generally, the more individualistic the culture is, the stronger the emphasis on the independent self.

### Empirical Research

Since the 1980s, individualism and collectivism have been of interest to scholars and researchers. Empirical data have consistently shown that there is substantial variation within cultures regarding behavior and psychological processes, and most of this research has focused on identifying the attributes of individualism and collectivism. The first empirical study that identified the factors of individualism versus collectivism was published in 1980 by Geert Hofstede, who examined IBM employees in 53 countries. In this study, the United States was identified as the most individualistic country.

In 2002, Daphna Oyserman, Heather M. Coon, and Markus Kimmelmeier published the first meta-analytic study of individualism and collectivism. The results showed that European Americans scored higher on individualism than individuals from countries such as Japan, Korea, Hong Kong, India, Taiwan, and Poland. The study also showed some unexpected results, such that there was no difference in individualism between European Americans and Indonesians, and that European Americans scored lower on individualism than individuals in Puerto Rico but higher in collectivism than people in Japan. Comparison of racial and ethnic groups within the United States showed that European Americans reported higher scores on individualism than Asian Americans but lower than African Americans. These results suggest that individualism, as well as collectivism, does not fully follow the expected patterns and that additional studies are needed to further



understand cultural differences among cultures, countries, and continents. Specifically, more data are needed from certain continents such as Africa, in which only a few populations have been examined in terms of individualism–collectivism.

### Mental Health, Illness, and Treatment

In individualistic cultures, individual maturity and mental health are associated with competence, ego strength, responsibility, and autonomy. Success is viewed as an individual accomplishment gained through ability and effort. Similarly, mental illness and failures are also seen as due to ability and effort and located within the individual. Compared with collectivistic cultures, higher rates of loneliness, depression, suicide, and marital dissatisfaction are found in individualistic countries. The role of counselors such as psychodynamic and person-centered counselors (whose theories were developed in Europe and North America) is to help clients to act on their own behalf via the use of insight and self-exploration. Clients are viewed as responsible for their own actions and decisions, and interventions are focused on fixing clients' internal deficiencies.

In the past decades, many scholars have pointed out biases and limitations of Westernized, traditional, and individualistic approaches to mental health and treatment. One common criticism is that the European American White male has been used as the norm for assessing behavior, resulting in a focus on individuation and separation as developmental processes and the view of autonomous behavior as healthy and desirable. Consequently, such views of development and counseling may be limited and biased for women and individuals of other cultural backgrounds.

*Johanna Nilsson and Ashley Heintzelman*

**See also** Acculturation (v3); Acculturative Stress (v3); Allocentrism (v3); Collectivism (v3); Cross-Cultural Psychology (v3); Cross-Cultural Training (v3); Cultural Encapsulation (v3); Cultural Values (v3); Culture (v3); Enculturation (v3); Familismo (v3); Idiocentrism (v3); Locus of Control (v3); Worldview (v3)

### Further Readings

Hofstede, G. (1980). *Culture's consequences: International differences in work-related values*. Beverly Hills, CA: Sage.

Oyserman, D., Coon, H. M., & Kemmelmeier, M. (2002).

Rethinking individualism and collectivism: Evaluation of theoretical assumptions and meta-analyses. *Psychological Bulletin*, 128, 3–72.

Triandis, H. C. (1993). Collectivism and individualism as cultural syndromes. *Cross-Cultural Research: The Journal of Comparative Social Science*, 27, 155–180.

Triandis, H. C. (1995). *Individualism and collectivism*. Boulder, CO: Westview Press.

Triandis, H. C. (2001). Individualism–collectivism and personality. *Journal of Personality*, 69, 907–924.

Triandis, H. C., & Gelfand, M. J. (1998). Converging measurement of horizontal and vertical individualism and collectivism. *Journal of Personality and Social Psychology*, 74, 118–128.

---

## INTELLIGENCE TESTS

---

Intelligence is a general mental capability that involves reasoning, planning, solving problems, thinking abstractly, comprehending complex ideas, and learning quickly from experience. The need to operationalize and make useful the construct of intelligence in educational, clinical, and employment settings led to a proliferation of standardized intelligence tests. *Standardization* refers to the development of consistent administration and scoring practices and predetermined guidelines regarding the interpretation of test scores.

*Intelligence tests* measure various abilities that may include auditory and visual memory, quantitative reasoning, verbal reasoning, conceptual and abstract reasoning, perceptual and motor processing, spatial reasoning, sequential reasoning, and attention and focus. Most measures assess multiple ability areas and often include both verbal and nonverbal reasoning tasks, although purely nonverbal measures also exist. The most frequently used individually administered intelligence tests are the Wechsler series of scales and the Stanford-Binet.

Intelligence and its relationship to educational achievement and future success is complex and may be influenced by cultural factors. Understanding the potential impact of socioeconomic status, stereotype threat, and other variables related to one's racial or ethnic group may be vital in obtaining an accurate estimate of an individual's intelligence. This entry discusses the potential impact of culture in intelligence testing, specifically (a) intelligence tests and



their use with diverse racial and ethnic groups, (b) culture and alternative forms of intelligence, (c) contextual and cultural considerations in measuring intelligence, and (d) culture and applied assessment.

### **Intelligence Tests and Their Use With Diverse Racial and Ethnic Groups**

Persistent discrepancies between racial and ethnic groups on standardized intelligence tests have been interpreted based upon a deficit model (i.e., lower scores are due to deficiencies). The degree to which an individual does well on an intelligence test is determined, in part, by what he or she has learned in his or her cultural context. Cultural context determines, in part, what constitutes intelligent behavior. The impact of these considerations becomes salient as these measures are used to classify and track students for special programs (e.g., gifted, special education).

All intelligence tests yield racial and ethnic group differences, particularly on verbal scales. Nonverbal tests of intelligence (e.g., Universal Nonverbal Intelligence Test) provide an alternative to verbally based tests. These nonverbal measures yield smaller racial and ethnic group differences when compared with verbal measures. Nonverbal measures include tasks tapping symbolic and spatial memory, analogical reasoning, and spatial reasoning. These measures are considered to be culturally reduced but not culture-free tests.

Many intelligence measures are standardized to yield an overall mean of 100 with a standard deviation of 15. Scores for particular racial and ethnic groups include Whites/Caucasians, 100; Blacks/African Americans, 85; Hispanics, midway between Blacks and Whites; Native Americans, approximately 90; and Asians and members of the Jewish community, above 100. These numbers reflect only averages, and the differences within each racial and ethnic group clearly exceed between-group differences.

In addition to overall intelligence score differences, variations in ability profiles are also noted. Ability profiles refer to the pattern of scores obtained across various subtests or areas. For example, Native Americans and Hispanics score relatively higher in nonverbal reasoning in comparison to verbal reasoning. Asians possess relative strengths in numerical reasoning and nonverbal reasoning in comparison to verbal abilities. The profile for Blacks/African Americans has been less consistent, but some studies

have revealed higher verbal reasoning abilities in comparison to visual. Cultural explanations have been posed to justify these profile differences as cultures reinforce particular forms of ability. On some intelligence tests (e.g., Wechsler series), extra points are awarded for quick performance on particular tasks. Not all cultures, however, emphasize speed. Indeed some would prioritize perseverance and meticulousness. A number of cross-cultural studies have found group differences in defining “intelligence.”

### **Culture and Alternative Forms of Intelligence**

Intelligence can be expressed in a number of ways; therefore, different forms of intelligence have been identified in the literature. Howard Gardner’s work identified the existence of multiple intelligences, including the following: interpersonal, intrapersonal, linguistic, logical-mathematical, bodily-kinesthetic, musical, and spatial. His theory specifically acknowledges the importance of culture in determining which abilities will be valued in various contextual settings.

Social intelligence encompasses social awareness and social facility. Social awareness refers to having empathy, attunement, empathic accuracy, and social cognition. Social facility includes synchrony, self-presentation, influence, and concern. Each of these domains requires cultural understanding and sensitivity to operate effectively in the social environment.

Emotional intelligence is defined as the abilities to (a) perceive accurately, appraise, and express emotion; (b) understand emotion and emotional knowledge; and (c) regulate emotions to enhance emotional and intellectual growth. The literature indicates that given that emotional responses are learned within a cultural context, understanding the complex nature of emotional intelligence requires understanding of cultural background.

Measures have been developed to assess these different domains of intelligence. The formats of these tests range from self-report paper-and-pencil instruments to behavioral indicators, including responses to scenarios.

### **Contextual and Cultural Considerations in Measuring Intelligence**

A number of contextual and culturally linked variables have been identified that impact performance on



intelligence tests. These include variables related to the individual being assessed (e.g., socioeconomic status, home environment, stereotype threat) and variables that pertain to the measures themselves (e.g., test bias, cultural loading, cultural equivalence, differential item functioning).

Researchers have debated the influence of socioeconomic status (SES) in predicting intelligence. Variables addressing SES have included parental occupation, school attainment (i.e., years of schooling completed), family income, and home atmosphere (e.g., cultural activities, reading materials). In general, results indicate that when SES is controlled (i.e., equated), the differences in intellectual performance between Whites and people of color are reduced. There is evidence that the correlations between SES indicators and intelligence may vary for different racial and ethnic groups.

Studies addressing the relationship between intelligence and home environment indicate that stimulating and nurturing home environments yield intellectually bright children. *Home environment* refers to the learning experiences provided within the family context, including reading to the child, providing play materials, academic/intellectual aspirations for children, language development models (e.g., emphasis on use of language, opportunities to enlarge vocabulary), and provisions for general learning (e.g., opportunities to learn inside and outside the home).

Stereotype threat (i.e., anxiety regarding one's performance on an ability test based upon stereotypes of his or her racial or ethnic group membership) has been applied to intelligence testing. This anxiety is salient when a negative stereotype (e.g., "Blacks are not intelligent") may be confirmed by one's performance and not by one's ability. Stereotype threat has been shown to lower the standardized test performance for groups whose stereotypes are linked to inferior abilities.

Test bias refers to the existence of systematic error in the estimation of some true value of test scores related to group membership. Bias is addressed empirically through studies of validity (i.e., construct, content, predictive). Validity refers to whether a particular test measures what it purports to measure. If a test is valid for some groups and not for others, then it is biased. Test bias with respect to racial and ethnic group membership is cultural bias. Most well-standardized intelligence tests have withstood challenges of cultural bias. To prevent cultural bias, test

developers may invite expert panels to review item content during the test development process, recruit standardization samples that reflect proportional sampling of various racial and ethnic groups based upon the national census, and identify specific reliability and validity procedures pertaining to particular racial and ethnic groups.

Cultural loading refers to the fact that all tests are developed within a cultural context. Therefore, they are inherently "loaded" to reflect the knowledge, values, and conceptions of intelligence for the cultural group upon which the test is based. A test can be culturally loaded but not culturally biased.

Cultural equivalence refers to a number of critical considerations in ability testing. For example, the content of the test items should be familiar to all racial and ethnic group members. The language and content of the test should have similar meaning for different racial and ethnic groups. The ability being examined should have equal relevance for different cultural groups.

Differential item functioning has been used to formulate alternative methods of scoring to address racial and ethnic group differences on aptitude measures. One such scoring method is based upon the cultural unfamiliarity hypothesis. Items on tests such as the Scholastic Assessment Test (SAT) include "hard" or "rare" as well as "easy" vocabulary words. Easy verbal items touch upon more culture-specific content and may be perceived differently depending upon one's cultural group. Harder items, on the other hand, are less ambiguous and therefore will be perceived similarly by members of all culture groups.

### **Application of Cultural Considerations to Intelligence Testing**

The problems that arise when culture is not considered in the process of intelligence testing are well documented. In the 1960s and 1970s disproportionate numbers of Black and Spanish-surnamed students were identified as retarded based upon standardized intelligence measures. Many were identified as "six hour retardates" given their limited academic skills during the school day, with higher-level survival and adaptation skills demonstrated in their communities. Court cases have challenged the use of intelligence tests with students of color.

Professionals must provide services to immigrants and refugees using translated versions of tests and



interpreters. Intelligence tests have been exported to other countries and renormed and revalidated. To ensure appropriate assessment practices, clinicians must consider the examinee's cultural background and experiences and understand the limitations of intelligence tests. An examiner must always strive to be better than the tests used.

*Lisa A. Suzuki*

**See also** Academic Achievement, Nature and Use of (v4); Achievement, Aptitude, and Ability Tests (v4); Achievement Gap (v3); Bias (v3); Cognition/Intelligence, Assessment of (v2); Cultural Equivalence (v3); Intelligence (v2); Quantitative Methodologies (v1); School Counseling (v1); Socioeconomic Status (v3); Stereotype Threat (v3)

### **Further Readings**

- Freedle, R. O. (2003). Correcting the SAT's ethnic and social-class bias: A method for reestimating SAT scores. *Harvard Educational Review*, 73, 1–42.
- Gardner, H. (2006). *Multiple intelligences: New horizons*. New York: Basic Books.
- Goleman, D. (2006). *Social intelligence: The new science of social relationships*. New York: Bantam Books.
- Helms, J. E. (1992). Why is there no study of cultural equivalence in standardized cognitive ability testing? *American Psychologist*, 47, 1083–1101.
- Steele, C. M., & Aronson, J. (1995). Stereotype threat and the intellectual performance of African Americans. *Journal of Personality and Social Psychology*, 69, 797–811.
- Valencia, R. R., & Suzuki, L. A. (2001). *Intelligence testing and minority students: Foundations, performance factors, and assessment issues*. Thousand Oaks, CA: Sage.

---

## **INTERRACIAL COMFORT**

---

Interracial comfort is described as the comfort level that a person feels around members of a race different from his or her own. Interracial comfort can be measured as awareness of the person, the presence or absence of anxiety about the other person, and the ability to go about the task at hand without being so cognizant of the other person's race. Interracial comfort can be applied to friendships, work, dating, relationships and marriage, or meeting complete strangers

on the street. Oftentimes people have different ideas about their own interracial comfort based on the role that the person from a different race is playing; for example, a person may experience a different comfort level working with a person from a race different from his or her own versus his or her ideas about dating or marrying a person from a race different from his or her own.

Our ideas about interracial friendships undoubtedly begin at home and can be reinforced or challenged when we enter school. School environment is clearly a factor in developing interracial friendships. Students who attend small, diverse schools will probably have more opportunities to form friendships with students of various races than will students who attend very large schools, because the larger the school is, the more opportunities there are to socialize with people who are of similar background. Another aspect of school-related interracial comfort is participating in teams, either academic or athletic, which allows for group success, cooperative learning, and an increase in multicultural sensitivity.

Interracial comfort in the area of dating and romance has been increasingly accepted throughout the United States and has increased as attitudes about members of diverse racial groups have changed. As people move from interracial dating into interracial marriage, ideas seem to shift. Until the mid-1960s, interracial marriage was a felony. The perceptions held by society seem to have shifted to allow interracial unions to exist; however, prejudice and stereotypes contribute to negative perceptions of couples who have married interracially. Some people believe that interracial marriages destroy traditions normally held by the family. Some argue that interracial marriages will not last because of incompatibility caused by racial differences. U.S. Census data from 2000 indicate that citizens reported 1,432,908 Latino/a–Caucasian marriages, 504,119 Asian American–Caucasian marriages, 287,576 African American–Caucasian marriages; 97,822 Latino/a–African American marriages, 40,317 Asian American–Latino/a marriages, and 31,271 Asian American–African American marriages.

It is clear that social norms provide the backdrop for interracial comfort for many people. It is also clear that early experiences can alter perceptions that people hold about members of racial groups other than their own. Interracial comfort appears to be something that needs to be explored throughout the life span, starting with positive school experiences



and progressing through work and social experiences held by the individual.

*Janice E. Jones*

*See also* Acculturation (v3); Biracial (v3); Color-Blind Racial Ideology (v3); Diversity (v3); Enculturation (v3); Interracial Marriage (v3); Personal Space (v3); Race (v3); Racial Identity (v3); Racial Microaggressions (v3); Racism (v3); Tokenism (v3)

### Further Readings

U.S. Census Bureau. (2000). [Census data]. Retrieved from <http://www.census.gov/main/www/cen2000.html>

---

## INTERRACIAL MARRIAGE

---

*Interracial marriage* is defined as a matrimonial union between members of two different races. It can be seen as a form of miscegenation (i.e., mixing of different races) or exogamy (i.e., a union outside of one's social group), depending on whether race or culture is applied to the definition.

*Race* is a term intended to designate the main subdivisions of the human species. Its core intention is to distinguish groups based on physical characteristics, such as skin pigmentation and hair texture. *Culture*, on the other hand, defines the way people play out their personal belief system, and thus, culture presents a more dynamic orientation to this issue. Because all humankind embody both race and culture, it is important to understand the roles they play in the lives of individuals who marry outside of their identified race, culture, or both.

### Nature of Racial Designation

Contemporary researchers suggest that race is largely a social construction that has little biological significance, despite the societal emphasis placed on race. Seemingly arbitrary and inconsistent boundaries have been established for determining racial heritage in the United States. For example, there are more than 560 federally recognized American Indian tribes in the United States. While the qualifications for membership into these tribes differ, some people of American Indian descent do not qualify for this racial designation unless they have a minimum blood quantum of one fourth.

Accordingly, possessing less than 25% Indian heritage is a racial disqualification for group membership, regardless of cultural practices and beliefs.

On the other hand, African Americans have been subjected to a one-drop rule. That is, persons with any degree of African ancestry—no matter how far back the lineage—are considered to be African American, regardless of an absence of cultural beliefs and practices. Amazingly enough, no other racial group in the world is subjected to this one-drop designation, and these differing policies of racial designation illustrate the social influence on defining race.

As these examples illustrate, inconsistent designations of race highlight the arbitrary nature of the definition, even though society subscribes to a strong biological rationale for utilizing racial designations.

### Legislative Influences on Interracial Marriages

This adherence to a strictly biological racial designation contributed to U.S. legislation supporting race-based segregation such as the Jim Crow laws, which were enacted in the late 1800s. This legislation was upheld in many southern states into the 1960s when the civil rights movement was initiated. Jim Crow laws stated that it was unlawful not only for White people to marry persons of Negro, Mongolian, Malay, or Hindu descent but also for Negro men and women to cohabit (i.e., share the same sleeping quarters) with White persons. Anyone found to be in violation of these laws was subjected to either imprisonment for up to 12 months or monetary fines. In 1967 *Loving v. Virginia*, the Supreme Court ruled against the remaining 13 states that upheld the antimiscegenation laws. This ruling initially spurred an uprising of Blacks protesting against White supremacy. Only after the settlement of this uprising did the phenomenon of interracial marriage begin to rise in occurrence.

As recently as 1983, the Texas Civil Liberties Union called for the removal of three justices of the peace who had refused to perform interracial marriages. Although there are currently no states that explicitly ban miscegenation, the practice continues to be a social taboo in many communities.

### Current Trends

In spite of the obstacles interracial couples face, interracial marriages are on the rise in the United States.



Census data indicate that interracial marriages have increased steadily over time, from 310,000 in 1970, to 651,000 in 1980, to 1.16 million in 1992, and to 2.7 million in 2000. American demographic changes are leading to increased contact among young people across racial and cultural lines in schools, in the workforce, and in better-integrated communities. By 2050, it is estimated that the percentage of U.S. population claiming mixed racial heritage will triple, climbing to 21%.

The incidence of interracial sex experienced an incline after the Supreme Court ruling of *Loving v. Virginia* in 1967. This increase led to a surge in the population of people who identify as biracial. As the population of these individuals increased, the basis for comparison became more difficult as larger numbers identified not with a single minority group but as a more ambiguous categorical group, biracial.

Interracial marriages today are more likely to occur between White females and Black males than in the past. However, Hispanics, American Indians, and Asians lead the trend of intermarriage with White partners. These statistics are likely to differ depending upon the U.S. region within which the couple resides. People living in the northern region show higher rates of interracial marriage than those living in the southern region. This trend, in part, is attributed to the historically significant migration of Black people to the northern regions coupled with the slow reaction of the southern states in responding to the civil rights movement.

### **Counseling Issues Facing Interracial Couples**

Given this rise in racial and cultural integration, counselors must be prepared to address multiple levels of issues unique to interracial marriages, including being able to distinguish between cultural issues and common issues. When seeking counseling, interracial couples do so for reasons such as finances, fidelity, and child rearing; however, the societal landscape of racial intolerance and the sometimes unintentional push for assimilation adds an extra dimension of difficulty for interracial couples, giving a multiplicative effect to contextual factors.

### **Family of Origin and Social Support**

Interracial couples may face a chaotic change from previously harmonious relationships with their respective extended families. Driven by implicit racist

beliefs, otherwise loving fathers or mothers may disapprove of their daughter or son marrying outside of their race. This disapproval may cause couples to disconnect from families of origin, thus causing relational strain and psychological distress.

This disconnection also may cause interracial couples to turn to sources of support outside the family, even though these sources (i.e., friends, colleagues, and community members) can potentially present greater societal oppression, stereotypical assumptions, and acceptance challenges. In an attempt to remove themselves from situations of racism and intolerance, interracial couples may intentionally isolate themselves or develop new communities that support their relationship.

### **Racial Identity**

Parents of biracial children often feel a sense of inadequacy in assisting their children's identification with biculturalism. Society often identifies children of dual racial parentage with whichever race their physical features most resemble. However, the child may not be *Black* enough to fit in with African American peers; conversely, the child may not be *White* enough to fit in with Caucasian peers. Subsequently, the child is placed in a tenuous situation wherein he or she cannot find acceptance anywhere. Integrating a healthy self-concept is a complex task for any adolescent, and social marginality magnifies this process for biracial youth.

Since the child may not strongly resemble either parent, biracial children may also have a difficult time identifying with either of their parents in attempting to resolve this duality. It is also possible that the child will arbitrarily identify with his or her most influential parental figure, which can ultimately result in peer conflict if the child's physical appearance does not support his or her choice of racial identification. As children become more aware of their own biracial heritage, societal racism becomes more salient and can disrupt the process of healthy identity formation.

While it is difficult to watch their children navigate through their racial identity formation, interracial couples also must resolve their own racial identity issues. While transitioning through life stages, marital intimacy may be disrupted if one spouse perceives that his or her partner, who may not hold similar cultural beliefs and practices, is subsequently unable to appreciate these unique and often difficult experiences.



## Counseling Implications

There exists a double-edged sword in working with interracial couples. Issues related to ethnic, racial, and cultural differences may be underlying presenting concerns (e.g., money, fidelity, child care) that bring a couple to therapy. However, counselors must be cautious in their zeal to attribute a racial explanation to these relational issues. It is inappropriate to define interracial couples simply by their interracial bond. To be competent, counselors need to become aware of the layered contexts in which the relationship exists.

In addition to their own awareness, counselors need to assist their clients in cultivating an appreciation for their own doubly rich cultural family systems. It is helpful to encourage couples to share their life stories, relate to each other's worldview, expect and respect culturally complex differences, and express the wide range of values, expectations, and cultural components found in their individual life stories that have now been merged together.

Because there exists a multitude of potential racial matches (e.g., Black–White, Latino/a–American Indian, Korean–Vietnamese), interracial couples do not form a homogenous group. There are between-group racial differences to consider, just as there are within-group racial differences. Thus, there is not a “one size fits all” counseling approach to working with the issues facing interracial couples. Instead, a multiculturally competent counselor must be aware of the internal and systemic contexts surrounding the relationship and must individually tailor treatment programs to the unique needs of this vastly diverse population.

*India Gray-Schmiedlin and Jesse A. Steinfeldt*

*See also* Bicultural (v3); Biracial (v3); Color-Blind Racial Ideology (v3); Cultural Values (v3); Culture (v3); Diversity (v3); Interracial Comfort (v3); Multicultural Counseling (v3); Multicultural Counseling Competence (v3); Multiracial Families (v3); Race (v3); Racial Identity (v3); Tokenism (v3); Transracial Adoption (v3)

## Further Readings

- Gullickson, A. (2006). Black/White interracial marriage trends, 1850–2000. *Journal of Family History*, 31(3), 289.
- Ho, M. K. (1990). *Intermarried couples in therapy*. Springfield, IL: Charles C Thomas.
- “Jim Crow” laws. Retrieved March 19, 2007, from [http://www.nps.gov/malu/documents/jim\\_crow\\_laws.htm](http://www.nps.gov/malu/documents/jim_crow_laws.htm)

- McFadden, J. (2001). Intercultural marriage and family: Beyond the racial divide. *The Family Journal: Counseling and Therapy for Couples and Families*, 9, 39–42.
- Qian, Z., & Lichter, D. (2007). Social boundaries and marital assimilation: Interpreting trends in racial and ethnic intermarriage. *American Sociological Review*, 72, 68–94.
- Reber, A. S., & Reber, E. S. (2005). *The Penguin dictionary of psychology* (3rd ed.). New York: Penguin.
- Volker, T., Karis, T. A., & Wetchler, J. L. (2003). *Clinical issues with interracial couples: Theories and research*. New York: Haworth Press.

---

## IVEY, ALLEN E. (1933– ): COUNSELING THEORY AND SKILLS TRAINING

---

Allen E. Ivey graduated from Stanford University in 1955 and received his Ed.D. from Harvard University in 1959. Early in his career, he served as Director of Counseling at Bucknell University and Colorado State University. Ivey began teaching at the University of Massachusetts, Amherst, in 1968, where he served as a professor for more than 30 years. He is the author of more than 35 books and more than 200 articles, chapters, and monographs. His work has been translated into 18 languages. In addition to his work as a scholar, Ivey founded Microtraining Associates, an independent publishing company that has led the way in producing videos and books related to skills training and multicultural development. Ivey's prolific work has had a significant impact on four major areas: multicultural counseling, skills training, developmental counseling, and counseling theory.

To understand Ivey's contribution to multicultural counseling, it is important to understand how three other lines of scholarship have influenced his ideas about cultural diversity. First, he developed the microskills training method that has become the most popular way to teach new counselors to use introductory helping skills. Second, Ivey was the originator of developmental counseling and therapy, a therapeutic approach based on Jean Piaget's theory of development. Third, Ivey has led the way in articulating the relationship between multiculturalism and traditional counseling theories.

## Skills Training

In the 1970s, Ivey published two groundbreaking books describing microcounseling, a structured



approach to training counselors in discrete helping skills (microskills) such as attending behavior, open invitation to talk, reflection and summarization, paraphrasing, and interpretation. Although the first edition of this book did not focus on culture, the second edition described the cultural-environmental-contextual implications of microtraining. Rather than focusing solely on internal variables, like self-actualization, counselors can help clients focus on external variables that may impact development. This early recognition of the need to explore the cultural environment led to the realization that appropriate attending and helping skills differ from one cultural context to another.

Part of Ivey's motivation for combining his interests in skills training and cultural diversity was inspired by feedback from cross-cultural counselors who observed that the same skills did not have the same impact on clients from different cultural backgrounds. Based on this feedback, Ivey realized that some attending behaviors, like direct eye contact, were helpful in one cultural context but may damage rapport with clients from another background. This led to the development of the concept of culture-centered skills. In 1993, Paul Pedersen and Ivey directly applied the microskills training method to the topic of culture-centered counseling and concluded that developing culture-centered skills involves increasing the counselor's ability to interact with different cultures. These authors stressed the now familiar idea that the effective use of *skills* should be based on both *awareness* and *knowledge*. The key to the development of culture-centered skills is to examine a specific culture, identify concrete skills that may be useful with this particular group, and develop a helping theory that can be tested in practice.

In the same way that microskills training has been applied to culture-centered counseling, Ivey has infused the idea of culture into skills training. The development of cultural skills has been an increasingly consistent theme in each subsequent edition of the classic text *Intentional Interviewing and Counseling*. In the most recent (2007) edition, Ivey and coauthor Mary Bradford Ivey suggest that the purpose of counseling is to facilitate client development in a multicultural society. Ivey and Ivey summarize the fundamental relationship between skills and culture by concluding that the same skills may have different effects on people from varying cultural backgrounds. Therefore, effective cross-cultural

counseling requires awareness that racial and ethnic groups may have different patterns of communication.

## Developmental Counseling

The theme of development has also had a significant impact on Ivey's ideas about culture. Ivey described his developmental counseling and therapy approach as a way to apply developmental concepts—drawn from Piaget, Erik Erickson, and Sigmund Freud—directly to the arena of counseling. In 1986, Ivey suggested that development always occurs within a cultural context and that counseling is influenced by both the therapist's and the client's cultural and historical backgrounds. In 1991, Ivey expanded the cultural emphasis in developmental counseling to highlight the idea of multicultural development. He suggested that counselors should facilitate clients' movement through different stages of cultural identity development. By focusing on culture in counseling, therapists can help clients move through stages related to conformity, dissonance, resistance and immersion, introspection, and synergistic awareness. The most recent (2005) description of this developmental approach expanded the definition of culture to include race and ethnicity as well as gender, religion, economic status, nationality, physical capacity, and sexual orientation. *Evolution of consciousness* and *liberation of consciousness* were described as goals related to facilitating cultural identity development in counseling. Clients are encouraged to tell their stories in ways that foster movement through different types of development and may result in both expanded awareness and congruent social action. Ivey's synthesis of culture and development has contributed to the recognition of cultural identity development as a central theme in the multicultural counseling literature.

## Counseling Theory

Ivey has been very influential in defining the relationship between multiculturalism and traditional theories of counseling and psychotherapy. In the first edition of his popular textbook surveying theories of counseling and psychotherapy, Ivey concluded that most counseling theories were based on White, middle-class culture and questioned whether it was appropriate to generalize these theories to other cultural contexts. Long before culture became a popular theme in the counseling literature, Ivey's book was the first



survey-of-theories text to directly address multicultural issues. A multicultural perspective has become a more overt theme in each subsequent edition of this book. In the most recent edition, Ivey described multiculturalism as a metatheory creating a framework that describes how different theories of counseling and psychotherapy represent different worldviews. Each theory was developed within a particular cultural context and will represent the biases of that culture in trying to understand clients and foster change. In this way, multicultural counseling encourages therapists to view the individual-in-context as well as understanding psychological theories within their own cultural context. In response to Ivey's groundbreaking work, the centrality of culture has been widely accepted in the counseling literature.

### Legacy

Three key strengths can be seen throughout Ivey's long and illustrious career. First, he has been at the forefront of exploring new ideas that may benefit the field of counseling and psychotherapy. Second, Ivey has been able to bring together pluralistic ideas from diverse sources and synthesize them in new ways. Third, he has always been deeply invested in translating theoretical ideas into pragmatic actions and teaching them to others in practical ways. Throughout his career, he has weaved together his interests in skills training, development, counseling theory, and multicultural diversity. Because of his dedication to pluralistic synthesis as well as practical application, Ivey's legacy will continue to have a significant impact on the way counselors think and act for decades to come.

*Jeff E. Brooks-Harris*

**See also** Counseling Skills Training (v2); Cross-Cultural Training (v3); Cultural Values (v3); Culture (v3);

Developmental Counseling and Therapy (v2); Multicultural Counseling (v3); Multicultural Counseling Competence (v3); Pluralism (v3); Relationships With Clients (v2)

### Further Readings

- Ivey, A. E. (1971). *Microcounseling: Innovations in interviewing training*. Springfield, IL: Charles C Thomas.
- Ivey, A. E. (1986). *Developmental therapy: Theory into practice*. San Francisco: Jossey-Bass.
- Ivey, A. E. (1991). *Developmental strategies for helpers: Individual, family, and network interventions*. North Amherst, MA: Microtraining Associates.
- Ivey, A. E. (1995). Psychotherapy as liberation: Toward specific skills and strategies in multicultural counseling and therapy. In J. G. Ponterotto, J. M. Casas, L. A. Suzuki, & C. M. Alexander (Eds.), *Handbook of multicultural counseling* (pp. 53–72). Thousand Oaks, CA: Sage.
- Ivey, A. E., & Authier, J. (1978). *Microcounseling: Innovations in interviewing, counseling, psychotherapy, and psychoeducation*. Springfield, IL: Charles C Thomas.
- Ivey, A. E., D'Andrea, M., Ivey, M. B., & Simek-Morgan, L. (2001). *Theories of counseling and psychotherapy: A multicultural perspective* (5th ed). New York: Allyn & Bacon.
- Ivey, A. E., & Ivey, M. B. (2007). *Intentional interviewing and counseling: Facilitating client development in a multicultural society* (6th ed.). Belmont, CA: Wadsworth.
- Ivey, A. E., Ivey, M. B., Meyers, J., & Sweeney, T. (2004). *Developmental counseling and therapy: Promoting wellness over the lifespan*. Mahwah, NJ: Lawrence Erlbaum.
- Ivey, A. E., & Simek-Downing, L. (1980). *Counseling and psychotherapy: Skills, theories, and practice*. Englewood Cliffs, NJ: Prentice Hall.
- Pedersen, P. B., & Ivey, A. E. (1993). *Culture-centered counseling and interviewing skills*. Westport, CT: Praeger.
- Sue, D. W., Ivey, A. E., & Pedersen, P. B. (1996). *A theory of multicultural counseling and therapy*. Pacific Grove, CA: Brooks/Cole.









---

## KWANZAA

---

Kwanzaa is an African American holiday that was created by Maulana Karenga, an authority on African studies. It was first celebrated from December 26 through January 1, 1967, in Los Angeles, California, and Kwanzaa continues to be celebrated annually at that time of year as a Black holiday embraced by millions of African Americans. Kwanzaa was inspired by the agricultural African people who gathered and celebrated annually at harvest time, but it currently is designed to meet the needs of African Americans living in the United States. It makes a cultural and political statement, providing an alternative to Christmas and the associated commercialism and emphasis on expensive gift giving during that holiday season.

Kwanzaa gives African Americans an opportunity to celebrate themselves and their history with gifts, mainly gifts given to children to acknowledge commitments made and kept. Children have always been at the core of Kwanzaa in light of how they influenced the spelling of the word; the original Swahili word *kwanza* means “first fruits,” but adding the extra *a* meant there were seven letters to represent the seven children at the first Kwanzaa program. The result is more than merely a word, allowing Kwanzaa to convey a distinct identity and holiday.

Kwanzaa also was made a 7-day holiday to establish and promote the *Nguzo Saba*: the seven basic principles that serve as the central focus of Kwanzaa and provide a Black value system. These seven principles are as follows:

1. *Umoja* (Unity)—To strive for and maintain unity in the family, community, nation, and race
2. *Kujichagulia* (Self-determination)—To define ourselves, name ourselves, create for ourselves, and speak for ourselves instead of being defined, named, and created for and spoken for by others
3. *Ujima* (Collective Work and Responsibility)—To build and maintain our community together and make our sisters’ and brothers’ problems our problems and to solve them together
4. *Ujamaa* (Cooperative Economics)—To build and maintain our own stores and other businesses and to profit from them together
5. *Nia* (Purpose)—To make our collective vocation the building and developing of our community in order to restore our people to their traditional greatness
6. *Kuumba* (Creativity)—To do always as much as we can, in the way we can, to leave our community more beautiful and beneficial than it was when we inherited it
7. *Imani* (Faith)—To believe with all our heart in our people, our parents, our teachers, and our leaders in the righteousness and victory of our struggle

There is no holiday named Kwanzaa that is practiced on the African continent, nor is there one that uses the distinct symbols, practices, or principles associated with Kwanzaa. Instead, Kwanzaa is a distinct African American holiday designed to respond to the social



conditions in which African Americans lived in the 1960s, while underscoring the cultural unity among all African descendants. The seven Nguzo Saba principles continue to represent a powerful acknowledgment of and response to the sociopolitical reality in which people of African descent live in the United States. These principles also constitute a paradigm and Africentric worldview upon which mental health professionals may draw when designing culturally relevant and appropriate research and interventions for African Americans.

*Barbara C. Wallace*

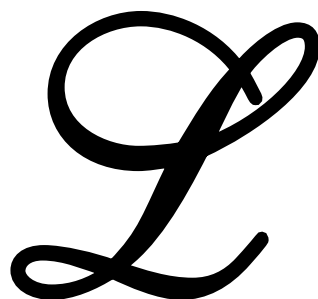
*See also* African Americans (v3); Afrocentricity/  
Afrocentrism (v3); Black Racial Identity Development

(v3); Cultural Values (v3); Ethnic Identity (v3); Ethnic  
Pride (v3); Racial Identity (v3); Racial Pride (v3)

### Further Readings

- Karenga, M. (1988). Black studies and the problematic paradigm. *Journal of Black Studies*, 18, 395–414.
- Karenga, M. (1994). *Maat, the moral ideal in ancient Egypt: A study in classical African ethics*. Los Angeles: University of Southern California.
- Karenga, M. R. (1965). *Kwanzaa: Origin, concepts, practice*. Los Angeles: Kawaida.
- Karenga, M. R. (1988). *The African American holiday of Kwanzaa*. Los Angeles: University of Sankore Press.





---

**LAFROMBOISE, TERESA DAVIS**  
**(1949– )**

---

Teresa Davis LaFromboise was born in a small southern Indiana town. She is of American Indian (Miami Nation) and European descent and is best known for her work in American Indian adolescent suicide prevention.

LaFromboise began her career as a middle school art and language arts teacher with the Turtle Mountain Band of Chippewa and later the Saginaw Chippewa in Michigan, where she also worked with the Johnson-O'Malley Program. Noticing that 80% of the American Indian students on the Saginaw Chippewa reservation were dropping out of school, she sponsored a group of her students to participate in Suitcase Theatre, a national youth performing arts program that aimed to empower youth and promote respect for cultural diversity. As LaFromboise became more aware of how limited her opportunities were, as a teacher, to impact student issues, she wrote a grant that was funded to provide counseling services for the Saginaw Chippewa middle school students. At that point in her career, her family moved to Norman, Oklahoma, where she worked as a teacher for homebound students and began her graduate studies, focusing on mental health issues among American Indians. LaFromboise began her doctoral education at the University of Oklahoma fully intending to provide clinical services to American Indians. As she became aware of the lack of published research addressing American Indians, her focus shifted to a career in academics and research. LaFromboise received her Ph.D. in counseling psychology from the

University of Oklahoma in 1979. She was on the faculty at the University of Nebraska–Lincoln and the University of Wisconsin–Madison before going to Stanford University.

LaFromboise's research topics include interpersonal influence in multicultural counseling, bicultural competence development, and ethnic identity and adolescent health. Her American Indian Life Skills Development is among the promising evidence-based treatments for youth suicide prevention and is used extensively in schools and public health prevention programs. LaFromboise has written extensively about multicultural service delivery. She is currently investigating the effectiveness of a culturally tailored suicide prevention intervention with American Indian youth in school and in home settings. In addition to assessing the impact of this intervention on the reduction of suicidal behavior, LaFromboise is exploring the role of cumulative stress, perceived discrimination, cultural identity, depression, and substance use on suicidal ideation. She teaches seminars titled Adolescent Development and Mentoring in an Urban Context, Racial and Ethnic Identity Development, Social and Emotional Learning in Schools, and Psychology and American Indian Mental Health. LaFromboise's research and published works have gained the respect and notice of academicians worldwide.

In the early 1990s, LaFromboise was appointed to the Office of Technology Assessment Committee to produce the report on adolescent health. Her daughter was an emerging adolescent at the time that LaFromboise served on this committee, which was also examining American Indian adolescent health statistics. During that time she became much



more aware of the issues impacting her daughter's current and future health. With an appointment to the National Research Council on the effectiveness of community-based interventions for youth, LaFromboise moved her research and work toward issues of resilience and positive youth development.

Among the honors LaFromboise has received are the Distinguished Career Contribution to Research Award from the American Psychological Association's Society for the Psychological Study of Ethnic Minority Issues, 2002; U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration Excellence Award, 2005; Effective Practices and Models in Communities of Color: Effective Behavioral Health Interventions for Children, Adolescents, and Families of Color from the First Nations Behavioral Health Association, 2005; and Who Made a Difference from the University of Oklahoma College of Education, 2004.

LaFromboise is currently the chair of Native American Studies at Stanford. She has served as president of the American Psychological Association Division 45: Society for the Psychological Study of Ethnic Minority Issues and on the American Psychological Association Council of Representatives.

Jacqueline S. Gray

**See also** American Indians (v3); Bicultural (v3); Cultural Values (v3); Depression (v2); Discrimination (v3); Discrimination and Oppression (v2); Ethnic Identity (v3); Multicultural Counseling (v3); Physical Health (v2); Resilience (v2); Stress (v2); Stress Management (v2); Substance Abuse and Dependence (v2); Suicide Postvention (v1); Suicide Potential (v2)

## Further Readings

- Bryant, A., Jr., & LaFromboise, T. D. (2005). The racial identity and cultural orientation of Lumbee American Indian high school students. *Cultural Diversity & Ethnic Minority Psychology, 11*(1), 82–89.
- LaFromboise, T. (1996). *American Indian life skills development curriculum*. Madison: University of Wisconsin Press.
- LaFromboise, T. (2006). American Indian youth suicide prevention. *Prevention Researcher, 13*(3), 16–18.
- LaFromboise, T. D., Hoyt, D. R., & Oliver, L. (2006). Family, community, and school influences on resilience among American Indian adolescents in the upper Midwest. *Journal of Community Psychology, 34*(2), 193–209.

Miranda, J., Bernal, G., Lau, A., Kohn, L., Hwang, W. C., & LaFromboise, T. (2005). State of the science on psychosocial interventions for ethnic minorities. *Annual Review of Clinical Psychology, 1*(1), 113–142.

Yoder, K. A., Whitbeck, L. B., Hoyt, D. R., & LaFromboise, T. D. (2006). Suicide ideation among American Indian youths. *Archives of Suicide Research, 10*(2), 177–190.

---

## LATINOS

---

The rapidly growing population of Latinos/as in the United States underscores the profound need for counselors to broaden their clinical treatment approaches to attend to specific culture-related concerns. Latinos/as are faced with a number of social, health, and psychological difficulties that affect their need for mental health services. The negative impact of these life circumstances has made Latinos/as susceptible to a variety of mental health problems. However, because of a number of institutional and cultural barriers to treatment, Latinos/as tend not to make use of available mental health services in U.S. society. To increase utilization and effectiveness of treatment, and decrease early termination, the Latino/a population requires counseling services that will meet their needs in ways that are culturally relevant. The more mental health services reflect the culture of the Latino/a client, the more likely the services will be utilized and effective.

Latinos/as are an ethnically diverse group that includes Mexican Americans, Puerto Ricans, Cubans, Dominicans, and Central and South Americans. The cultural roots of each Latino/a country are a distinct mixture of indigenous, European, and African influences, resulting in differences in cultures for each country and differences in racial makeup of the individuals of that country. As a result of this blending of cultures, the term *Hispanics* has often been rejected by groups who believe the term excludes the indigenous and African influences, while others believe that the term *Hispanics* is a generic term imposed on Latinos/as by the U.S. Census to calculate the numbers of a new population group. Consequently, the term *Latinos/as* rather than *Hispanics* is used in this entry to reflect a more inclusive and politically progressive term. Furthermore, because of the differences in ancestry among and within each country, Latinos/as vary greatly in terms of racial makeup, with a blend of Spanish, Native American, Black, and Asian descent.



Therefore, the term *Latinos/as* emerges not only as an inclusive ethnic term, but also as a term that contains a racial component as well, leading others to claim the term is somewhat ambiguous.

Latinos/as make up the largest racial/ethnic group in the United States, comprising an estimated 37.4 million people, which is equivalent to 13.3% of the U.S. population. Projections for comparative growth rates indicate that the Latino/a population will increase at a rate 3 to 5 times faster than the general population with an estimated 100 million by the year 2050, resulting in one in four Americans identifying themselves as Latino/a. Currently, Mexican Americans comprise the majority of Latinos/as in the United States, followed by Central and South Americans, Puerto Ricans, Cubans, and other Latinos/as. The Latino/a population is geographically concentrated, with 87% residing in 10 states: California, Texas, New Mexico, Colorado, New York, Florida, Illinois, New Jersey, Arizona, and Massachusetts.

Because the Latino/a population is a rapidly growing ethnic group, the need for services to address their mental health concerns is tantamount. Latinos/as face a number of sociocultural, physical, and mental health problems, including immigration and acculturation stress, language barriers, disrespect for their culture, discrimination in employment and education, and poverty. This constellation of negative life circumstances makes Latinos/as vulnerable to mental health problems that require specific psychotherapeutic services.

### **Mental Health Needs of Latinos**

For Latinos/as who immigrate to the United States, immigration can be a source of considerable stress. As a result of being transplanted into a foreign culture and away from the familiarity of his or her own culture, the individual can experience a negative impact on his or her mental health. Moreover, some immigrants arrive in the United States as political refugees with the additional psychological distress of the experiences of war and violence in their native countries. Furthermore, many Latinos/as immigrate to this country without family members, resulting in a lack of a social support network and feelings of loss and guilt for the family members they left behind. Additionally, many Latinos/as settle into poverty-stricken neighborhoods, often with dilapidated housing conditions and high crime rates, where illegal drugs and gangs are

often present. These are persistent stressors that adversely impact the new immigrants.

In addition to the stress associated with relocation to the United States, immigrants may experience stress caused by the cultural conflict between their own culture and the new culture in the United States; this is termed *acculturative stress*. Stress of acculturation is associated with high levels of depression, anxiety, and physical health problems. Furthermore, the differences in the level of acculturation among Latino/a family members may lead to family discord and stress. The school system allows for children to become more quickly acculturated than their parents, resulting in a form of cultural conflict within the family. Parents are often not able to speak English or feel uncomfortable speaking English, a situation that can lead to their children serving as social and legal mediators for them, giving rise to a power imbalance in the relationship between the children and parents. Children who find themselves in the roles of social and legal mediators experience heightened stress and anxiety due to the increased sense of responsibility and authority in these roles.

Another source of stress experienced by Latinos/as that could account for higher incidences of mental health problems is the discrimination and racism they experience as minorities. Discrimination and racism can take the form of denial of services, difficulty on the job, firing from the job, demeaning insults, or more severe events, such as hate crimes and other violence. Psychological distress, reduced self-esteem, feelings of disempowerment, depression, and poorer physical health are cited frequently as psychological and physical consequences of discrimination and racism.

Poverty is yet another source of stress for Latinos/as. Latinos/as are twice as likely to live below the poverty level as the total U.S. population. In 1999, 23% of Latinos/as lived below the poverty level compared with 8% of European Americans. Additionally, 40% of Latino/a children living in the United States live below the poverty level. There is substantial evidence that psychological disorders are most common and severe among the impoverished and lowest socioeconomic classes. Research has indicated that lower-socioeconomic individuals suffer from a mental illness at a rate of 2 to 3 times higher than those in the higher socioeconomic arena. Some of the adverse psychological affects associated with poverty and a lower-socioeconomic stratum include anxiety, depression, low self-esteem, and loneliness.



Some of the contributory factors to the higher rate of poverty among Latinos/as can be attributed to relocating to the United States, lack of educational attainment, discrepancy in occupation, and disparity in occupational pay. Many Latinos/as leave their native country without any financial means on which to live. Additionally, in some cases, they arrive illegally without an ability to get government support or decent-paying jobs. In addition, Latinos/as have the lowest high school and college completion rates (51.3% and 9.7%, respectively) compared with African Americans (66.7% and 11.5%, respectively), Whites (79.9% and 22.2%, respectively), and Asian Americans (81.8% and 39.1%, respectively). As a result of low educational attainment, Latinos/as tend to procure jobs that are lower paying, less stable, and more hazardous. Furthermore, these jobs tend to have no medical or long-term financial benefits. Among the types of occupations procured by Latinos/as, 52% have labor and craft jobs, whereas only 6% are employed in professional or technical occupations. Latinos/as with the same educational level as European Americans earn less in monthly income. Latinos/as with high school diplomas earn an average of \$1,092 per month, whereas European Americans earn \$1,405 per month. Additionally, this inconsistency can also be found in Latinos/as with master's degrees (monthly income of \$2,840) as compared with European Americans with master's degrees (monthly income of \$3,248). As a result of the discrepancy in education, types of occupations, and pay, Latinos/as experience feelings of disempowerment, stress, anxiety, and depression.

Still another area that impacts the needs of mental health services for Latinos/as is the high rates of health-related complications. These health issues may result in a number of negative consequences, such as educational setbacks, unemployment, family problems, and marital discord. Latinas are getting pregnant at a rate of 51% before the age of 20, compared with the national average of 30%. Additionally, Latinas currently have the highest birth rate of all ethnic groups, approximately twice the national average.

Latinos/as are also disproportionately represented among the population in their use of drugs and alcohol. Latino men (31%) have higher rates of alcohol use and dependence than European American men (21%). Furthermore, many substance abuse programs appear to have difficulty recruiting, retaining, and successfully treating minority clients. Consequently, Latinos/as are less likely than other ethnic

groups to seek substance abuse treatment and to complete treatment.

Furthermore, Latinos/as are overrepresented in the diagnosis of human immunodeficiency virus (HIV); Latinos/as account for 17% of adult male cases, 20% of adult female cases, and 27% of pediatric cases. For Latinos/as ages 25 through 44, HIV/AIDS infection is the second leading cause of death.

In summary, as the population of Latinos/as increases, so will their need for mental health services. Latinos/as suffer heightened stress related to acculturation, discrimination, poverty, lower-paying occupations, lack of educational attainment, discrepancy in pay, pregnancy, drug use, and HIV/AIDS. To the extent that stress leads to mental health problems, Latinos/as experience unique situations that generate a greater risk of psychological problems and need for mental health services, creating a necessity to find ways to address Latinos/as' unique mental health needs.

### **Latinos/as and Mental Health Services**

Although there is an evidenced association between Latinos/as' experiences and psychological distress, review of the research indicates that Latinos/as tend not to make use of available mental health services. Latinos/as tend to severely underutilize community outpatient services and university counseling centers and overutilize inpatient services. For instance, Latinos/as were less likely (8.4%) than their European American counterparts (16.8%) to visit a mental health professional, and Latinos/as reported greater delays in receiving psychological services than European Americans (22.7% and 10.7%, respectively). Furthermore, Latinos/as tend to drop out of treatment very quickly, with 50% dropping out after the first session compared with 30% for European Americans. Length of treatment is an important factor in mental health treatment: Findings indicate that the longer clients stay in treatment, the more beneficial the outcomes are.

Researchers have attempted to hypothesize explanations for underutilization of mental health services by Latinos/as. Currently, two different theories have been proposed: the institutional barrier theory and the cultural barrier theory. The institutional barrier theory posits that Latinos/as desire services, but factors inherent in the mental health institutional system pose barriers to utilization. The cultural barrier theory assumes that clients want help, but aspects within



the Latino/a culture hamper them from seeking out mental health services.

The institutional barrier theory pertains to the barriers found within the institution, or in the structural components of the institution, that provides psychological services. These variables include the geographic location of the mental health service center, cost of treatment, schedule of services, and lack of culturally relevant treatments. The location of the organization is a key factor in serving the Latino/a population. To better serve this population, mental health services need to be located within the Latino/a community, near public transportation, or both. Additionally, the monetary cost of the mental health treatment must not cause a financial burden on the family. With many Latinos/as living at or below the poverty level and being unemployed or having lower-paying jobs and less-stable employment, psychological treatment is considered a luxury. Therefore, consideration of finances must be taken into account when offering psychological services. Mental health services should be offered in the evening and weekends because family members may have difficulty taking time off from work. Additionally, requiring clients to come in on a weekly basis may not be feasible for many Latino/a families. Many Latinos/as are not employed in occupations that have benefits that allow for time off, and child care may be an additional financial issue. Lastly, mental health services should include interventions that are culturally relevant to the Latino/a client by considering Latino/a cultural worldview, beliefs, and values. By providing services that reflect the culture of the Latino/a client, the more likely the services will be effective.

### **Culturally Relevant Mental Health Services for Latinos/as**

Latinos/as comprise persons of various ethnic, racial, and national backgrounds, and yet there are many commonalities among them. Many times, Latino/a cultural beliefs and values are antithetical to the beliefs and values that are found within the traditional Western-based psychotherapies, thus requiring counselors to adapt new ways of approaching therapy. Additionally, providing effective services to the Latino/a population requires counselors to assume roles that are at times different from the traditional counselor role. Counselors must also consider the language of the client when providing mental health services. Lastly, counselors need to be

aware of and assess the societal factors impacting the Latino/a client. A therapist's failure to consider these variables can result in early termination and ineffective treatment.

Latinos/as live with a collectivistic worldview in which immediate and extended family, community, and social networks are valued more than the individual and emphasis is on interdependence rather than independence. Traditional psychotherapies share an individualistic worldview, with concentration on the individual and independence in therapy. An intense focus on the individual and independence would be completely foreign to a Latino or Latina client and may cause uneasiness, resulting in early termination and ineffective treatment. In terms of consideration of the collectivistic worldview, a therapist should consider incorporating interdependence as a continued goal and including immediate and extended family members in therapy.

Psychotherapy is not value free, even when the counselor intends to stay neutral. In fact, values play a significant role in counseling, influencing theories of personality and pathology, interventions, goals of treatment, and treatment outcome. As a result, a counselor's value system affects his or her perception of the nature of the client-counselor relationship, as well as the process and outcome of treatment. The client also enters counseling with a value system, which includes beliefs about the appropriateness of counseling, nature of the client-counselor relationship, and expectations for treatment. Therefore, in terms of mental health treatment, if a counselor's value system is opposed to that of the client's value system, then these differences in value system may lead to the counselor labeling a client as "pathological" or "resistant to treatment," and/or the client prematurely terminating treatment and/or receiving treatment that results in ineffective outcomes. Consequently, it would be in the counselor's best interest to work within the value system of the client. When working with a Latino/a client, one would incorporate the following values that are inherent within the Latino/a culture: *familismo*, *simpatia*, *personalismo*, *respeto*, *machismo*, *marianismo*, religiosity, and folk illness beliefs.

*Familismo* is described as a strong attachment of individuals to their families and strong feelings of loyalty, reciprocity, and solidarity. Latinos/as view the family as the single most important reference group, providing influence on decision making, reinforcement of traditional values and patterns, and emotional



security. Culturally relevant therapy would involve asking about family members, including family members in therapy, and interviewing family members. By incorporating the immediate family members in therapy, Latinos/as may be able to work in an environment that most closely relates to their Latino/a values. Additionally, a counselor may also want to include extended family members and kinship ties such as *compadrazgos* (i.e., godparents) in the counseling sessions. In considering the strong attachment to the family, counselors should not focus treatment on independence from the family. In addition, individual family members are seen as a reflection of family functioning. Therefore, any negative personal information discussed is viewed as a reflection of the entire family functioning, and disclosing this information to “outsiders” is unacceptable and offensive. Furthermore, because family members are expected to turn to one another for support, then it may be perceived as an insult to the family if an individual family member relies on an “outsider” for support. When considering the value of familismo in therapy, the counselor needs to be sensitive to the client’s ability to openly disclose to an “outsider.” This uneasiness with disclosure should not be construed as pathological or resistant to treatment.

Latinos/as strongly adhere to the value of *simpatia*, which includes promoting social relationships that are pleasant and without conflict. As a result, there exists a tendency in Latinos/as to avoid interpersonal conflict and emphasize positive behaviors in agreeable situations. However, mainstream psychotherapy places a value on confronting problems, issues, and/or people. Consequently, when working with Latino/a clients, counselors should consider finding ways to approach conflict situations in a more positive way, for example, having the client approach the issue with the individual from a place of concern for the other person rather than an individualized place. Additionally, lack of confrontation or desire to confront by Latino/a clients should not be viewed as pathological.

*Personalismo* is defined as a valuing of connectedness with others and basing these connections on trust. There is a personal bond and sharing that exists in all interpersonal relationships, including professional relationships. However, many Western psychotherapies value a detached professional relationship that may seem foreign to Latinos/as that adhere to the value of close interpersonal relationships. Subsequently, when working with Latino/a clients, therapists should

consider being less detached and using self-disclosure as a means to making the clients feel more comfortable.

The Latino/a value of *respeto* refers to deference afforded to those individuals with higher authority in the relationship, such as parents, elders, and authority figures (e.g., doctors, religious officials, and those with higher education). To the extent that adherence to the value of *respeto* mandates respect and credibility for those that are older and/or have a higher educational level, counselors would be highly respected and considered credible. As a result, a Latino/a client may put more value on, and agree more often with, the counselor’s suggestions or interpretations in session. Therefore, it is advised that counselors be aware of how the relationship may be strongly influenced by their behaviors.

The Hispanic value of *machismo* is used to describe male roles and attitudes, whereas *marianismo* is used to describe female roles and attitudes. These values are significant factors in which Latinos/as develop a sense of identity. Within the value of *machismo*, men are granted considerable freedom, whereas women are much more restricted. Moreover, *machismo* is associated with men having dominance over the affairs of the family and wife, but it also includes courage and protection of the family and wife. This Latino/a value conflicts with the mainstream psychotherapy value of egalitarian relationships; thus, counselors should consider the dominant and protective role of the husband and/or father that may exist when working with a Latino/a individual, couple, or family. Questioning the division of household responsibilities may also help a counselor understand Latino/a gender roles when seeing an individual, couple, or family. In a family that honors Latino/a traditional male and female gender roles, a counselor should consider greeting the male of the family first. In addition, men who adhere to *machismo* often prefer not to demonstrate or admit to any vulnerability or emotion. Consequently, counselors should not stress the expression of vulnerability and emotion when working with Latino clients. The value of *marianismo* pertains to the expectation that women aspire to be like the Virgin Mary by acquiring the characteristics of humbleness, self-sacrifice, and other-centeredness. Furthermore, the value of *marianismo* dictates that women must be willing to endure the suffering that motherhood often requires, live in the shadow of their husbands and children, and support their husbands and children by all means necessary. To work with a Latina client, a counselor needs to be



aware that mothers and wives feel an honor in dedicating themselves completely to their family. A culturally sensitive counselor would not propose self-care to a mother who upholds the Latino/a value of *marianismo*, because self-care would be considered selfish and overindulgent. The recommended way of introducing self-care to a Latina client would be to emphasize that the client would be a better mother and/or wife if she took care of herself. Additionally, a culturally aware counselor should be sensitive to the attitude that some Latina women may feel uncomfortable discussing their own feelings and needs with their spouses or family.

Religiosity plays a significant role in the lives of Latinos/as, including a way of maintaining cultural identity and community connection. For many Latinos/as, social activities center in the church, allowing for social support and feelings of connectedness. Furthermore, the religious official is often a primary confidant to Latino/a patrons. Therefore, a counselor should explore the client's spirituality and connectedness to the church in the assessment process and may consider including the client's religious official as part of a multidisciplinary team in treatment.

Folk illnesses are sets of physical and personal symptoms believed to be caused by supernatural or natural events that are external to the individual. For example, *Mal Puesto* is characterized by severe psychological symptoms, such as hallucinations, mania, and delusions, resulting from a supernatural cause. Furthermore, the belief in folk illness includes a belief in folk healers, such as *Espiritistas* for Puerto Ricans, *Santeros* for Cuban Americans, and *Curanderos* for Mexican Americans. The reason Latinos/as may seek out folk healers may come from the desire to see someone that shares their cultural beliefs about the causes of and cures for mental health problems. This value is also contrary to the mainstream psychotherapy view that psychological problems are seen as residing within the individual and under the control of the individual. Therefore, it might be beneficial for a counselor to consult a spiritual leader, shaman, or medicine man/woman or to include a traditional folk healer reflective of the community culture as part of a multidisciplinary team. Furthermore, some mental health clinics have included traditional activities for their clients, for example, sweat lodges, medicine wheels, talking circles, and so on. Although some Latinos/as may not consult traditional folk healers, they at times continue to subscribe to traditional folk remedies, such as herbs and tonics. A culturally sensitive counselor

working with Latinos/as should be aware and accepting of these traditional supplements and, if experienced, may want to recommend some forms of them.

Another factor to consider when providing culturally relevant services to Latinos/as is the type of counselor role taken by the provider. Western-based therapies are often regimented to a role of providing services in an office setting within a specified treatment session time and getting clients to experience insight and/or catharsis; these may be factors that are irrelevant to the life experiences and needs of many Latinos/as. Some Latino/a clients do not have the financial means or time needed to travel to mental health centers; thus, counselors should consider leaving their offices and venturing into the client's environment—into homes, schools, and community centers and programs. Additionally, by entering the client's environment, counselors will then be better able to understand societal factors impacting their Latino/a clients and reach out to those individuals who are underserved. Counselors should also adjust the time in session to meet the needs of the client, including shorter sessions if the client is unable to attend for the traditional 50 minutes. Lastly, counselors should consider engaging in alternative roles to the traditional insight-oriented psychotherapy role, such as advocate, change agent, consultant, and advisor. For example, in the advocate role, counselors may take an active role in contacting bureaucratic organizations, whereas in the advisor role, counselors may advise their clients as to the possibility of difficulties and conflicts they may encounter as they attempt to adjust and live in their new culture.

Yet another element in providing culturally relevant treatment to Latinos/as is inclusion of culturally linguistic appropriate services. It is believed that words expressed in the bilingual's first language may have richer meanings and allow for easier access to emotions. Therefore, having bilingual Latino/a clients talk about events in Spanish fosters them to experience their emotions more fully, whereas the use of English may allow them to use intellectual defenses that assist in distancing themselves from their emotions. Counselors may want to encourage Latino/a clients to switch between languages depending on the desired level of emotional expression. Even if the counselor is not bilingual, the counselor can be attuned to the nonverbal expression as the client speaks in Spanish, while allowing the Latino/a client to experience an emotional release.



Lastly, counselors need to be aware of the specific societal factors that impact their Latino/a clients. Counselors must make a full assessment of the client's experience of political, social, and economic factors affecting his or her ability to adjust and live in the United States. Mental health service providers should then address these factors in the treatment in terms of prevention and remediation.

In conclusion, the growing Latino/a population will continue to be underserved and ineffectively served if mental health providers continue to base their treatment on Western-based, mainstream psychotherapy. It is essential that mental health providers understand the importance of the role of ethnicity in the psychological treatment of Latino/a clients. Subsequently, it is imperative to adjust traditional Western-based psychotherapy goals of treatment, interventions used in treatment, and treatment outcomes to reflect Latino/a cultural worldview, beliefs, and values. Furthermore, because of the increased risk of mental health problems associated with the political, social, and economic factors uniquely impacting the Latino/a population, it is essential that counselors consider these societal factors and address them accordingly in treatment.

Elizabeth D. Fraga

**See also** Acculturation (v3); Acculturative Stress (v3); Bilingual Counseling (v3); Career Counseling, Immigrants (v4); Career Counseling, Latinos (v4); Collectivism (v3); Communication (v3); Cross-Cultural Psychology (v3); Cross-Cultural Training (v3); Cultural Values (v3); Demographics, United States (v3); Espiritismo (v3); Ethnic Minority (v3); Familismo (v3); Immigrants (v3); Machismo (v3); Marianismo (v3); Multicultural Counseling (v3); Religion/Religious Belief Systems (v3); Spirituality/Religion (v2); Visible Racial/Ethnic Groups (v3)

## Further Readings

- Arredondo, P., & Perez, P. (2003). Counseling paradigms and Latina/o Americans. In F. Harper & J. McFadden (Eds.), *Culture and counseling: New approaches* (pp. 115–132). Boston: Allyn & Bacon.
- Atkinson, D. R., Morten, G., & Sue, D. W. (1998). *Counseling American minorities: A cross cultural perspective* (5th ed.). Dubuque, IA: William C. Brown.
- Burnam, M. A., Hough, R. L., Karno, M., Escobar, J., & Telles, A. (1987). Acculturation and lifetime prevalence of psychiatric disorders among Mexican Americans in Los Angeles. *Journal of Health and Social Behavior*, 28, 89–102.
- Casas, J. M., & Vasquez, M. J. T. (1996). Counseling the Hispanic: A guiding framework for a diverse population. In P. B. Pedersen, J. G. Drugans, W. J. Lonner, & J. E. Trimble (Eds.), *Counseling across cultures* (4th ed., pp. 146–175). Thousand Oaks, CA: Sage.
- Garcia, J. G., & Zea, M. C. (1997). *Psychological interventions and research with Latino populations*. Needham Heights, MA: Allyn & Bacon.
- Fraga, E. D. (2003). *The relationship among perceived client-counselor ethnic similarity, perceived client-counselor Hispanic cultural value similarity, and counseling process and outcome variables*. Unpublished doctoral dissertation, University of California, Santa Barbara.
- Fraga, E. D., Atkinson, D. R., & Wampold, B. E. (2004). Ethnic group preferences for multicultural counseling competencies. *Cultural Diversity & Ethnic Minority Psychology*, 10, 53–65.
- Lopez, S. R., Lopez, A. A., & Fong, K. T. (1991). Mexican-Americans' initial preference for counselors: The role of ethnic factors. *Journal of Counseling Psychology*, 38, 487–496.
- Moore, J., & Panchon, H. (1985). *Hispanics in the United States*. Englewood Cliffs, NJ: Prentice Hall.
- Paniagua, F. A. (1994). *Assessing and treating culturally diverse clients: A practical guide*. Thousand Oaks, CA: Sage.
- Ponterotto, J. G., Casas, J. M., Suzuki, L. A., & Alexander, C. M. (1995). *The handbook of multicultural counseling*. Thousand Oaks, CA: Sage.
- Ramos-Sanchez, L., Atkinson, D. R., & Fraga, E. D. (1999). Mexican Americans' bilingual ability, counselor bilingualism cues, counselor ethnicity, and perceived counselor credibility. *Journal of Counseling Psychology*, 46, 125–131.
- Santiago-Rivera, A. L., Arredondo, P., & Gallardo-Cooper, M. (2002). *Counseling Latinos and la familia: A practical guide*. Thousand Oaks, CA: Sage.
- Sue, D. W., & Sue, D. (1990). *Counseling the culturally different: Theory and practice*. New York: Wiley.
- U.S. Census Bureau. (2002). *Statistical abstract of the United States. The national data book*. Washington, DC: Author.

---

## LEARNED HELPLESSNESS

---

Learned helplessness is a condition that is brought about by repeated exposure to negative stimuli. The result is that the individual learns that there are no options and no possibility for an escape from the negative stimuli. Helplessness exists when an individual's actions have no perceived positive effect on outcomes.



Learned helplessness is when an individual learns the response of resigning oneself passively to aversive conditions rather than taking action to change, escape, or avoid them. This learning occurs through repeated exposure to inescapable or unavoidable aversive events. Research by Martin Seligman has shown that helplessness is prominent in humans and has emotional, cognitive, and motivational consequences. He discovered from his research that prior experience, lack of discriminative control, and the importance of outcomes are three factors that contribute to learned helplessness. The concept has been successful at explaining the response of members of a minority group to the pressures of living in an oppressive cultural milieu.

### **Applications to Understanding Responses to Oppression**

Learned helplessness is an important psychological construct to assist in understanding the experience of a minority member living in an oppressive society. The negative stimuli in this situation are the perpetual onslaughts of the pernicious racism that is present in U.S. culture. It is important to point out that these negative stimuli do not need to be severe (e.g., lynching) to have their effect. It is the omnipresent, repeated exposure to oppression, oftentimes in the form of microaggressions, that can create learned helplessness. The recipient of these repeated assaults eventually comes to accept them and sees no other possible options. Institutionalized racism also influences personal behaviors and decisions made by minorities that lead to learned helplessness. This perceived lack of options makes the current social and economic power structure seem inescapable and unchangeable.

A related concept that contributes to the understanding of the dynamics of racism is the fundamental attribution error. The fundamental attribution, also known as correspondence bias or overattribution effect, is the tendency to explain other people's behavior in dispositional terms, while underemphasizing situational influences. For example, if an African American tells a European American that he or she is unemployed, the European American may view the individual as lazy or unmotivated, ignoring that there may be a high unemployment rate or a lack of economic opportunity for the individual. The sociocultural and economic milieu in which an individual is living may create a state of learned helplessness (the unemployed African American has been denied economic opportunity for so long that he or she may come to

accept it as an immutable condition), yet the outside observer explains this individual's behavior in terms of internal causes, such as pathological personality or lack of moral character.

### **Development of the Concept**

In early 1965, Seligman and his colleagues, while studying the relationship between fear and learning, accidentally discovered an unexpected phenomenon while replicating Ivan Pavlov's classical conditioning experiment. Pavlov's 1905 experiment demonstrated that if a ringing bell or tone is repeatedly paired with a presentation of food, a dog will salivate. Later, upon hearing the ringing of the bell without the food, the dog will salivate. In Seligman's experiment, instead of pairing the tone with food, he paired it with harmless shock. The idea was that after the dog learned to associate the tone with the electrical shock, the dog would feel fear on the presentation of a tone and would then run away or attempt to avoid the shock in some way.

This treatment was carried out for many days, and after this conditioning phase, the same dog was placed, unrestrained, in a large box that had a low fence dividing the box into two sections. Seligman and his colleagues made sure that the dog could see the fence and easily jump over the fence to escape his section any time he wished. They then rang the same bell and expected the dog to jump over the fence because he was conditioned to associate this bell with pain from the electrical shock. Instead, they were surprised that the dog did not move! They then decided to subject the conditioned dog to an electrical shock; again there was no response on the part of the dog. Next, they put an unconditioned dog (one that had never experienced inescapable electrical shock) in the same box. This dog immediately jumped over the fence to the other section as soon as the shock occurred. It seems that the conditioned dog, which was repeatedly subjected to pain, learned that trying to escape from the shocks was useless. In other words, the dog learned to be helpless.

### **Extension of the Concept to Humans**

Seligman and his colleagues started a scientific revolution resulting in more focus on cognitive psychology instead of focusing solely on behavioral psychology. His theory of learned helplessness was extended to human behavior. Through experiments with humans, Donald Hiroto and Seligman determined strong support for the theory that helplessness involved learning that



one did not have control over events. Seligman led other helplessness researchers to reach the conclusion that the helplessness phenomenon, as produced in animal and human laboratories, was similar to certain failures of human adaptation.

Learned helplessness explained a lot of things, but then researchers began to find exceptions of people who did not get depressed, even after many bad life experiences. Seligman discovered that a depressed person thought about the bad event in more pessimistic ways than a nondepressed person. He called this thinking “explanatory style,” borrowing ideas from attribution theory.

Explanatory style is the process by which individuals explain why they are victims to a negative event. There are three components to explanatory style. The first such component is internality. *Internality* refers to the degree with which one feels responsible for the cause of the event or the degree to which one believes that it is someone else’s responsibility. The second characteristic is stability. *Stability* refers to whether the event was a one-time occurrence or whether it will continue indefinitely. The third component of explanatory style is globality. *Globality* refers to the extent of the negative event upon the individual. We can see how an individual from a marginalized group could come to feel a low level of internality (the individual’s situation is molded by external forces over which he or she has no perceived control), a high level of stability (the oppressive components of the culture are embedded into the bedrock of our society and are not going away), and a high degree of globality (racism impacts every aspect of life for the person of color). An event can impact a minor aspect of the individual’s life or affect every aspect.

Symptoms of learned helplessness include lack of motivation, listlessness, cognitive breakdown between actions and outcomes (i.e., inability to link actions to the consequences they bring about or blaming others or external factors for one’s situation, condition, and outcomes), boredom, anxiety, frustration, anger, hopelessness, and depression.

*Gregory Benson, Paul E. Priester,  
and Asma Jana-Masri*

**See also** Action Theory (v4); Career Barriers Inventory (v4); Classism (v3); Client Attitudes and Behaviors (v2); Discrimination (v3); Discrimination and Oppression (v2); Fatalism (v3); Person–Environment Interactions (v2);

Power and Powerlessness (v3); Prejudice (v3); Racial Microaggressions (v3); Racism (v3); White Privilege (v3)

### Further Readings

- Hiroto, D. S., & Seligman, M. E. (1975). Generality of learned helplessness in man. *Journal of Personality and Social Psychology*, 31, 311–327.
- Jones, E. E., & Harris, V. A. (1967). The attribution of attitudes. *Journal of Experimental Social Psychology*, 3, 1–24.
- Seligman, M. E. (1992). *Helplessness: On depression, development, and death*. New York: W. H. Freeman.
- Seligman, M. E. (2006). *Learned optimism: How to change your mind and your life*. New York: Random House.

---

## LEONG, FREDERICK T. L. (1957– )

---

Frederick T. L. Leong is a first-generation Asian American of Chinese descent, who was born and educated in Malaysia. He came to the United States in 1975 on an international student scholarship to study for a B.A. in psychology at Bates College in Lewiston, Maine. He graduated cum laude and Phi Beta Kappa in 1979 with high honors in psychology. His undergraduate honors thesis, “Males’ Responses to Female Competence,” was published in *Sex Roles* in 1983. He was also the founder and first president of the International Student Club at Bates College. After graduating from Bates, he spent some time working as a psychiatric aid at the Institute of Living in Hartford, Connecticut.

Leong went to the University of Maryland, where he completed graduate studies with a double specialty in counseling and industrial/organizational psychology in 1988. His dissertation was titled “Cross-Cultural Epidemiology of Psychological Disorders: A Comparison of Asian-Americans and White Clients in Hawaii’s Mental Health System.” During his graduate studies he was also selected as a Minority Fellow of the Minority Fellowship Program, American Psychological Association, from 1984 to 1986. As part of the doctoral program, he completed a 2-year internship at Dartmouth Medical School in Hanover, New Hampshire, where he focused on psychodynamic psychotherapy. Leong’s academic appointments include the following: (a) instructor and then assistant professor in the Department of Psychology at Southern Illinois University; (b) associate professor,



full professor, and director of training in the Department of Psychology at Ohio State University; (c) full professor and director of the counseling psychology program in the Department of Psychology at the University of Tennessee; and (d) full professor in the Department of Psychology at Michigan State University, where he was hired to lead the Multicultural Initiative and is serving as director of the Center for Multicultural Psychology Research.

Leong has authored or coauthored more than 110 articles and 60 book chapters in psychology. He has coedited 10 books, including *The Psychology Research Handbook: A Guide for Graduate Students and Research Assistants* (1996; second edition 2005, Sage), *Handbook of Racial and Ethnic Minority Psychology* (2003, Sage), *Handbook of Asian American Psychology* (1999; second edition 2006, Sage), and *Suicide Among Racial and Ethnic Groups: Theory, Research, and Practice* (in press, Routledge). He has delivered over 100 presentations at professional meetings and has been invited to lecture, present, or be part of an expert panel at more than 50 events. Leong's other professional contributions and roles include serving on the editorial boards of numerous psychology journals (e.g., *Psychotherapy: Theory, Research, Practice & Training*; *Journal of Counseling Psychology*; *Journal of Career Assessment*; *Cultural Diversity & Ethnic Minority Psychology*; *Journal of Career Development*; *Asian Journal of Social Psychology*; *Asian American & Pacific Islander Journal of Health*; *The Counseling Psychologist*; and *Psychological Assessment*) and being guest editor of numerous special issues of journals on topics that have focused on ethnic, racial, minority, or international issues (e.g., *Career Development Quarterly*, *Journal of Vocational Behavior*, *Psychotherapy: Theory, Research, Practice & Training*, and *Death Studies*). Other editorial positions have included the following: (a) associate editor for International and Cross-Cultural entries in Alan Kazdin's *Encyclopedia of Psychology*, (ii) counseling section editor for Charles Spielberger's *Encyclopedia of Applied Psychology*, and (c) editor for a book series focused on racial and ethnic minority psychology.

Leong is a member of various associations and has been appointed Fellow of the American Psychological Association (APA; Divisions 1, 2, 12, 17, 45, and 52), the Association for Psychological Science, the Asian American Psychological Association, and the International Academy for Intercultural Research. He has

also held various offices in professional associations (e.g., chair of the APA Student Affiliate Group of Division 17, treasurer of the Association for Multicultural Counseling and Development, member of the board of directors for the Asian American Psychological Association, president of the Ohio Association for Multicultural Counseling and Development, president of the Asian American Psychological Association, president (and founder) of the Division of Counseling Psychology (Division 16) for the International Association of Applied Psychology, president of the APA Society for the Psychological Study of Ethnic Minority Issues).

As president of the Asian American Psychological Association (AAPA; 2003–2005), Leong continued to improve the structure and functioning of the association by incorporating the following: (a) Several bylaws were changed, and a new membership category of Fellows was established. This recognized the outstanding and distinguished contributors to the AAPA, some of whom have been recipients of the Lifetime Achievement Award and the Distinguished Contributions Award and those who were past presidents of the Association. The second major bylaw change that was passed involved the formation of the Council of Past Presidents (COPP) that would serve as a consultant and support system for the functioning of the Association. The third bylaw change involved the procedures for the formation of new divisions. Since then, new divisions such as the Division of Students (DoS) and the Division of South Asian Americans (DoSAA) have been formed. (b) Additional initiatives have included the formalization of the Association's Policies and Procedures Manual to ensure continuity between administrations. (c) In addition, the *Handbook of Asian American Psychology* was launched, with several members of the AAPA Executive Committee serving as coeditors (Arpana G. Inman, Angela Ebreo, Lawrence Hsin Yang, Lisa M. Kinoshita, and Michi Fu) and with many members as authors of chapters for the *Handbook*. The editorial team decided to donate the royalties from all future proceeds from the *Handbook* to the Association. (d) Leong also initiated the production and distribution of the association's Digital History Project in an effort to prevent the loss of the association's important documents and historical archives. The Digital History Project involved digitizing all of the documents from the Association's historical archives onto CDs for distribution.

Leong has served on many APA committees (e.g., Committee on Employment and Human Resources,



Committee on International Relations in Psychology; Committee on Psychological Test and Assessment; the Implementation Task Force for the Commission on Ethnic Minority Recruitment, Retention, and Training; and the Advisory Committee of the Minority Fellowship Program). In the summer of 2006 he was elected to the Executive Council of the International Test Commission. Leong also serves on the APA Board of Scientific Affairs.

Leong's service and dedication to the field of psychology has also extended to the international arena. He has participated actively in international congresses of psychology and has been invited to organize numerous symposia at these congresses. Examples of these include the Pacific Science Congress in Beijing (1996), the International Congress of Applied Psychology in Singapore (2002), the International Congress of Psychology in Beijing (2004), and the International Congress of Applied Psychology in Athens (2006). He is also working on organizing a symposium on the intersection between personnel psychology and vocational psychology for the International Congress of Psychology in Berlin in 2008.

Leong has consistently supported the development and advancement of psychology in Asia and on Asian issues. On many occasions he has been invited to serve as a discussant at conferences featuring Asian issues. He has served as an external examiner on doctoral dissertations in Pakistan, Singapore, Hong Kong, Bangladesh, and the United Arab Emirates. He has invested time in teaching and researching in the Asia-Pacific region by undertaking visiting professor appointments at the University of Hawai'i, Chinese University of Hong Kong, and National University of Singapore. Other efforts in this area include the development of journals in Asia. For example, he served on the editorial boards of the *Journal of Psychology in Chinese Societies*, *Asian Journal of Social Psychology*, and *The Asian Psychologist*. He has been involved in several grant-funded projects with Fanny Cheung at the Chinese University of Hong Kong, which has involved regular trips to Asia. While at the Ohio State University, the University of Tennessee, and Michigan State University, Leong has recruited, mentored, and taught numerous international students from Asia and Asian American doctoral students.

Leong has also received numerous awards and nominations. For example, he received the Ralph F. Bardie Memorial Research Award from the American Association for Counseling and Development in 1986.

In 1987 he received the Young Investigator Award at the International Congress on Schizophrenia Research held in Clearwater, Florida; the APA Minority Fellowship Program's Achievement Award for Teaching and Training in 1992; the Distinguished Contributions Award from the Asian American Psychological Association in 1998; and the John Holland Award from the APA Division of Counseling Psychology in 1999. Most recently, he received the APA Award for Distinguished Contributions to the International Advancement of Psychology at the 2007 APA convention in San Francisco for all his international work.

Leong's major research interests center on issues of cross-cultural psychotherapy and mental health, especially with Asians and Asian Americans. His organizational psychology interests involve cultural and personality factors related to career choice, work adjustment, and occupational stress. For the past decade Leong has devoted much time and effort toward internationalizing counseling and clinical psychology through his research, scholarly writing, and professional activities. For instance, Leong has served as the coeditor of the International Forum, a section devoted to advancing international perspectives within *The Counseling Psychologist*, where he has authored some of the pioneering papers recommending the internationalization of the field of psychology. He also served as a member of the APA Committee on International Relations in Psychology.

Arpana Gupta

**See also** Asian American Psychological Association (v3); Asian Americans (v3); Bicultural (v3); Career Counseling, Asian Americans (v4); Cross-Cultural Psychology (v3); Cross-Cultural Training (v3); Discrimination (v3); Discrimination and Oppression (v2); Model Minority Myth (v3); Multicultural Counseling (v3); Multicultural Counseling Competence (v3); Multicultural Psychology (v3); Stereotype (v3); Visible Racial/Ethnic Groups (v3)

### Further Readings

- Leong, F. T. L. (Ed.). (2006). *Handbook of Asian American psychology* (2nd ed.). Thousand Oaks, CA: Sage.
- Leong, F. T. L., & Austin, J. T. (Eds.). (2006). *The psychology research handbook: A guide for graduate students and research assistants*. Thousand Oaks, CA: Sage.
- Leong, F. T. L., & Leach, M. M. (in press). *Suicide among racial and ethnic groups: Theory, research, and practice*. London: Routledge.



---

## LOCUS OF CONTROL

---

Locus of control refers to an individual's overall beliefs regarding whom or what is in control over events that occur in his or her life. People may attribute their chances of success and failure to either external or internal causes. Development of locus of control likely stems from a combination of family background, culture, and past experiences. People with an internal locus of control may come from families that focus on effort and responsibility. On the other hand, those with an external locus of control may come from backgrounds where there is lack of life control. Since the locus of control construct was first introduced, it has undergone considerable explanation, and several theories about locus of control have arisen.

### Types

#### *Internal Locus of Control*

People with an internal locus of control often believe that they are in control of their own destinies and happenings in their lives. People with an internal locus of control likely see a relationship between the effort they put into an endeavor and the outcome. People with an internal locus of control feel that events that happen to them are a result of their own work and effort. The benefit of an internal locus of control is that people feel in control of their life situations and responsible for what happens to them. Thus, they may be likely to work hard in order to do well in educational and vocational areas.

#### *External Locus of Control*

People with an external locus of control are more likely to believe that their fate is determined by chance or outside forces that are beyond their control. People with an external locus of control see environmental causes and situational factors as being more influential than internal ones. These individuals would more often see luck rather than effort as determining whether they succeed or fail. A benefit of this viewpoint is that people with an external locus of control may be better able to cope with failure or trauma because they do not blame themselves for what happens to them. However, an external locus of control may be harmful in that it may lead to feelings of helplessness and loss of personal power.

### Explanation of Construct

#### *Multicultural Considerations*

From a traditional psychological perspective, an internal locus of control is considered indicative of a healthy, adaptive, and self-determined approach to life. An external locus of control would be associated with apathy, passivity, and pathology. It is important to realize that the locus of control construct was developed within the perspective of a Eurocentric worldview. As a result, the construct assumes that individual control and choice are to be highly valued. The assumption that an internal locus of control is to be preferred to an external locus of control assumes that individualism and self-determination are inherently valuable. Thus, the Eurocentric locus of control construct pathologizes worldviews that de-emphasize individual choice and control. Moreover, the Eurocentric conception of locus of control ignores the role that discrimination and oppression play in undermining opportunities and choices of members of marginalized communities.

Cultures with a collectivistic worldview, as found in some African American, Asian, Latino/a, and Native American cultural groups, may value commitment to relationships above individual concerns and identify with a larger social group more so than do individualistic cultures. For example, in some Asian cultural settings, a family and group orientation is valued above individual needs. From this perspective, cooperation with the goals of family or community would be considered more important than self-determination. Members of such a culture may be likely to endorse an external locus of control, since external forces such as family and societal expectations play a prominent role in their lives. Thus, in this context, an external locus of control would indicate not pathology, but rather a socially sanctioned respect for the influence and expectations of family and society.

It is therefore important to recognize the culture-specific perspective inherent in the traditional conceptualization of locus of control, which views internal locus of control as optimal. For individuals who do not identify with the dominant cultural worldview, it may be inappropriate to apply the traditional use of locus of control as an indicator of psychological health, as attributes that are normal and healthy within the dominant cultural context could be considered indicative of pathology in individuals from a nondominant culture.

For marginalized groups, external locus of control may be a result of a realistic perception of limitations



caused by racism, discrimination, or socioeconomic status. For example, for individuals who regularly experience discrimination based on their race, it would be accurate to attribute difficulties they experience to external forces. From the traditional standpoint, such external attributions would indicate a lack of self-determination rather than recognition of discrimination. Consequently, the individual's experience of discrimination would be invalidated, and the external locus of control resulting from such experiences may lead to an assumption of pathology on the part of the individual.

Consideration should be taken when applying locus of control concept to multicultural populations. Locus of control should be understood as a concept that is embedded in a European American cultural worldview, and limitations of applying it with more collectivistic cultures should be recognized. Marginalized individuals might endorse greater levels of external control, not as a result of psychopathology or lack of self-determination, but as a result of actual experiences of discrimination and limitations placed on them by society.

## History

Julian Rotter first described the concept of locus of control in the 1950s. Rotter was viewed as one who was able to bridge the gap between behavioral and cognitive psychology when he developed the locus of control construct. Rotter theorized that behavior was significantly directed by the use of reinforcements, such as punishments and rewards. These punishments and rewards subsequently shaped the way people interpret the results of their own actions. The original locus of control formulation classified generalized beliefs concerning who or what influences things along a bipolar dimension of control between internal and external.

Other theorists, including Hanna Levenson, developed alternative theories of locus of control. Whereas Rotter explains locus of control as being bipolar, Levenson's model asserts that there are three dimensions: internality, chance, and powerful others. Internality is similar to Rotter's internal locus of control, in which people believe that they are in control over events that happen to them. Those who endorse chance would attribute events to luck. And those who consider control to be in the hands of powerful others would attribute events to others who have more power and control. According to Levenson, one can endorse each of these dimensions of locus of control independently and at the same time.

## Related Perspectives

Expectancy, which concerns future events, is a critical aspect of locus of control. Locus of control is grounded in expectancy-value theory, which describes human behavior as determined by the perceived likelihood of an event or outcome occurring and the value placed on that event or outcome. Expectancy-value theory states that if individuals value a particular outcome and believe that taking a certain action will produce that outcome, then they are more likely to take that action.

Self-efficacy is a concept introduced by Albert Bandura and refers to an individual's belief in his or her ability to perform a certain task at a given time. Self-efficacy and locus of control are related; people may believe that they are in control of how some future events turn out, and they may or may not believe in their own ability to perform a certain task. For example, athletes may believe that they have control over how well they perform (internal locus of control), but they may not have the belief that they are capable of putting in the training to succeed (low self-efficacy).

Attributions are explanations that people give to explain why some event has occurred. Like locus of control, attributions can be classified—among other ways—as either internal or external. Attribution theory has been utilized to explain the difference between highly motivated individuals and low achievers. Attribution theory explains high achievers as being willing to take risks to succeed and low achievers as avoiding success because they believe it is based on luck and will not happen again.

*Terri L. Jashinsky and Joshua Scherer*

**See also** Allocentrism (v3); Barriers to Cross-Cultural Counseling (v3); Collectivism (v3); Cross-Cultural Training (v3); Cultural Values (v3); Decision Making (v4); Empowerment (v3); Fatalism (v3); Individualism (v3); Meaning, Creation of (v2); Multiculturalism (v3); Self-Efficacy/Perceived Competence (v2); Self-Esteem (v2); Self-Esteem, Assessment of (v2); Worldview (v3)

## Further Readings

- Lefcourt, H. M. (Ed.). (1981). *Research with the locus of control construct*. New York: Academic Press.
- Lefcourt, H. M. (1982). *Locus of control: Current trends in theory and research*. Hillsdale, NJ: Lawrence Erlbaum.
- Levenson, H. (1974). Activism and powerful others: Distinctions within the concept of internal-external control. *Journal of Personality Assessment*, 38, 377–383.



- Marks, L. I. (1998). Deconstructing locus of control: Implications for practitioners. *Journal of Counseling & Development*, 76(3), 251–260.
- Rotter, J. B. (1966). *Generalized expectancies for internal versus external locus of control of reinforcement*. Washington, DC: American Psychological Association.
- Rotter, J. B. (1982). *The development and applications of social learning theory*. New York: Praeger.
- Sue, D. W., & Sue, D. (2003). *Counseling the culturally diverse: Theory and practice* (4th ed.). New York: Wiley.

## LOSS OF FACE

Loss of face expresses loss of social status, a matter of social ostracism, in Asian collective cultures that esteem fulfilling social obligations. One's face shows to others one's identity and integrity. Thus face is personal *and* interpersonal, individual *and* social, both at once. Face represents social confidence and communal esteem in a person's integrity, social respectability a person deserves, and one's self-respect in meeting obligations, communal, and unwritten. Loss of face is serious, for fulfilling the social requirements is essential to one's status and prestige in a society, and to lose face amounts to being branded "immoral" in public.

Asian individuals develop subtle and intricate communications to maintain face against its "loss," which damages one's social standing. To lose face is to lose social status and prestige, in embarrassment, shame, anger, and self-blame for being ostracized from social intercourse. Loss of face carries intense emotions due to three factors: one's deep shame, the importance of others' opinions, and high values a person holds of the Asian tradition. For example, senior and traditional Asians may feel more disturbed at losing face than young ones do.

Loss of face may be due to oneself, friends, or family members to whom one's reputation is tied, or when someone *else*, whoever it is, violates one's standards and jeopardizes one's reputation. One may lose face in three situations: when one fails to meet social expectations, when others do not treat one with respect that one deserves, and when one's ingroup members fail to fulfill their social roles and responsibilities.

Those who have experienced loss of face may resort to three sorts of behaviors to redress the loss. First, when one has violated social expectations,

*compensation* is taken to restore one's face. Second, when others have violated social expectations to cause one to lose face, one could cut relations with them in *retaliation*. Third, when neither compensatory nor retaliatory actions are feasible or acceptable, one may *defend oneself* by devaluing the opponents or de-emphasizing the seriousness of losing face in "this specific" instance.

Loss of face has relevance to cross-cultural counseling. The implications of loss of face for Asians are subtle, critical, and negative. Asians use the term *loss of face* to express their embarrassment, humiliation, and disappointment. With knowledge about loss of face, cross-cultural practitioners and theorists will better grasp Asian people's emotions related to loss of face.

Moreover, loss of face applies to every culture in which individual dignity counts. People's appropriate comportment to appropriate persons is so essential to human decency and integrity that racial prejudices and personal partiality cause psychological injuries. The seriousness of woes of refugee camps, for example, can be explained as brutal loss of face.

Loss of face is an issue of utmost importance to human mental health, worthy of careful sensitive attention by all counselors in all fields. Counselors do well to watch how Asian people restore the loss of face, to become the fourth Western way (besides the three mentioned earlier), of recovering the loss of face.

Ruth Chao, Heather Knox,  
Francis L. Stevens, and Rebecca Wagner

*See also* Asian Americans (v3); Bicultural (v3); Career Counseling, Asian Americans (v4); Collectivism (v3); Confucianism (v3); Cross-Cultural Psychology (v3); Cross-Cultural Training (v3); Cultural Values (v3); Culture (v3); Filial Piety (v3); Identity (v3); Multicultural Counseling (v3); Social Identity Theory (v3)

## Further Readings

- Bedford, O. A. (2004). The individual experience of guilt and shame in Chinese culture. *Culture and Psychology*, 10, 29–52.
- Ho, D. Y.-F., Fu, W., & Ng, S. M. (2004). Guilt, shame and embarrassment: Revelations of face and self. *Culture and Psychology*, 10, 64–84.
- Kim, J. Y., & Nam, S. H. (1998). The concept and dynamics of face: Implications for organizational behavior in Asia. *Organization Science*, 9, 522–534.



## LOW-CONTEXT COMMUNICATION

Anthropologist Edward T. Hall introduced the construct of low-context communication to describe the degree to which people rely on contextual factors rather than the explicit and transmitted part of the message to derive meaning in communication. In low-context (LC) communication, people attend to the explicit, communicated speech to gather information. LC communicators place less emphasis on the context that surrounds the communication event than on the communication itself. LC communication may be adaptive when transactions occur in dynamic contexts that are rapidly changing. LC communication involves messages that tend to be direct, precise, and open. LC communicators tend to openly exchange information so that they can better predict each other's behaviors. Finally, LC persons may be direct and open about disagreement.

Hall proposed that the nervous system has developed an information-processing mechanism whereby it can effectively cope with the information overload through a culturally determined process called *contexting*. This process posits that individuals need only to select a portion of the total information available in an event to create meaning. The information that is not selected for processing but needed to create meaning is filled in by context. According to Hall, as contexting decreases in a communication event, more information is needed from the explicit code to create meaning.

Culture shapes the contexting process by socializing individuals to organize their past experiences according to a prescribed system of symbolic representations. This pattern of symbolic representations determines the cultural norms, rules, and expectations that guide how people communicate with one another.

LC communication occurs to different degrees in all cultures but may predominate in certain cultures. LC predominance is found in the North American (i.e., U.S.), Australian, German, Swiss, Scandinavian, and other Northern European cultures. Individuals within these cultures tend to compartmentalize their personal and work relationships.

When a client says to the counselor, "You've been really helpful, but I don't think I will need any more counseling," an LC communicator may take the expression at face value and form an impression that the client benefited from counseling and is now ready to terminate. LC may be particularly beneficial in aspects of counseling that place importance on accurate and precise information, such as when conducting risk assessment, recording notes, and reporting diagnostic information to insurance companies.

*Yong S. Park and Bryan S. K. Kim*

**See also** Barriers to Cross-Cultural Counseling (v3); Bilingual Counseling (v3); Bilingualism (v3); Communication (v3); Counseling Skills Training (v2); Cross-Cultural Training (v3); Culture (v3); E-Counseling (v1); High-Context Communication (v3); Meaning, Creation of (v2); Multicultural Counseling (v3); Translation Methods (v3)

### Further Readings

- Gudykunst, W. B., & Ting-Toomey, S. (1988). *Culture and interpersonal communication*. Newbury Park, CA: Sage.
- Hall, E. T. (1976). *Beyond culture*. Garden City, NY: Anchor Press.
- Hall, E. T., & Hall, M. R. (1990). *Understanding cultural differences*. Yarmouth, ME: Intercultural Press.





---

## MACHISMO

---

Historically, the term *machismo* is a derivative of the Spanish word *macho*. Although the term *machismo* is Mexican in origin, the construct of machismo is an international phenomenon. *Macho* is a term that describes a male animal or specific types of tools related to husbandry. The term was translated by European Americans to describe a concept for Latino men and Latino male behavior. Ultimately, the universal term *machismo* came to describe a negative set of hypermasculine behaviors among Latino men. Machismo is countered by the traditional Latino/a standard of femininity, *marianismo* (a construct defined by the Virgin Mary's feminine virtue) and *hembrismo*. *Marianismo* describes women as spiritually superior to men, capable of enduring great suffering, whereas *hembrismo* describes women's strength and perseverance. However, for the Mexican people, and for many Latinos/as, solely viewing machismo from the negative or antisocial derivative of the term is debatable. A more culturally relevant and sensitive perspective includes both positive and negative aspects of the term.

Currently, the one-sided negative historical perspective has been substituted with an expanded, dialectical perspective that assumes a more gender-positive stance without minimizing negative characteristics associated with the term. This dialectical perspective defines *machismo* within a social, political, and cultural context as both progressive and reactionary to the historically and socioeconomic realities of society. As a result of these variables, the masculine

ideology of the term *machismo* is prevalent in the United States and is not solely a characteristic of Latino/a Americans. Studies have shown that next to Latinos/as, White Americans are the second highest ethnic group in their value of traditional masculinity. A significant difference between the masculine construct valued by White Americans and the Latino/a machismo is the social acceptance of these concepts by one group over another. For example, when masculine ideologies such as toughness, competition, and assertiveness are associated with White males, the terms are more socially accepted than when applied to Latino males. Machismo or the idea of masculinity varies within the cultural, social, and economic groups that comprise that society. If machismo is examined from this more expanded perspective, the term becomes more complicated but also prevents the formation of a reductionistic perspective that permeates Western society and assumes that all Latinos/as, and all racial/cultural groups, manifest machismo in similar ways.

Latino/a American machismo has been socially misconstrued as synonymous with negative terminology such as *chauvinism*, *exaggerated aggressiveness*, *emotionally restrictive*, *controlling*, and *homophobic*. While machismo is multidimensional, consisting of both positive and negative elements, the positive elements have been neglected in the Western interpretation. The positive dimensions are, in reality, the most central components of machismo. They include honor, respect, bravery, dignity, and family responsibility. These virtues are of tremendous importance and a source of great strength for the Latino/a community. Examining machismo from this more dialectical



perspective, which includes both the positive and negative aspects, allows for increased flexibility and utility within a therapeutic or counseling setting when working with clients.

A counselor may emphasize these positive values with the Latino/a client—encouraging the client to utilize these resources to facilitate adaptive behaviors and personal growth. In addition, challenges may also arise in counseling a client who values machismo. Potential barriers include the client's discomfort with expressing emotional vulnerability, resistance to disclosure in the counseling setting, and avoidance of counseling altogether. This is troubling because reluctance to discuss personal issues has been shown to result in depression and a limited ability to cope with traumatic life events. Therapeutic encounters such as these may be seen as degrading and antimasculine for men who place emphasis on a traditional machista value system. Additionally, it is debatable whether or not a male therapist is seen as a more viable option for machista men than a female therapist.

Regardless of the client's issue, the culturally responsive counselor must consider each individual client's unique worldview. Machismo, although widely valued by the Latino/a community, varies on an individual and social basis. Likewise, an understanding of machismo can be extended across all cultures to better counsel individuals who value similar ideologies. Cultural responsiveness requires the unbiased knowledge of cultural constructs, such as machismo, as well as the recognition of each individual's uniqueness. With this awareness, a counselor can optimize therapy by watching for potential obstacles and compensating for these challenges with unlimited wealth of individual and cultural strengths.

*Miguel E. Gallardo and Shannon Curry*

*See also* Career Counseling, Latinos (v4); Cross-Cultural Training (v3); Cultural Values (v3); Culture (v3); Latinos (v3); Marianismo (v3)

### Further Readings

- Fragoso, J. M., & Kashubeck, S. (2000). Machismo, gender role conflict, and mental health in Mexican American men. *Psychology of Men & Masculinity*, 1(2), 87–97.
- Gonzalez, R. (Ed.). (1996). *Muy macho: Latino men confront their manhood*. New York: Doubleday Press.

- Torres, J. B., Solberg, S. V., & Carlstrom, A. H. (2002). The myth of sameness among Latino men and their machismo. *American Journal of Orthopsychiatry*, 72(2), 163–181.

---

## MARIANISMO

---

*Marianismo* is a term first proposed in the literature in the 1970s as a way to describe a set of values and norms associated with being a woman in Latin American culture. It was initially conceptualized as a response to the term *machismo*, suggesting that marianismo occurs in the context of machismo. Marianismo generally refers to the cultural expectation that a woman be passive and submissive along with being sexually pure. These traits respond to those prescribed by machismo, which expects a man to be active, aggressive, and sexually experienced.

Marianismo traces its roots to the Spanish colonization of Latin America. One of the biggest legacies of the Spanish conquest was their religious beliefs. Roman Catholicism holds in high regard the figure of *la Virgen María* (Spanish for “the Virgin Mary”). Only the purest of women could be chosen by God to be the mother of His son. Mary lived the ultimate sacrifice in giving herself up to God's will: a life of self-denial, purity (e.g., virginity), and devotion to motherhood that was duly rewarded with eternal salvation and the privilege of giving birth to Jesus.

Marianismo stems from these ideals. The term refers to the expectation that women live as the Virgin Mary did. Women are expected to be submissive to men and meet their every need in a passive and unassertive manner. They are loving, caring, and docile—completely devoted to their roles as wives, mothers, and life bearers. To accomplish this, women must renounce their own needs, acting in a spiritual and immaculate manner.

Marianismo prescribes a set of norms that encourages women to maintain and promote cultural values at their own expense or face public scrutiny as an alternative. Women are held in high regard by others if they have children and are caring mothers. Single mothers and divorcees are frowned upon, as they have acted in a self-serving and egotistical manner by disrespecting the sanctity of matrimony and placing their own needs before those of the family. These values are passed down from generation to generation. Caring mothers teach their young men to be wary of sensual, manipulative, and



possessive girls who see sex for anything other than procreating. (These “bad” women are thought of as loose and deceitful or as whores.)

Marianismo will impact the way counselors work with and conceptualize clients. Help-seeking behavior is discouraged, and women may have a difficult time committing or engaging in therapy. They may present with concerns related to gender-role strain and may be more prone to accept problems as “part of being female.” Gender-inconsistent behaviors (e.g., substance abuse, aggressiveness) may increase a sense of worthlessness. Confrontation is often avoided. Sexuality and other intimate concerns may be brought up with much shame—if at all. Infidelity is tolerated only if it comes from men. Men may also view assertive women as “problematic” and may sabotage self-promotion efforts of women who “argue all the time.” Both men and women may initially see female therapists as caretakers, more capable than male therapists of solving problems in a fair and unselfish manner.

Culturally competent counselors who want to appropriately work with marianismo in therapy will need to increase their level of comfort with, and knowledge of, traditional gender norms. They may need to determine the level of acculturation of their clients to assess how engrained these cultural values are. Interpersonal conflict may surface between men who ascribe to traditional machismo cultural values and women who denounce marianismo (and vice versa). Exploring family relationships will also help counselors to understand the extent to which marianismo values are present. Women may choose male partners haphazardly and may stay in potentially abusive relationships longer for the sake of their children. Marianismo has also been associated with poorer physical and mental health in women.

As the definitions of *marianismo* have developed, so have the terms associated with it. One such term is *hembrismo*. Hembrismo seizes on the more positive traits of marianismo to redefine the role of women in Latin American culture. Aligned with the power that the Virgin Mary demonstrated in helping shape Catholicism by giving birth to Jesus, hembrismo conceptualizes women as strong, proactive players who shape lives—their own as well as those of others. They are morally and spiritually superior to men. They also carry the strength to help keep families together, transmitting norms and cultural values in their roles as single parents, mothers, breadwinners, and heads of households. Hembrismo is therefore not

quite the counterpart or response to machismo that marianismo is but rather an additional and more affirming way to conceptualize Latinas.

Luis A. Rivas

*See also* Acculturation (v3); Career Counseling, Latinos (v4); Colonialism (v3); Cross-Cultural Training (v3); Cultural Values (v3); Culture (v3); Latinos (v3); Machismo (v3); Sexism (v3)

### Further Readings

- Gil, R. M., & Vázquez, C. I. (1996). *The María paradox: How Latinas can merge old world traditions with new world self-esteem*. New York: Putnam.
- Stevens, E. P. (1973). Marianismo: The other face of machismo in Latin America. In A. Pescatello (Ed.), *Female and male in Latin America* (pp. 90–101). Pittsburgh, PA: University of Pittsburgh Press.

---

## MARSELLA, ANTHONY J. (1940– )

---

Anthony J. Marsella, Emeritus Professor of Psychology, University of Hawai‘i, Honolulu, is a pioneer in the study of cultural determinants of psychopathology and therapies. He has also been a major contributor to cross-cultural psychology and global and international psychology. Many of his writings are considered essential reading for students and scholars in psychology, psychiatry, and the social sciences. During his career he has been a leader in the field, challenging the ethnocentricity and inherent cultural and racial biases of Western psychology and psychiatry assumptions and practices. In an article published in 1998, he voiced the need for a new and expanded cross-cultural emphasis in psychology for the global era, calling for psychology to recognize and reconsider its cultural/racial biases and to acknowledge the validity and value of the traditional healing psychologies used in different cultures. In this publication and related publications on internationalizing the psychology curriculum, Marsella proposed changes in the training of psychologists to prepare them to participate in a global era filled with the complex challenges of poverty, war, migration, terrorism, urbanization, and population growth. His more recent writings have focused on these global problems and



proposed solutions, calling for peace and social justice and for better understanding of terrorism through the use of cultural psychology approaches.

Marsella was born in Cleveland, Ohio, on September 12, 1940, into a first- and second-generation Sicilian family that maintained the rich cultural traditions of their ancestral heritage. The large family dinners, gender role distinctions, expressive emotions, the centrality of children, and religious and superstitious practices were part of everyday life. He spoke Sicilian with his grandmother, other relatives, and his stepfather, with whom he had a nurturing caring relationship. Marsella claims that even in these early years he had become acutely aware of the complexities of cultural differences and the power of one's ethnic culture to shape one's identity and worldview. This was especially true when he entered school and encountered the contrasting values and expectations of the dominant culture of the day. His adjustment to school was initially quite difficult, and he, like so many others from immigrant families, often found himself embarrassed about his Sicilian heritage. This was to change later in his life when he began to grasp the nuances and abuses of cultural power, marginalization, and privilege. Indeed, in 2004, in collaboration with Elizabeth Messina, he organized the Italian-American Psychology Assembly, to promote studies and collegiality among psychologists interested in Italian culture and history.

At an early age, the nascent educational and psychological testing program at his school suggested he had exceptional intellectual skills. This was puzzling to his teachers, as his family was essentially poor and uneducated. Thus, how could he speak and write so fluently? Nonetheless, because of his test performance, he soon became a subject for psychometric demonstrations at nearby universities, colleges, and clinics. He remembers the audience's applause and laughter when, at 8 years old, he successfully answered a question about the meaning of the term *apocalypse* in a demonstration session. He never told the audience that he had heard the priest use the term the previous Sunday in a sermon.

During high school years at John Adams High School, a large public inner-city school in Cleveland, Anthony emerged as a school leader (e.g., president of the Student Council and president of the senior class) and also participated in athletics and community activities. His academic and extracurricular record resulted in his selection as Teenager of the Year in 1958 in a

citywide contest sponsored by the *Cleveland Press* leading to a 4-year General Motors Scholarship to Baldwin-Wallace College in Berea, Ohio. It was here that he fell in love with psychology and subsequently graduated with honors in psychology. During his undergraduate years, he was a volunteer at local mental hospitals where he interacted with severely disturbed clients, stimulating a lifelong interest in schizophrenia, mood disorders, and trauma, that subsequently became the topic of his doctoral dissertation in clinical psychology at Pennsylvania State University.

It was at Baldwin-Wallace College that Anthony met his wife of 43 years, Joy Ann Marsella, Professor Emeritus, Department of English, University of Hawai'i. They were married in 1963 and together survived the peregrinations of graduate school, fieldwork, and the development of professional careers.

In 1964, Marsella entered the Ph.D. program in clinical psychology at Pennsylvania State University. It was here that his long interests in cultural variations in behavior were nurtured and sustained as he began to work with George Guthrie, an established cross-cultural psychologist who pioneered studies of Filipino child development. From Penn State, he went on to Worcester State Hospital for his internship. There he was mentored further in cross-cultural studies by Juris Draguns, a notable figure in the field of culture and mental health. Following a Fulbright Research scholar award to the Philippines in 1967, and a stint as field director of a psychiatric epidemiology project in Sarawak, Malaysia, that examined rates of mental disorder among Iban tribes people, he received an appointment as a National Institute of Mental Health Culture and Mental Health Fellow at the University of Hawai'i in 1968.

Marsella remained at the University of Hawai'i, rising to the rank of full professor of psychology until his retirement in 2003. At the University of Hawai'i, he began a career-long research effort studying ethnocultural variations in psychopathology and psychology among Chinese American, Hawaiian American, Filipino American, and Japanese American populations. His publications in these projects called attention to basic differences in the expression and rates of mental illness and in normal patterns of behavior. In a bold study, he explored variations in the sensory patterns and sense uses of different ethnic groups. In 1978, he was appointed the director of the World Health Organization Psychiatric Research Center in Honolulu, one of twelve centers around the world engaged in



international studies of psychosis. It is noteworthy that he was the only psychologist to serve in this capacity across the World Health Organization centers.

Throughout his 35-year career, Marsella supported the fusion of personal and professional goals. He proposed a Transcultural Mental Health Code that calls for professionals and scholars to adopt a total lifestyle characterized by advocacy and a commitment to progressive ideas to advance the field, including the use of factor-analytic stress-resource interactional and ecological models. He also has been pivotal in introducing indigenous terms and concepts into the field to ensure epidemiological accuracy, as well as increasing the use of qualitative methods as a source of insight into the cultural construction of reality. Another major contribution in advancing the field was Marsella's recognition and application of multiple culturally responsive healing principles in therapies rather than adherence to single approaches (e.g., cognitive-behavioral therapy, psychoanalysis). His work in promoting issues in cross-cultural psychology, internationalizing the field, and doing psychological practice and research from a comprehensive framework that incorporates the ecological, social, political, and economic context has been pivotal in advancing the field.

As of 2007, Marsella has published 14 edited volumes, most in the area of cultural and international psychology, and 160 book chapters, journal articles, and technical reports in a wide range of areas, such as depression and disorders across cultures, culture and conflict, culture and mental health, social justice, global psychology, traditional healing, culture and psychopathology, internationalizing mental health, cross-cultural imagery, schizophrenia across cultures, and intercultural relations. He also served as a senior editor for the *Wiley Encyclopedia of Psychology* and the *Oxford-American Psychological Association Encyclopedia of Psychology*. Many of his 96 graduate students went on to become highly published major contributors to cultural and international psychology, including Pamela Hays (Professor, Antioch University), Howard Higginbotham (Professor, Newcastle University, Australia), Hwang Kwang Kuo (Professor, National Taiwan University), Velma Kameoka (Professor, University of Hawai'i), Junko Tanaka-Matsumi (Professor, Gakushuin University, Japan), and Anne Marie Yamada (Professor, University of Southern California). But perhaps more importantly, his graduate students include more than 30 international and ethnic minority students. Marsella

now lives in Atlanta, Georgia, where he continues to write and lecture and also to cook, read, travel, and ponder the vicissitudes of life.

*Fred Bemak*

**See also** Bicultural (v3); Counseling Skills Training (v2); Cross-Cultural Psychology (v3); Cultural Values (v3); Multicultural Counseling (v3); Multiculturalism (v3); Multicultural Psychology (v3); Poverty (v3); Social Justice (v3)

### Further Readings

- Carr, S. C., Marsella, A. J., & Purcell, I. P. (2002). Researching intercultural relations: Towards a middle way? *Asian Psychologist*, 3, 58–64.
- Marsella, A. J. (1998). Toward a "global-community psychology": Meeting the needs of a changing world. *American Psychologist*, 53, 1282–1291.
- Marsella, A. J. (2006). Justice in a global age: Becoming counselors to the world. *Counseling Psychology Quarterly*, 19, 121–132.
- Marsella, A. J., & Pedersen, P. (2004). Internationalizing the counseling psychology curriculum: Toward new values, competencies, and directions. *Counseling Psychology Quarterly*, 17, 413–423.
- Marsella, A. J., & Quijano, W. Y. (1974). A comparison of vividness of mental imagery across different sensory modalities in Filipinos and Caucasian-Americans. *Journal of Cross-Cultural Psychology*, 5, 451–464.
- Marsella, A. J., & Yamada, A. M. (2002). Culture and mental health: An introduction and overview of foundations, concepts and issues. In I. Cuéllar & F. A. Paniagua (Eds.), *Handbook of multicultural mental health: Assessment and treatment of diverse populations* (pp. 3–24). San Diego, CA: Academic Press.
- Moghaddam, F. M., & Marsella, A. J. (Eds.). (2004). *Understanding terrorism: Psychosocial roots, consequences, and interventions*. Washington, DC: American Psychological Association.
- Shizuru, L. S., & Marsella, A. J. (1981). The sensory processes of Japanese-American and Caucasian-American students. *Journal of Social Psychology*, 114, 147–158.

---

## MODEL MINORITY MYTH

---

The model minority myth refers to a set of stereotypes that are composed of several positive qualities purportedly unique to all Asian Americans. Asian Americans



represent a very diverse population in the United States, with approximately 29 distinct ethnic groups differing in languages, religions, and customs. However, the model minority myth tends to generalize more toward East and Southeast relative to all Asian American groups. The model minority myth generally characterizes this group as intelligent, academically conscientious, educationally achieving, skilled in math and science, respectful, obedient, well-behaved, well-assimilated, self-disciplined, serious, hardworking, affluent, and professionally successful, particularly in business, science, and technology.

### History of Asian American Stereotypes

Although the current and most common stereotype of Asian Americans that exists in the United States is the model minority myth, stereotypes about this population have evolved through numerous changes since the first wave of Asian immigrants in the mid-1800s. These stereotyped images have included the “pollutant,” the “coolie” (i.e., an unskilled Asian laborer), the “deviant,” the “yellow peril,” the “gook” (i.e., used to describe North Vietnamese soldiers during the Vietnam War), as well as the model minority.

Political and economic issues have largely influenced the evolution of Asian American stereotypes. Asian immigrants were often portrayed in the media as the pollutant, coolie, and deviant during the 1800s and 1900s. These Asian stereotypes originally evolved from White Americans’ feelings of threat and invasion by Chinese immigrants during the unstable and depressed economy between the 1870s and 1890s. Because of their willingness to work for lower wages, Chinese immigrants were used as scapegoats, often facing attacks for sending money made in the United States back to their families in China and becoming work competitors with small American farmers and workers. Eventually, the *yellow peril* terminology was coined by journalists to warn White Americans that the Chinese and Japanese were going to take over the United States and destroy their civilization; thus, the press depicted Asians as irrational, dark, and inassimilable.

The yellow peril stereotype was extended to other Asian groups as the wars with Japan, Korea, and Vietnam evolved. At the same time, the restrictions on the immigration of Asian women and the bans on miscegenation contributed to the image of “asexual” Asian men. Therefore, Asian men were often depicted as either hypermasculine and dangerous or as impotent

and sexually undesirable in popular fiction and movies. During the wars, the use of comfort women by the Japanese military in Asia contributed to the stereotypes of Asian women as exotic and promiscuous. The U.S. media also sexualized Asian women and depicted them as submissive, quiet, mysterious, or untrustworthy. Asian women also were portrayed to fall in love with White men rather than Asian men.

During the civil rights movement and Black Power movement in the 1960s, and possibly in reaction to these movements, the model minority stereotype first appeared in popular media in *U.S. News and World Report* in 1966; this was followed by similar articles in *Newsweek* in 1984 and *Time* magazine in 1987. Asian Americans were described as a racial minority group that had overcome hardship and discrimination through hard work and determination and were, therefore, set as an example for other ethnic minority groups to follow. Many have argued that the characterization of Asian Americans as a model minority was developed as a political propaganda against other racial minority groups by creating a racial triangulation between White Americans, Asian Americans, and African Americans, such that Asian Americans are triangulated as alien to White Americans but superior to African Americans. More specifically, it was used to place the blame of racism and social inequality in the United States onto the minorities themselves, suggesting that African Americans and Latinos/as did not have the intelligence or discipline for success that Asian Americans possessed and that other minority groups should try to be as well-behaved and obedient as Asian Americans. This marked the beginning of the model minority myth that would come to dominate the image of Asian Americans in the United States.

### The Model Minority Myth Today

An abundance of evidence suggests that the model minority myth is still alive and well today. For example, current media primarily depict Asian Americans as successful, affluent, intelligent, wise, technologically skilled, industrious, altruistic, and highly driven to achieve academic excellence and professional accomplishments. Research has demonstrated that White American students hold the model minority myth about Asian Americans, such as perceiving Asian Americans as being more successful in technical careers than social careers and characterizing Asian Americans as hardworking, intelligent, self-controlled, cautious,



obedient, and being loyal and committed to family. Also, studies have shown that the model minority myth has been accepted by other ethnic and racial groups and internalized by Asian Americans.

Although the model minority myth often emphasizes positive stereotyped traits, it is important to note that some negative stereotypes have continued to exist about Asian Americans. For example, stereotypes that describe Asian Americans as quiet, shy, and overly compliant remain commonplace. Women of Asian descent continue to be depicted as exotic and subservient, whereas Asian men are often portrayed as asexual, submissive, and nerdy.

### **Impact on Asian American Populations**

The prevalence of the model minority myth, as well as its acceptance in U.S. society, has raised some concerns about the influence of these racial stereotypes on Asian Americans. Specifically, demographic profiles seem to suggest that Asian Americans have greater purchasing power, obtain higher education degrees, have higher standardized test scores, earn a greater median income, own more homes, and save more earnings than other ethnic groups in the United States. Although these demographic profiles continue to fuel the model minority myth, a closer examination of these statistics demonstrates that Asian Americans receive lower incomes given their higher levels of education. Also, studies have found that Asian American college students are not as academically successful (i.e., having a lower grade point average, higher dropout rates due to medical reasons, greater risk of academic probation, and lower placement on the Dean's list) as the stereotype would suggest when compared with their White counterparts. Furthermore, Asians who are high academic achievers and seem to fit the model minority myth actually consist of a very selective sample (i.e., some but not all Asian Indians, Chinese, Taiwanese, Korean, and Japanese), while many of the underprivileged and less-successful Asian groups (i.e., Cambodian, Indonesian, Malaysian, and Hmong) are often neglected. This bias is also reflected in the media portrayal of model minority Asian Americans, with East Asian Americans most visibly displayed in U.S. advertisements, South and Southeast Asian Americans less visibly displayed, and several other Asian groups almost never portrayed in the media (i.e., Afghans,

Bangladeshis, Pakistanis, Malaysians, and Indonesians). Although the model minority myth may describe some Asian Americans, existing evidence suggests that this stereotype certainly does not accurately represent all Asian Americans, and within-group differences (e.g., ethnicity, socioeconomic status) are often ignored.

In addition, recent research has demonstrated that the highly positive generalizations of the model minority myth may have negative implications. For example, Asian Americans have commonly been excluded from universities' affirmative action policies because of the misperception that, unlike other ethnic minority groups, Asian Americans will succeed academically without any additional assistance. Research has focused on the negative impact of the model minority myth and on the popular stereotype that Asian American students do not need academic or personal help and are more psychologically adjusted than other groups. The underutilization of mental health services by Asian Americans, in general, also led to the erred belief that Asian Americans do not need psychological services, which has contributed to the lack of attention to the physical and mental health of Asian Americans and a dearth of culturally sensitive services for this population. In fact, preliminary research suggests that the additional pressure to maintain and live up to the model minority image may contribute to negative psychological adjustment for Asian Americans (e.g., depression), especially given Asian parents' awareness of their minority status in the United States and fear of downward mobility, as well as the cultural value placed on education by Asian American families. In particular, Asian Americans who may not have the talent or motivation for a career in mathematics or sciences may suffer from stress and feelings of inadequacy and failure.

### **Future Directions**

Because the model minority myth is generally used to portray select Asian American groups, future research needs to be conducted to identify the needs of less-visible Asian American groups. Results from such research can help better identify Asian American groups that may be in need of, and benefit from, affirmative action and other forms of academic and emotional support on U.S. colleges and universities campuses. More qualitative research should also be conducted to better understand the differential impact



that the model minority myth may have across various Asian American groups. Furthermore, more research is needed to explore and determine the effects that internalizing the model minority myth may have on Asian Americans' career choices, experiences of academic pressure and stress, and physical and psychological health. This type of knowledge may be particularly helpful not only for college administrators who are concerned about the success and well-being of their student body, but also for mental health professionals in better understanding the experiences of Asian American clients and identifying more culturally relevant resources. As Asian Americans tend to underutilize psychological services, university counseling centers need to develop more culturally appropriate outreach interventions for Asian American students to reduce the stigma of seeking counseling and provide culturally sensitive counseling services to better meet the needs of Asian American students. Counselors working with Asian American clients should examine their own stereotypes against, and assumptions about, Asian Americans; evaluate the impact of the model minority myth and internalizations of these stereotypes on clients' career development; and assess potential anxiety and stress related to expectations or pressures of maintaining the model minority image.

*Yu-Wei Wang and Frances C. Shen*

**See also** Academic Achievement (v2); Asian Americans (v3); Bias (v3); Career Counseling, Asian Americans (v4); Cultural Paranoia (v3); Identity (v3); Multicultural Counseling Competence (v3); Racism (v3); School Counseling (v1); Social Discrimination (v4); Stereotype (v3)

## Further Readings

- Espiritu, Y. L. (1997). *Asian American women and men: Labors, laws, and love*. Thousand Oaks, CA: Sage.
- Kawai, Y. (2005). Stereotyping Asian Americans: The dialectic of the model minority and the yellow peril. *The Howard Journal of Communications*, 16, 109–130.
- Lee, S. J. (1994). Behind the model-minority stereotype: Voices of high- and low-achieving Asian American students. *Anthropology & Education Quarterly*, 25, 413–429.
- Success story of one minority group. (1966, December). *U.S. News & World Report*, 61, 73–76.
- Sue, S., & Kitano, H. H. (1973). Stereotypes as a measure of success. *Journal of Social Issues*, 29, 83–98.

Toupin, E., & Son, L. (1991). Preliminary findings on Asian Americans: The model minority in a small private east coast college. *Journal of Cross-Cultural Psychology*, 22, 403–417.

Yee, A. H. (1992). Asians as stereotypes and students: Misperceptions that persist. *Educational Psychology Review*, 4, 95–132.

---

## MONOCULTURAL

---

The term *monocultural* is used in several fields to refer to a single homogeneous culture that de-emphasizes diversity. In the United States, a Western or White hegemonic culture has been emphasized. Under this monocultural perspective, dominant American cultural values, expectations, behaviors, and definitions are presumed to be superior to values of other cultures. Thus, to the degree that minority groups internalize the monocultural worldview of the dominant group (i.e., assimilate), those groups come to see themselves through the perspective of the dominant group.

In counseling psychology, the dominant monoculture used to describe the processes of individual and group counseling has been that of a European American perspective. Underlying this Eurocentric ideology is the assumption that people from minority and marginalized groups ought to assimilate their behaviors, attitudes, beliefs, values, language, and perceptions to the dominant's group culture (i.e., European Americans) in order to attain uniformity and unity. Implied in this paradigm is that there is something inadequate about the minority groups' culture and behavior.

As a field, counseling psychology was shaped by this Eurocentric paradigm, which assumes that existing Eurocentric theories are generalizable despite differences among groups. In fact, all traditional counseling theories, assessments, diagnoses, and treatments are embedded in the Eurocentric paradigm. Hence, the training of counseling psychologist historically was rooted in this same paradigm. Based on their training and the dominant practices of the field, counseling psychologists were likely to ignore alternate interpretations of reality and culturally grounded healing methods that might be utilized by different cultural or racial groups. This oversight—and the adherence to the Eurocentric ideology—has resulted in the misdiagnosis, mistreatment, and victimization of persons from minority and marginalized



groups who have sought psychological help. Furthermore, the inaccuracies and mistruths about minority and marginalized groups perpetrated by the unquestioned use of the Eurocentric paradigm have created a stigma toward psychological help within these communities, resulting in their underutilization of psychological services (even in the face of great need).

Monocultural views have been challenged for their exclusionary principles by those who want to include and value the experiences of human diversity. Specifically, the ideology of multiculturalism shifts the perspective to illuminating the experiences and voices of all human beings by focusing on issues of race, ethnicity, sexual orientation, age, gender, education, religion, disability, and socioeconomic status. Multiculturalism challenges the implicit assumptions of Eurocentric bias embedded in dominant monoculture. Hegemony and assimilation are rejected; instead, the various cultures, traditions, and values of different groups in the United States are celebrated and valued.

For years, multiculturalists have affirmed the need to diversify psychology. Issues of justice, fairness, and ethical practice, for instance, have been at the back-drop of multicultural counseling. Most importantly, multicultural counseling advocates use culturally appropriate and sensitive theories, assessment, and treatment modalities in hopes of increased utilization of psychological services and positive counseling outcomes for persons from minority and marginalized groups. Currently, the progressive development of multicultural competence is becoming the model to guide practitioners, researchers, and educators and is changing the face of the counseling psychology field. Several efforts—including the creation of multicultural guidelines for education, teaching, research, and practice for psychologists and the infusion of multicultural courses into programs and departments—reflect the transformation of psychology. The field has expanded its view of what it means to be a competent practitioner in today's heterogeneous American society. In making the necessary transition from a monocultural to a multicultural paradigm, the field recognizes the need to improve training, research, and practice.

*Brenda X. Mejia and Rachel L. Navarro*

**See also** Assimilation (v3); Bicultural (v3); Cross-Cultural Training (v3); Cultural Encapsulation (v3); Cultural Values (v3); Culture (v3); Deficit Hypothesis (v3);

Ethnocentrism (v3); Eurocentrism (v3); Multicultural Career Assessment Models (v4); Multicultural Counseling Competence (v3); Multiculturalism (v3); Worldview (v3)

### Further Readings

- Constantine, M. G., & Sue, D. W. (2005). *Strategies for building multicultural competence in mental health and educational settings*. Hoboken, NJ: Wiley.
- Kramer, E. M. (2003). *The emerging monoculture: Assimilation and the "model minority."* Westport, CT: Praeger.
- Mio, J. S., Barker-Hackett, L., & Tumambing, J. (2005). *Multicultural psychology: Understanding diversity in America*. Boston: McGraw-Hill.
- Schlesinger, A. (1998). *The disuniting of America: Reflections on a multicultural society*. New York: W. W. Norton.

---

## MULTICULTURAL COUNSELING

---

Multicultural counseling is one of the major theoretical forces in psychology. It emerged as a necessary backlash to traditional psychological theories that assumed that Eurocentric/White and middle-class values are societal norms. Competence in multicultural counseling is crucial in societies with multiple representations of cultural groups whose social power and privilege statuses are differentiated based on visible (e.g., race, gender) and invisible (e.g., homosexual/bisexual/transgendered orientation, language) attributes.

### Minority Worldviews, Therapist Biases, and Relationship Dynamics

Multicultural counseling is best understood in relation to competence guidelines published and enforced by professional counseling and psychology associations in multicultural countries (e.g., United States). A tripartite model presented by Derald Wing Sue and his colleagues in 1992 provided a conceptual basis to delineate three key components of multicultural counseling competency: (1) knowledge of cultural minority groups, (2) awareness of therapist's own worldview and cultural biases, and (3) application of culturally appropriate skills to intervene with client's presenting concerns as well as therapist biases.



## Cultural Knowledge

In the past, multicultural counseling has focused on knowledge of cultural characteristics (e.g., Asians are collectivistic) and culture-specific tactics purported to be preferred by minority clients (e.g., Asians prefer a directive counseling approach). Stanley Sue and Nolan Zane have argued that knowledge of this kind, however, is distal to positive treatment goals as it perpetuates cultural stereotypes and ignores the individual differences within the respective minority groups. What is more important is therapist knowledge of the within-group differences in minority clients' cultural identity development. Some minority group members aspire to or internalize majority values, some embrace their cultural roots and reject the majority culture, and some attempt to appreciate and integrate both majority culture and cultural roots toward developing a bicultural identity. Theories of racial identity development, including the work of Janet E. Helms and her colleagues, and lesbian/gay/bisexual identity development, including the work of Reynolds and Hanjorgiris, have delineated the identity confusion and conflicts between self-acceptance and self-rejection among cultural minorities during the process of developing awareness of and confronting oppression and marginalization. As such, multicultural counseling competence entails therapist empathic understanding of the catalytic impact of majority oppression on the identity development and coping of minority clients.

Recognizing that both clients and therapists are products of cultural socialization that assigns them a majority or minority status, multicultural counseling emphasizes therapist knowledge of how cultural upbringing and ascribed status shaped their own worldview. Along with micro-knowledge of cultural group characteristics and macro-knowledge of societal forces that perpetuate and exacerbate client's counseling concerns, multicultural counseling emphasizes therapists' knowledge of their own attitudes and biases toward other cultural groups, especially therapists who are members of the majority group. Rather than developed through the lens of a single theorist, multicultural counseling is rooted in a culture-centered tradition, recognizing the therapists and the mainstream theoretical approaches they are trained to use are also culture bound. In a multicultural counseling relationship, therapist credibility is reflected by competence to discern and curb the therapist's own biases that may result in discriminatory, oppressive, or

racist practice throughout the assessment, diagnostic, and intervention process.

## Minority Group

Multicultural counseling is concerned with the psychological development and psychosocial (mal)adjustment of clients who are ascribed a power-disadvantaged societal status due to their cultural group membership. Regardless of their numerical representation in a given society, these cultural groups are considered minorities in sociopolitical power. Consequently, they are subjected to experiences of discrimination, racism, or oppression. Multicultural counseling literature has focused on women, non-White Americans in predominantly White societies (e.g., Asians, Blacks, Latino/as in the United States), and people with homosexual/bisexual/transgendered orientations.

## Majority Group

Of equal if not more significance, multicultural counseling examines and delineates the psychosocial impact of oppression caused by people who internalized the power afforded by virtue of their cultural group membership. These people represent the majority group as the imbued sociopolitical power enables them to maintain and consolidate their privileged status at the expense of other minority groups. Sexism, racism, and heterosexism have been associated with the majority groups of men, Whites (e.g., White Americans), and heterosexual people in multicultural societies.

## Counseling Process and Intervention

To address the common problems of premature termination and attrition by minority clients in psychotherapy, therapist competence to establish credibility is considered essential to positive treatment outcome. *Credibility* refers to the client's perception of the therapist as effective and trustworthy. Minority clients' underutilization of and attrition from psychotherapy have been attributed to their perception that psychotherapy is a tool to conform them to the majority worldview. In other words, therapists and psychotherapy lose credibility when minority clients do not have trust and faith that their counseling concerns will be understood from their cultural belief system. Therapist credibility can be ascribed, achieved, or both. *Ascribed credibility* refers to the position or status assigned to



the therapist by the minority client. Therapist race, gender, and age are some of the determining factors. Such status may be afforded independently of the therapist skills. For example, a Black client who had repeated experiences with White racism may ascribe low credibility to a White therapist. A female therapist may be perceived as more credible than a male therapist by a female client who is a victim of rape. Regardless of the therapist skills, ascribed credibility is somewhat beyond the therapist's control. *Achieved credibility* refers more directly to skills demonstrated during the therapeutic encounter. Credibility is achieved when therapist actions lead a skeptical and guarded client to trust the therapist and stay in counseling. Achieved credibility is related to therapist skills to offer conceptualization that is congruent with the minority client's belief system, as well as provide intervention strategies that are appropriate and acceptable within the client's cultural system.

In a cross-cultural dyad, a minority client may ascribe initial credibility based on a particular therapist attribute (e.g., racial match in which a Black client believes a Black therapist would understand experiences of racism). Yet when a therapist fails to consider the client's cultural system and minority status (e.g., a Black therapist who denies existence of societal racism) in the assessment, conceptualization, and intervention process, the therapist loses achieved credibility. Despite the initial ascribed credibility, low achieved credibility may result in client distrust of the therapist, nondisclosing behaviors, and attrition from therapy. On the other hand, a minority client may ascribe low credibility due to a particular therapist status attribute (e.g., cross-racial dyad in which therapist race triggers client's feelings of racism). Yet, therapist ability to depersonalize, contextualize, and empathize with the client's initial guardedness and skepticism may enhance the therapist's achieved credibility, thereby decreasing client defensiveness and facilitating client retention in therapy.

Beyond credibility, social justice is the ultimate concern for which therapists and the profession of psychotherapy enable and empower minority clients. Multicultural counseling, therefore, focuses on therapist knowledge of the intricate factors that facilitate and impede the counseling relationship and dynamics between a therapist and client from different cultural groups.

In clinical practice, multicultural counseling positions and conceptualizes clients' presenting concerns within the context of societal discrimination, racism, or

oppression. It seeks to help clients whose counseling concerns are rooted in their minority status to re-attribute sources of distress to contextual rather than personal causes. In training and supervision, multicultural counseling delineates and analyzes if the power differential due to counselor and client's majority-minority group statuses adversely affects the quality of the therapeutic relationship, such as premature termination or conforming minority clients to majority values. As such, effective intervention focuses not only on the minority client, but also on the therapist cultural biases, as well as the interplay of majority-minority values in the therapeutic relationship. Recognizing the catalytic impact of majority oppression, multicultural counseling intervenes at both the individual and the systemic level. Beyond individual psychotherapy, multicultural counseling engages in advocacy for, and empowerment of, minority clients to achieve social justice.

In sum, multicultural counseling entails therapist competence in the following three domains: (1) empathic knowledge of the impact of societal oppression on the identity development and conflicts of clients who are ascribed a minority status by virtue of cultural characteristics, (2) recognition and confrontation of the therapist's own cultural biases and internalized worldview of the majority group, and (3) skill to discern and apply cultural knowledge to instill trust and credibility in the cross-cultural therapeutic relationship. Beyond individual psychotherapy, therapists also intervene in social advocacy and empowerment of minority clients for the cause.

*Kwong-Liem Karl Kwan*

**See also** Acculturative Stress (v3); Barriers to Cross-Cultural Counseling (v3); Bilingual Counseling (v3); Cross-Cultural Psychology (v3); Cultural Accommodation and Negotiation (v3); Discrimination (v3); Ethnocentrism (v3); Eurocentrism (v3); Multicultural Counseling Competence (v3); Multiculturalism (v3); Multicultural Psychology (v3); Oppression (v3); Social Justice (v3); Sue, Derald Wing: Contributions to Multicultural Psychology and Counseling (v3); Therapist Techniques/Behaviors (v2)

### Further Readings

American Psychological Association. (2002). *Guidelines on multicultural education, training, research, practice, and organizational change for psychologists*. Washington, DC: Author.



- Helms, J. E., & Cook, D. A. (1999). *Using race and culture in counseling and psychotherapy: Theory and process*. Needham, MA: Allyn & Bacon.
- Reynolds, A. L., & Hanjorgiris, W. F. (1999). Coming out: Lesbian, gay, and bisexual identity development. In R. M. Perez, K. A. Debord, & K. J. Bieschke (Eds.), *Handbook of counseling and psychotherapy with lesbian, gay, and bisexual clients* (pp. 35–56). Washington, DC: American Psychological Association.
- Sue, D. W., Arredondo, P., & McDavis, R. J. (1992). Multicultural counseling competencies and standards: A call to the profession. *Journal of Counseling & Development*, 70, 477–483.
- Sue, S., & Zane, N. (1987). The role of culture and cultural techniques in psychotherapy: A critique and reformulation. *American Psychologist*, 42, 37–45.

---

## MULTICULTURAL COUNSELING COMPETENCE

---

Multicultural counseling competence—the intentional consideration and utilization of culture to facilitate therapeutic change—has become one of the most critical forces guiding the discipline of counseling psychology. In response to both the diversifying of the population of the United States and the civil rights, women’s rights, and gay and lesbian rights movements of the 1960s and 1970s, pioneers in the counseling profession instigated changes in their theories and practices. One of the enduring changes is the profession’s deploring of racist, ethnocentric, sexist, and heterosexist practices, which were found to be ubiquitous in the mental health system. Although the deplorable practices sometimes were unintentionally motivated, the consequences for consumers, nevertheless, were deleterious. Among the more formidable initiatives were attempts to make counseling more accessible to members of disenfranchised groups and also the development of new competencies to shape and guide counseling practice.

Counseling psychologists, led by visionaries such as Derald Wing Sue, Patricia Arredondo, Stanley Sue, William Cross, Joseph Ponterotto, Janet Helms, Gargi Roysircar, Teresa LaFromboise, Michael D’Andrea, Thomas Parham, Paul Pedersen, Allen Ivey, Donald Atkinson, Madonna Constantine, Donald Pope-Davis, Hardin Coleman, and others, drew formal critiques of a mental health system that had been steeped in racist

practices for nearly a century. The findings and conclusions of their careful analyses were disturbing. Traditional theories of counseling and psychotherapy were developed primarily by European White middle-class men without consideration of the cultural zeitgeist in which their theories were rooted. Training followed from these theories and reinforced European ideas about normalcy and pathology. Racial and ethnic minority clients often were underserved, more likely provided with substandard care from inexperienced therapists, and more likely to terminate prematurely than were White clients. A call for systemic-wide change was heeded.

D. W. Sue and his colleagues have been among the most influential counseling psychologists to respond to the call for change. In 1982 the team of scholars published a groundbreaking article titled “Position Paper: Cross-Cultural Counseling Competencies.” The position paper provided a general description of three competencies: attitudes and beliefs, knowledge, and skills. Attitudes and beliefs pertain to counselors’ self-awareness as cultural beings and their sensitivity to, and respect of, cultural differences with their clients. Knowledge is having a good understanding of sociopolitical systems, particular client populations, generic characteristics of counseling, and institutional barriers for minority clients. A broad range of skills are deemed necessary, covering verbal and nonverbal communications and also institutional interventions. In 1992 D. W. Sue and another group of scholars expanded on the tripartite model in an article titled “Multicultural Counseling Competencies/Standards: A Call to the Profession.” Intending to provide a new lens through which counseling could be conceptualized and practiced, the Standards offered important initial perspectives for the field. The Standards were organized in a 3 (characteristics) × 3 (dimensions) matrix format in which the characteristics (i.e., counselor awareness of own assumptions, values, and biases) were each grounded along the three dimensions of beliefs and attitudes, knowledge, and skills. The Standards implored counselors to develop a more nuanced understanding of their own cultural identities, as well as those of their clients, and to best use this understanding to help develop therapy strategies and interventions.

In addition, the authors made two other assertions. They argued for the broad inclusion of multicultural perspectives in the areas of assessment, practice, training, and research. They advocated the adoption of these standards by the American Association of



Counseling and Development, which later was renamed the American Counseling Association.

The publication of the Standards and the resulting discourse were pivotal in the multicultural counseling competence movement. They heightened awareness of the need for better training and practice, and they stimulated discourse on the topic not only among counseling psychologists but in the larger professional organizations as well. Professional codes of ethics were revised to include multicultural considerations, and the field enjoyed a proliferation of conference presentations, trainings, symposia, and extensive publications. One important publication was commissioned by the Association for Multicultural Counseling and Development. Titled "Operationalization of Multicultural Counseling Competencies," the 1996 article was authored by Arredondo and colleagues. Extending the scholarship of Sue and colleagues, these authors organized the multicultural counseling competencies into three domains: counselor awareness of own cultural values and biases, counselor awareness of client's worldview, and culturally appropriate intervention strategies. Overall, 31 competency statements and 119 explanatory statements were described in the article. Another influential publication, *Guidelines on Multicultural Education, Training, Research, Practice, and Organizational Change for Psychologists*, was published in 2003 and approved as policy of the American Psychological Association. These guidelines, cochaired by Nadya Fouad and Arredondo, build on the aforementioned documents related to multicultural counseling competencies.

Although the Standards were pivotal in advancing the movement, they are not without criticisms. Doubt was cast on the adequacy of the Standards to reflect the multifaceted nature of multicultural counseling competence. For instance, researchers noted that the therapeutic relationship was not reflected in the Standards even though the relationship is widely acknowledged as a critical component in therapeutic change. Compelling research by a leading multicultural scholar substantiated the criticism. Additional debate arose about whether the construct of multicultural counseling competence should be limited to conversations about race and ethnicity or whether *culture* ought to be defined more broadly to include considerations of individuals from a wide array of disenfranchised and often-overlooked groups (e.g., women; gay, lesbian, bisexual, and transgendered people; people with disabilities). The Standards led to the development of several self-report

measures intended to capture the complex construct of multicultural counseling competence. The three best known of these measures are the Multicultural Awareness/Knowledge/Skills Survey, the Multicultural Counseling Inventory, and the Multicultural Counseling Knowledge and Awareness Scale. While the field generally regarded these instruments as positive first steps, their publication actually posed several additional challenges to the profession. Problems with the instruments themselves soon became apparent. Because the instruments were self-report, they introduced a social desirability confound. They also failed to capture the complex experiences of clients in therapy.

As the movement continues to advance, difficult questions remain. Is counseling competence the same as multicultural counseling competence? Can the multicultural counseling competencies be construed as being synonymous with cultural competence? Is multicultural counseling inclusive or exclusive? The following propositions are set forth to answer these questions. First, multicultural counseling competence and counseling competence are synonymous. Therefore, a competent counselor should be able to attend to cultural considerations in counseling. Second, the unequivocal purpose of multicultural competence is the facilitation of therapeutic change. The achievement of this purpose hinges largely on counselors' attention to cultural considerations. Third, multicultural counseling competencies are subsets of multicultural counseling competence. Therefore, the competencies must be coordinated and integrated in a fashion that achieves the purpose of the construct. Fourth, the multicultural counseling competencies must be defined prescriptively. Their prescriptions should guide counselors in *how* to intervene with clients, not simply describe *what* they should do. Fifth, multiculturally competent counselors can facilitate therapeutic change, regardless of their, or their clients', backgrounds. This places a greater emphasis on the process nature of the construct as opposed to requiring counselors to have an in-depth knowledge of various cultural groups.

The literature on the construct has yielded stimulating discussions that fall into five general categories: (1) asserting the importance of multicultural competence; (2) characteristics, features, dimensions, and parameters of multicultural competence; (3) training and supervision; (4) assessing cultural competence; and (5) specialized applications. In each of these categories, a number of important issues are raised. The



emergence of a number of models of multicultural competence is particularly noteworthy. Examination of these models reveals the intense thinking that has taken place and complexity inherent in multicultural competence.

In retrospect, multicultural competence has moved from obscurity to the periphery and then to the center of counseling training, research, and practice. Its central role now is unmistakable. In looking to the future, much more needs to be accomplished if the profession is to explicate exactly what it means to be multiculturally competent. To provide all clients with the type of care they rightly deserve, the profession cannot rest on the achievements of the past.

*Charles R. Ridley and Debra Mollen*

**See also** Acculturation (v3); Barriers to Cross-Cultural Counseling (v3); Bilingual Counseling (v3); Counseling Skills Training (v2); Cross-Cultural Training (v3); Cultural Accommodation and Negotiation (v3); Ethnocentrism (v3); Eurocentrism (v3); International Developments, Counseling (v1); Multicultural Counseling (v3); Multiculturalism (v3); Multicultural Psychology (v3); Sue, Derald Wing: Contributions to Multicultural Psychology and Counseling (v3); Therapist Techniques/Behaviors (v2)

## Further Readings

- American Psychological Association. (2003). Guidelines on multicultural education, training, research, practice, and organizational change for psychologists. *American Psychologist*, 58, 377–402.
- Arredondo, P., Toporek, R., Brown, S. B., Jones, J., Locke, D. C., Sanchez, J., & Stadler, H. (1996). Operationalization of multicultural counseling competencies. *Journal of Multicultural Counseling and Development*, 24, 42–78.
- Constantine, M. G., & Ladany, N. (2001). New visions for defining and assessing multicultural counseling competence. In C. M. Alexander, J. M. Casas, J. G. Ponterotto, & L. A. Suzuki (Eds.), *Handbook of multicultural counseling* (2nd ed., pp. 482–498). Thousand Oaks, CA: Sage.
- D'Andrea, M., & Daniels, J. (2001). Expanding our thinking about White racism: Facing the challenge of multicultural counseling in the 21st century. In C. M. Alexander, J. M. Casas, J. G. Ponterotto, & L. A. Suzuki (Eds.), *Handbook of multicultural counseling* (2nd ed., pp. 289–310). Thousand Oaks, CA: Sage.

- Ponterotto, J. G., & Casas, J. M. (1991). Value systems in counseling: A racial/ethnic minority perspective. In J. G. Ponterotto & J. M. Casas (Eds.), *Handbook of racial/ethnic minority counseling research* (pp. 49–66). Springfield, IL: Charles C Thomas.
- Pope-Davis, D. B., Coleman, H. L. K., Liu, W. M., & Toporek, R. L. (Eds.). (2003). *Handbook of multicultural competencies in counseling and psychology*. Thousand Oaks, CA: Sage.
- Ridley, C. R. (2005). *Overcoming unintentional racism in counseling and psychotherapy: A practitioner's guide to intentional intervention* (2nd ed.). Thousand Oaks, CA: Sage.
- Roysircar, G., Sandhu, D. S., & Bibbins, V. E. (Eds.). (2003). *Multicultural counseling competencies: A guidebook of practices*. Alexandria, VA: Association for Multicultural Counseling and Development.
- Sue, D. W., Arredondo, P., & McDavis, R. J. (1992). Multicultural competencies/standards: A call to the profession. *Journal of Multicultural Counseling and Development*, 20, 64–68.
- Sue, D. W., Bernier, J. B., Duran, M., Feinberg, L., Pedersen, P., Smith, E., et al. (1982). Position paper: Cross-cultural counseling competencies. *The Counseling Psychologist*, 10, 45–52.
- Sue, D. W. & Sue, D. (2003). *Counseling the culturally diverse. Theory and practice* (4th ed.). New York: Wiley.

---

## MULTICULTURALISM

---

The term *multiculturalism* refers to a perspective in which diversity in backgrounds and experiences related to race, ethnicity, gender, sexual orientation, age, religion, disability, education status, and socioeconomic class is recognized. In the United States, multiculturalism has been described as a social movement that celebrates and values *pluralism*, or differences between individuals and groups. From a political stance, pluralism ensures that *all* citizens of society are affirmed and that the fundamental principles of democracy are honored. Multiculturalism advances the view that the cultural heritages and experiences of different racial and ethnic groups are legitimate and enrich society at all levels. As a movement, multiculturalism values the dignity, human rights, and diversity of people.

## Historical Considerations

Concern for multiculturalism evolved out of sociopolitical movements and educational approaches. Historically,



multiculturalism became integrated into official government policies following the civil rights movements of the latter 20th century, which sought to terminate racism, sexism, and segregation. The efforts of many African Americans and other people of color, such as Latinos/as and American Indians, who organized and demonstrated for equal rights throughout the 1900s, led to milestone changes in racial and ethnic discriminatory practices. The civil rights struggles of these various racial/ethnic groups and their allies granted all citizens in the United States, regardless of their racial or ethnic group membership, access to many aspects of mainstream society, including education, employment, and housing, as well as ensuring voting rights. Major legislation changes in the latter 20th century abolished discrimination on the basis of religion, race, sex, handicap, or national origin. In sum, the civil rights movements in the 20th century contributed significantly to the protection and justice of people of color by implementing social justice policies that protected and represented the human rights of all Americans.

Unfortunately, despite these critical civil rights victories, many people of color today continue to face overt and covert forms of racism and discrimination as well as a double standard regarding their abilities and skills. For example, many people of color continue to be systematically excluded from important positions in schools and other institutions. And when people of color hold positions of power, they may be viewed as “token” representatives or as “experts” on minority issues (e.g., Black and Latino/a professors may be expected to teach the multicultural courses even if they are unprepared to do so).

Furthermore, the propagation of racial stigmatization continues to play a central role in maintaining racial and ethnic inequality in the United States. Empirically unfounded ideas about biological inferiority and cultural pathology of various racial/ethnic groups, for instance, continue to be propagated by various institutions and in some educational settings. Backlash movements against multiculturalism in employment and academic settings have emphasized the rights of majority workers and students to continued access to critical funding. Moreover, other recent movements attempting to install an “Academic Bill of Rights” for students have apparently targeted scholars who promote multiculturalist perspectives, and increasing hostility toward immigrants and their children is, at the same time, being promoted in some legislatures. In sum, as the 21st century begins, civil

rights victories that characterized the previous century seem imperiled, and multiculturalism has lost ground within the sociopolitical and educational structures that once supported it. However, many multicultural scholars continue their work in education and psychology, continuing to call for research, training, and practice in competencies necessary to work with various racial/ethnic groups.

## Multiculturalism in Education

Educational settings have always been important to multiculturalism. Throughout the 19th century and well into the 20th century, state laws existed that systematically excluded or separated children and adolescents of African American, Latino/a (particularly Mexican), and American Indian heritage from mainstream schools. Not only were these students segregated, school systems that served these children often were hostile to their cultural values, customs, and native languages.

A seminal historical event in the education of all Americans was the 1954 case of *Brown v. Board of Education of Topeka*, which dismantled racially segregated schools. This judicial decision was an important turning point in equal access to education for all. The decision also had implications for the field of psychology, marking the first time psychological research was used in a court decision. Similarly, the enactment of the Civil Rights Act in 1964 paved the way for additional legislation that prevented discrimination based on race, color, religion, or national origin. Additionally, the Bilingual Education Act of 1968, and later 1974, passed under Title VII of the Elementary and Secondary Education Act, granting equal access to curriculum for language minority children and providing funding for programs for students with limited English proficiency. Unfortunately, controversy has always surrounded the inclusion of multicultural perspectives in education, a topic that is discussed more fully in a later section of this entry.

## Multiculturalism in Psychology

In addition to education, multiculturalism also has been a major force in psychology. Multiculturalism in psychology reflects a comprehensive paradigm in which the knowledge and skills needed for the profession have evolved out of the historical and sociopolitical changes in society. The movement toward



multicultural counseling, for instance, occurred in tangent with the civil rights movement, the advocacy work of counselors and psychologists in the early 1970s, and the subsequent establishment of several racially/culturally based professional associations (e.g., the Association of Black Psychologists, the Association of Psychologists Por La Raza, and the Asian American Psychological Association).

In the 1973 American Psychological Association (APA) Vail conference, psychologists began to focus on the significance of race and culture in theory, research, and practice. For example, the recommendation and implementation of subsequent training in cultural diversity for doctoral students evolved out of this conference. In addition, the establishment of the Office of Ethnic Minority Affairs, followed by the Board of Ethnic Minority Affairs and the Division of Ethnic Minority Affairs, represents concrete efforts by the APA to promote and encourage competent and ethical practices and fair treatment of psychologists and their potential clients, research participants, and trainees. Throughout the years, the initiatives of these offices have expanded participation of psychologists of color in the APA, who still represent less than 10% of all psychologists. These entities also help to recruit and retain ethnic minority students and prepare all psychologists for an increasingly diverse society. In addition, these offices have recognized and supported policies and programs that encourage pluralism and multiculturalism in the United States. For example, under the recommendation of the Board of Ethnic Minority Affairs, the APA approved a resolution against an English-only initiative in 1990.

A number of subsequent APA publications also have highlighted the need to prepare psychologists to work effectively with diverse populations. These include the *APA Accreditation Handbook*; the *Guidelines for Providers of Psychological Services to Ethnic, Linguistic, and Culturally Diverse Populations*; the *Guidelines and Principles for Accreditation of Programs of Professional Psychology*; and, most recently, the *Guidelines on Multicultural Education, Training, Research, Practice, and Organizational Change for Psychologists*.

Today psychologists work and interact with individuals from all walks of life, and thus they are encouraged to be cognizant of issues related to all of the dimensions of multiculturalism in their education, training, research, and practice. In counseling psychology, in particular, multiculturalism emphasizes

respect for the life experiences and cultural values of diverse individuals and groups as a fundamental principle of competent assessment, diagnosis, and treatment. As cultural beings, multicultural psychologists also are aware of their beliefs, attitudes, and impact on individuals with whom they work.

## Debates About Multiculturalism

Multiculturalism in the United States is not without controversy. A central debate is the universal versus relative nature of multiculturalism. On the universal side is the argument that there is only one race—the human race. In other words, because all human beings are members of the human race, they share common aspects, such as life experiences (e.g., birth, death, and happiness), similar biological makeup, and the capacity to use language and symbols. The underlying assumption of universalism is that all people are essentially alike, and this should be the primary emphasis of educational and psychological interventions.

Conversely, the relativism argument states that each culture possesses values, norms, and ideals, and social practices unique to that group. Membership in a particular culture shapes and influences individuals and group members. Through the process of socialization, individuals acquire the knowledge, belief systems, cultural patterns, and values needed to function in their group. The underlying assumption of relativism is that people are not alike. As a result, mainstream practices are deemed inappropriate when they exclude unique culture and life experiences. Instead, treatment should include differences to most effectively work with people.

## Multicultural Education

Among the controversies surrounding multiculturalism is a general debate about multicultural education. Proponents of multicultural education argue strongly that a multicultural curriculum and multiculturally trained teachers ensure that *all* students have an equal educational opportunity according to their needs, values, and learning styles. Thus, multicultural pedagogy necessitates that teachers alter their instruction to meet the needs of diverse students, as based on race-culture, linguistic diversity, gender, socioeconomic class, religion, sexual orientation, and disability.

Moreover, advocates of multicultural education challenge the Anglo-Eurocentric perspectives that



underlie the curricula of most U.S. school systems; these curricula are viewed as unresponsive and ineffective for culturally diverse students. Multiculturalists argue that when educators teach solely from a Eurocentric view, they lose non-White students because they are taught that they are not part of the story. The exclusion from historical events, coupled with various types of cultural incongruencies in curricula, is viewed as a significant factor explaining why many students of color disengage from academics. The strong disconnection in the curricula between the students' culture and school culture has been referred to as "cultural imperialism" to describe how the dominant's group experience and culture have been established as the norm in educational systems.

Multiculturalists note that it is fallacious to conclude that the numerical majority in the United States should be considered the dominant group whose worldview is assumed to be superior and the basis of universality. The previous ideal of assimilation into an Anglo-American model where immigrant students, for example, were expected to get rid of their cultural traits in order to be taught "American" values and behavior also is rejected because it perpetuates the eradication of many cultures and the inferiority of other groups and their traditions. In addition, cultural dispositions associated with autonomy, competition, individualism, and internal locus of control place some children (e.g., low socioeconomic status) at a disadvantage because they are not equipped with the skills rewarded in the school environment that are predominantly operated by middle-class White European American teachers and administrators.

Multicultural education is anchored in the principles of inclusiveness, diversity, and unity. Far from being a source of divisiveness, many advocates assert, multicultural education helps to unify a divided nation. They recognize that the multicultural education model is beneficial for everybody, not just racially/culturally diverse students of color, because it prepares all students to understand multiple perspectives and to function in an increasingly multicultural society. More importantly, supporters contend that a multicultural curriculum fosters the development of cognitive abilities by teaching students to become critical thinkers and innovators and to function as humane citizens.

Critics, on the other hand, argue that multicultural education departs from conventional studies of Western civilization in the direction of a more "revisionist history" by rewriting history from a different point of view

to misrepresent facts or events. Opponents contend that multicultural education opposes Western traditions because it aims to recognize and empower historically oppressed groups. Thus, critics confound multiculturalism with an anti-Western stance by contorting it as an attempt to change or rewrite history rather than provide a more holistic framework. Other critics believe that multicultural education is simply an entitlement curriculum for students of color and a mechanism for providing therapy to females and culturally and linguistically diverse students, objectives deemed inappropriate for education and for which teachers should not be held responsible.

Another major criticism of multiculturalism is that it is destructive of the values that unite Americans. This view stems from the suggestion that multiculturalism disparages the *unum* and venerates *pluribus* by discarding the ideals of assimilation and integration and instead calling attention to specific ethnic, cultural, and gender experiences. Thus, some critics believe that multiculturalism takes attention away from unifying experiences of being "American."

### **Bilingual Education**

Underlying controversies about multiculturalism are issues of language and culture. Bilingual education and programs for diverse language learners illustrate one example of this ongoing debate. Historically, bilingual abilities have been viewed as a handicap rather than an asset to the learning environment. Indeed for much of the 20th century, many educators believed that being bilingual actually slowed learning and diminished intelligence rather than increased performance and cognitive complexity. Unfortunately, most studies between the late 1800s and the 1960s yielded findings linking bilingualism with lower academic performance. However, recent reviews of this research reveal many of these studies were flawed in their methodologies, including their definitions of *intelligence* and their sampling techniques.

Biases toward bilingualism also have been reflected in public policies affecting school systems that serve bilingual students. For example, a landmark and progressive 1976 law passed in California enabling education programs for limited-English-proficient students framed the issue as a "language problem" to be solved by transitioning students from their native language into English, with an unfortunate outcome of prejudicing these students against



their own languages. In short, the legislated goals of bilingual education programs were to dispense with native languages as quickly as possible, in order that English might be learned.

Although bilingual education continues in many public schools, legislation in more recent years has reflected increasingly hostile attitudes toward providing funding for school learning in any other language but English. The ongoing debate regarding bilingualism in the United States has been summarized by educators Kenji Hakuta and Eugene García in this way: "Is bilingualism strictly the knowledge and usage of two linguistic systems, or does it involve the social dimensions encompassed by the languages?" (1989, p. 374).

Anti-bilingual education perspectives view this form of education as a barrier to learning English and detrimental to student academic achievement. This view holds that English should be the only form of instruction because of the importance of developing content knowledge and literacy in English. The use of the primary language in the classroom and at home is believed by some to cause a cycle of dependence. In the English-only model, teachers alter their instruction for English language learners with the goal of transitioning students after 1 year of intensive English instruction. In addition, proponents of English-only education contend that only English proficiency prepares students to function in U.S. society and does not harm their self-esteem as has been suggested. In several states, such as California, Arizona, and Massachusetts, English-only initiatives have been adopted.

Opponents of English-only education state that bilingual education is more effective because this approach results in biliteracy; for example, instruction is delivered in the students' primary language and in English, sending the message that being bilingual is important. Furthermore, these opponents' suggestion that bilingual education creates dependency is simply unfounded and, instead, represents English-only proponents' deep lack of appreciation for linguistically and culturally diverse students.

In the face of strong criticism regarding the need for more effective programs targeting bilingual students, scholars today emphasize the potential positive impact of dual language learning. Recent research indicates that learning in a second language may actually facilitate cognitive functioning, particularly cognitive flexibility and metalinguistic awareness. More sophisticated research has revealed that language

learning, whether first- or second-language, uses the same basic cognitive processes. As Hakuta and García note, learning dual languages "share[s] and build[s] upon a common underlying base rather than compete[s] for limited [cognitive] resources" (p. 375).

Proponents of bilingual education also argue that bilingualism serves as a bridge between the school and home to strengthen learning. To require students to speak only English at home and school, they contend, is to deprive an equal opportunity to learn. Moreover, advocates for bilingual education have argued that it takes longer than 1 year for students to obtain the language skills needed to perform complex abstract tasks. Also, cultural identity is critical to self-esteem, and language is significant in the formation of identity. Banning students from speaking their native language, critics maintain, can be demoralizing and result in lower self-esteem of English learners.

Clearly, the controversy around bilingual education is complex with differing views about the best way to educate diverse language learners. These differing views have had important implications for legal and policy legislations. Indeed, the passage of Proposition 227 in California is illustrative of legislation of an English-only ideology (this legislation also reverses the previously mentioned legislation from the 1970s) and illustrates the continuing debate of multicultural education in the United States.

### **Affirmative Action**

Another multicultural policy implemented to advance historically racial/ethnic groups in the United States is affirmative action. Initiated in 1965 by President Lyndon Johnson to correct discrimination on the basis of race, ethnicity, and gender, affirmative action has been a highly contentious issue. Opposition to affirmative action began after the popular Allan Bakke case in 1978, in which Bakke claimed reverse discrimination because he was rejected from medical school for 2 consecutive years. Bakke argued that he was rejected because the school admitted less-qualified minority applicants under a special admissions program designed to help minority students. Since then, terms such as *preferential treatment* and *reverse discrimination* have been used to express opposition to affirmative action. Affirmative action opponents have attempted, and continue to attempt, to advocate policies that dismantle equal opportunity in higher education and employment.



Conversely, affirmative action advocates counter that the history of slavery in the United States coupled with racial discrimination continues to put several racial/ethnic groups, such as African Americans, Latinos/as, and American Indians, at political and economic disadvantages. Affirmative action, they assert, is justified reparation for social and historical inequality. The reality today, these advocates uphold, is that Whites continue to hold the power, privilege, and wealth in the United States. Thus, affirmative action programs promote critical opportunities for access and advancement to historically oppressed individuals and groups.

Affirmative action programs have been implemented in learning institutions to foster educational diversity for students and faculty. In higher education institutions, affirmative action policies are utilized as a strategy to enroll ethnically and racially diverse students. Advocates maintain that multiculturalism and affirmative action practices in universities promote racial unity and expand the discourse to multiple perspectives. In a major victory for the University of Michigan in the early 2000s, the Supreme Court upheld the right of educational institutions to sustain affirmative action policies that consider race as one of the various factors in the admission process. Among the most compelling evidence cited in favor of this decision were the educational benefits (e.g., intellectual improvements) obtained from participating in ethnically and culturally diverse classrooms.

### Implications for Clinical Practice

Given the increasing diversity of the population of the United States, competent and racially/ethnically diverse educators, practitioners, and researchers within the field of psychology are in great demand. In particular, psychologists must be prepared to meet the needs and demands of multicultural clients. Historically, however, issues of race, ethnicity, and culture, along with other important dimensions of diversity (e.g., gender, socioeconomic status, and sexual orientation), have been ignored in the field of psychology. For example, conventional models of psychological theories and treatment are encapsulated by Eurocentric perspectives; nonetheless, they have been assumed to be appropriate for non-White clients in the same way that Eurocentric curricula have been viewed as appropriate for culturally and linguistically diverse students.

Western theories of psychology were conceptualized under a culturally universal perspective (*etic*),

which defines concepts of normality and abnormality as similar across cultures. Furthermore, the etiology, course, and manifestation of disorders are presumed to be the same across individuals despite their culture. As noted earlier, multiculturalists propose that a solely universalist assumption may be oppressive for diverse clients. Consequently, when practitioners operate from an *etic* perspective, they may be perpetuating monocultural and ethnocentric biases.

On the other hand, when practitioners operate from a culturally specific perspective (*emic*), they are aware that culture and life experiences affect the origin and expression of disorders. As a result, they are more likely to use culture-specific strategies for counseling and therapy. The challenge for psychologists, researchers, and educators is to revise existing major theories and incorporate multicultural perspectives to improve understanding and interventions for diverse clients. Moreover, multiculturalism compels psychologists to reevaluate their personal beliefs and perspectives.

### Multicultural Competency

Competency models of multicultural counseling have been developed to improve the quality and effectiveness of psychotherapy services for multicultural individuals. Derald Wing Sue first outlined the characteristics of culturally competent psychologists in three areas: (1) awareness of personal values and beliefs around issues of race and ethnicity toward culturally diverse clients; (2) knowledge of diverse cultures, worldviews, and experiences; and (3) utilization of effective skills or techniques when working with clients of color. This tripartite model was later expanded and refined to include specific characteristics of multicultural counselors: awareness of their personal biases, understanding their client's worldview, and developing culturally suitable intervention strategies.

Following the refined tripartite model, Patricia Arredondo and her colleagues delineated specific behavioral expressions of the awareness, knowledge, and skills areas of competencies in an attempt to clearly define the constructs. D. W. Sue and colleagues also developed a comprehensive that delineated multicultural counseling competencies for counselors and organizations. In this body of literature, the role of psychologists in working to ameliorate the effects of racism and advocating for clients is emphasized.

Respect for individual and group differences is a major principle of multiculturalism. When this standard



is extended to psychology, it applies to the role of psychologists and their knowledge, awareness, and skills. As professionals working with diverse people, psychologists must have an honest desire to learn about and explore different cultures and backgrounds. They must become aware of how their attitudes, feelings, and perceptions are likely to influence the therapeutic process and outcomes. Without a willingness to unlearn perceptions and judgments of prejudice, racism, ageism, and heterosexism, for example, multicultural competence becomes difficult to attain.

Finally, a glance at the population of the United States clearly indicates the steadily increasing numbers of racially and ethnically diverse people in all aspects of society. If educators, psychologists, and other professionals hope to meet the mission of promoting psychological well-being, multicultural concerns must be examined. In sum, multicultural perspectives have the power to promote human well-being and the potential to enrich and transform members of society through the exploration and understanding of human diversity.

*Brenda X. Mejia and Marie L. Miville*

**See also** Acculturation (v3); Affirmative Action (v3); Bicultural (v3); Bilingual Counseling (v3); Bilingualism (v3); Cultural Accommodation and Negotiation (v3); Cultural Encapsulation (v3); Cultural Equivalence (v3); Cultural Relativism (v3); Cultural Values (v3); Culture (v3); Diversity (v3); Ethnocentrism (v3); Eurocentrism (v3); Multicultural Counseling (v3); Multicultural Counseling Competence (v3); Multicultural Psychology (v3); Pluralism (v3); Universalism (v3)

### Further Readings

- Abreu, J. M., Chung Gim, R. H., & Atkinson, D. R. (2000). Multicultural counseling training: Past, present, and future directions. *The Counseling Psychologist*, 28(5), 641–656.
- American Psychological Association. (1993). Guidelines for providers of psychological services to ethnic, linguistic, and culturally diverse populations. *American Psychologist*, 48, 45–48.
- American Psychological Association. (2003). Guidelines on multicultural education, training, research, practice, and organizational change for psychologists. *American Psychologist*, 58(5), 377–402.
- Arredondo, P., Toporek, R., Brown, S. P., Jones, J., Locke, D. C., Sanchez, J., et al. (1996). Operationalization of multicultural counseling competencies. *Journal of Multicultural Counseling and Development*, 24, 42–78.
- Constantine, M. G., & Sue, D. W. (2005). *Strategies for building multicultural competence in mental health and educational settings*. Hoboken, NJ: Wiley.
- Crawford, J. (1997). *Best evidence: Research foundations of the Bilingual Education Act*. Washington, DC: National Clearinghouse for Bilingual Education.
- Curry, G. E., & West, C. (1996). *The affirmative action debate*. Cambridge, MA: Perseus.
- Ezorsky, G. (1991). *Racism and justice: The case for affirmative action*. Ithaca, NY: Cornell University Press.
- Hakuta, K., & García, E. E. (1989). Bilingualism and education. *American Psychologist*, 44, 374–379.
- Sue, D. W., Arredondo, P., & McDavis, R. J. (1992). Multicultural counseling competencies/standards: A call to the profession. *Journal of Multicultural Counseling and Development*, 20, 64–88.
- Sue, D. W., Carter, R. T., Casas, J. M., Fouad, N. A., Ivey, A. E., Jensen, M., et al. (1998). *Multicultural counseling competencies: Individual and organizational development*. Thousand Oaks, CA: Sage.
- Taylor, C. (1994). *Multiculturalism: Examining the politics of recognition*. Princeton, NJ: Princeton University Press.

---

## MULTICULTURAL PERSONALITY

---

The multicultural personality refers to a constellation of traits, attitudes, and behaviors that predispose individuals to adapt successfully to culturally diverse environments. The conceptual roots of the multicultural personality can be traced to work in clinical psychology and counseling psychology in the United States and personnel psychology in the Netherlands. Manuel Ramirez, working in the southwest region of the United States, discussed the multicultural personality as a synthesis of the resources learned from different cultures that enable people to develop cultural flexibility in navigating their environments. Ramirez is a clinical psychologist, and his work focuses on helping clients develop bicultural coping and adaptation skills.

Writing from a counseling and positive psychology perspective, Joseph G. Ponterotto and colleagues discussed the multicultural personality in terms of its relationship to psychological well-being. Working with the general population, these authors hypothesized that given the rapidly changing demographic landscape of the United States, which is becoming an increasingly multicultural, multilingual society, those individuals



who exhibited multicultural personality dispositions would adapt more successfully and embrace more fully the diverse components of society and therefore would experience a higher quality of life.

While counseling and clinical psychologists in the United States were developing the construct of the multicultural personality, two researchers in the Netherlands, Karen Van der Zee and Peter Van Oudenhoven, working from the specialties of personnel and organizational psychology, were also conceptualizing a version of the construct. These researchers were interested in studying personality variables of corporate expatriates that predicted success (personal life satisfaction and work productivity) while living and working in a new country.

After an extensive review of the theory and research that possibly related to the multicultural personality, Ponterotto and his colleagues presented an integrated and comprehensive working definition of the construct. They defined the construct as multidimensional and inclusive of the following traits: emotionally stable, secure in one's multiple identities (e.g., racial, gender, religious, ethnic), intellectually curious regarding novel cultures, culturally empathic, feeling centered with regard to spirituality, cognitively flexible, introspective, and committed to social justice.

Though a relatively recent construct, the multicultural personality appears to be correlated to a number of variables central to the work of counselors, namely, life satisfaction, work success, and quality of life. Research on the construct, however, is still in its early stages, and additional studies are needed before counselors can make any definitive conclusions regarding the importance of the construct or even its uniqueness relative to more global personality traits. At present, the most comprehensive assessment of the construct is the 91-item Multicultural Personality Questionnaire developed in the Netherlands by Van der Zee and Van Oudenhoven. If ongoing research continues to find that the multicultural personality is related to important life variables, then counselors and other mental health professionals will want to work toward assessing and then increasing their clients' levels of multicultural personality development. The construct holds great promise for theory and research in counseling.

*Joseph G. Ponterotto*

*See also* Acculturation (v3); Bicultural (v3); Change Agent (v3); Cultural Accommodation and Negotiation (v3);

Ethnic Identity (v3); Identity Development (v3); Multicultural Psychology (v3); Personality Assessment and Careers (v4); Personality Theories (v2); Personality Theories, Traits (v2); Racial Identity (v3)

### Further Readings

- Ponterotto, J. G., Utsey, S. O., & Pedersen, P. B. (2006). *Preventing prejudice: A guide for counselors, educators, and parents* (2nd ed.). Thousand Oaks, CA: Sage.
- Ramirez, M., III. (1999). *Multicultural psychotherapy: An approach to individual and cultural differences* (2nd ed.). New York: Pergamon Press.
- Van der Zee, K. I., & Van Oudenhoven, J. P. (2000). The Multicultural Personality Questionnaire: A multidimensional instrument of multicultural effectiveness. *European Journal of Personality*, 14, 291–309.

---

## MULTICULTURAL PSYCHOLOGY

---

Multiculturalism has been called the “fourth force” of psychology by Paul B. Pedersen, Pius K. Essandoh, and others (following psychoanalysis, behaviorism, and humanism as schools of thought). Multicultural psychology is a major influence in contemporary psychology and includes such broad topic areas as racial identity development, acculturation, prejudice and stereotyping, and multicultural competence. Research focused on multicultural psychology differs from other schools of thought in psychology because, in addition to a focus on individual and intrapsychic factors, the cultural context is considered an important aspect of the lives of individuals and groups. Some important questions in multicultural psychology are the following: How do factors in the cultural context impact individual differences, and how do psychological phenomena vary across cultures?

Although the terms *multicultural* and *cross-cultural* are often used interchangeably, they differ slightly in meaning. Multicultural psychology considers the influence of contextual variables (e.g., race or ethnicity) on human functioning in diverse societies. Cross-cultural psychology focuses on relationships between individuals and/or groups from different cultures. Cross-cultural psychology also focuses on comparisons between cultural groups (e.g., contrasting cultural values, practices, etc.).



## History

The history of multicultural psychology is best understood within the context of sociopolitical oppression in the United States. According to the American Psychological Association (APA), psychologists' explicit involvement in controversies related to cultural issues began with *Brown v. the Board of Education of Topeka* in 1954. In this case, psychologists provided significant information regarding the detrimental effects of segregated education for children of color, empirically challenging the notion of "separate but equal." This case also was the first time that psychological research was incorporated in a Supreme Court decision. Political movements and subsequent legislation and policies, such as the Civil Rights Act of 1964, exerted an influence on psychologists' integration of multicultural issues in research and practice. In 1971, the National Institute of Mental Health Office of Minority Research was founded, making funding available specifically for research with racial and ethnic minorities.

Although psychologists have addressed racial and cultural issues in their professional work for more than a century, culture was not explicitly considered an important variable in professional practice until the Vail Conference of Graduate Educators in Psychology in 1973. Recommendations from the conference included the integration of cultural diversity training in psychology graduate programs. Since that time, there has been an explosion of research on multicultural training and competence.

In addition to racism and other forms of cultural oppression as a driving force of multicultural psychology, recent demographic changes have been at the center of discussions about the importance of multicultural competence in psychological research and practice. According to the 2000 U.S. Census, the ratio of racial/ethnic minorities to White people is increasing dramatically. In some parts of the country, such as some areas of California and Texas, people of color (e.g., African Americans, Latinos/as, Asian Americans) are no longer a minority, and many population experts believe that current racial/ethnic minority groups will become the numerical majority in the United States by the middle of the 21st century. Multicultural psychologists such as Derald Wing Sue and Pedersen state that there is an ethical imperative to practice culturally competent psychology. Moreover, demographic trends in the country have led many

psychologists to understand the value of incorporating cultural issues into research and practice, minimally because of the increasing likelihood that they will encounter racial/ethnic minority people in their work. Indeed, in 1997 Christine C. Iijima Hall stated that mainstream psychology was becoming obsolete in the face of these demographic changes.

## Prejudice and Stereotypes

Research on prejudice and stereotyping in social psychology has contributed to understanding the links between individual cognition, prejudice (i.e., negative social attitudes), and discriminatory behaviors toward various groups, providing an essential cornerstone to multicultural psychology. John F. Dovidio, Ana Validzic, and Samuel L. Gaertner cite research on the "contact hypothesis" in understanding prejudice between groups. The contact hypothesis purports that prejudice arises from limited contact with groups other than one's own, and increasing contact with another group is one way to reduce bias. However, it is not simply the contact but also the conditions under which the contact occurs that lead to decreased intergroup biases (e.g., cooperative interactions between the groups).

In addition, social psychologists have explored the consequences of belonging to a stigmatized group. For example, Claude M. Steele and Joshua Aronson defined the term *stereotype threat* to reflect the impact that negative stereotypes about stigmatized groups (e.g., women and African Americans) can cause individuals from these groups to experience anxiety that may lead to a negative impact on performance. This anxiety arises from fear of being reduced to generalizations made about members of a socially stigmatized group. Their research has been extended to other stigmatized groups, such as people of low socioeconomic status, although more recent research indicates the stereotype threat can occur to most individuals regarding any social group membership, such as being male or being White. However, given the continued underrepresentation of certain groups in several settings (e.g., people of color and women in math and sciences), it is these individuals who are at higher risk of suffering negative social consequences associated with stereotype threat.

Other researchers have proposed complex hypotheses about intergroup relations to help explain prejudice and stereotypes. One example is Marilynn B. Brewer's optimal distinctiveness theory. According



to Brewer, individuals do not simply value their own group (ingroup) and devalue other groups (outgroups). Instead, they strive for a balance between fitting in or belonging to a group, in conjunction with standing out or being distinctive from that group. The optimal distinctiveness theory suggests that although understanding ingroup experiences is important, ingroup attraction does not by itself imply outgroup repulsion. Instead, Brewer suggests, there are specific phenomena (e.g., attitudes of moral superiority, perceived threat) that may link ingroup loyalty with prejudice against outgroups.

### **Racial/Ethnic Identity Development Models**

In *Counseling the Culturally Diverse*, D. W. Sue and David Sue review both racial-cultural minority and White racial identity development as these apply to the work of psychologists and counselors. Such models address individual differences within racial/ethnic groups, going beyond demographic or phenotypic definitions of race and ethnicity to address the psychological meaning of racial/ethnic group membership. Various identity models pertaining to racial/ethnic minorities have been proposed by others, including William E. Cross's Nigrescence model; Janet E. Helms's model of Black racial identity development; and Donald R. Atkinson, George Morten, and D. W. Sue's minority identity development model. These models share in common the articulation of developmental processes whereby people of color (a) initially value the dominant group and devalue their own group, (b) then value their own group and devalue the dominant group, and (c) finally move beyond these conflicts to value both groups. Although most scholars no longer ascribe to invariant stage models, these racial/ethnic identity models provide a framework for understanding the psychological impact that racial/ethnic group membership has on identity development and social constructions of the self.

Helms also developed a model of White racial identity development. Central to this model is the influence of racism on White identity. In the White racial identity development model, the first three levels, or statuses, incorporate racism as a core feature of development, ranging from a lack of awareness about race and racism to beliefs in White superiority. The last three statuses involve the development of a non-racist White identity and include the painful realization that

racism does exist that may lead to overidentification with people of color in a way that actually perpetuates racism; focusing on the meaning of Whiteness and White privilege; and the development of awareness regarding White privilege, along with decreased feelings of guilt and a commitment to antiracism.

Understanding the racial/ethnic identity statuses of clients can help mental health professionals to focus on systemic issues that play a role in presenting problems. Studies have found relationships between various psychological variables and racial/ethnic identity statuses. For people of color, less "mature" or sophisticated identity statuses (i.e., pre-encounter, encounter) have been linked to high anxiety, low self-esteem, depression, and psychological distress. However, other studies have yielded different results, such as positive relationships between less-mature or sophisticated statuses and low anxiety. This may be attributed to variations in the expression of racial/ethnic identity status. For example, William Cross and Beverly Vandiver suggest that it is possible for some individuals to have racial/ethnic identity statuses marked by less-mature strategies yet have healthy personality profiles because race may be of low salience to their identities. Janet Helms and Donelda A. Cook describe in depth some of this research as well as important applications of racial identity to various psychological services, including individual therapy, group counseling, and supervision.

Psychologists focusing on multiracial and biracial people have suggested that traditional racial/ethnic identity development models may not be adequate or appropriate for understanding mixed-race people. Though monoracial identity development models have been used with multiracial populations, other theorists have proposed separate models of identity development for biracial/multiracial people. W. S. Carlos Poston proposed the first of these models in 1990. Incorporating the concept of "reference group orientation" (as opposed to personal identity) cited in previous racial identity development models, Poston described five stages of biracial identity development: personal identity, choice of group categorization (pressure to choose one group), enmeshment/denial (conflicted feelings regarding choice of group), appreciation (of multiple identities), and integration (experience of wholeness, valuing all ethnic and racial identities).

Similar to earlier monoracial identity development models, Poston's model is a stage model ranging from immature to mature identity resolutions. Others who



focus on multiracial identity, such as Maria P. P. Root, have questioned the idea that there is a single process of identity development that applies to multiracial people, or to people in general. She instead proposes an ecological approach to understanding multiracial identity, emphasizing various contextual factors that influence the way in which multiracial people see themselves. Unlike Poston, she does not believe that integration of ethnic identities is a necessary identity resolution. Multiracial people can identify with one group or the other, change their identity based on context, identify with multiple groups, or develop a new and independent identity as multiracial.

In a review of the literature on both racial/ethnic identity development and psychological functioning of biracial people in 2005, Marie L. Miville pointed to the need for research that captures the fluidity of biracial and multiracial identity. Qualitative studies conducted by psychologists such as Root and Miville and colleagues have begun to capture themes not addressed by traditional identity development models thus far (e.g., simultaneous identification as both a monoracial and a multiracial person).

Other multicultural psychologists have focused on ethnic identity. For example, Jean S. Phinney uses the term *ethnicity* to encompass both race and culture, noting disagreement within psychology over what “race” really means. Similar to psychologists who focus on racial identity rather than race as a descriptive or demographic variable, Phinney suggests that it is important to understand the meaning of ethnicity, including the subjective meaning and experience of people from different ethnic groups and the various labels that people use to describe their own ethnicity. In her 1996 article on American ethnic groups, Phinney states that “ethnic identity is a complex cluster of factors that define the extent and type of involvement with one’s ethnic group” (p. 923). Her multigroup ethnic identity model has several components that address the complexity of ethnic identification, including self-identification (chosen ethnic group label), ethnic behaviors and practices, affirmation and belonging, positive evaluation, preference for the group, and ethnic interest and knowledge. Phinney developed an oft-used scale based on the multigroup ethnic identity model that contains 14 Likert-type items on the components of ethnic identity (listed in the previous sentence) and six items on “other” group identity. The subscales have been adequately reliable, with higher reliability among college students than

high school students, suggesting that ethnic identity might become more stable with development. Studies have found that self-esteem is positively correlated with ethnic identity and that ethnic identity is usually more strongly endorsed among people of color than among White people.

## Acculturation and Biculturalism

Considering the increasing diversity of the United States and most other modern societies, acculturation is an important topic in multicultural psychology. Acculturation is a process of individual and group change that occurs when cultural groups come into contact. Understanding the process of acculturation is important when working with immigrant clients because they are adjusting to the dominant culture. Moreover, other racial/ethnic groups undergo an acculturation process because the dominant culture does not include the multiple racial and ethnic groups that are a part of the United States. For example, many African Americans experience an acculturation process when growing up in Black communities and then attending schools or working in predominantly White settings. John W. Berry describes various acculturation strategies, including assimilation and marginalization. Acculturation can lead to *acculturative stress* as individuals navigate multiple cultural norms and try to meet group expectations that often conflict. However, as with racial and ethnic identity development, acculturation is not a linear process that occurs in the same ways or directions for all people and groups. Research on acculturation has shown that in some contexts, acculturation to the dominant culture can have positive psychological effects, but in many others, acculturation to the dominant culture is detrimental to development as individuals and groups lose support from their culture and communities of origin.

Psychologists such as Theresa LaFromboise and her colleagues have challenged the assumption that individuals from nondominant cultural groups are necessarily “marginal people.” LaFromboise and colleagues critiqued several models of second-culture acquisition as inadequate because they traditionally relegated racial/ethnic minority cultures to an inferior status. These researchers then presented a theory of bicultural competence that states that, although racial and ethnic minorities will experience discrimination and hardships in an oppressive culture, the experience



of living in two cultures does not necessarily predict dysfunction. In fact, the experience of being bicultural may be positive because individuals living in more than one culture have access to multiple resources and ways of being that can result in both cognitive and emotional flexibility. The strength of both individual (ego) identity and cultural identity is an important factor in coping with biculturalism. LaFromboise and colleagues proposed six dimensions of bicultural competence: knowledge of cultural beliefs and values, positive attitudes toward majority and minority groups, bicultural efficacy, communication ability, role repertoire, and a sense of being grounded. They further suggest that individuals living in more than one culture can experience multiple adaptive processes, not simply assimilation to the dominant culture or its antithesis, withdrawal from the dominant culture. Indeed, individuals may make conscious choices regarding their level of biculturalism in certain settings (e.g., high school).

### Multicultural Competence

In August 2002, the APA adopted the *Guidelines on Multicultural Education, Training, Research, Practice, and Organizational Change for Psychologists*. These guidelines were an important step in a long history of work on multicultural counseling competencies. This work began in 1982 when D. W. Sue and others in the Society of Counseling Psychology (APA Division 17) proposed the Cross-Cultural Counseling Competencies. The purpose of the APA guidelines is to provide a rationale for the need to address multiculturalism and diversity, specifically those involving racial/ethnic interactions, in addition to reviewing relevant research and providing standards for integrating cultural concerns into the varied work of psychologists.

The APA multicultural guidelines are divided into six categories: commitment to cultural awareness and knowledge of self, commitment to cultural awareness and knowledge of others, education, research, practice, and organizational change and policy development. The influence of years of research on multicultural competence in counseling is evident in the document. The competencies focus first and foremost on psychologists' awareness of their own culture, attitudes, and so on. Psychologists' awareness, knowledge, and skills in working with people from various cultures are central to multicultural counseling competence. The literature also focuses on psychologists' understanding of their

clients' cultural values and worldview from a nonjudgmental standpoint.

In addition to the three dimensions of multicultural competence (attitudes and beliefs, knowledge, and skills), multicultural psychologists have proposed three characteristics of multiculturally competent practitioners. The characteristics are a commitment to actively engaging in a process of understanding one's own attitudes, including values and biases; a commitment to understanding the worldview of clients who are culturally different; and a commitment to developing intervention strategies that are appropriate and relevant for each client based on his or her cultural experiences. There are specific competencies related to each dimension for each of the characteristics.

Although measurement of multicultural competence is complicated because of self-report bias and the various instruments available, multicultural competence and training have been linked to positive outcomes for both counselors and clients. For example, multicultural competence and exposure to multicultural training have been linked with counselor empathy, White racial consciousness, White racial identity attitudes, and interracial comfort. In addition, multicultural case conceptualization ability has been linked to multicultural competence.

Some studies also have focused on the multicultural competence of supervisors. In a recent study by Arpana G. Inman, supervisor multicultural competence was related to the working alliance between supervisor and supervisee and to supervisee satisfaction with supervision. In addition, the working alliance served as a mediator between supervisor multicultural competence and satisfaction with supervision.

### Multicultural Training

To facilitate the development of multicultural competence in counseling and other forms of applied psychology, multicultural psychologists such as D. Sue have focused on effective multicultural training. D. Sue reviewed various models of multicultural training, including a generic approach that assumes traditional techniques are applicable to all cultures; the etic approach, which seeks to understand the universal aspects of human experiences that go beyond cultural differences; and the emic, or culture-specific, approach. Although each approach has its shortcomings, some multicultural psychologists, such as D. W. Sue, have argued that it is crucial to simultaneously



attend to individual, group, and human (universal) characteristics in counseling. It is important to note that traditionally, professional psychologists have focused much more on individual and etic (“universal”) approaches than on those that take group differences into account.

D. Sue also described the various ways in which multicultural training may be implemented into the counseling curriculum. He identified four approaches: the single course approach, multicultural counseling as an area of concentration, the interdisciplinary model, and the integration model. In the integration model, material regarding cultural differences is a part of each and every course in a training program. Although this may be the ideal approach, many programs continue to use the single course approach. In addition, most multicultural training programs today are more successful in addressing attitudes-beliefs and knowledge than in addressing skills.

Recently, Timothy B. Smith, Madonna G. Constantine, and colleagues conducted a meta-analysis on multicultural education in mental health graduate programs. This study, focused on outcomes of multicultural training programs, showed that multicultural education had an overall positive effect on factors such as multicultural competence, racial prejudice, and the client–counselor relationship. This study provides further support for D. Sue’s and others’ call for psychology training programs to integrate multicultural issues throughout their curricula.

### Focus of Multicultural Psychology

Although great strides have been made regarding the acceptance of multicultural issues in psychology, there is still debate regarding the definition and focus of the term *multicultural*. According to D. Sue, some scholars define multicultural psychology broadly, stating that every interpersonal encounter is multicultural because all individuals are cultural beings. This approach considers multiple dimensions of diversity to be a part of the purview of multicultural psychology (e.g., religion, gender, sexual orientation, age, and social class). This definition also considers the cultural experiences of the majority group to be a part of multicultural psychology. At a minimum, some scholars argue that racial/cultural contexts of these other dimensions should be a focus of both research and practice in multicultural psychology.

Other multicultural psychologists take a more specific approach to the definition and focus of multicultural psychology, arguing that integrating aspects other than race and ethnicity into multicultural psychology overly broadens the field, thereby minimizing the true effects of these two variables. In addition, some scholars who support this perspective argue that although social identities other than race and ethnicity may be important, multicultural competence and multicultural research as they stand today do not necessarily apply to gender and other cultural experiences.

Although the majority of research in multicultural psychology has focused on race and ethnicity, recent work by feminist multicultural psychologists such as Louise B. Silverstein has begun to incorporate gender and other identity experiences. In addition, several APA divisions, such as those that founded the National Multicultural Conference and Summit (Society for the Psychology of Women; Society for the Psychological Study of Ethnic Minority Issues; Society of Counseling Psychology; and Society for the Psychological Study of Lesbian, Gay, and Bisexual Issues), have called for their members to develop practice guidelines and to conduct research regarding multiple demographic identities. A common theme of multicultural psychology today is understanding multiple processes of oppression, as highlighted by the title of the 2007 National Multicultural Summit: “The Psychology of Multiple Identities: Finding Empowerment in the Face of Oppression.”

*LeLaina Romero and Marie L. Miville*

*See also* Acculturation (v3); Bicultural (v3); Cross-Cultural Psychology (v3); Cross-Cultural Training (v3); Culture (v3); Diversity (v3); Ethnic Identity (v3); Ethnicity (v3); Identity Development (v3); Multicultural Counseling (v3); Multicultural Counseling Competence (v3); Multiculturalism (v3); Pluralism (v3); Prejudice (v3); Race (v3); Racial Identity (v3); Social Identity Theory (v3); Stereotype (v3)

### Further Readings

- American Psychological Association. (2003). Guidelines on multicultural education, training, research, practice, and organizational change for psychologists. *American Psychologist*, 58, 377–402.
- Brewer, M. B. (1999). The psychology of prejudice: Ingroup love or outgroup hate? *Journal of Social Issues*, 55, 429–444.



- Cross, W. E., Jr., & Vandiver, B. J. (2001). Nigrescence theory and measurement: Introducing the Cross Racial Identity Scale (CRIS). In J. G. Ponterotto, J. M. Casas, L. M. Suzuki, & C. M. Alexander (Eds.), *Handbook of multicultural counseling* (2nd ed., pp. 371–393). Thousand Oaks, CA: Sage.
- Dovidio, J. F., Validzic, A., & Gaertner, S. L. (1998). Intergroup bias: Status, differentiation, and a common in-group identity. *Journal of Personality and Social Psychology*, 75, 109–120.
- Essandoh, P. K. (1996). Multicultural counseling as the “fourth force”: A call to arms. *The Counseling Psychologist*, 24, 126–137.
- Helms, J. E., & Cook, D. A. (1999). *Using race and culture in counseling and psychotherapy: Theory and process*. Needham Heights, MA: Allyn & Bacon.
- LaFromboise, Teresa, Coleman, H. L. K., & Gerton, J. (1993). Psychological impact of biculturalism: Evidence and theory. *Psychological Bulletin*, 114, 395–412.
- Miville, M. L. (2005). Psychological functioning and identity development of biracial people: A review of current theory and research. In R. T. Carter (Ed.), *Handbook of racial-cultural psychology and counseling* (Vol. 1, pp. 295–319). New York: Wiley.
- Pedersen, P. B., Draguns, J. G., Lonner, W. J., & Trimble, J. E. (2002). *Counseling across cultures* (5th ed.). Thousand Oaks, CA: Sage.
- Phinney, J. S. (1996). When we talk about American ethnic groups, what do we mean? *American Psychologist*, 51, 918–927.
- Root, M. P. P. (1999). The biracial baby boom: Understanding ecological constructions of racial identity in the 21st century. In R. Hernandez-Sheets & E. R. Hollins (Eds.), *Racial and ethnic identity in school practices: Aspects of human development* (pp. 67–90). Mahwah, NJ: Lawrence Erlbaum.
- Silverstein, L. B. (2006). Integrating feminism and multiculturalism: Scientific fact or science fiction? *Professional Psychology: Research and Practice*, 37, 21–288.
- Smith, T. B., Constantine, M. G., Dunn, T. W., Dinehart, J. M., & Montoya, J. A. (2006). Multicultural education in the mental health professions: A meta-analytic review. *Journal of Counseling Psychology*, 53, 132–145.
- Steele, C. M. (1997). A threat in the air: How stereotypes shape intellectual identity and performance. *American Psychologist*, 52, 613–629.
- Sue, D. (1997). Multicultural training. *International Journal of Intercultural Relations*, 21, 175–193.
- Sue, D. W., & Sue, D. (2003). *Counseling the culturally diverse: Theory and practice* (4th ed.). New York: Wiley.

## MULTIRACIAL FAMILIES

As the numbers of both transracial adoptions and interracial relationships have increased, the notion of family has expanded in recent decades beyond the traditional monoracial nuclear family. Changes in both of these factors have influenced family compositions and resulted in a larger number of immediate families (i.e., parents and their children) comprising more than one race and, subsequently, individuals and families who identify with multiple races. As this population increases, it is critical for mental health professionals to develop greater knowledge of, and competence in, working with multiracial families.

### Definition

Multiracial families are those consisting of parents of different races and their biracial/multiracial offspring. Within the realm of the interracial family literature, however, there has been disagreement as to the meaning of the term *multiracial*. Some theorists assert that the term should be used only to describe a family composed of more than one race (e.g., a multiracial family), stating that offspring of interracial marriages have only two racial heritages (i.e., they are biracial). Others have used it to describe both families and individuals, asserting that children of a monoracial parent and a biracial parent or of two biracial parents may identify with more than two races and, therefore, would consider themselves to be multiracial. Furthermore, parents of the same race who adopt a child outside of their race also comprise multiracial families. It is important to note that multiracial families are determined by the race, not the ethnicities, of their members.

### Historical Perspective

Political and federal policy changes have caused an increase in the number of interracial unions and, thereby, multiracial families, in the United States. Before 1967, 16 states still deemed it unlawful to marry outside one's racial group. Following the Supreme Court ruling of the case *Loving v. Virginia*, which overturned the last antimiscegenation law, the prevalence of interracial marriages increased substantially. Approximately 13% of marriages in the United States include persons of different races, and interracial marriage rates for Asians and Latinos/as are



nearly 3 times that of Blacks and 5 times that of Whites. In fact, by the late 1990s, more than 30% of Asian or Latino/a individuals had spouses of another race (most often White). Such changes have caused a considerable increase in the population of biracial children and multiracial families in the United States.

According to the 2000 Census, there are nearly 7 million self-identified biracial and multiracial people. Of those responders who reported a multiracial background, 93% reported two races, 6% reported three races, and 1% reported three or more races. Overall, approximately 1 in 40 persons identify as multiracial, and by the year 2050, it is estimated that 1 in 5 people will identify as multiracial.

Policy changes throughout the past several decades also have changed the face of adoption, permitting more in-country transracial and international transracial adoptions and increasing the number of multiracial families in the United States. Large numbers of interracial adoption placements began in the 1940s with a growing prevalence of international adoptions. Adoptions of Black children by White parents were not as prevalent during the 1940s and 1950s, but they grew in number during the 1960s and peaked in 1971 with approximately 2,500 Black/White transracial adoptions. In the 1970s the numbers of transracial adoptions with Asian and Latino/a children steadily rose. Because of the disproportionate number of children of color in the foster care system and the prevalence of White parents looking to adopt, legislation was passed in 1994 to encourage the practice of transracial adoption. The Multiethnic Placement Act stated that placement agencies could not delay an adoption based solely on racial factors. When agencies still did not follow this act, it was reinforced in 1996 with the Removal of Barriers to Interethnic Adoption Act and then in 1997 with the Adoption and Safe Families Act. Since that time, the number of multiracial families formed by transracial adoptions has increased.

### Extant Literature

A substantial amount of research has addressed racial identity development in people of color and White individuals of monoracial families, yet there is a distinct void in empirical literature pertaining to the racial identity development of individuals living in multiracial families. Moreover, the literature on multiracial families is predominantly conceptual and

theoretical in nature and tends to focus on models of identity development.

### Identity Models

Multiracial identity may be more complex than monoracial identity in that multiracial individuals have a choice of how they identify racially: with the race of either one of their parents or with the race of both parents. Society generally has held the false notion that a "solid" sense of identity is one in which an individual identifies exclusively with one race, but multiracial individuals are confronted with a more complicated process in terms of understanding their racial identity. Rather than exploring the meaning of this complexity and the fluidity inherent in the identity of multiracial individuals, some people have deemed multiracial identity as a precursor to feelings of confusion, uncertainty, and marginalization. In response to these assumptions, scholars have sought to better understand the experience of multiracial individuals by developing racial identity models specifically for this population. They purport that multiracial identity development is a qualitatively different experience from monoracial identity development and that several important issues need to be considered in the context of multiracial identity development. These issues include, but are not limited to, a lack of multiracial role models representing various multiple racial group backgrounds, conflicting racial identifications imposed by others, and feelings of rejection from members of the racial groups that comprise the background of biracial or multiracial individuals.

Identity development models pertaining to transracially adoptive families are even sparser than those developed for other multiracial families. One model, the cultural-racial identity model, describes 16 possible cultural-racial identities for transracially adopted youth. These identities are determined by four axes: the adoptee's birth culture, the adoptive parents' culture, the adoptee's race, and the adoptive parents' race. The model is intended to illustrate the complexity of racial identity for transracially adopted individuals, as well as to depict how various contextual situations and familial beliefs can affect transracially adopted individuals' understanding of themselves.

### Psychological Outcomes

Findings on psychological adjustment outcomes for individuals of multiracial families are inconsistent



across studies and indicate that, although there are differences inherent in multiracial families as compared with monoracial families, these differences are not necessarily risk factors for poor developmental outcomes. Such discrepancies in the research point to important methodological aspects (e.g., use of monoracial measures on multiracial populations) that can make results inconclusive or misleading.

### Implications for Counseling

American society continues to place a negative connotation on the processes that result in multiracial families (i.e., interracial unions and transracial adoptions). Individuals in multiracial families often are expected to justify who they are and how they see themselves. Racial/ethnic background inquiries faced by many multiracial individuals convey a message from society that there is something wrong with identifying with more than one race; this message can contribute to feelings of isolation and low self-esteem among many multiracial individuals. These feelings of isolation often manifest within multiracial family dynamics when parents fail to understand or support the complexities associated with having a mixed racial heritage (e.g., biracial or multiracial children) or a race different from that of both parents (e.g., transracial adoptees).

If parents of multiracial or biracial children have not resolved some of their own racial identity issues, they might expect their children to choose one race over the other(s). Adoptive parents of transracial adoptees may purport a monoracial family identity, expecting their child to identify primarily with the family's race rather than embracing a multiracial family identity. Given the influence of others' (particularly parents') perceptions on the salience of race for multiracial individuals and transracial adoptees, exploration into the impact of parents' racial identities may further inform counselors' understanding of multiracial families. As such, family therapy may be a particularly useful and appropriate mode of counseling for

individuals of multiracial families. Counselors working with these families should not assume that their presenting problems are specifically racially or culturally based. However, it is imperative they consider how the family's presenting problems are intertwined with the social and psychological implications of being multiracial.

*Rebecca M. Redington  
and Madonna G. Constantine*

*See also* Biracial (v3); Ethnic Identity (v3); Family Counseling (v1); Identity Development (v3); Interracial Comfort (v3); Interracial Marriage (v3); Parent-Adolescent Relations (v1); Race (v3); Racial Identity (v3); Racism (v3); Transracial Adoption (v3)

### Further Readings

- Cooney, T. M., & Radina, M. E. (2000). Adjustment problems in adolescence: Are multiracial children at risk? *American Journal of Orthopsychiatry*, 70, 433-444.
- DeBerry, K. M., Scarr, S., & Weinberg, R. (1996). Family racial socialization and ecological competence: Longitudinal assessments of African-American transracial adoptees. *Child Development*, 67, 2375-2399.
- Javier, R. A., Baden, A. L., Biafora, F. A., & Camacho-Gingerich, A. (Eds.). (2007). *Handbook of adoption: Implications for researchers, practitioners, and families*. Thousand Oaks, CA: Sage.
- Milan, S., & Keiley, M. K. (2000). Biracial youth and families in therapy: Issues and interventions. *Journal of Marital and Family Therapy*, 26, 305-315.
- Miville, M. L., Constantine, M. G., Baysden, M. F., & So-Loyd, G. (2005). Chameleon changes: An exploration of racial identity themes of multiracial people. *Journal of Counseling Psychology*, 52, 507-516.
- Radina, M. E., & Cooney, T. M. (2000). Relationship quality between multiracial adolescents and their biological parents. *American Journal of Orthopsychiatry*, 70, 445-454.
- Vonk, E. M., & Angaran, R. (2001). A pilot study of training adoptive parents for cultural competence. *Adoption Quarterly*, 4, 5-18.









---

## NATIONAL ASSOCIATION FOR THE ADVANCEMENT OF COLORED PEOPLE

---

The National Association for the Advancement of Colored People (NAACP) is the premiere civil rights organization in the United States with the largest membership and longest record of combating racism and discrimination. As a democratic, independent, grassroots organization, the NAACP played a vital role in every major civil rights struggle in the 20th century. The NAACP pioneered the combined use of litigation, lobbying, political action, education, and social action within a national social reform movement spanning decades. The organization is renowned for obtaining equal access to integrated education, the right to vote, residential housing, and public accommodations for Black Americans, in particular, radically improving their lives.

The official founding of the NAACP is February 12, 1909, the 100th anniversary birthday of former President Abraham Lincoln. However, the conference planned for that date was held May 31 to June 1, 1909; at that conference, the National Negro Committee was formed. When the committee met again, in May 1910, the name National Association for the Advancement of Colored People (NAACP) was adopted, with incorporation in 1911.

### Why Was the NAACP Needed?

The 14th Amendment (1868) to the Constitution guaranteed Blacks (freed from slavery in 1865) the same freedoms and rights as Whites. The 15th Amendment

(1870) guaranteed the right to vote, regardless of race. However, equality for Blacks remained elusive, at the dawning of the 20th century, as an epidemic of race riots reigned; Whites entered Blacks' homes, lynched occupants of all ages, and burned down homes and businesses. Also common were false accusations of Blacks raping White women, insulting Whites, or committing other crimes; mobs removed Black suspects from jail and lynched them.

With formation of the NAACP, a solution arose involving lawyers traveling across states to defend the accused; legal scholars devising strategies for the enforcement of the 14th and 15th Amendments and all existing laws and enactment of new laws to secure civil rights; activist social workers garnering public sympathy; diverse religious leaders lending moral imperative to reform; and journalists educating the public on the racial discrimination, constitutional rights, and lawful action to secure exercise of those rights. The official monthly NAACP publication, *The Crisis*, provided such education, building grassroots support for reform. Hence, the NAACP filled a void, mobilizing resources and people of all races and religions for a social reform movement.

### Branches, Membership, and Key Historical Developments

The NAACP has over 2,000 branches across the United States, including youth, college, and international chapters. With membership in the hundreds of thousands, most members have been women. Membership peaked in 1963, the year of the March on Washington, with 535,000 dues-paying members.



The NAACP has roots in what began in 1905 as the Niagara movement—a group of influential African Americans that first met in Canada under the leadership of the Black Harvard scholar William Edward Burghardt Du Bois. In 1906, three Whites became members—activist social workers Mary White Ovington and Henry Moskowitz and prominent journalist William English Walling. A 1908 race riot in Springfield, Illinois, the hometown of former President Lincoln, underscored the crisis of violence against Blacks. Walling wrote an article, calling of others to take a stand. Prominent White reformers responded, meeting in May 1909 with Du Bois, Niagara movement members, and the antilynching crusader and journalist Ida B. Wells-Barnett. They formed the National Negro Committee, renamed the National Association for the Advancement of Colored People (NAACP) at their 1910 conference. Initially, most elected officials were White, including first president Moorefield Storey. The only Black official, Du Bois was director of publicity and research (1910–1934) and editor of *The Crisis*. Jewish leadership was prominent, including the first chairman of the legal committee, Arthur B. Springard.

An integrated team of lawyers won three important Supreme Court decisions within 15 years, helping secure the right to vote, regardless of race; striking down racial restrictions on access to residential housing; and making courts an effective weapon in the fight for full citizenship. Other citizenship rights and racial discrimination cases were chronicled in *The Crisis*, highlighting injustice suffered by real people and motivating many to become NAACP members and activists—building a grassroots and financial base. Also, across the first three decades, an unsuccessful campaign for an antilynching bill was led by James Weldon Johnson—the African American chief executive officer (CEO) from 1920 to 1930. Johnson initiated NAACP field staff positions, expanding organizational reach.

Walter White, an African American with features allowing him to pass for White when traveling to investigate cases, became CEO in 1931. During his tenure, White utilized state conferences, regional meetings, and annual national convention workshops to prepare members for changes to come with litigation. In 1939, the NAACP organized the NAACP Legal Defense and Educational Fund, Inc. (known as the LDF)—permitting collection of tax-deductible contributions as a 501(c)3 to support expanding litigation.

Across the 1940s, the NAACP created regional offices to support distant branches. Annual campaigns increased membership and funds. Cases focused on practices to bar Blacks from equal access to residential housing; Thurgood Marshall successfully argued they were unconstitutional and unenforceable. Other cases involved White primaries and educational discrimination in the South. The main architect of NAACP legal strategy was Charles Hamilton Houston. Houston selected Marshall to assist him.

After the death of Houston in 1950, Marshall was assisted by Robert L. Carter. The legal team included White and Jewish lawyers, including Jack Greenberg. Some cases challenged unfair voter registration laws. By 1951, Wilkins and Clarence Mitchell, Jr. formed powerful coalitions with labor unions and Jewish organizations—both central to lobbying. The 1954 Supreme Court decision *Brown v. Board of Education of Topeka* led to school desegregation, the most important victory won by the NAACP. In legal arguments, the use of social psychological evidence provided by Kenneth Clark was pioneered.

Another strategy involved coalition building (e.g., with the Southern Christian Leadership Conference, Congress on Racial Equality, and Student Nonviolent Coordinating Committee), as well as activism via marches, sit-ins to desegregate lunch counters, and boycotts. The NAACP supported the 1955–1956 Montgomery bus boycott, triggered by lifetime NAACP member Rosa Parks's refusal to give up her seat on a bus for a White passenger. Coalitions also brought tension. Becoming executive secretary in 1955, Wilkins frequently disagreed with Martin Luther King, Jr., over strategy: King's nonviolent mass protests versus the NAACP's litigation and lobbying. Mitchell, head of the NAACP Washington Bureau, was heralded as the leading lobbyist of his era, working closely with Wilkins and helping to secure the 1964 Civil Rights Act, followed by the Voting Rights Act of 1965. The historic 1963 March on Washington was another victory the NAACP helped to coordinate through coalitions.

In the 1970s, cases covered violation of Blacks' voting rights. Across the 1970s and 1980s, Jack Greenberg provided leadership for the Legal Defense Fund for cases on school integration, equal employment, fair housing, and voter registration. Some cases covered enforcement of the new civil rights legislation of the 1960s, including public accommodations and health care. Campaigns were started on prisoners'



rights and against capital punishment. Also, in 1982, the NAACP registered more than 850,000 voters—a milestone. In 1982, the Supreme Court upheld the argument of William T. Coleman, LDF board chair, against granting tax exemptions to religious schools that discriminate.

The LDF assisted in passage of the Civil Rights Act of 1991, restoring protections against job bias. In 1993, the NAACP endorsed and participated in the march by gays and lesbians in Washington, D.C. Controversy and financial scandal led to the 1994 ouster of the Reverend Benjamin Chavis as CEO. Revitalizing leadership followed: Myrlie Evers-Williams became chair of the board of directors in 1995; Democratic congressman and head of the Congressional Black Caucus, Kweisi Mfume, became president and CEO in 1996; Julian Bond became board chair in 1998; and, after Mfume's resignation, the business executive, Bruce S. Gordon, became president and CEO in 2005. Also, in the past decade or so, the NAACP (a) launched an economic reciprocity program in response to anti-affirmative action legislation springing up around the country, (b) launched a campaign against an increase in youth violence, and (c) negotiated agreements to increase diversity in television and film. Thus, up to the present day, the NAACP continues to be a vital organization.

Barbara C. Wallace

*See also* Affirmative Action (v3); African Americans (v3); Civil Rights (v3); Discrimination (v3); Racism (v3); Stereotype (v3)

### Further Readings

- Berg, M. (2005). *"The ticket to freedom": The NAACP and the struggle for Black political integration*. Gainesville: University Press of Florida.
- Greenberg, J. (1994). *Crusaders in the courts: How a dedicated band of lawyers fought for the civil rights*. New York: Basic Books.
- Jonas, G. (2005). *Freedom's sword: The NAACP and the struggle against racism in America, 1909–1969*. New York: Routledge.
- Wedin, C. (1998). *Inheritors of the spirit: Mary White Ovington and the founding of the NAACP*. New York: Wiley.
- Wilson, S. K. (Ed.). (1999). *The Crisis reader: Stories, poetry, and essays from the N.A.A.C.P.'s Crisis magazine*. New York: Random House.

Wilson, S. K. (1999). *In search of democracy; The NAACP writings of James Weldon, Walter White, and Roy Wilkins (1920–1977)*. New York: Oxford University Press.

---

## NATIONALISM

---

Nationalism is a sociopolitical ideology that defines the solidarity, history, and destiny of a human population based on a nation or national origin. Nationalism is either the consequence or the basis for establishing nation-states throughout the world, usually distinguished by borders confining a nation to a certain territory or homeland. Today, most of the world's population lives in nation-states, which have a national identity typified by a common language, a flag, and other national emblems. However, because of the diversity of many nations, various social movements (e.g., Black Nationalism) use the term *nationalism* to distinguish their cultural identity from the dominant national identity of the nation in which they live.

### Origins and Historical Development

Nationalists, historians, and political theorists debate whether nations created nationalism or nationalism created nations. Most staunch nationalists contend that preexisting nations, dating back thousands of years, provide a foundation for every human to fit within a world category that has a unique identity. In contrast, modernist theorists argue that local and religious loyalties were the dominant ideological influences until only about 200 years ago when European states endeavored to modernize their societies and establish a basis for armies and taxation. Most theorists agree that nationalism is based on a powerful ideology that is rooted in real, imagined, and invented memories of conflict, a homeland, traditions, mythology, and customs.

Non-Eurocentric accounts of the origins of nationalism are scant in the literature. Most theories of nationalism indicate that the European nation-states marked the beginnings of nationalism. In the late 18th and early 19th centuries, nationalist movements advanced throughout European societies. Some of the movements were formed in opposition to monarchies and religious empires, whereas others sought to unify fragmented territories into larger nations. The movements generally opposed autocratic regimes and royal families. Nationalist movements also sought to define



their territory and competed for borders. By the late 19th century, most of Europe was organized into nations. However, the nations spawned from the American Revolution, the South American independence struggles, and the Haitian Revolution predate most European nationalist movements.

Because of modernization and colonialism, by the early 20th century, nationalism was essential to the survival of most of the human populace. Populations with local loyalties were dominated by vast armies representing large nations. Some colonized populations successfully adapted a national identity in order to defeat tyrant nations (e.g., India's nationalist struggle to end British rule). Other populations (e.g., Native Americans and Australian aborigines) who never, or only recently, claimed a national identity were ruled, displaced, and oppressed by organized nations for centuries.

Nationalism also became linked to racial divisions, as many nations began to use race, or ethnic origin, to enlighten their national identity. By the beginning of the 20th century, race became the basis for most nations—an ideology that posed challenges for multiethnic nations. In the United States, President Woodrow Wilson influenced the worldview on nations through his “Fourteen Points,” which challenged the legitimacy of multiethnic empires, such as the Ottoman Empire and the Austro-Hungarian Empire. In addition, Wilson's domestic policies fueled Black and White nationalist separatist movements in the United States. The Ku Klux Klan's primary propaganda tool, the film *The Birth of the Nation*, opens with a quote from Wilson hailing the Klan as “a veritable empire of the South, to protect the Southern Country.” Black Nationalism, largely influenced by Marcus Garvey, also originated during this period, as a result of the United States's open bigotry and what many African Americans perceived as the betrayal of the Republican Party.

Abroad, nationalism based on racist extremism emerged during the period between World War I and World War II. State leaders such as Adolf Hitler and Benito Mussolini used extreme versions of nationalism such as fascism and Nazism, which held that race and national identity superseded individual rights. After gross human rights violations, including the Holocaust, fascism and Nazism lost popular support after World War II, but they remain the dominant ideology of modern White supremacists and other White nationalist organizations worldwide.

By the mid-20th century the largest wave of nationalism came from African colonies achieving

independence. Many native Africans found it necessary to adopt the language and borders drafted by their European colonists in order to build the national identity necessary to fight for independence. After violent and peaceful anticolonialist movements succeeded, Africa transformed from a collection of European colonies to a continent of nation-states. However, borders drafted by European explorers encompassed many very distinct languages, cultural identities, and localized loyalties to ruling “tribes.” Many tribal wars were amplified by European and Western powers arming factions that supported their economic interests. Pan-Africanist movements, such as the African National Congress, are Africa's most successful nationalist movements in unifying large numbers of native Africans for the purpose of creating a viable African state.

### Nationalism Within Nations

Amplified nationalism usually emerges during international competitions, such as the Olympics, when people worldwide don their nations' emblems and cheer for national heroes. Elevated nationalism is also usually necessary for a nation's government to launch a far-reaching agenda. Arguably, the high levels of nationalism that took place in the United States after 9/11 softened opposition to the subsequent wars in Iraq and Afghanistan and stimulated new domestic surveillance methods.

Today, because most nation-states are firmly established, nationalism is more commonly used to describe various social and political movements within nations that seek to define and unify a group with social, economic, or ethnic traits that are distinctive enough to distinguish it from others within the same nation. Within nations, nationalist movements have sought to strengthen national unity, especially during times of crisis (e.g., flag campaigns after the attack on the World Trade Center in 2001); reject foreign influences and limit immigration, sometimes motivated by cultural conservatism and xenophobia; and affirm the distinct identity, culture, and struggles of a marginalized population (e.g., Black Power movements in the United States).

Nationalist movements within nations almost inherently attract controversy. In the past, nationalism in national politics has often emerged as a pretext to war. In some extreme cases, nationalism has promoted ethnic cleansing and genocide, such as in Nazi Germany,



the Balkans, and Rwanda. Secession is a less extreme but still controversial consequence of nationalism and includes both successful and unsuccessful attempts to completely withdraw from a nation and create a new nation. Secession often leads to civil wars, such as those experienced in the United States and Sudan.

In contrast, many empowerment organizations that promote social, political, and economic equality through social reform and tactical resistance consider themselves nationalists. Many such nationalist movements are not seeking to secede or overthrow the government of their nation. However, they are often heavily scrutinized and covertly targeted by national governments. In the United States, for example, during the 1960s, the Federal Bureau of Investigation (FBI) targeted Black civil rights organizations, Puerto Rican nationalists, Native American organizations, and the New Left/antiwar movements through COINTELPRO (Counter Intelligence Program). Post-Watergate congressional hearings revealed that the FBI opened more than 500,000 files on more than 1 million Americans during the COINTELPRO era to investigate subversion and dissent. Some believe that overzealous nationalism promoted by the government, such as the former House Committee on Un-American Activities, leave nations vulnerable to the type of abuse in power experienced during COINTELPRO.

### Criticisms and Critiques

The scope and complexion of nationalism has changed throughout the centuries. Originally, nationalists sought to create nations. Today, nationalists strive primarily to redefine nations and assert national identity. Nationalism—and the geopolitical mandate that all nations be organized into separate states—dominates world culture. National governments and nationalist movements within nations are often in conflict with governments promoting a national identity. The recent emergence of multinational agendas (e.g., the European Union) and globalism have added to the complexity of nationalism as a political force.

Far-reaching claims, divisiveness, militarism, radical agendas, and cultural conservatism have led to widespread criticisms and critiques of nationalism. Liberals and pacifists argue that nationalism traditionally leads to intolerance and causes conflict and war between world populations. Liberal ideology generally de-emphasizes national identity and focuses on individual liberties. By contrast, many groups who are

not liberal in the traditional sense (e.g., the Nation of Islam and Puerto Rican independence movements) combat national governments with nationalism. Antiracists campaign against nationalist attitudes that promote chauvinism and xenophobia, but they do not necessarily challenge the existence of nation-states. Most liberals and antiracists are usually neutral toward, or supportive of, nationalist organizations that form in opposition to unjust national policies.

While most antinationalists target negative attitudes, such as xenophobia, and consequences, such as war, of nationalism, some ideologies challenge the legitimacy of nation-states. Marxist revolutionaries have called for a world revolution to end nation-states and engender a global state unrestricted by borders. Cosmopolitanism also supports a world state but de-emphasizes common struggles or resistance to power among the majority social class. By contrast, cosmopolitans promote cooperation among nations through international laws. Many nationalists and antiglobalists are suspicious of cosmopolitan ideas.

### Implications for Counseling

Nationalism can invoke strong emotions that can weaken one's ability to be impartial, a quality most believe is essential for counseling. Some nationalists are genuinely motivated by their desire to improve conditions for a marginalized group. Other nationalists have extremist views that are influenced by bigotry. On a macro level, state-sponsored nationalism may have the intended or unintended effect of promoting cultural conservatism and reducing general acceptance of foreign citizens.

Therefore, while striving to understand the impact of nationalism on their clientele, counselors must recognize their own thoughts and biases regarding nationalism and how nationalism may influence their subjective worldview. Like the world's populace, the vast majority of counselors live in a nation-state dominated by a national agenda, usually promoted by the government. At various times, particularly during times of national crisis, a counselor's allegiance to, or dissonance with, his or her government's agenda may lead to close-mindedness, conflict, and confusion. Overall, counselors working within nations or with people influenced by nationalism must be both open-minded and sensitive to the needs of marginalized populations and keenly aware of paranoia, xenophobia,



political cults, and other thought problems associated with extreme nationalism.

Ivory A. Toldson

*See also* Colonialism (v3); Cultural Values (v3); Culture (v3); Ethnic Identity (v3); Ethnocentrism (v3); Eurocentrism (v3); Immigrants (v3); Racial Identity (v3); Worldview (v3); Xenophobia (v3)

### Further Readings

- Bellier, I., & Wilson, T. M. (2000). *An anthropology of the European Union: Building, imagining and experiencing the new Europe*. Oxford, UK: Berg.
- Blackstock, N. (1976). *COINTELPRO: The FBI's secret war on political freedom*. New York: Vintage Books.
- Cheah, P., & Robbins, B. (Eds.). (1998). *Cosmopolitics: Thinking and feeling beyond the nation*. Minneapolis: University of Minnesota Press.
- Lawrence, P. (2005). *Nationalism: History and theory*. Harlow, UK: Pearson Education.
- Maddox, G. (1993). *African nationalism and revolution*. New York: Garland.
- May, S., Modood, T., & Squires, J. (2004). *Ethnicity, nationalism, and minority rights*. Cambridge, UK: Cambridge University Press.
- Moses, W. J. (1978). *The golden age of Black nationalism, 1850–1925*. Hamden, CT: Archon Books.

---

## NATIONAL LATINA/O PSYCHOLOGICAL ASSOCIATION

---

The National Latina/o Psychological Association (NLPA) is a national professional psychological organization that represents Hispanic/Latino/a issues in psychology. NLPA was founded in 2002 under the leadership of Patricia Arredondo, who became the founding NLPA president. The mission of NLPA is to generate and advance psychological knowledge and foster its effective application for the benefit of the Hispanic/Latino/a population.

NLPA was a reinvigoration of the National Hispanic Psychological Association (NHPA), which had been founded in 1979 at a conference of Hispanic psychologists convened at Lake Arrowhead, California. The conference was jointly sponsored by the Spanish-Speaking Mental Health Research Center and the National Institute of Mental Health. By 2002 NHPA

membership had declined, and it was not possible for the remaining members to sustain momentum for the organization. The last president of NHPA was Maryann Santos de Barona. Despite the decline of NHPA, there was still general interest in the profession in organizing around Latino/a psychology. For example, during the 1990s a series of conferences were held that focused on Latino/a psychology and were highly successful. The transformation of NHPA to NLPA parallels the growth of interest in ethnic/minority psychology and issues of multicultural competence in counseling and psychology during the late 1990s and the early 21st century, as well as the overall growth and migration of the U.S. Latino/a population. Events such as the 1999 and 2001 National Multicultural Summit and Conference, diversity-focused American Counseling Association (ACA) and American Psychological Association (APA) conventions, and the pioneering presidencies of key APA and ACA divisions by Arredondo and Melba Vasquez fueled interest in Latino/a psychology. Therefore the stage was set for the 2002 Rhode Island Latino Psychology Conference where Arredondo led the chartering of NLPA. NLPA membership was, and continues to be, open to individuals committed to the mission of NLPA; being of Latino/a heritage is not a requirement.

NLPA is one of the five groups that the APA recognizes as an Ethnic Minority Psychological Association under the auspices of the Council of National Psychological Associations for the Advancement of Ethnic Minority Interests (CNPAAMEI). The other members of CNPAAMEI are the Asian American Psychological Association, the Association of Black Psychologists, the Society of Indian Psychologists, and Division 45 of the APA—the Society for the Psychological Study of Ethnic Minority Psychology. Although affiliated with the APA, NLPA is an independent organization. In 2006 the Council of Representatives of the APA (the governing body of the APA) invited the presidents of the national Ethnic Minority Psychological Associations to speak to the Council and efforts began to establish a seat on the Council of Representatives for each of the organizations. Although there is a national structure for the organization, NLPA has also been successful in establishing and allying with independent state (e.g., California, Texas, New Jersey) and regional (e.g., Midwest Association of Latino/a Psychologists) Latino/a psychology organizations. While primarily located in the United States, NLPA membership also reflects an international perspective on Latino/a psychology in that NLPA members are found in



Guatemala and Puerto Rico, and the president of the *Sociedad Interamericana de Psicología* was one of the founding members of NLPA.

NLPA membership grew dramatically after the 2002 Latino Psychology Conference in Rhode Island. In October 2004 NLPA held the inaugural NLPA national conference in Scottsdale, Arizona. The president of NLPA at that time was Patricia Arredondo, and the theme for this conference was Advancement in Latino Psychology 2004: Strengthening Psychology Through Latino Family Values. More than 200 psychologists, academics, researchers, graduate students, and undergraduate students were in attendance at this 3-day conference. NLPA conferences were held biannually, and the 2006 conference was held in Milwaukee, Wisconsin, home to the second president of NLPA, Azara Rivera-Santiago. The conference theme was Latina/o Psychology in the 21st Century: New Trends and Challenges in Research and Practice. In 2005 Jose Cervantes was elected as the third president of NLPA followed by Edward Delgado-Romero who was elected in 2007 to be the fourth president.

In addition to the biannual conference, NLPA members meet annually at the APA and ACA conventions. NLPA also maintains a website with a database of resources relating to Latino/a psychology, recent research publications, announcements, and resources for student and professional development. NLPA manages an electronic listserv and a quarterly bilingual newsletter (*El Boletín/The Bulletin*) that highlights member activities and announcements. NLPA also sponsors several professional and student awards that are presented at the biannual NLPA conference, including the Distinguished Professional Career Award, the Distinguished Professional Early Career Award, the Star Vega Distinguished Service Award, the Cynthia de las Fuentes Dissertation Award, and the Distinguished Student Service Award.

The organizational structure of NLPA is similar to that of other ethnic minority associations. The elected positions are as follows: president, secretary, treasurer and membership chair, and student representative. There are also several additional positions and committees within the organization, including newsletter

editor and assistant editors, APA liaison, historian, public relations, awards, and student and professional development coordinators. Finally, to facilitate the dissemination of information in both English and Spanish, a large Spanish translation team exists within NLPA. Graduate student involvement and mentorship are integral to NLPA. The graduate student representative is a member of the executive committee who works as an advocate for student issues and concerns and serves as a liaison between professionals and students.

The term *Latina/o* was chosen for two reasons: first, the term *Latino* was chosen over the term *Hispanic*, as the term *Latino/a* was considered more politically progressive and inclusive. Second, although it is grammatically incorrect to list the feminine form of a Spanish word first (*Latina/o* instead of *Latino/a*), the founders of NLPA felt that it was important to both embrace and challenge Latino traditions (e.g., using a Spanish term but challenging potentially sexist linguistic hierarchy).

The membership and visibility of NLPA continues to grow. Current members are professionals, students, institutions, and lifetime founding member contributors, and as of 2006 they totaled more than 500 members. NLPA continues to work toward advancing psychological knowledge and the application of research in the field of Latino/a psychology, promoting the educational and professional advancement of Latino/a psychologists, and fostering an awareness of issues faced by Latino/a mental health professionals in their work.

Edward A. Delgado-Romero  
and Lisa M. Edwards

*See also* Arredondo, Patricia (v3); Asian American Psychological Association (v3), Association of Black Psychologists (v3); Latinos (v3); Society for the Psychological Study of Ethnic Minority Issues (v3); Society of Indian Psychologists (v3)

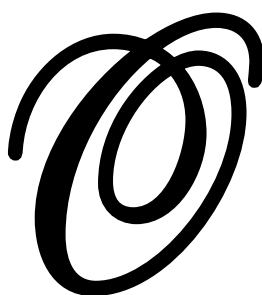
### Web Sites

National Latina/o Psychological Association:  
<http://www.nlpa.ws>









---

## OPPRESSION

---

The concept of oppression has been written about by scholars and educators in various fields. Oppression has been defined as a system that allows access to the services, rewards, benefits, and privileges of society based on membership in a particular group. Oppression involves the abuse of power whereby a dominant group engages in unjust, harsh, or cruel activities that perpetuate an attitude or belief that is reinforced by society and maintained by a power imbalance. It involves beliefs and actions that impose undesirable labels, experiences, and conditions on individuals by virtue of their cultural identity.

In the counseling and psychology literatures, the term *oppression* is often discussed in relation to privilege. *Privilege* refers to attitudes and behavior that reinforce the notion that one group's beliefs and standards are superior to those of other groups. Systems of privilege and oppression operate in the workplace, education, housing, media, and the legal system, which perpetuate inequities for some and unearned advantages and opportunities for others. Social inequities, cultural imposition of a dominant group on minority groups, and cultural disintegration and re-creation of the oppressed groups characterize systems of oppression. Oppressive systems are manifest in prejudicial attitudes and discrimination in areas such as race, ethnicity, religion, gender, class, and sexual orientation.

Fred Hanna, William Talley, and Mary Guindon describe two modalities of oppression (oppression by force and oppression by deprivation) and three types of oppression (primary, secondary, and tertiary).

Primary oppression refers to overt acts of oppression, including oppression by force and oppression by deprivation. Secondary oppression involves individuals benefiting from overt oppressive acts. Individuals involved in secondary oppression do not actively engage in oppressive acts but also do not object to others who do engage in overt oppressive acts and benefit from the aggression. Tertiary oppression, also referred to as internalized oppression, refers to the identification of the dominant message by members of the minority group, often to seek acceptance by the dominant group. Like secondary oppression, tertiary oppression can be passive in nature.

Paulo Freire's writings on oppression have significantly influenced the fields of education and counseling. He is considered a major founder of liberation pedagogy and based his theory on his experiences with teaching peasants and disenfranchised persons in Brazil. In his best-known work, *Pedagogy of the Oppressed*, Freire discussed the "banking" concept of education in which a knowledgeable teacher projects an absolute ignorance onto others, who are passive recipients of information, as an instrument of oppression. Such education attempts to control thinking, promote passivity, and stifle creativity. Oppression is described as any situation in which some individuals prevent others from engaging in the process of inquiry. Human beings are viewed as alienated from their own decision making. In contrast, the revolutionary educator uses problem posing or liberating education in which students become critical coinvestigators who are in dialogue with the teacher. Freire introduced the term *conscientização*, or the process of developing a critical consciousness, advocating for



the development of awareness of oneself within one's social context. According to Freire, a crucial component of critical consciousness is helping students understand how they learned to define themselves as their oppressors viewed them.

The study of oppression is prominent in the field of postcolonial studies (see, e.g., the writings of psychiatrist Frantz Fanon). This entails the study of the interactions between European nations and the societies they colonized in the modern period and, more specifically, the deleterious effects of European colonization on various cultures in the world. Research in postcolonial studies is growing, as postcolonial critique allows for a wide-ranging investigation into power relations in various contexts. Topics in the field include the impact of colonization on postcolonial history, economy, science, and culture; the cultural productions of colonized societies; agency for marginalized people; and the state of the postcolony in contemporary economic and cultural contexts.

Feminist scholars have described the complexity of multiple intersecting identities. Depending on the context, one may be an oppressor or be oppressed. For example, a man of color may be the recipient of racism, but he may exploit women. Similarly, a White woman may oppress people of color and simultaneously experience oppression, or sexism, in relationships with men. The work of feminists of color such as Angela Davis and bell hooks has also informed understandings of multiple oppressions. They describe the "double or triple jeopardy" of racial and ethnic minority women who often experience oppression associated with race, class, gender, and sexual orientation. Chicana feminists such as Delores Degaldo Bernal, Chela Sandoval, and Paula Moyahave have discussed the survival skills needed for managing multiple oppressions and experiences of marginalization, such as those associated with language issues, immigration and migration, generation of residence in the United States, and religion.

The writings of such scholars, educators, philosophers, and social justice advocates have influenced the field of counseling and psychology. Psychologists such as Beverly Greene and Lillian Comas-Díaz have discussed the clinical implications of multiple oppressions and intersecting identities. In fact, the fields of counseling and psychology have moved from a focus on intrapsychic factors to an analysis of the interplay between intrapsychic and contextual forces, such as oppression, and its impact on psychological functioning. "Internalized oppression" is a central theme in minority psychology. Internalized oppression is seen

as common to many colonized or formerly colonized individuals, and has also been discussed with respect to sexual minority populations. Internalized racism and internalized homophobia are two forms of internalized oppression. *Internalized oppression* refers to a condition in which oppressed individuals and groups come to believe they are inferior to those in power. The oppressed eventually comes to believe an identity that is consistent with the oppressor's stereotyped perceptions of the oppressed. The internalization of oppression leads to a devalued self-worth among the oppressed. Internalized oppression can lead to self-hatred, self-concealment, feelings of inferiority, isolation, and powerlessness. Fanon described the self-doubt and identity confusion in colonized persons that results from the continuous denial of their humanity. Racism is seen as a form of colonialism in which oppressors inscribe a mentality of subordination in the oppressed. Oppression has been linked to a range of psychiatric problems, including depression, anxiety, posttraumatic reactions, identity confusion, substance abuse, domestic violence, and eating disorders, as well as physical ailments such as high blood pressure. The high rates of suicide, alcoholism, and domestic violence among Native Americans have been linked to a history of oppression and its internalization.

Internalized oppression has also been discussed in the counseling and psychology in relation to identity development. The identity development process varies according to specific aspects of identity. Identity development is often characterized as an individual's movement from internalized oppression or privilege, lack of awareness or salience with regard to a particular identity, toward increased awareness of societal oppression and/or privilege, cognitive flexibility, and internal standards of self-definition. Racial and ethnic identity development theorists such as William Cross and Janet Helms have argued that internalized oppression may lead oppressed individuals to highly value the dominant racial and ethnic group and devalue their own. The development of a critical consciousness regarding one's role in perpetuating racism and oppression is a significant aspect of achieving a nonracist White identity. Feminist identity development also involves a recognition and understanding of internalized sexism and its effects.

### Application to Counseling

Given the interrelatedness of oppression and privilege, the multidimensional and complex nature of both these



constructs, and their relationship to mental health issues, clinicians must be able to identify and understand the complexity of clients' multiple identities and address issues related to the various forms of oppression and privilege. Oppression in the form of racism and discrimination has been identified as a stressor that affects psychological functioning, adjustments, social adaptation, and physical health. Clinicians' misdiagnosis of individuals from oppressed groups is common, as majority norms are often used as the standard against which all clients are compared. In addition, clinicians may mistake trauma-like reactions to oppressive circumstances for intrapsychic pathology. Culturally and contextually influenced expressions of distress may be misunderstood.

The Multicultural Counseling Competencies, a self-assessment form developed by the Association for Multicultural Counseling and Development and endorsed by both the American Counseling Association and the American Psychological Association, offers guidelines for becoming a culturally skilled counselor, which includes a commitment to self-awareness and knowledge of various types of oppression. In addition to the Multicultural Counseling Competencies, there has been an increased focus on social justice and social action related to multicultural counseling. In this context, therapists are not only aware and knowledgeable about oppression but take action against the causes and conditions of oppression. Guidelines for psychotherapy with girls and women; guidelines on multicultural education, training, research, practice, and organizational change; and guidelines for lesbian, gay, bisexual, and transgendered clients continue to be developed.

Educators and therapists as social justice agents must address issues of oppression and privilege at the training level and the practice level. Studies support the importance of exploring oppression and privilege issues within coursework (i.e., facilitation of multicultural counseling competency) and suggest that not addressing these constructs may in fact obstruct the therapeutic process and compromise the client's identity, as well as lead to misunderstanding and misinterpretation of the client's perspective and actions. In fact, social activism has also been viewed as an important aspect of identity development for members of marginalized groups. The literature suggests several strategies for addressing oppression and privilege issues at both training and practice levels. These strategies involve liberating both the oppressor and the oppressed and include awareness of self, establishment of empathy, and building of coalitions. Specifically, educators and

therapists encourage students and clients to explore their cultural identities, become knowledgeable about the sociocultural and historical backgrounds of their students and clients, and apply this awareness and knowledge to inform culturally relevant practice.

## Future Directions

Conceptualizations of oppression in the counseling literature have evolved over time. More recent perspectives have moved from a dualistic approach and pointed to the complex dynamics of oppression and privilege that vary across contexts. This position considers the impact of multiple social identities and situations.

More recent research has focused on the development of inventories that assess awareness of and attitudes toward oppression and privilege, the effects of multiple oppressions on individuals' mental health, and counseling interventions designed to decrease the deleterious effects of oppression on mental health.

*Julie R. Ancis and Catherine Y. Chang*

*See also* Classism (v3); Deficit Hypothesis (v3); Discrimination (v3); Discrimination and Oppression (v2); Multicultural Counseling Competence (v3); Prejudice (v3); Racism (v3); Sexism (v3); Social Class (v4); Social Discrimination (v4); Social Justice (v3); White Privilege (v3)

## Further Readings

- Ancis, J. R. (Ed.). (2004). *Culturally responsive interventions: Innovative approaches to working with diverse populations*. New York: Brunner-Routledge.
- Arredondo, P. (1999). Multicultural counseling competencies as tools to address oppression and racism. *Journal of Counseling & Development*, 77, 102–108.
- Freire, P. (1970). *Pedagogy of the oppressed*. New York: Herder & Herder.
- Hanna, F. J., Talley, W. B., & Guindon, M. H. (2000). The power of perception: Toward a model of cultural oppression and liberation. *Journal of Counseling & Development*, 78, 430–441.
- hooks, bell. (1984). *Feminist theory from margin to center*. Boston: South End Press.

---

## ORGANIZATIONAL DIVERSITY

---

The workforce of the United States continues to grow more diverse. Employment equity legislation has



made organizational diversity an issue of legal, ethical, and strategic interest. Data reported in 2005 by the Equal Employment Opportunity Commission (EEOC) indicate an increase in the percentage of people of color in the private sector from 27% in 1998 to 30% in 2003. In 2005 the Department of Labor reported that while foreign-born workers currently account for 15% of the workforce, up from 11% in 1998, they have also accounted for 46% of the net increase in the labor force since 2000. The percentage of women in the workforce has also risen. In 2004, 59% of all women were in the workforce, up from 43% in 1998, as compared to 75% and 73% of men in the workforce in 2004 and 1998, respectively. Additionally, the Bureau of Labor Statistics projections for 2004–2014 predict the number of workers over 55 years old will grow by 49.1%, outpacing growth in the entire workforce by five times. The number of disabled Americans in the workforce increased from 29% in 1998 to 35% in 2004, according to the National Organization on Disability. These trends indicate that the workforce continues to become more heterogeneous on multiple dimensions.

There are two major perspectives on what characterizes the term *diversity* should encompass in organizational settings. One perspective defines *diversity* based on the demographic characteristics covered in the civil rights legislation enforced by the EEOC. This defines diversity in terms of race/ethnicity, gender, age, national origin, religion, veteran status, and disability. The other perspective is broader, encompassing the EEOC categories as well as other distinguishing characteristics, including sexual orientation, values, abilities, personality characteristics, education, languages spoken, physical appearance, marital status, geographic origin within the United States, tenure with the organization, functional specialization, and economic status. Although a broader definition of diversity may be more inclusive because it encompasses the many ways in which organizational members can differ from one another, it is also problematic in that it ignores the power differences associated with the powerful impact of race, gender, and disability status. The narrower EEOC definition includes only the legally protected categories—groups whose social identities limit their access to societal and organizational resources.

Although it is important to acknowledge that diversity can be constructed across multiple aspects of a person, the impact of different identities is certainly not equal. Segregation in organizations and the

demographics of organizational hierarchies reflect American society broadly, which shapes the expectations and experiences of employees. Power, authority, and leadership are allocated disproportionately to certain demographic groups; hence, access to higher-level positions is likely to be difficult for historically disadvantaged groups. Although organizations are more diverse in sheer numbers in the workforce, this diversity is not seen within a given job type or across levels within organizations. Data from the 2000 Census indicate that job segregation by race and gender are common in the workplace. According to EEOC data, although White men make up 37% of the private industry workforce, they comprise 85% of all officials and managers and only 21% of all service positions. Whereas women of color make up 15% of the private industry workforce, they comprise only 6.3% of the officials and managers and 25% of all service positions. Thus, positions of power and authority in the private sector are populated disproportionately by White males. Low-wage sectors continue to be dominated by women and people of color, where they have little access to training or advancement opportunities; such thwarted access is a well-documented source of stress and turnover.

Employee reactions to diversity in organizations as well as concerns about racial and gender segregation in the workforce are often framed as issues of organizational justice. Researchers have found that government-legislated programs, such as affirmative action and elective organizational diversity initiatives, evoke strong feelings from historically advantaged and disadvantaged group members alike. Historically disadvantaged group members are often disappointed at the limited resources devoted to preventing discrimination. Conversely, members of historically advantaged groups may perceive that too many resources are devoted to achieving equity and preventing discrimination. Research has found that members of both groups experience stress over these concerns.

The experience of stress in diverse organizations depends on where an individual is located in the organizational hierarchy. Segregation into work that is not fulfilling or that limits one's career opportunities is an experience shared by many foreign-born workers, female workers, and people of color. Additionally, workers may find they have been hired into a department where they are the only member of a visible minority group and thus face the stress of working in a homogeneous environment. Possibly treated or



perceived as “token” members of a group, they may be expected to represent their community, racial/ethnic group, or gender. This situation has been demonstrated to lead to stereotype threat, a situation where an individual is concerned that he or she will confirm a negative stereotype about his or her group. Stereotype threat has been demonstrated to impair performance in these situations and can cause psychological strain. Token members of visible minority groups may also experience the stress of attempting to maintain their cultural identity while adapting to a homogeneous work environment that may not value their cultural identity and may be overtly or subtly racist or sexist. Consequences of this type of stress can include the following: resentment at having to do one’s work as well as adapt to social norms that seem arbitrary, exhaustion at the extra effort required to adapt to the norms of the workplace, frustration and anger in response to racism, lowered performance outcomes, reduced organizational commitment, cynicism, turnover, and long-term physical outcomes such as elevated blood pressure. Such workers are likely to need the support of psychological or wellness services that an organization offers, if they feel comfortable using them. Unfortunately, they may then encounter a psychologist or human resource staff person who fails to understand that the homogeneous environment is a source of stress and therefore does not provide real support for the individual, or worse, compounds the experience of social isolation, which leads to further reduced work and negative health outcomes.

There is also research on the stress experienced by historically advantaged group members when they find themselves working in diverse work settings. In a study on the effects of diversity on psychological and behavioral commitment to organizations, researchers found that White men experienced the greatest difficulty in adapting to diverse work units. The impact of having greater gender and racial diversity led to increased absenteeism, lowered organizational commitment, and the increased likelihood of turnover. Possible factors accounting for this stress may include the concerns that many White Americans have about appearing prejudiced. Thus, it might be more stressful for Whites to work with people of color because of the worry that they may appear prejudiced. Status factors have also been found to influence preferences for type of jobs for both men and women, who prefer to work in male-dominated groups because of men’s historically advantaged status. Researchers have found that

gender affects wages; controlling for all other factors, a manager earns more money when his or her subordinates are predominantly male. This research suggests that diversity can be stressful for all concerned, albeit for different reasons.

Initially, organizations were motivated to address diversity by the need to comply with the EEOC legislation. However, as affirmative action programs have been challenged in court cases, legal compliance has become only one of the reasons that organizations cite for engaging in diversity efforts. Currently, most organizations that are engaged in diversity initiatives describe their interest in diversity as a reflection of the belief that it makes good business sense to do so. The business case for focusing on diversity suggests that to stay competitive, organizations must respond to demographic changes by learning to strategically manage a diverse workforce and appeal to a diverse customer base. Some organizations have responded by hiring according to the demographics of their customers. Unfortunately, this approach can exacerbate job segregation and limited career mobility by channeling women and racial/ethnic minorities into areas where their customer base matches their identity group. The emphasis on the business case may also create the impression that issues of discrimination and inequality are of little importance, thus heightening the sense of cynicism among women and racial/ethnic minorities, for whom these are issues of central psychological importance.

The limitations of this approach have been noted by researchers who suggest that a more optimal way to capitalize on demographic diversity is by focusing on the potential for learning and innovation that a diverse workforce offers. The variety of perspectives that accrue from different cultural or experiential backgrounds can offer an organization new and potentially more flexible, improved ways of working. This requires openness to change and innovation generally, because it invites genuine debate over how to do the work of the organization and who should have the opportunities to do that work. A learning approach could help reduce job segregation. Although research on the benefits of diversity remains mixed, some patterns are emerging. Those organizations that have adapted a learning and innovation approach to diversity and that have been able to create a climate where individuals can truly learn from the diversity of perspectives that exists within their organizations have been financially successful.

The workforce of the United States will continue to become more diverse, providing challenges and



opportunities for organizations. In addressing this, organizations have used different definitions of diversity in crafting their responses. The approach that best addresses issues of power and intergroup conflict is one based on the EEOC guidelines, since the guidelines pertain to the groups that have experienced the greatest limitations in the workplace, as well as high levels of stress. However, those who have not historically experienced discrimination are now experiencing stress in adapting to more diverse organizations. Counseling psychologists will play a critical role in helping workers cope with the stress of working in diverse organizational environments. Researchers have identified significant potential for organizations that use diversity proactively, as a source of learning and innovation, rather than in a narrower and more reactive fashion. This is an important area for research in understanding how to leverage diversity for both individuals and organizations.

*Brenda K. Johnson and Caryn J. Block*

**See also** Affirmative Action (v3); Assimilation (v3); Career Counseling (v4); Demographics, United States (v3); Diversity (v3); Diversity Issues in Career Development (v4); Interracial Comfort (v3); Multiculturalism (v3); Political Correctness (v3); Racial Identity (v3); Stereotype Threat (v3); Tokenism (v3)

### Further Readings

- Ely, R. J., & Thomas, D. A. (2001). Cultural diversity at work: The effects of diversity perspectives on work group processes and outcomes. *Administrative Science Quarterly*, 46(2), 229–273.
- Jackson, S. E., Joshi, A., & Erhardt, N. L. (2003). Recent research on team and organization diversity: SWOT analysis and implications. *Journal of Management*, 29(6), 801–830.
- Kochan, T., Bezrukova, K., Ely, R., Jackson, S., Joshi, A., Jehn, K., et al. (2003). The effects of diversity on business performance: Report of the diversity research network. *Human Resources Management*, 42(1), 3–21.
- Linnehan, F., & Konrad, A. M. (1999). Diluting diversity: Implications for intergroup inequality in organizations. *Journal of Management Inquiry*, 8(4), 399–414.
- Ragins, B. R., & Gonzalez, J. A. (2003). Understanding diversity in organizations: Getting a grip on a slippery construct. In J. Greenberg (Ed.), *Organizational behavior: The state of the science* (pp. 125–163). Mahwah, NJ: Lawrence Erlbaum.

Stockdale, M. S., & Crosby, F. J. (2004). *The psychology and management of workplace diversity*. Malden, MA: Blackwell.

---

## ORTHOGONAL CULTURAL IDENTIFICATION THEORY

---

Orthogonal cultural identification theory argues that in a pluralistic environment, individuals may identify with more than one culture without necessarily sacrificing one cultural identity for another. The central element of this theory is that identification with any one culture is independent from identification with other cultures. Cultural identification can be distinguished from ethnic self-labels, or ethnic group categorizations, such as Latino/a, Mexican, American Indian, African American, and European American. Ethnic labels can gloss over the heterogeneity of cultural identification within ethnic groups because not all individuals who use the same label may identify with the culture in the same manner or to the same degree. Ethnic self-labels also may not accurately represent the way in which individuals identify with more than one culture. Generally, cultural identification is dynamic and complex and can be defined as following a culture's way of life (e.g., participation in traditional activities, cultural behaviors, feeling successful within a culture, and/or family involvement in cultural activities). An example of the complexity of cultural identification is that within ethnic groups, individuals vary not only in their range of cultural identification (e.g., from strong to weak to nonexistent) but also in their identification with one culture, multiple cultures, or none. Orthogonal cultural identification theory argues that cultural identification is the result of the interaction between the individual and his or her environment, which may include family cultural identification, ethnic peers, and available traditional activities. Cultural identification is also distinct from cultural/ethnic identity, which can be defined as a social identity that represents the emotional value and significance of belonging to an ethnic group.

### Importance

This theory made a significant conceptual contribution to both research and counseling, in that it



acknowledged the influence of a pluralistic environment and normalized experiences of identification with multiple cultures. Previous acculturation theories assumed that developing a dominant majority cultural identification would result in loss of the ethnic minority culture. Thus, a significant advance of this theory is the conceptualization of biculturalism as a dual identification with more than one culture without any necessary loss of either culture.

Moreover, the improved quantitative assessment of cultural identification that resulted from this theory advanced the study of ethnic identity and acculturation beyond simple categorizations of individuals to capture more of the complexity inherent in cultural identification. As such, the theory reflects the dynamic and fluid nature of cultural identification of individuals within pluralistic societies by representing a wide range of combinations of cultural identifications. Identification with any one culture can range from “low” to “high” along a continuous dimension and is not necessarily dependent on identification with other cultures.

Eugene Oetting and Fred Beauvais developed an instrument that has been used frequently in the literature, wherein survey questions are phrased in this way: “Are you a success in the . . . (culture identified) . . . way of life?” Responses range from “a lot” to “not at all” in this instrument. Each set of questions is asked separately for different cultures. Typically, six items are used in this scale and include family way of life, personal way of life, family success, personal success, family cultural traditions, and personal cultural traditions. A total score can be created for each culture separately and then combined or used separately. Additionally, orthogonal cultural identification theory advanced the state of the study of cultural change by making the measurement more inclusive for both majority and minority cultures, whereas previous measures were specific only to certain ethnic minority groups.

## Research

The prevalent “melting pot” analogy of the immigrant experience in the United States assumed that immigrants would “melt” or assimilate into the U.S. dominant culture by leaving behind their native culture. Researchers argued that living in an environment with more than one culture may be difficult due to negotiating more than one set of values, norms, and identities; thus, it was presumed that such individuals would experience more stress and often feel

marginalized. Based on this model, it was assumed assimilation would result in the best mental health and adaptation because of the inherent stress in negotiating more than one culture. However, the reality of immigrants as well as native groups has been that individuals maintain aspects of their original culture while integrating the dominant culture. Researchers are continuing to find that maintenance of one’s culture of origin is not pathological; rather, it can be an adaptive approach that promotes mental health and well-being. Additionally, the orthogonal cultural identification theory demonstrates that maintaining one’s culture does not impede adaptation to the dominant culture, as had been assumed in melting pot theories.

Current cultural identification and acculturation models are based on the “cultural stew” analogy. In this analogy, individuals, like the vegetables or meats in a stew, contribute to the overall U.S. dominant culture; yet they may also retain their cultural integrity and can be identified separately. As such, individuals may maintain their cultural integrity while contributing to the dominant culture. The orthogonal cultural identification theory has contributed much to the understanding of the complexity of cultural change and cultural identification. Furthermore, this research has helped document that individuals can successfully integrate and maintain more than one culture. This theory is distinctive from other acculturation models in that it allows for change over the life span and more options for cultural identification with more than one culture.

The orthogonal cultural identification theory has improved understanding of biculturalism, where individuals identify with two cultures simultaneously. Teresa LaFromboise and her colleagues have described bicultural individuals as those who are able to use behaviors and language at the appropriate times and contexts because they have experience and knowledge of both cultures. Researchers have argued that biculturalism is the most adaptive outcome for some minority groups, in part because the nature of their environment is bicultural. However, recent work suggests that being bicultural may be stressful and that successful integration of biculturality may be the most significant factor for mental well-being. Research has suggested that to understand how culture impacts mental health, it is important to assess the fit between the individual and the multicultural environment.

The orthogonal cultural identification theory has made significant conceptual and measurement



advances in the study of culture at an individual psychological level. The central aspect of this theory is that cultural identification is separate and independent when there is more than one culture. This theory more accurately reflects the pluralistic nature of culture. Additionally, it portrays individuals as active social agents who have the power to determine their own cultural identification with more than one culture. Multicultural individuals can be defined as those who identify with more than one culture simultaneously. This theory identified not only that assimilation to U.S. culture did not automatically indicate loss of ethnic culture but also that maintenance of ethnic culture may be a positive adaptive strategy for minority ethnic groups in the United States.

### Implications for Counseling

Maintenance of a positive ethnic identity may be beneficial for minority and immigrant mental well-being. Counselors should be aware that biculturalism may be adaptive in certain settings; however, bicultural environments may also create stressful experiences for some individuals and successful integration for different identities may be necessary. The alternation model of acculturation may be helpful in understanding how bicultural individuals can switch between cultural frameworks based on situational cues and their bicultural competency. Counselors may integrate multicultural self-assessments into their practice to assist individuals in understanding how cultural context influences their personal histories as well as their current behaviors. Increasing awareness of cultural identities and resolving related cultural context stressors may be integral to improved therapeutic outcomes for some individuals. An example of bicultural identification is a Mexican American student who is successful in higher education (e.g., a task that may entail internalized aspects of cultural values characteristic of dominant U.S. worldviews) while at the same time

successful in maintaining strong family ties (e.g., a value that may reflect Mexican ways of endorsing familismo). This individual would feel equally successful in both the U.S. and Mexican ways of life. Additionally, this example demonstrates that being successful in the U.S. way of life does not necessarily mean that one is not successful in the Mexican way of life. However, as noted by Manuel Ramirez, the potential conflict, contradictions, and stress that some individuals experience in negotiating more than one cultural way of life may be addressed within a counseling setting.

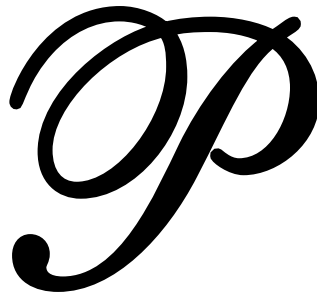
Andrea J. Romero

**See also** Acculturation (v3); Acculturative Stress (v3); Assimilation (v3); Bicultural (v3); Cultural Accommodation and Negotiation (v3); Cultural Equivalence (v3); Cultural Values (v3); Culture (v3); Enculturation (v3); Ethnic Identity (v3); Identity Development (v3); Second Culture Acquisition (v3); Stress (v2)

### Further Readings

- LaFromboise, T., Coleman, H., & Gerton, J. (1993). Psychological impact of biculturalism: Evidence and theory. *Psychological Bulletin*, 114, 395–412.
- Oetting, E. R., & Beauvais, F. (1990–1991). Orthogonal cultural identification theory: The cultural identification of minority adolescents. *International Journal of the Addictions*, 25, 655–685.
- Phinney, J. S. (1990). Ethnic identity in adolescents and adults: Review of research. *Psychological Bulletin*, 108, 499–514.
- Ramirez, M., III. (1998). *Multicultural/multiracial psychology*. Northvale, NJ: Jason Aronson.
- Romero, A., & Roberts, R. E. (2003). Stress within a bicultural context for adolescents of Mexican descent. *Cultural Diversity & Ethnic Minority Psychology*, 9, 171–814.





---

## PACIFIC ISLANDERS

---

*Pacific Islanders* refers to the indigenous people of the Polynesian, Micronesian, and Melanesian islands. *Polynesia* refers to the islands settled by Polynesians, which includes (but is not limited to) Tahiti, Hawai‘i, American and Western Samoa, Tonga, Rapanui (Easter Island), the Cook Islands, and French Polynesia. *Micronesia* refers to the islands in the Western Pacific with its main islands being the Caroline Islands (including Federated States of Micronesia and Palau), the Gilbert Islands, and the Mariana Islands (including Guam). The Chamorros are native to Guam and the Northern Marianas. The islands of Melanesia consist of Papua New Guinea, Solomon Islands, Vanuatu, New Caledonia, and Fiji. The history of the three divisions of the Pacific Islands is tied to the colonization process of the Pacific (also referred to as Oceania) and is related to the geographic locations of these islands rather than commonalities of culture and language. However, two areas of commonalities exist across these island cultures: (1) commitment to cultural values such as the emphasis on family, interdependence, holism, and harmony with nature; and (2) historical trauma due to colonization and the current challenges facing many Pacific cultures to maintain their cultural identity, lands, and traditions. To be consistent with the language of the U.S. Census, *Pacific Islander* will be referred to as a racial category.

In the field of counseling, there is some debate in terms of the distinction between race, ethnicity, and culture, yet no conclusion has been made indicating whether *Pacific Islander* is a racial or ethnic category.

Each island has unique cultural aspects that may be similar to or different from those of other nearby islands; therefore, generalizations about chains of islands should be interpreted with caution given the heterogeneity within the Pacific Islands’ cultures and their respective native inhabitants.

The 2000 U.S. Census was the first census to have *Pacific Islander* as a distinct racial category separate from *Asian* for all 50 states. The 2000 Census included three specific Pacific Islander groups—Native Hawaiian, Samoan, and Guamanian or Chamorro—as well as a separate Other Pacific Islander response category for people to write in their Pacific ancestry. Other Pacific Islander groups living in the United States are Tahitian, Tokelauan, Mariana Islander, Saipanese, Palauan, Carolinian, Kosraean, Pohnpeian, Chuukese, Yapese, Marshallese, I-Kiribati, Fijian, Papua New Guinean, Solomon Islander, and Ni-Vanuatu. In the 2000 U.S. Census, the total number of individuals who identified as fully or partially Pacific Islander was 874,414 people (0.3% of the total U.S. population), with 398,835 reporting solely as Pacific Islander and 475,579 as Pacific Islander in combination with one or more races. The increase in Pacific Islanders (who indicated only one racial category) living in the United States was 9% from 1990 to 2000, while the increase of Pacific Islanders who indicated one or more races increased 140% within this same time period. The Pacific Islander racial category consists of more than 20 different groups with the 4 largest accounting for slightly over three fourths (76%) of this racial group: Hawaiians (n = 401,162; 45.9%) constituted the largest cluster of Pacific Islanders, followed by the Samoans (n = 133,281; 15.2%), the Chamorros



or Guamanians ( $n = 92,611$ ; 10.6%), and the Tongans ( $n = 36,840$ ; 4.2%). The other Pacific Islander ethnicity categories ranged from a total of 18 (Ni-Vanuatu) to 12,581 (Fijian) people living in the United States.

Pacific Islanders also reported the highest concentration of individuals who recorded as being of more than one race in comparison with all other races in the United States and the only race that had a higher number of people indicating multiple racial categories than a sole racial category. Pacific Islanders are becoming increasingly a multiracial and multiethnic population. Pacific Islanders live throughout the United States, with nearly three quarters (73%) living on the West Coast of the continental United States and Hawai'i.

### **History of Pacific Islanders and the United States**

The United States is the colonial landlord of more than 2,300 islands in the Pacific (excluding Hawai'i). The only Pacific island that officially became a state of the United States was Hawai'i, in 1959. Guam, American Samoa, and Northern Mariana Islands are U.S. territories, and the Republic of the Marshall Islands, Federated States of Micronesia, and the Republic of Palau are considered freely associated states. Guam is considered an unincorporated territory of the United States because not all provisions of the U.S. Constitution apply to this territory; however, the government was organized based on the U.S. Constitution, including an elected representative to Congress.

### **Status of Pacific Islanders in the United States**

Pacific Islanders, in general, have lower median earnings (for both men and women), have lower family income, and are less likely to hold management and professional positions in comparison with the total U.S. population. In addition, Pacific Islanders have higher rates of poverty (17.7%) in comparison with Caucasians (11.5%) and Asian Americans (9.4%). Pacific Islanders have a high prevalence rate of high school graduates: 78% (compared with 90% for Caucasians and Asian Americans) but are concentrated in the lower percentage of persons having completed a bachelor's degree (14% compared with 24% of the total U.S. population) and graduate degrees (4% for Pacific Islanders and 10% for Caucasian Americans).

Pacific Islanders have higher prevalence rates of smoking, alcohol consumption, and obesity, while having a lower survival rate for cancer, in comparison with Caucasians and other racial and ethnic groups. Unfortunately, knowledge about the prevalence rates of mental health issues and the needs of Pacific Islanders is limited given the low numbers of Pacific Islander participants in epidemiological studies. However, studies on Native Hawaiians have found Pacific Islanders to be at risk for depression, anxiety, substance abuse disorders, and suicide. Many indigenous populations in the Pacific are facing similar challenges and health risk factors.

### **Research on Pacific Islanders**

The proliferation of empirical research on counseling, treatment, and mental health issues among Asian Americans in the past 25 years has masked the paucity of research among Pacific Islanders. Furthermore, research on cultural values, norms, beliefs, attitudes, and family dynamics in Pacific Islander cultures have been advanced through ethnography and anthropology investigations leaving psychological theories and interventions without a solid culturally appropriate foundation upon which to build a body of knowledge. The emergence of stereotypes from ethnographic research of Pacific Islander cultures has resulted in appropriate concern about the value of extant knowledge in guiding psychology and clinical interventions. Without overdramatizing the limitations of past anthropological studies, an example may be found in the classic work of Margaret Mead, who portrayed Samoans as warm, easygoing, pleasant, happy people with playful and open sexual relationships living in a society lacking competition, aggression, and hierarchy. Results from ethnographic studies were used as evidence to support the stereotype of the Pacific Islander as lazy, promiscuous, happy, easygoing, and nonassertive. These stereotypes have been further perpetuated and maintained by the tourism industry and the media. Further research has found Pacific Islanders and their respective cultures to be much more complex than these initial anthropological studies demonstrated, with heterogeneity within and between cultural groups within the Pacific Islander community. Generalizations need to be interpreted with caution given the varying degree of Western contact and influence, interracial relationships, migration, and heterogeneity among the various peoples and cultures of the Pacific Islands.



## Cultural Values

Pacific Islander communities have come together to reclaim their identity, their land, their cultural values, and their spiritual beliefs to strengthen themselves and their families after years of colonization. The movement of “indigenous ways of knowing” and re-embracing cultural strengths to help heal past historical injustices can be seen in multiple Pacific Islander communities, including the Native Hawaiians, Tongans, and the aboriginal peoples of Australia and New Zealand. This cultural renaissance of ethnic beliefs, values, customs, expectations, and practices has also created a sense of pride and strength to help empower indigenous groups to create their own empirical investigations about their own people.

At the center of Pacific Islander culture is the family system, that is, the network of interpersonal relationships that shape the processes by which cultural practices and values are transmitted, maintained, and affirmed. The network of relationships is at the *piko* (Hawaiian for “center”) of health and healing processes and can be a strong source of support and identity in Pacific Islander culture. A person’s family can consist of extended family and informal relationships such as friends and family members of friends. The Pacific Islander’s concept of self is tied to the view that the individual, society, and nature are inseparable and key to psychological and physical health. Such relational and emotional bonds that shape the individual, family, and community have implications for psychological functioning and well-being.

Mental health symptoms may be related to disharmony or dysfunction within the family or collective unit. A conflict within this network of social relationships can lead to mental illness such as depression, substance abuse, anxiety, alienation, and isolation. The etiology of mental illnesses and its respective symptoms can be seen as related to disharmony or discord within social relationships. Therefore, treatment of mental health issues using indigenous health practices may focus on treating social relationships rather than the individual.

Another critical component to understanding Pacific Islanders is the concept of a sense of place in connection to one’s identity. Place is the source of one’s worldview, genealogy, and existential foundation. The connection to a place or land is also embedded with responsibility and obligation to the land, the place itself, and one’s kin. Space in contrast to place

refers to where a person is living or dwelling; however, it may not be the origin of one’s identity. A person’s space may be dictated by circumstances in his or her life, such as living on the continental United States for educational or work opportunities.

One of the most common misunderstandings about Pacific Islanders is the assumption that by either living away from one’s island or being born elsewhere somehow means that person is less “native” or “indigenous” to the islands. Mental health professionals may make an erroneous claim that if Pacific Islanders are not living in their “place,” they have forfeited their identity as indigenous or native Pacific Islanders. However, this need to “legitimize” or “authenticate” a Pacific Islander’s identity and cultural heritage can feel like negating this person’s sense of identity and the essence of his or her *mana* (Hawaiian for “life force”). Another misconception about Pacific Islanders is the idea of migration as being one way toward another place, such as the continental United States, rather than circular migration. Circular migration occurs when people may live away from the islands but return home for long visits or move back in later stages of their lives (e.g., after having children or after retiring).

Another similar feature among Pacific Islanders is the emphasis and importance placed on one’s cultural identity. The importance of knowing one’s ancestral heritage and its respective connection to the land can be viewed as a key element in developing a coherent sense of self. There are terms within the language such as *Fa’a Samoan* (“the Samoan way of life” or “the Samoan way”) or *anga fakatonga* (“the Tongan way”) that indicate this connection between one’s culture, heritage, the land, and cultural identity. However, this importance placed on cultural identity and the influence of Western individualism and capitalism has had an effect of the definition and development of Pacific Islanders’ cultural identity.

## Psychological Issues Facing Pacific Islanders

The issues facing Pacific Islanders are also embedded in the events in history and similar challenges faced by other groups of color living in the United States. These issues include acculturation, ethnic identity, the effects of colonization and annexation, and the effects of racism, discrimination, and oppression. Charles Darwin indicated that “wherever the European has trod, death seems to pursue the aboriginal.” One issue that Native



Hawaiians and Chamorros have had to face is the cultural genocide of the indigenous peoples of the islands. Explorers who came to the Pacific Islands brought with them many foreign diseases for which the native populations had no immunity; the results were death and infertility among the native people. In addition, contact with foreigners also led to warfare, thus increasing the death toll of the indigenous peoples of the islands. The colonization process and cultural genocide of Pacific Islanders, such as Native Hawaiians, has been noted as a major contributor to the prevalence of depression, anxiety, and despair among these indigenous people. Missionaries in the 1820s came to the Pacific Islands to help save souls of the native inhabitants. Along with Christian doctrine, Western cultural norms were also transmitted as the ideal to these indigenous cultures. The result was the emphasis on native people to conform and assimilate to Western values. This included Western notions of economic and sociopolitical development, such as private ownership of land and the restructuring of hierarchy and privilege based on wealth rather than on genealogy. These radical shifts and changes in the social, political, economic, and religious structures within these indigenous communities resulted at times in ethnocide, that is, the destruction of the Pacific Islanders' way of life.

The study of the psychological impact of Western contact resulting in colonization and annexation of Pacific Islanders is in the early stages of development in research. Models and theories have indicated that the accumulation of losses—including land, language, culture, ancestors, and kin—can lead to depression, anxiety, drug and alcohol abuse, deviant behavior, and suicide. The stressors associated with colonization can include historical trauma and the effects of the multiple losses and the ripple effects throughout indigenous peoples' daily lives and significant life events. The need to perpetuate one's culture after such significant loss is a responsibility felt by many indigenous peoples; this need can influence life decisions such as choice in a partner or spouse, where to live, the pursuit of higher education, career choice, and child-rearing practices.

Decolonization has been greatly discussed in Pacific Islander communities politically, economically, and psychologically. Decolonization refers to the process where a colonized group of people develop a consciousness based on the remnants of the traditional culture and redefine and reassert their identity and unique qualities that historically guided their existence. This may entail sovereignty, the reacquisition of

land, and the rediscovering and reaffirming of indigenous epistemology to guide one's life in understanding the past, present, and future. An example of this renewed identity is the reemergence of traditional and indigenous healing practices, which is being researched by mental health professionals. Indigenous healing practices can be helpful in treating symptoms of psychological distress while also empowering Pacific Islanders in maintaining traditional customs and practices. The colonization process associated with the acquisition of Pacific Islands was accompanied by the institutionalization of ethnic categories as formal social entities used to dictate rights and privileges within a society. This socialization process has raised the importance of cultural identity to a new level. Not only is cultural identity important to the well-being of the Pacific Islanders, but it has been empowered to be a critical source of political power and economic influence.

These latent issues, which have both historical and current influence on the psychological and social well-being of the Pacific Islander peoples, ultimately shape their cultural identity. The postcolonization struggles, including the need to maintain their cultural identity, are a prevalent theme across many Pacific Islander communities, including Samoan, Tongan, Chamorro, Hawaiian, and aboriginal Australian communities. Pacific Islander literature reflects this struggle in stories of indigenous people living on the margins in order to express their identity finishing their lives in isolation, madness, and suicide. These stories demonstrate that the Western notion of "functioning" may in fact be inherently pathological for Pacific Islanders.

A testimony of resilience of Pacific Islanders is the circular migration pattern of indigenous peoples returning to their homelands, revitalizing their native cultures, affirming their sense of place and cultural identity, and utilizing their "Western" knowledge to help their communities to become self-sufficient and to heal from the detrimental effects of previous colonization. The efforts to maintain one's language, spirituality, cultural healing practices, and customs have resulted in feelings of pride, strength, renewal of spirit, and hope for the future of Pacific Islanders. The reclaiming of one's culture, land, and identity can be empowering and healing. The social process in Western communities to quantify and essentialize racial groups in order for those groups to receive benefits from the government (e.g., land acquisition by blood quantum) has implications for Pacific Islander



communities. The Western socialization process of legitimizing or authenticating who is to be considered “native” to the islands has led to fractions within Pacific Islander communities. It has also created a social class system within Pacific Islander groups with a social elite class defining who is “native” or “indigenous” and who has access to resources such as education, land acquisition, and economic opportunities.

### Counseling Pacific Islanders

As a group, Pacific Islanders have not received much attention in studies of racial and ethnic groups in counseling. One of the main reasons for this lack of attention is the trend of combining Asian American and Pacific Islander groups together, which has led to a paucity of counseling literature focused on this racial group as a separate entity. This aggregation of the data for Asian American and Pacific Islanders has led to Pacific Islanders being invisible or misrepresented in public policy and the mental health field. The ramifications of this collapsing of these racial/ethnic groups have been the failure to understand the health needs of Pacific Islanders, the impact of social history on assessment of mental health factors, undercounting of Pacific Islanders in general, and a limited awareness of the poverty, discrimination, and the adjustment of these indigenous groups in the United States. Also, by combining Pacific Islanders with Asian Americans, there has been a lack of knowledge by clinicians and mental health professionals about the historical similarities of these indigenous groups in the Pacific to other Native Americans living in the United States.

It is important to note that the social norms found in Western models of counseling—such as individualism and the need to separate from one’s family of origin after a certain age—may not be applicable to Pacific Islanders. In fact, these Western norms may be viewed by Pacific Islanders as pathological and detrimental to their social network. In addition, symptoms of distress, such as depression, anxiety, or suicidal ideation, should be viewed within the historical context of the Pacific Islander and understood that it may be a reflection of an unhealthy society rather than a problem that lies within the individual.

Asian Americans and Pacific Islanders have limited availability and access to mental health services and tend to underutilize counseling services. Possible explanations for this underutilization are the lack of trained healthcare professionals who are fluent in

Pacific Islander languages and lack of understanding of Pacific Islanders’ history and worldviews. Counselors that have been trained in working with culturally diverse clients may be applying Asian American values that do not fit for Pacific Islanders, which may lead to early termination. For example, despite assertions that Asian Americans and Pacific Islanders express more somatic symptoms and that shame and stigma may be related to the lack of utilization of mental health services, there is no empirical research to support this claim with Pacific Islander samples. In addition, given that 17% of Pacific Islanders are below the poverty level, they may lack health insurance to pay for mental health services. Access to mental health providers and their respective services may also be problematic because of the remote and rural locations where Pacific Islanders reside.

With the emphasis on family as the social unit and the need to maintain harmony within one’s extended kin, family therapy based on the values of the Pacific Islander group may be an effective invention that is culturally congruent with the values and beliefs of this population. For example, *ho‘opono‘ono*, a Native Hawaiian indigenous healing practice, focuses on “setting right” family issues or conflict to maintain harmony with one’s family, community, and ancestors in the spiritual world. Similarities within this practice exist when compared with other Western family therapy models, but its uniqueness lies in (a) the goals of the *ho‘opono‘ono* (seeking family harmony through confession and the seeking of forgiveness within the group rather than within oneself), and (b) the spiritual focus (including prayer and seeking help from the spiritual world, for example, from a higher power or ancestors that have passed on) of the sessions.

Given the paucity of research about the mental health needs of Pacific Islanders within the United States, more research is needed focusing on Pacific Islanders and the groups within this racial category. Future research of Pacific Islanders should include (a) the prevalence rates of mental health issues; (b) the availability, accessibility, and utilization of counseling services within this population; (c) culturally competent therapies, prevention, and intervention strategies; (d) cultural factors that help promote well-being and protect against mental illnesses; and (e) help-seeking behavior, including indigenous health practices and Western models of therapy.

The literature on indigenous communities reveals links between sovereignty issues and health, with



economic and political freedom being key to the well-being of native peoples. It has been proposed that the restoration of the rights and privileges of these communities—including self-governance, the freedom to cultivate and practice the cultural traditions of ancestors, and having a relationship with the environment—will help promote the psychological well-being of Pacific Islanders. In light of the history of colonization and oppression of Pacific Islanders, it is understandable that political factors such as self-governance would be linked with the promotion of physical and mental health.

Predictably, Pacific Islanders have a place in counseling and psychology in spite of the limitations of extant research. Pacific Islanders have a history of being invisible or marginalized within the field of psychology, and this is being remedied accordingly. Yet the indigenous people of these islands have been a part of social changes and resurgence of their cultures, the migration of cultures, and the adaptation of their people. With the importance of multicultural competence in counseling, researchers have taken on the challenge of understanding these unique populations of people and their mental health needs. Future research on Pacific Islanders and counseling should be designed to improve upon the ability to serve these populations with full understanding of their histories and the strengths and resilience of their cultures.

Laurie D. McCubbin

**See also** Acculturation (v3); Colonialism (v3); Cultural Values (v3); Culture (v3); Espiritismo (v3); Ethnicity (v3); Familismo (v3); Multiculturalism (v3); Nationalism (v3); Poverty (v3); Race (v3)

### Further Readings

- Andrade, N. N., Hishinuma, E. S., McDermott, J. F., Johnson, R. C., Goebert, D. A., Makini, G. K., et al. (2006). The National Center on Indigenous Hawaiian Behavioral Health study of prevalence of psychiatric disorders in native Hawaiian adolescents. *Journal of the American Academy of Child and Adolescent Psychiatry*, 45(1), 26–36.
- Grieco, E. M. (2001, December). *The Native Hawaiian and Other U.S. Pacific Islander population: 2000* (Census 2000 Brief No. C2KBR/01-14). U.S. Census Bureau. Retrieved May 13, 2006, from <http://www.census.gov/prod/2001pubs/c2kbr01-14.pdf>
- McCubbin, H., & McCubbin, L. (1997). Hawaiian American families. In M. K. DeGenova (Ed.), *Families in a cultural context*. Mountain View, CA: Mayfield.
- Office of Minority Health. (2006). [Native Hawaiian/Other Pacific Islander profile]. Retrieved May 21, 2006, from <http://www.omhrc.gov/templates/browse.aspx?lvl=2&lvlID=71>
- U.S. Department of Health and Human Services. (2001). *Mental health: Culture, race, and ethnicity: A supplement to mental health: A report of the surgeon general*. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services.

---

## PEDERSEN, PAUL BODHOLDT (1936– )

---

Paul Bodholdt Pedersen, considered by most psychologists to be the founder and major contributor to multicultural psychology and cross-cultural counseling and psychotherapy, was born on May 19, 1936, in Ringsted, Iowa. Located in a rural farming community in northern Iowa near the Minnesota border, the tiny community of Ringsted provided Pedersen with a strong, stable set of values that encouraged hard work, kindness, spirituality, generosity, compassion, and a respect for all living things. His family and community members were deeply religious; thus, many of his cherished childhood memories mirrored his experiences in the local Danish church. Pedersen traced his deep respect and appreciation for humanistic-spiritual perspectives to his family and community members of Danish, Norwegian, and Swedish ancestry. Much of his youth was spent working on the family farm in a secure family-centered environment. Pedersen's parents were avid collectors of books and placed a high premium on reading and music. Although his father and sister were accomplished musicians, Pedersen struggled to master the violin. After 7 years of lessons, he put the violin aside and turned his interests to reading as many books as he could find.

After graduating high school, Pedersen enrolled in Grand View Junior College in Des Moines, Iowa, and completed his Associate of Arts degree in 1956. He transferred to the University of Minnesota and graduated in 1958 with a concentration in history and philosophy; in 1959, he earned a Master of Arts degree in American Studies at Minnesota. Following his



interests in religious studies, Pedersen received a Master of Theology degree in 1962 from the Lutheran School of Theology in Chicago. Then, in 1966, Pedersen earned a Master of Science degree in counseling and student personnel psychology from the University of Minnesota. In 1968 Pedersen received his Ph.D. in Asian Studies, with a concentration in the fields of counseling, cultural history, comparative religion, and political theory, from Claremont Graduate School in Claremont, California. His doctoral dissertation was titled *Religion as the Basis of Social Change Among the Bataks of North Sumatra*, adapting the 500-item Church Youth Research Inventory to Chinese and Malay/Indonesian languages.

Pedersen's abiding interests and commitment to promoting the importance of culture in psychology were sparked by his early travels hitchhiking across Europe and his academic appointments, beginning in 1962 as a visiting lecturer in ethics and philosophy and the chaplain at Nommensen University in Medan, Sumatra, Indonesia. He studied Mandarin Chinese full-time in 1968 in Taiwan. From 1969 to 1971, Pedersen was a part-time visiting lecturer in the Faculty of Education at the University of Malaya; also, he was the youth research director for the Lutheran Church of Malaysia and Singapore. While in Indonesia and Malaysia, Pedersen quickly realized that what he had learned about conventional counseling approaches at the University of Minnesota and Claremont Graduate School did not accommodate the worldviews of Malaysians, Chinese, and Indonesians. The daily dose of rich deep cultural experiences combined with the challenges associated with understanding culturally unique life-ways and thought-ways quietly planted the seeds for his plans to develop, advocate, and promote the value and significance of considering cultural differences in the counseling and clinical psychology professions.

In 1971, Pedersen accepted the position of assistant professor in the Department of Psycho-educational Studies at the University of Minnesota in Minneapolis; he also held a joint appointment as an international student advisor in the International Student Office. Drawing mainly on his experiences in Indonesia, Malaysia, and Taiwan and his daily counseling sessions with international students at Minnesota, Pedersen's growing concern for the relevance of conventional counseling approaches led him to consider more culturally sensitive counseling strategies. As an alternative to the use of conventional counseling education

approaches, Pedersen devised and implemented his well-known and well-respected triad training model. Pedersen describes triad training as a self-supervision model where the counselor processes the positive and negative messages a client is thinking but not saying in counseling. Articulating these hidden messages and checking out their validity helps the counselor (a) see the problem from the client's viewpoint, (b) identify specific sources of resistance, (c) diminish the client's need for defensiveness, and (d) help the client develop recovery skills for getting out of trouble.

In 1975, Pedersen accepted an appointment as a Senior Fellow at the Culture Learning Institute at the East-West Center in Honolulu, Hawai'i. From 1978 to 1981, he was director of a large, predoctoral training grant from the U.S. National Institute of Mental Health titled Developing Interculturally Skilled Counselors. With eight predoctoral trainees, Pedersen conducted training programs that emphasized cross-cultural counseling approaches primarily through use of the triad training model; the programs brought together counselors from several Asian countries, North America, and countries in Oceania to learn the fundamentals of the then-emerging field of cross-cultural counseling. Pedersen closely maintained his Hawaiian appointments and ties for the rest of his illustrious career by serving as a visiting professor of psychology at the University of Hawai'i at Mānoa and as a Fellow at the East-West Center.

In 1982, Pedersen accepted an appointment at Syracuse University as professor and chair of the Department of Counselor Education. In 1995, he received the professor emeritus title at Syracuse and subsequently accepted an appointment as a professor in the Department of Human Studies at the University of Alabama at Birmingham. In 2001, after a year as Senior Fulbright Scholar at Taiwan National University and after marrying Doris H. F. Chang, Pedersen formally retired from academic life and moved back to his much beloved Hawai'i to continue his writing, traveling, and scholarly interests. He retained his appointment as a visiting professor in the Department of Psychology at the University of Hawai'i at Mānoa. Pedersen has three married children and five grandchildren in Minnesota.

Pedersen's remarkable career includes the publication of more than 40 books and more than 150 book chapters and journal articles; the concept of culture is the common thread that runs through all of them. In reviewing Pedersen's extraordinary accomplishments, one quickly realizes that he is imaginative and



farsighted. Among many of his significant initiatives, in 1973 Pedersen organized and chaired the first symposium dealing with cross-cultural counseling and presented it at the American Psychological Association's annual convention in Montreal, Canada. Symposium panelists, together with other authors, contributed to the first major book in the field of cross-cultural counseling; Pedersen was the senior editor and was assisted by Walter J. Lonner and Juris Draguns, and later by Joseph E. Trimble. Titled *Counseling Across Cultures*, the book is now in its sixth edition in an expanded version that is almost twice the length of the first edition.

Most scholars in the counseling and psychotherapy fields consider Pedersen's edited book published in 1999 titled *Multiculturalism as a Fourth Force* to be a milestone in the history of psychology. The book surveyed the prospect of moving toward a universal theory of multiculturalism that recognizes the psychological consequences of each cultural context. Pedersen and his colleagues argued that the fourth force supplements the three forces of humanism, behaviorism, and psychodynamism for psychology.

Along with his commendable scholarly accomplishments, Pedersen has been actively involved in research activities, many of which received external funding. He was codirector of an intercultural communication laboratory for 60 Japanese/U.S. intercultural communication experts at Nihonmatsu, Japan, funded by the Lily Foundation; director of U.S. Department of Education-funded research on sex-role stereotypes in higher education; director of a 3-year National Institute of Mental Health mental health training program; and director of a 2-year Harvard Institute for International Development project in Indonesia to evaluate and upgrade training at Bank Rakyat Training Centers. Pedersen was awarded many grants, including a 6-year grant from the National Science Foundation to study the re-entry adjustment of engineers returning to Taiwan after study abroad; a National Institute of Education grant to develop a measure of cross-cultural counseling skill; a State of New York Department of Social Services grant to develop mental health training materials geared toward treating unaccompanied refugee minors; and an Asian Foundation grant to co-organize a conference in Penang, Malaysia, on constructive conflict management in a cultural context.

Because service to the professional community is an important value for Pedersen, he has found time to serve on numerous boards and committees. His activities have included 3 years as president of the Society for Intercultural Education Training and Research

(SIETAR); series editor for Sage Publications' *Multicultural Aspects of Counseling* (MAC) Series; and advising editor for a Greenwood Press book series in education and psychology. Additionally Pedersen is a board member of the Micronesian Institute located in Washington, D.C., and an external examiner for Universiti Putra Malaysia, University Kebangsaan, and Universiti Malaysia Sabah in psychology. From 1999 to the present, Pedersen was a Senior Fulbright Scholar teaching at National Taiwan University. Within the American Psychological Association Pedersen was a member of the Committee for International Relations in Psychology (CIRP) from 2001 to 2003 and was invited to give a master lecture at the American Psychological Association Convention in Los Angeles in August 1994. Pedersen also is a Fellow of Divisions 9, 17, 45, and 52 of the American Psychological Association.

By all professional and personal standards, Pedersen is a visionary as he has contributed significantly to the emergence of multiculturalism in psychology and in related disciplines. Pedersen's commitment to multiculturalism extends well beyond the mental health professions. In thinking about the future of multicultural counseling and social justice, Pedersen firmly believes that the multicultural perspective will evolve into a perspective that acknowledges how people may share the same common ground expectations, positive intentions, and constructive values even though they express those expectations and positive intentions through different and seemingly unacceptable behaviors. He also maintains that counselors and psychologists must generate a balanced perspective, wherein both similarities and differences of people are valued, and at the same time avoid partisan quarreling and get on with the important task of finding social justice across cultures.

Joseph E. Trimble

**See also** Cross-Cultural Psychology (v3); Cross-Cultural Training (v3); Culture (v3); Multicultural Counseling (v3); Multicultural Counseling Competence (v3); Multiculturalism (v3); Multicultural Psychology (v3); Universalism (v3)

### Further Readings

- Connerley, M. L., & Pedersen, P. B. (2005). *Leading in a multicultural environment: Developing awareness, knowledge, and skills*. Thousand Oaks, CA: Sage.
- Marsella, A., & Pedersen, P. (Eds.). (1981). *Cross-cultural counseling and psychotherapy*. New York: Pergamon Press.



- Pedersen, P. (Ed.). (1999). *Multiculturalism as a fourth force*. Philadelphia: Brunner/Mazel.
- Pedersen, P. (2000). *Handbook for developing multicultural awareness* (3rd ed.). Alexandria, VA: American Counseling Association.
- Pedersen, P. (2000). *Hidden messages in culture-centered counseling: A triad training model*. Thousand Oaks, CA: Sage.
- Pedersen, P. (2004). *One hundred and ten experiences for multicultural learning*. Washington, DC: American Psychological Association Press.
- Pedersen, P., & Carey, J. (2003). *Multicultural counseling in schools* (2nd ed.). Needham, MA: Allyn & Bacon.
- Pedersen, P., Draguns, J. G., Lonner, W. J., & Trimble, J. E. (Eds.). (2007). *Counseling across cultures* (6th ed.). Thousand Oaks, CA: Sage.
- Pedersen, P., Marsella, A., & Sartorius, N. (Eds.). (1984). *Mental health services: The cross-cultural context*. Beverly Hills, CA: Sage.
- Ponterotto, J. G., & Pedersen, P. B. (1993). *Prejudice prevention: A developmental counseling perspective*. Beverly Hills, CA: Sage.

---

## PERSONAL SPACE

---

Personal space can be described as the amount of space around individuals that allows them to feel comfortable. People's expectations and needs for personal space may differ based on race, ethnicity, gender, and/or social class. For some people, this may mean keeping others at arm's length, whereas for others it may entail moving in very closely when they communicate. From a cultural point of view, different cultures have different ideas about appropriate personal space, and personal space holds different meanings when one considers the variables of social class and gender. People have their own individual ideas about what is comfortable to them and what is not comfortable in terms of personal space.

The world of business has brought the idea of personal space into the forefront as a vital consideration. For example, when conducting business, it is important and considered proper to maintain appropriate personal space based on what the host or majority culture considers to be personal space. Within dominant White American cultures, this may mean a firm handshake, staying about 3 feet away from other people during interactions, and not touching them in any way other than a handshake. However, in, Japan, a bow

between two people, placed 2 to 3 feet apart, is a standard greeting and a sign of respect; further, the extent of the bow may differ across social and professional contexts.

Personal space is a form of nonverbal communication. For human beings, ideas and expectations about personal space may differ depending on whether interactions are occurring with strangers, family members, or intimate partners. Furthermore, in some cultural contexts, norms and expectations about personal space may be directly related to the social standing or class of the people involved. For example, in some cultures, people from higher social standings or classes tend to be more formal and maintain larger distances in personal space, whereas those who are from lower social standings or classes tend to have smaller distances of personal space. Moreover, gender differences can play an important role in personal space, as men, in general, find it more difficult to touch or be touched than do women.

In a counseling situation, maintaining appropriate personal space while trying to develop a therapeutic and empathic relationship can be a challenge. Personal space is an important aspect of therapy and when misused, it can be seen as threatening; further, when cultural norms are not respected or are violated, lapses in the working alliance may ensue. In cross-cultural counseling dyads, personal space may be a valuable means of communicating cultural respect. For example, if a client who identifies with a culture that endorses greater physical expression of care and support shares a personal, emotional story, the client may be expecting a hug or gentle touch on the arm from her or his counselor. However, if the counselor does not ascribe to those norms and does not express her or his empathy through such physical displays, the client may feel unheard or disrespected. On the other hand, if the counselor wants to offer a hug or gentle touch and the client has distinct ideas about personal space and boundaries, the client may feel threatened by the touch. It is very important for counselors to remember that their own racial/cultural worldview may differ from their client's worldview, and that will, in turn, have an impact on the therapeutic relationship that they are able to develop.

Janice E. Jones

*See also* Barriers to Cross-Cultural Counseling (v3); Communication (v3); Cultural Values (v3); Culture (v3); Worldview (v3)



### Further Readings

Hall, E. T. (1966). *The hidden dimension*. Garden City, NY: Doubleday.

---

## PLURALISM

---

In its general sense, pluralism refers to the existence and validity of a variety of beliefs, values, realities, and identities. Pluralism has been used to describe the variety of beliefs and values that exist within a society (e.g., political pluralism), a discipline (e.g., scientific pluralism), or culture (e.g., cultural pluralism). In the multicultural counseling literature, pluralism refers to the existence and inclusion of all aspects of diversity (e.g., individual diversity, group diversity) within a society or culture (cultural pluralism). Pluralism carries the inherent belief that the inclusion, validation, and affirmation of multiple aspects of diversity are intrinsically valuable to the overall well-being of a group or community.

### Philosophical and Sociological Perspectives

The origins of pluralism as a philosophical thought can be traced to Western philosophy, with roots in early Greek philosophy. Developed in the 5th century B.C. by philosophers Empedocles and Anaxagoras, pluralistic philosophy sought to provide a different explanation for the natural world. Natural world phenomena were previously defined by the Ionian philosophers as based in a single element; pluralistic philosophy challenged this notion and posited that natural world phenomena were based in multiple elements. From this philosophical basis comes the contemporary view of pluralism that posits the existence of multiple realities. Neither of these views of pluralism accounts for a complete explanation of total reality.

From this background, sociological aspects of pluralism were developed. Within sociological theory, pluralism is the social condition that accepts, embraces, validates, and celebrates the multiple cultures and the many beliefs and values that exist in a society. The strength and health of such a society is predicated upon the belief that such a diverse collection of cultures and beliefs is a valuable and integral component to the welfare of that society.

### Counseling and Pluralism

In 1990, Paul Pedersen dubbed multiculturalism as the “fourth force” in counseling, which would shift the existing paradigms of counseling and therapy to integrate the cultural experiences and identities of clients. Multiculturalism was seen as the next wave in counseling that would promote the value of a culture-centered approach in working with clients and promote the value of a pluralistic society. Since Pedersen’s naming of this fourth force in counseling, the multicultural movement within counseling has grown, and with it has grown the increasing recognition of the value of pluralism in society.

The foundation for multicultural counseling is the inherent assumption and valuing of pluralism. Pluralism, in this sense, was initially seen as the collection of various racial or ethnic cultures and worldviews. Pluralism and culture-centric counseling attempted to then define culture and its constructs (e.g., identity) from etic and emic perspectives. As pluralism and multiculturalism continued to grow and to be explored within the counseling literature, the definition of *culture* also grew to encompass other aspects of personal and social identity, including, for example, socioeconomic status, gender, sexual orientation, spirituality and religion, physical ability, and numerous other personal and social variables, both seen and unseen. From this, the term *cultural pluralism* was then used to reflect the multifaceted and multidimensional nature of culture and identity.

Pluralism and multiculturalism are intimately tied together within the counseling profession. Although both terms may be used interchangeably, *pluralism* connotes the broader philosophical principle whose roots are in ancient Greek philosophy whereas *multiculturalism* is used to refer to the inclusion of various cultural and racial groups and identities. More recently, *multiculturalism* has been used to refer to the broad spectrum of individual and group diversity to include sexual orientation, physical ability status, spirituality and religion, and socioeconomic status, among the variety of individual and group differences.

### The Growth of Pluralism in Counseling

For the greater part of the 20th century, the counseling profession has relied on theories and practices of counseling with clients that have been based on Western, Eurocentric teachings, perspectives, and values. For the most part, the majority of mainstream counseling



theories have reflected this Western ethnocentric approach to working with clients, which has neglected the role of cultural and individual differences in identity and values formation. Only within the latter part of the 20th century did pluralism and cultural pluralism gain ground within the counseling profession.

The increasing presence of pluralism in counseling can be directly evidenced in the increase of publications, the development of educational curricula, and the establishment of organizational policies and statements that affirm pluralism. Since Pedersen's claim that multiculturalism is the fourth force in counseling, there have been numerous publications that address issues of cultural pluralism within the counseling profession. Landmark publications in this area include *Counseling the Culturally Diverse: Theory and Practice*; *Counseling and Psychotherapy: A Multicultural Perspective*; and the *Handbook of Multicultural Counseling*.

A number of graduate programs in counseling have recognized the need to prepare graduates for counseling in a pluralistic society. Graduate programs in counseling have been developed to reflect training and education in the principles of multicultural counseling. Though graduate programs have gradually made the shift to an inclusion of multicultural issues within their curricula, full integration of multiculturalism that reflects the basic tenets of inclusion in pluralistic philosophy is still needed.

Professional counseling and psychological associations have pioneered a variety of publications, guidelines, policies, and resolutions proclaiming the importance of multiculturalism and the value of a pluralistic society. Organizations such as the American Counseling Association and the American Psychological Association have developed guidelines and standards that endorse the importance of a pluralistic society and the development of multicultural awareness, knowledge, and skills in the work of the counselor. While these and other organizations have professed the importance of multiculturalism and pluralism in counseling clients and in counselor development, continued work is necessary to promote and integrate these guidelines and pronouncements within the greater counseling profession.

### Social Justice and Pluralism

The counseling profession has recently attended to the concept of social justice within its theory and practice. However, the idea of social justice has existed within

other disciplines (e.g., theology) before it gained the attention of the counseling profession. Social justice has as its foundation the core values and philosophical tenets of pluralism; that is, social justice strives to advocate for, and to bring justice to, those individuals, peoples, groups, and cultures that suffer from oppression and social stigma. Social justice is, then, an action that promotes the values of pluralism within societies and organizations.

Within the counseling profession, pluralism and social justice embrace the notion of counselors as agents of prosocial change. Social justice and pluralism recognize the role of the counselor in advocating for the needs and rights of clients who experience social oppression. Beyond that, social justice and pluralism also recognize the role of the counselor as an active member within the community to work toward advancing the work of social justice and pluralism within the community in ways that promote social welfare and cultural pluralism.

Ruperto M. (Toti) Perez

*See also* Bicultural (v3); Cultural Relativism (v3); Culture (v3); Diversity (v3); Ethnocentrism (v3); Idiocentrism (v3); Multiculturalism (v3); Pedersen, Paul Bodholdt (v3); Social Justice (v3); Universalism (v3); Worldview (v3)

### Further Readings

- Ivey, A. E., D'Andrea, M., Ivey, M. B., & Simek-Morgan, L. (2007). *Counseling and psychotherapy: A multicultural perspective* (6th ed.). Boston: Allyn & Bacon.
- Ponterotto, J. G., Casas, J. M., Suzuki, L. A., & Alexander, C. M. (Eds.). (2001). *Handbook of multicultural counseling* (2nd ed.). Thousand Oaks, CA: Sage.
- Sue, D. W., & Sue, D. (2008). *Counseling the culturally diverse: Theory and practice* (5th ed.). New York: Wiley.

---

## POLITICAL CORRECTNESS

---

A little more than a decade after the demands for Black, Latino/a, and women studies on college campuses across the nation in the late 1960s, universities witnessed a new articulation of inclusion. With the rise of hate speech and racially motivated incidents on campuses in the 1980s and 1990s, universities began to find ways to help create a learning environment in which all students felt respected, valued, and free to



actively participate in the community life of these institutions. Universities implemented speech codes as one method of creating a more inclusive learning environment; these codes were later ruled unconstitutional because they were considered to be too vague to be administered fairly. Books that critiqued efforts to establish a multicultural curriculum were published on the coat tails of these cases, including Dinesh D'Souza's oft-referenced treatise *Illiberal Education: The Politics of Race and Sex on Campus*. The tension between those fighting for antisexist, antiracist, and multicultural education on campus and those, such as D'Souza, who wanted to maintain the status quo fueled the rise of the "political correctness" debate in and outside of the academy.

*Political correctness* (PC) is a hotly contested term with different meanings across ideological stances. Although the term *PC* reportedly dates back centuries and, some would argue, has more modern-day usage as early as the 1930s with the Frankfurt School, the term is most identified with public discourse about inclusive language, behaviors, and policies over the past 2 decades. PC as a concept was created and legitimized by conservatives, or the political right. Neo-conservatives alleged that policies designed to prevent the use of offensive language to a wide range of social groups (e.g., racial/ethnic minorities, lesbian/gay, bisexual/queer/transgendered individuals, persons with disabilities, women) were politically repressive and infringed on freedom of speech. From this perspective, being "PC" silenced viewpoints that countered multicultural and inclusive agendas, including the perspectives that race is biological and reparative therapy can "cure" gay and lesbian individuals. In essence, it has been argued that being PC limits the terms of debate negatively and punishes those with more conservative viewpoints.

On the other hand, progressives and radicals argue against the existence of PC as a concept. From this perspective, political correctness is conceptualized as a rhetorical argument arranged by the political right to dismiss efforts to create safe public spaces in which various marginalized social groups are protected from the use of slurs and epithets and have the right to name, define, and study their own lived experiences. Many adopting this perspective view the term *PC* as pejorative. Feminist scholar Sara Mills argued for antisexistism (antiracism, heterosexism, oppression, etc.) because it simultaneously adopts a stance against social group oppression while questioning the validity

of claims about "correctness." By using more descriptive terms, one locates the problem as one of oppression (e.g., racism) as opposed to one of control (e.g., political correctness).

The field of counseling has been indirectly influenced by the PC debates. The movement for multicultural counseling competencies emerged in the 1980s, during a time in which other disciplines were also reconstructing their curriculum to become more inclusive. Training programs have struggled with finding ways to provide a curriculum supporting the development of multicultural counseling competencies with students who oppose interrogating their own core beliefs and assumptions. Some students argue that they should not be pressured to explore their (negative) beliefs about certain social groups (e.g., lesbian, gay, bisexual, and transgendered individuals); in essence, these students assert that political correctness in the field has infringed on their personal and/or religious beliefs.

Helen A. Neville

**See also** Bias (v3); Color-Blind Racial Ideology (v3); Discrimination (v3); Diversity (v3); Classism (v3); Multicultural Counseling Competence (v3); Multiculturalism (v3); Organizational Diversity (v3); Racism (v3); Sexism (v3)

### Further Readings

- Brace, C. L. (1995). Race and political correctness. *American Psychologist*, pp. 725–726.
- Dong, D. (2006). Free speech and multiculturalism in and out of the academy. *Political Psychology*, 27, 29–54.
- Ladany, N., Friedlander, M. L., & Nelson, M. L. (2005). Heightening multicultural awareness: It's never been about political correctness. In N. Ladany, M. L. Friedlander, & M. Lee (Eds.), *Critical events in psychotherapy supervision: An interpersonal approach* (pp. 53–77). Washington, DC: American Psychological Association.
- Mills, S. (2003). Caught between sexism, anti-sexism and "political correctness": Feminist women's negotiations with naming practices. *Diversity & Society*, 14, 87–110.

---

## POVERTY

---

Poverty is a global problem. Using the U.S. dollar as a hallmark for living standards, approximately



2.8 billion people live on less than 2 dollars a day, and almost 1.2 billion live on less than 1 dollar a day. Given the differing living standards across nations, a dollar has different weight depending on context. But in the United States, how much does it cost to live adequately? That is, what is the minimum one should expect to have to provide for adequate housing, food, health care, and transportation for instance? And more importantly, what measure should one use to indicate when an individual or family has fallen below these standards of acceptable living? To understand poverty in the United States, it is important to address (a) the consequences of poverty, (b) the definitions of poverty, and (c) counseling and psychology's understandings of poverty and social class and classism in relation to poverty and future research and practice.

### Consequences of Poverty

Poverty's effect on individuals, families, and communities is a growing and deleterious problem. For instance, U.S. Census Bureau data show that in 2002, 8% of Whites were in poverty, unchanged since 2001. Among African Americans, 24.1% were in poverty, which was higher than the 22.7% reported in 2001. For Asian Americans, the poverty rate was 10.1%, unchanged from 2001. And for Latinos/as, the poverty rate remained unchanged from 2001 to 2002 at 21.8%. For children, the percentage in poverty remained unchanged at 16.7% from 2001 to 2002. The poverty rate for families rose from 4.9% to 5.3%, and the percentage of female households remained unchanged at 26.5%.

Factors that contribute to the rise in poverty include the decrease in real wages earned by lower-educated workers and the increase in single-parent families. Real wages may be considered the actual worth of income an individual receives after inflation and other adjustments are considered; unadjusted wages, for instance, may seem to be high, but considering the actual worth of the wage in relation to inflation, the unadjusted wage may be an erroneous figure. Furthermore, those with 12 or fewer years of schooling experienced the greatest decrease in their earning power. This group of the working poor, or those with regular employment but living in near-poor or poverty conditions, has increased by 35% from 1990 to 1998. For many families, limited income restricts their ability to invest in their children's education and future, thereby limiting children's future social class mobility and furthering the intergenerational transmission of poverty.

Research also suggests that poverty is overrepresented among recent immigrants; African, Latino/a, and Native American communities; women and single mothers; and children. The research shows overwhelmingly that transient and persistent (chronic) experiences of poverty have the most serious consequences for children and adolescents. Essentially, poverty creates an environment wherein risk factors converge. For instance, for children and adolescents in an unsafe or violent and crime-prone environment, options for exercise and outdoor play are limited. Consequently, children's health behaviors are affected, and outcomes may be increasing rates of sedentary behaviors, childhood obesity, and diabetes. Poverty also increases the exposure to other toxicities, such as lead poisoning and pesticides, and to low birth-weight—all related to later intellectual and social functioning. Other effects of poverty on children and their development may be evidenced in IQ scores, graduation rates, or adequate educational environments. Children who have experienced poverty may also exhibit higher aggression and conduct problems than children who have not experienced poverty, psychophysiological stress, and developmental delays. Additionally, experiencing poverty in preschool and early years decreases the probability that these children will graduate from high school when compared to experiencing poverty later in their education. Finally, for many children, there are deleterious effects of poverty on their mental health and emotional life. For instance, children who live in families experiencing financial stress also may have lower social competence.

Poverty creates situations where toxicities converge and limit the developmental potential of children and adolescents. For adults and children, poverty also creates situations of psychological strain and stress, which are related to poor health. For example, in one study, nuns, who in their adult life shared similar diet, health care, housing, and lifestyles, had patterns of disease and incidences of dementia that were related to their socioeconomic status almost 50 years earlier before becoming nuns. The results suggested the long-range effects of poverty in a person's life. Furthermore, if access to health care is held constant, those living in poverty tended to have poorer health than those in higher social class groups. Therefore, chronic psychological stress related to living in poverty has a greater effect on an individual's health than structural and societal safety nets such as adequate healthcare services. Because those in



poverty or who are poor often have the worst mental health prognoses, there is little doubt that a mental health gradient exists. For those living in poverty, the prospect of experiencing psychological stress and limited access to mental health care is high; whereas for those individuals living in higher social classes, their psychological outlook is better as well as their access to mental health care. Those in poor and impoverished environments may experience psychological stress and, consequently, have higher rates of mental illness.

Two main theories have been posited to explain this mental health gradient. In the social causation theory, it is posited that individuals are made vulnerable to psychological stress as a result of living in poverty. In the social selection theory, individuals experiencing mental health problems are likely to be from economically disadvantaged settings and/or have a downward social mobility resulting from problems in their social and occupational life. Some research suggests that evidence supports both theories and that the evidence is generally mixed. Yet the overwhelming evidence supports the social causation theory, that is, poverty makes people vulnerable to mental health problems. In one example of a natural experiment, 1,420 rural children ages 9 to 13 were given annual psychiatric assessments for 8 years (1993–2000). Approximately 25% of the children were Native American and the rest were predominantly White. About halfway through the study, an Indian casino opened on the reservation and increased family incomes through a supplement. Of the Native American families, 14% moved out of poverty (ex-poor), 53% remained poor (persistently poor), and 32% were never considered poor. Results showed ex-poor children's psychiatric problems dropped to the never-poor level, while those who were persistently poor remained high in rates of psychiatric problems. But the results for the ex-poor were symptom specific such that conduct and oppositional-defiant disorders decreased, but anxiety and depression were unaffected.

Although research into impoverishment, deprivation, and poverty shows a relationship with poor physical health, mental health, and educational outcomes, it is still unclear what constitutes poverty. Typically, the U.S. Census Bureau definitions are used, but the research also varies in operationalizing poverty from author to author. It is important to understand how poverty is generally conceptualized and used in the

extant literature in a way inclusive of multiple definitions of poverty.

## Definitions of Poverty

*Poverty*, as a term, has been used to both denote (signify literally) and connote (signify indirectly) situations of deprivation. Poverty may be a transient situation, a persistent state, an abstract demarcation between rich and poor, or an indicator of insufficiency. Often, what is considered poverty varies by study. Variations in the definitions of poverty have allowed for a nuanced understanding of the contexts in which poverty can be salient and for which comparisons can be difficult to make. For instance, using one definition of poverty to understand urban versus rural poverty is difficult given differing living standards, the composition of people of color, and context-specific stressors such as access to health care, violence and crime, and the monetary value of governmental subsidies.

In the United States, the standard definition for poverty comes from the Census Bureau and the Department of Commerce, which identify monetary income as the sole criteria for determining a poverty threshold. In 2002 for example, the poverty threshold, pre-tax income, for a family of four, consisting of two parents and two children, was \$18,244. Monetary income does not include any capital gains or non-cash benefits such as public housing, food stamps, or Medicaid.

The poverty thresholds offer one measure to understand who may be considered poor in the United States, but it should not be used as the sole criterion. If a family's income is above the poverty threshold, the family is not considered to be in poverty even though actual monetary benefits from their "above-poverty income" may be slight and, in fact, they are still poor. To illustrate, a family of five has a poverty threshold of \$22,509. Even if their total family income was \$25,000, they would not be considered "in poverty" given the current criteria. Although they would be considered "near poverty or near poor," they still are above the official poverty threshold.

The Census Bureau calculates three categories of poverty based on an income-to-poverty ratio. This ratio is calculated by dividing the family's income by their poverty threshold. Given the previous example of the five-member family whose income was \$25,000 and a poverty threshold of \$22,509, their ratio would be 1.14. In this example, this family is above 1.0, which is the



threshold for a family of their size, but below 1.25, which is considered near poor. Families who are below 1.0 or below .50 are considered either at poverty or in severe poverty, respectively.

The poverty threshold was originally developed in 1963 and 1964 by Mollie Orshansky. Orshansky did not develop the poverty threshold as a standard budget for a family. That is, Orshansky did not determine the list of goods and services needed for a family of a particular size to exist at a determined level. Except for food stuffs, there was no standard, and there still is no standard, for minimum consumption needs for a family. Instead, what could be determined were food expenditures in a family, and Orshansky determined the minimum income needed to afford basic food stuffs and then multiplied that amount by three. The multiple of three was derived from a 1955 Department of Agriculture's Household Food Consumption Survey that found families typically used one third of their household-budget, after-tax income, on food. The problem for many families under this definition is that this amount did not consider other needs, such as housing, clothing, medical costs, and transportation.

Several criticisms of the criteria for the current poverty threshold have been presented. First, although the poverty threshold is updated annually for inflation, the poverty threshold does not consider actual growth in consumption. That is, the food expenses do not reflect rising living standards and other consumption; instead the current poverty threshold reflects today's dollar. The problem with this is that the living standard was set 30 years ago. The poverty thresholds do not consider the cost of fuel, child care, technology, health care, and housing, to name a few. Second, the poverty threshold is a standard, regardless of geography. Therefore, the poverty threshold is the same for someone living in rural areas as it is in an urban setting wherein living standards and costs of living may vary greatly.

Recommendations have been made to the Census Bureau and the Office of Management and Budget to revise their calculations. In 1995, a National Academy of Sciences (NAS) panel recommended new ways to measure income, families' needs, and other aspects related to measuring poverty. The NAS panel recognized that official poverty indices did not account for the effect of taxes and medical expenses on those in poverty and did not account for the relative change in costs of food in relation to housing, clothing, and medical costs. The NAS panel developed six alternative measures, each accounting for different and

related family income and expenses such as food stamps or housing subsidies, and each estimate is adjusted for family size. Each of the different measures produces varying levels of poverty depending on the criterion used. For example, even though the official poverty rate in 2003 was 12.7%, the Census Bureau reports poverty rates ranging from 8.3%, which used a comprehensive definition of income, to 19.4% using a definition of poverty excluding governmental payments.

Yet, regardless of what metric is used to assess poverty, the condition of poverty and its physical, psychological, and societal consequences need to be addressed and rectified. Poverty is clearly a social justice concern and a social inequity with consequences across all spectra of society. One potential direction to better understand poverty in psychology is to connect it with the study of social class and classism.

### Poverty, Social Class, and Classism

Poverty is one outcome of sociostructural (e.g., legal, education, and economic systems) forces that marginalize and oppress individuals, creating inequities (injustice and unfairness) and inequalities (social and economic disparities). Poverty intersects with race and racism, and the aggregate effects on people of color are deleterious. Consequently, one outcome for many people of color is limited access to adequate and necessary health care. Those in poverty or poor conditions may have access to health care, but it may be in the form of emergency room visits rather than preventive care or regular health visits. Additionally, those in poverty may experience truncated, ineffective, or poor care when they are seen by physicians and psychologists. Another problem is the increased exposure to environmental racism. Environmental racism is an example of settings wherein toxicities—such as lead contamination, electromagnetic radiation, and refuse and waste management facilities—are generally isolated to poor and/or racial and ethnic communities.

Although poverty is easily identified, it is not well understood by counselors and psychologists. In part, the vagueness of poverty is linked to counseling and psychology's poor conceptualization of social class and classism. One study of counseling journals and counseling psychology journals found more than 450 different terms used to discuss social class and socioeconomic status. In this review of 20 years of journals, the term *poverty* was used in the following ways:



economic pressures of poverty, high-risk poverty, live in poverty, poverty, poverty level, poverty line, poverty rate, economic poverty, and poverty level incomes. Similar to poor conceptualizations of social class and classism, psychology's limited understanding of poverty may contribute to the limited theoretical and empirical literature.

For counselors, psychologists, and other mental health care workers, poverty is not only a static monetary demarcation (i.e., the poverty line) but also a representation of varying levels of deprivation and marginalization. The poor, near poor, and working poor may all experience the deleterious effects of poverty, for example, exposure to environmental toxins (e.g., lead), poor schools, inadequate food, lack of transportation, and violence, to name a few. Poverty is a context that creates the conditions wherein various physical and psychological problems may arise. There is no singular causal link, but psychologists should consider a constellation of problems. For instance, counselors and psychologists should be aware of job demands and environments in which many people who are poor find themselves. High levels of stress, lack of autonomy and independence, and lack of decision-making ability are related to poor physical health indicators, such as cardiovascular disease, depressed mood, and cognitive deterioration. Additionally, the additive effect of living in impoverished neighborhoods and working in stressful and demanding jobs may also affect people's worldview and perception of others.

For instance, people in lower social class groups tend to describe their world as hostile, dominating, and unfriendly. Furthermore, these same individuals are likely to anticipate less-friendly interactions with others. It may be that these individuals are constantly reminded of their low status and that this, in turn, reinforces their perception of a hostile world. For counselors and psychologists, awareness and sensitivity to interactions with clients and the covert and subtle ways in which status is communicated are important considerations. Additionally, developing a strong working alliance and therapy relationship may entail additional effort to prove oneself as credible and trustworthy. Counselors and psychologists may also find themselves challenging clients' "paranoia" about hostile climates and interactions. Sensitivity to clients' setting and predicament is important; dismissing and denying their hypersensitivity to interpersonal "slights" may be counterproductive in psychotherapy.

Poverty, much like social class and classism, needs to be conceptualized within a coherent theory that encompasses causes and consequences. In developing a theoretical model to conceptualize social class, classism needs to be an integral function. Much like race and racism, social class and classism are co-constructed; that is, social status differences cannot materialize without social and individual forces that exclude and marginalize certain groups and individuals. Similarly, by conceptualizing social class and classism as a worldview wherein an individual attempts to maintain his or her social class standing through classist behaviors and attitudes, poverty research may also benefit from connecting the environment to a person's psychological understanding, perception, or coping. Examining the psychological function of poverty does not diminish or minimize the sociostructural oppression experienced by those in poverty, but it may provide researchers and clinicians with more tools for prevention and intervention within these communities.

William Ming Liu

*See also* Abuse (v2); Classism (v3); Deficit Hypothesis (v3); Oppression (v3); Physical Health (v2); Racism (v3); Social Class (v4); Socioeconomic Status (v3); Substance Abuse and Dependence (v2)

### Further Readings

- Costello, E. J., Compton, S. N., Keeler, G., & Angold, A. (2003). Relationships between poverty and psychopathology: A natural experiment. *Journal of the American Medical Association*, 290, 2023–2029.
- Evans, G. W. (2004). The environment of childhood poverty. *American Psychologist*, 59, 77–92.
- Fisher, G. M. (1992). The development and history of the poverty thresholds. *Social Security Bulletin*, 55(4), 3–14.
- Gallo, L. C., Smith, T. W., & Cox, C. M. (2006). Socioeconomic status, psychosocial processes, and perceived health: An interpersonal perspective. *Annals of Behavioral Medicine*, 31, 109–119.
- Geronimus, A. T., Bound, J., Waidmann, T. A., Hillemeier, M. M., & Burns, P. B. (1996). Excess mortality among Blacks and Whites in the United States. *New England Journal of Medicine*, 355, 1552–1558.
- Liu, W. M., Ali, S. R., Soleck, G., Hopps, J., Dunston, K., & Pickett, T., Jr. (2004). Using social class in counseling psychology research. *Journal of Counseling Psychology*, 51, 3–18.



- Orshansky, M. (1988). Counting the poor: Another look at the poverty profile. *Social Security Bulletin*, 51(10), 25–51.
- Sapolsky, R. (2005, December). Sick of poverty. *Scientific American*, 293(6), 92–99.
- Short, K. S., & Garner, T. I. (2002, July). *A decade of experimental poverty thresholds: 1990–2000*. Paper presented at the annual meeting of the Western Economic Association, Seattle, Washington.
- U.S. Census Bureau. (2003). Poverty in the United States: 2002. *Current Population Reports, P60-222*. Washington, DC: U.S. Department of Commerce.
- Wood, D. (2003). Effect of child and family poverty on child health in the United States. *Pediatrics*, 112, 707–711.

---

## POWER AND POWERLESSNESS

---

Power is a broad concept that is used in many contexts, including sociological and psychological realms. The term *power* has become so expanded and widely used that some believe it has lost strength in its use and value. Diverse conceptualizations of the power construct exist, which are based on the differing theories and philosophies that are present in research and literature. Power may be described as the ability or practice of exerting control over others or as the capability to influence others. Power is also presented as an innate ability to take action to make changes in one's life or in a community, nation, or the world.

Three identified types of power include force, influence, and authority. *Force* may be put forth through physical power, psychological power, or social power. *Influence* suggests the exercise of personal power, and *authority* includes traditional authority, legal or rational authority, and authority based on a person's disposition. Power has further been described as being a strong influence in the exercise of oppression; that is, those who are in power are able to oppress those with less power. Conceptualizations of power are also demonstrated in self-efficacy, as power may influence the extent to which an individual believes he or she is able to carry out a particular task or goal. Power is viewed by some as an object and a possession to which some have ownership of and others do not. Others view power not as an object but rather as a position in a relationship or social milieu. Power may be viewed in various contexts as either real or perceived, and it can be described as

either a fixed construct or a variable aspect of a social relationship.

The opposite of power is powerlessness. Powerlessness refers to the expectancy that people's behaviors cannot determine the outcomes or reinforcements that they seek. Powerlessness may further be explained as the lack of strength or the absence of power. People experiencing powerlessness may feel out of control and have no solution to regain control. Subsequent to feeling out of control comes the lack of capability to be in command of most aspects of one's life. Powerlessness also can be considered as the absence of complete authority or status to affect how others will act toward others. It is viewed by some that, when confronting powerlessness, individuals may be able to affect or change the negative behaviors (e.g., compulsions and addictions) of either themselves or others. Confronting and addressing powerlessness is believed by some to be what helps people to change past events that have had a negative impact on people's current lives, or to help people change things that they may have attempted to change in the past with little success. People may experience feelings of powerlessness when considering areas where they feel a lack of strength, competence, or skills to overcome realities in life that have no solution or answer. For example, people may feel powerlessness when considering persistent problems facing society that are not currently solvable, such as widespread violence and war or a cure for AIDS or cancer.

Powerlessness can be a learned feeling or response that occurs when individuals are kept in powerless positions repeatedly and over long periods of time by others who are in positions of power. These powerful others are able to exercise their power via money, social position, or physical strength. Power may also be exerted over others through legal status or military force. Powerlessness may further be felt by individuals who are targets of racism or ethnic discrimination. When individuals feel powerlessness, they may feel hesitant, afraid, or unwilling to express their feelings, fearful that what little they have will be taken from them.

The externally imposed powerlessness of racial, class, and gender oppression may be enforced through various means including economic, social, or physical ways. People in positions of power may have control over others in determining, for example, who gets jobs, who is given opportunities in education, and how help is given to those with financial needs. When those in powerful positions are exercising control over



less-powerful groups, collective power and direct action may be used to facilitate empowerment and overcome the feelings of powerlessness. Collective power refers to the power generated by an organized group. An example of collective power would be the formation of a union. An example of direct action to address powerlessness would be the development of a lawsuit or the arrangement of a strike. A powerful formula for effective action against powerful others would be one that combines the collective power with direct action, such as the formation of a workforce union that works together (collective power) and coordinates a strike effort (direct action).

People may also experience feelings of powerlessness if they have been abused. When powerlessness becomes a chronic and repeated occurrence, these continuous, persistent feelings of powerlessness may lead people to become afraid to feel and express their needs. This may result in people becoming immobilized or developing feelings of helplessness. People may unwittingly become immune to the feeling of powerlessness, possibly leading them to experience hindered growth and development. When powerlessness is learned, people may feel that they are responsible for their powerlessness. People with whom powerlessness is learned may remain in powerless positions, even when the external forces of power have decreased or diminished. These continuous feelings of powerlessness may lead one to then enter into situations that repeat experiences of powerlessness, such as engaging in a relationship with an abusive person. Powerlessness may also become internalized and lead people to self-abusive behaviors, compulsive behaviors, or depression. It has been suggested that one of the most harmful forms of powerlessness occurs when external forms of powerlessness are combined with the learned feelings of powerlessness, which may lead individuals without power to a position in which they feel insecure or unable to assert their rights.

### Power in Counseling Relationships

Therapists and counselors are equipped with an array of skills to work effectively with clients. In counseling, it is not unusual for imbalances of power to surface. The historical view of therapy is similar to the medical model of illness, in which those seeking mental health services are seen with regard to symptom presentation and are subsequently prescribed a treatment to reduce those symptoms. This view of mental health focuses

on mental health disorders as illnesses that require a cure to solve the presenting problems. Thus, with regard to power, this traditional medical model and approach to mental health treatment puts the therapist in a dominant role of a healer, with the client in a position of needing to be fixed or cured. From this traditional perspective, power differences may present in the relationship between the counselor and the client because of the perceived roles of the counselor and client. Additional imbalance of power between the counselor and the client may occur due to characteristics of either the counselor or client, such as racial, gender, age, and education differences. Some theorists believe that a power imbalance may be beneficial in a counseling relationship, suggesting that a counselor's power and perception of expertise lead to less resistance and more engagement from the client. Furthermore, some imbalance of power may be viewed as unavoidable. Because some imbalance of power may be inevitable and is considered by some as beneficial to therapeutic change, counselors ought to practice caution and awareness when exploring the dynamics of their relationships with clients. This may be accomplished by working to address and confront power positions and possible feelings of powerlessness, both outside of the counseling relationship as well as between the counselor and the client. This is particularly critical when the counseling relationship includes a cross-racial or cross-gender dyad.

Most theories of counseling often present information as being appropriate for all populations, suggesting that it is fitting to treat all clients of various racial, cultural, or ethnic backgrounds the same. This biased approach attempts to universalize the experience and social context of the White middle class. In clinical settings, psychological conditions may be better understood when issues of power, such as powerlessness or helplessness, are considered. The tendency of those in privileged positions to ignore, disregard, or pathologize the experiences of marginalized people can have damaging effects on the counselor–client relationship. In counseling, therapists may work to focus on patient's strengths, which can be a way of knowing and problem solving that relates to modification of this tendency to pathologize targeted people. For example, expression of resistance can be identified and validated, the resilience that clients use to manage oppression can be acknowledged, and the ethical implications of the client's struggles can be identified. Counselors may work with clients to address



power imbalances. Working with clients to recognize and address feelings of powerlessness—within and beyond the counseling session—may possibly lead clients to experience thoughts of empowerment.

## History and Development

Several theorists describe various thoughts regarding the concept of power. Friedrich Nietzsche is commonly viewed as a contemporary theorist with reference to the power construct. Nietzsche coined the concept of “will of power,” which refers to the domination over others and over environments. From a social and political perspective, Keith Dowding’s explanation of power differentiates between outcome power and social power. Dowding describes outcome power as the ability of individuals or groups to bring about change, and social power is referred to as the ability of groups or individuals to change the structures of other individuals or groups in order to bring about change.

Michel Foucault and others have argued that power should not and cannot be interpreted as a possession, an entity, or an object; rather, Foucault suggests that power is present only from its exercise within the structure of society or a particular point in time. Foucault contends that power is available to everyone but has different effects depending on who is acting and the context of that action. From Foucault’s perspective, control and resistance to power can occur at any time and in any place. Foucault critiques the concept of oppressor and oppressed and instead offers the idea of power as stemming from relationships that are always dynamically changing. Foucault’s contention was that people in power roles, such as psychologists, use their positions to oppress individuals who diverge from the norm. This is demonstrated throughout historical conceptualizations of mental health, in which psychologists are regarded as authorities in defining and reinforcing standards of normalcy and aberrance, thus exercising control and power through their positions.

In literature, multiple forms of power are presented. In sociological literature, power comes in two forms: as coercive and as choice. In its coercive form, power is the capacity to act in a manner that influences the behavior of others even against their wishes, possibly with the use of force. This type of power is also known as primary power and is considered the most destructive form of power in society today. Power as choice refers to the capacity to act in a manner that influences the behavior of others without

violating free moral choice. To practice this form of power is described as the height of self-control. Other literature describes several types of power that are manifested in the following five forms: coercive power, reward power, legitimate power, expert power, and referent power. As described in the previous paragraph, coercive power refers to the type of power in which a punishment exists. The second type of power, reward power, involves the power one has to provide rewards. Legitimate power is the power that is gained via legitimate means, such as a law enforcement position. Expert power refers to the type of power that is gained through educational or experiential endeavors. Lastly, referent power refers to the power gained by an individual due to respect.

## Examples

### *Race and Power*

Dominant groups have a tendency to disregard injustice or fail to recognize the persistent systems of inequality that exist in their societies. *Dominant discourse* is a term that refers to the recognition process that people often encounter when they begin to explore ways in which they have disregarded issues of oppression. Dominant discourse describes the manner in which dominant groups may begin to acknowledge their previous failures to recognize that oppression exists. Dominant discourse occurs as people start questioning what would ordinarily be regarded as unbiased. People then search to explore the underlying values embedded within their perceived cultural norms. The analysis that occurs through dominant discourse shifts attention to the specific contexts that shape culturally appropriate beliefs.

The subtle approval of certain arrangements of racial privilege and power is an especially important implication. The biases embedded within dominant discourse are hidden by their exceeding normalcy, and this sense of order allows this subtle approval to persist in society and communities without questioning. The construct of dominant discourse can be used to investigate how unrecognized cultural assumptions surround counseling theory and the practice of therapy. People’s examination of their own biased realities and practices influences the shaping of larger social contexts and the underlying values of those individuals. The understanding of this concept is critical to the professional development of counselors and



counselors in training, particularly those who are from dominant cultures in society, such as White counselors. Multicultural awareness that results from deconstructive inquiry and analysis may create knowledge and understanding that help future therapists look beyond their own learned views and beliefs.

### **Addictions and Power**

Individuals with addiction concerns are often drawn to particular kinds of mood changes or highs. There are specific addiction highs to which individuals are attracted, such as arousal, satiation, and fantasy. Arousal causes sensations of strong, unchecked power and gives the individual feelings of being all-powerful and untouchable. This arousal often comes in the form of taking substances such as amphetamines, cocaine, and ecstasy, and from gambling, sexually acting out, spending, stealing, and behaving in other risky or unsafe ways. Arousal gives those with addictions the sensation of omnipotence and overcoming any feelings of powerlessness. Yet people with addictions may eventually lose all feelings of power, and to get additional power they may return to the object or behavior that provided the arousal, ultimately becoming dependent upon it. People who are addicted to arousal become engulfed by fear, as they fear their loss of power and that others will discover how powerless they are.

Alcoholics Anonymous (AA) and the other 12-step programs based on AA principles teach that individuals with addictions are powerless over alcohol or drugs and that recovery necessitates acceptance of powerlessness. Some argue that this may be a convenient paradigm for some people, such as those who have been given to believe that they are responsible for controlling the world and everything in it, namely White, mainstream, heterosexual men. Promoting a sense of powerlessness may aid in easing the discomfort regarding areas over which they may have little or no control. However, other individuals utilize 12-step programs, namely, individuals from varying socioeconomic classes, women, racial and ethnic minorities, individuals from various sexual orientations, and other populations. Feminist theorists, in particular, have described the endorsement of powerlessness among women in various contexts as a confinement method meant to make certain that women remain depoliticized and as a part of a pattern of degradation of women. Some have argued that the theory of addiction, which asserts individual responsibility, is harmful to women because the

theory denies the political, social, and economic realities that organize women's lives.

### **Disability and Power**

The history of counseling people with disabilities originated following World War I after the vast demand for services for veterans with acquired disabilities. The beginning of services for people with disabilities included the development of post-World War I rehabilitation and social agencies for people in need of assistance. The industrialized economy garnered the creation of a select number of adaptive devices that were of significant help to people with disabilities who were capable of work. Today, people with disabilities may experience societal barriers of independent living. Societal barriers may include governmental policy, minimal accommodation, negative attitudes, or discrimination. People with disabilities may feel that the barriers and negative attitudes toward them serve to augment their disabilities, decrease their independence, and enlarge their sense of powerlessness. Thus, the dimension surrounding power and disability may put people in positions of needing help while also feeling resistant to accept help from others. Counselors working with people with disabilities may work toward empowerment of people with disabilities, advocacy, and assisting people with disabilities in areas of accommodations and work.

### **Sex/Gender and Power**

There is general agreement that men and women differ in the degree to which they hold powerful positions in certain fields. Although various cultures may value the different kinds of power differently, male heterosexual power is almost universally respected. Males typically have more power than woman in the public arena outside the home and in leadership positions. Men usually control powerful institutions that sustain the social hierarchy, such as the government, military, and law. Women typically have far more responsibilities in the home than do men, often in daily caretaking activities. Though women may have more power in the home than men may have, this power is not analogous to public power. Although the distribution of power between men and women in the United States has changed over the past few decades, men continue to hold distinct power over women. Westernized culture has traditionally linked women's



economic and social power with appearance. Within current gender-power relations, women's access to power is connected to their acceptance of mainstream beauty ideals.

In some racial/ethnic groups, gender roles are clearly defined. For example, in traditional Latino/a families, males are considered to be in superior roles within a well-defined family hierarchy. The male is the head of the household who sets the rules within the family. A macho concept of the exaggerated importance of being male is instilled in male children from a very early age. Marianismo, sometimes viewed as the submissive and obedient female, permeates the conventional role of wife imparted upon the Latina.

### **Age and Power**

Age is one domain in which power differs across groups. In general, children have less control over their lives and the lives of others than do adults. Various cultures differ in how they distinguish age-related obligations and power, yet most cultures do make a distinction between the power of adults and the power of children. Some societies have a strong focus on the hierarchies related to age, specifically that older individuals have more control and power. In certain racial/ethnic minority groups, older-age individuals are often given a significant amount of respect and authority. Cultural values play a major role in the treatment of the elderly. In the Native American culture, elders are respected for their knowledge and experience, and they are considered to be invaluable community resources. Elders traditionally hold positions of power in their communities and are valued for their experience and wisdom. In traditional Latino/a culture, older adults are generally given great deference. The Latino/a elderly continue to hold a central role in the family and are treated with respect, status, and authority. The elderly are thought to have an inner strength so they can be a resource for the younger generations and are links to the past. In many Asian cultures, age is associated with many positive features, as age often denotes wisdom, authority, and the freedom to be flexible and creative. A conventional Japanese ritual is the *kankrei*, which acknowledges the release of the older person from the responsibilities of middle age and recognizes new freedoms and capabilities. In a majority of African societies, old age is believed to be a sign of divine blessing, and in some of African languages the elder is the "big person."

With regard to age as it relates to gender, researchers have demonstrated a shift in the perception of interpersonal power of women with age. In these studies, power included both the personal characteristics of self-respect and empowerment and the interpersonal component of influence over others. The disparity in power between men and women appears to shift over the life span. Studies have documented an increase in the perceived strength, confidence, and interpersonal power of women later in life. Likewise, studies have also demonstrated a decrease in the perceived power of men in older age groups. In many African societies, women who reach middle age experience the elimination of restrictions in an often gender-typed society. As women reach middle and older age, their power is approximately the same as that of men.

### **Multicultural Considerations**

The question of how to address inequality is often presented, especially when considering this issue with people of privilege and those in controlling positions. The concept of power becomes a part of this question. Differences in power are less apparent to people in privileged positions, because people in privileged situations are more willing to accept a view of American society as classless and color-blind—supporting what literature describes as the myth of a level playing field. However, this viewpoint ignores the experience of marginalized groups and people in less-privileged positions. This view would discount issues such as discrimination and injustice that marginalized groups frequently face. The social differences can become extremely relevant to some, while remaining obscured to those who view the world as equal.

When power differences are not addressed, the likely disconnection between oppressed and privileged groups remains. Through educational and training opportunities, along with experience, people may begin to recognize and acknowledge their cultural biases. Acknowledgment of cultural biases leads people to become more aware of their endorsement of Eurocentric attitudes and behaviors. These attitudes and behaviors could be represented in styles of communication, nonverbal behaviors, and beliefs and values about society, family, and individuals. A deconstructive examination of one's own views can help one to move beyond a one-sided description, such as a "them" and "us" viewpoint, and more toward a dialogue in which one's cultural assumptions are questioned.



This may lead to self-awareness, multicultural competence, and personal and professional growth.

*Terri L. Jashinsky and Melissa K. Smothers*

*See also* Barriers to Cross-Cultural Counseling (v3); Classism (v3); Counseling Process/Outcome (v2); Discrimination (v3); Empowerment (v3); Hope (v2); Learned Helplessness (v3); Multicultural Counseling (v3); Multiculturalism (v3); Oppression (v3); Positive Psychology (v2); Prejudice (v3); Racism (v3); Relationships With Clients (v2); Self-Efficacy/Perceived Competence (v2); Self-Esteem (v2); Sexism (v3); Social Justice (v3); White Privilege (v3); Worldview (v3)

### Further Readings

- Albee, G. W., Joffe, J. M., & Dusenbury, L. A. (1988). *Prevention, powerlessness, and politics: Readings on social change*. Newbury Park, CA: Sage.
- Dowding, K. M. (1996). *Power*. Minneapolis: University of Minnesota Press.
- Friedman, A., Tzukerman, Y., Wienberg, H., & Todd, J. (1992). The shift in power with age: Changes in perception of the power of women and men over the life cycle. *Psychology of Women Quarterly*, 16, 513–525.
- Friedman, D. (1987). Getting powerful with age: Changes in women over the life cycle. *Israel Social Science Research*, 5, 76–86.
- Griscom, J. (1992). Women and power: Definition, dualism, and difference. *Psychology of Women Quarterly*, 16, 389–414.
- Haines, E. L., & Kray, L. J. (2005). Self-power associations: The possession of power impacts women's self-concepts. *European Journal of Social Psychology*, 35, 643–662.
- Holmes, E. R., & Holmes, L. D. (1995). *Other cultures, elder years*. Thousand Oaks, CA: Sage.
- Krestan, J. (Ed.). (2000). *Bridges to recovery: Addiction, family therapy, and multicultural treatment*. New York: Free Press.
- Lips, H. M. (1991). *Women, men, and power*. Mountain View, CA: Mayfield.
- Maroda, K. (2004). A relational perspective on women and power. *Psychoanalytic Psychology*, 21, 428–435.
- Twerski, A., & Nakken, C. (1997). *Addictive thinking and the addictive personality*. New York: MJF Books.

or an irrational suspicion or hatred of a particular group, race, or religion. In legal terms, prejudice has been defined as an irrational hostile attitude directed against an individual, a group, a race, or their supposed characteristics. Prejudicial behavior is responsible for a significant amount of anguish, psychological and emotional pain, and abuse of the target in cross-cultural and intergroup encounters. Examples of prejudicial behaviors include everyday life events of racism, sexism, and classism that can heighten subjective experiences of stress. Similarly, stresses experienced by women; intersexual, gay, lesbian, and transgendered people; religious minorities; and Arabs, Muslims, and Pakistanis (considered “villains” by some after September 11, 2001) may have their origins in personal and social prejudices.

Prejudices are defended strongly, as early cultural socialization experiences mold beliefs about people across ways of life. Prejudices can be embedded in worldviews (e.g., beliefs, values, and assumptions) and are integrated in individuals' expectations of others. Given the different definitions of prejudice, most theorists agree that it involves some kind of a negative assessment or evaluation of the “other.”

Theorists have stated that prejudices are attitudes that involve negative feelings such as loathing, hatred, or contempt. Discrimination, on the other hand, refers to behaviors, often motivated by prejudices, wherein people are treated differently (e.g., negatively), based on group membership (e.g., culture, religion, gender, complexion, ethnicity, sexual orientation). Prejudice degrades the human experience and can motivate people to behave in destructive ways.

Prejudiced beliefs are often related to stereotypes. Stereotyping involves the inaccurate categorizing of people. Stereotyping ascribes negative characteristics to people on the basis of their group membership or other visible characteristics. Some theorists consider stereotypes pictures that people carry about others which are usually flawed and lead to assumptions. Prejudice, discrimination, and stereotyping are interrelated and tend to feed on each other. Such attitudes and behaviors may affect the self-actualization of stigmatized people negatively and result in significant human suffering. Counseling psychologists have argued that bearing prejudices has deleterious consequences. At a minimum, prejudice and discrimination can contribute to identity crises for the target populations and members of distinct cultural groups as they struggle with negative evaluations and projections.

---

## PREJUDICE

---

*Prejudice* has been defined as a preformed adverse judgment or opinion that is not grounded in knowledge,



All cultural groups display prejudice toward others, regardless of their status (i.e., dominant or non-dominant group membership). People born and raised in racist, sexist, ageist, heterosexist, and otherwise oppressive systems tend to operate from internalized beliefs that are informed by these hierarchies. Though processes involving “unlearning” the socialization reinforce prejudices, individuals may begin to address how holding on to prejudices influences their appraisals of themselves and others. Moreover, being the target of prejudices may become a significant part of cultural socialization experiences, thus shaping how individuals respond toward members of other groups. When individuals are confronted with something or someone different from themselves, they may view the new object negatively if they themselves have been targets of prejudice and discrimination.

### Why Does Prejudice Occur?

Early theorists constructed prejudice as a survival response to the extent that categorical thinking served to identify enemies and threatening situations. Knowing and recognizing members of one’s ingroup (e.g., family, clan, community) was imperative if one was to survive; outgroup members often fought for ownership and access to vital resources, including land, wealth, and power. Although recent literature has attended to emotional, social, economic, and historic dimensions of prejudice, psychologists also have proposed that prejudice is partly a result of normal human functioning.

Categorical thinking intrinsic to prejudice is employed when people distinguish ingroup from outgroup members, and it informs the perception of greater similarity within a group and dissimilarity between groups than actually exists. In other words, individuals may perceive members of their own groups as more similar to them than they are in reality, and outgroup members are perceived to be more homogenous, such that they also are seen as interchangeable and expendable. Biases toward others are strengthened not out of hatred toward others but rather from positive perceptions of, and favoritism for, the ingroup (i.e., ingroup bias). Diverse races and cultures have ingroup biases; further, positive cultural identity development factors include positive emotions and self-appraisal as a member of a given cultural group.

According to social dominance theory, people feel more positively about themselves when they denigrate others. This creates a false sense of superiority,

although it may have no basis in reality. It is further noted that the mechanism fueling prejudicial behavior is a desire to disparage others to ensure the perception of superiority and goodness. It has been suggested that prejudice and discrimination serve to maintain institutional oppression and affirm a sense of superiority among dominant groups across social locations (e.g., race, gender, and class). For example, it can be argued that within the present social structure, White males who are identified as middle and/or upper class (i.e., owning class) may hold prejudices that serve to maintain their status as dominant. Several studies have linked social dominance to anti-Black and anti-Arab prejudice, sexism, nationalism, opposition to gay rights, and other attitudes concerning social hierarchies.

### Historical Perspective

Psychology started focusing on prejudice in the 1920s, when the emphasis was on American and European race theories that were developed to support the belief that Whites were the superior race. The emphasis started to shift in the 1930s and 1940s with progress in civil rights, challenges to colonialism, and a growing concern about antisemitism. Following the Holocaust, theories concerning personality variables that created a predisposition to prejudice became a focus of study. The most influential proposition was that underlying prejudicial behavior was an authoritarian personality.

The authoritarian personality was described as cognitively rigid and dichotomous, deferential to authority, and strictly adherent to social rules and hierarchies. Within this personality style, prejudices were thought to maintain categories and rules that were defended. Although this hypothesis had been met with criticism for lacking empirical support, later research supported the claims that related authoritarianism to political conservatism, hierarchical worldviews and endorsement of social dominance orientations, and categorical thinking.

The original expressions of prejudices tended to be blatant, open, and direct, indicating a person’s attitude and behavior in one simultaneous act (e.g., lynching, restriction of voting rights). Given the protests of stigmatized people and the changes in laws and understanding of the oppression caused by such prejudices, racism, sexism, classism, and all other types of prejudice have been moved into a new domain called modern and aversive racism, sexism, and classism. Recent changes in legal and social norms have curtailed overt



discrimination, but they also have fueled the emergence of more subtle forms of oppressions. For example, modern racism is characterized by the acknowledgment that racism exists alongside denial and attempts to address and resolve persistent inequities in today's society, under the claim that specific racial and cultural groups make unfair demands. Similarly, an example of modern sexism is endorsing the statement that it is not acceptable to consider women unintelligent compared with men while not endorsing measures to equal employment and wage disparities that women face. In effect, prejudices are said to evidence more subtly in current society.

### Cross-Cultural Counseling

As mentioned, prejudice can be considered a maladaptive response to the anxieties people face or self-generate in response to human differences. It is maintained that this anxiety is exacerbated by the central existential problem of how one should live, what kind of person one should be, and whether that way of being has value. People living with condemnation of their skin color, gender, age, disability, sexual identity and orientation, or all of these, struggle with negative prejudicial behavior and stereotypes imposed upon them. This leaves the work of addressing the identity crisis of stigmatized individuals to psychologists, counselors, and therapists.

Recent research has psychological distress among the target populations, especially as it relates to prejudice, discrimination, and social stigma research. Additional research has documented the influence of experiencing prejudice and discrimination on psychological distress as well as the influence of mediating and moderating factors that can influence the extent to which individuals experience anxiety or stress related to prejudice (e.g., self-esteem). Empirical evidence has been found that people who endorse worldviews that teach tolerance and respect for diversity are resilient to defensive manifestations of intolerance; further, people who endorse such worldviews may actually become more tolerant under ambiguous, anxiety-provoking situations.

Counselors and mental health professionals are encouraged to recognize how their own prejudices may influence counseling processes. Psychologists have asserted that all human encounters are cross-cultural encounters on the basis of differences in gender, race, culture, ethnicity, age, sexual identity and orientation, religion, class, religion, and disability and other social

positionalities. As a function of being socialized in hierarchies wherein social groups are ascribed power and members of groups are assumed to be deficient based on differences, counselors are likely to carry prejudices that can influence their assessment treatment of diverse clients. Moreover, given the power of the counseling role, such ascription of prejudices to clients may have implications beyond the scope of the consultation room. For example, some counseling psychologists have argued that foundational theories of psychological normality and abnormality were based in Eurocentric worldviews that reflected favoritism for that ingroup and perceived outgroups (e.g., people of color) and their cultures as deficient. Prejudices may evidence to the degree that values and experiences characteristic of a specified group of people may not be valued or legitimated within Eurocentric or androcentric theories of psychology.

In addition, counselors and mental health professionals may be invested in their prejudices such that they manifest defenses in their work with culturally diverse clients. Counseling psychology literature has presented several defense mechanisms that are believed to emerge in cross-cultural and cross-racial counseling, specifically when the counselor is White and the client is a visible racial/ethnic group member; these defense mechanisms include color-blind racial attitudes, color consciousness, cultural transference and counter-transference, cultural ambivalence, and pseudo-transference. Color-blindness is a lack of consideration of race, whereas color-consciousness overemphasizes the sociopolitical construct of race. Cultural transference and counter-transference refer to the exchange of racial and cultural projections between counselors and clients, as informed by each party's personal experiences with members of the other parties' racial-cultural group. Cultural ambivalence refers to counselors' preoccupation with their own issues as they confront race, including White guilt for historical atrocities and focusing on their personal racial privileges rather than the clients' experiences. Pseudo-transference refers to the refusal to take responsibility for one's prejudices and discrimination, such that clients are blamed for breakdowns in the relationship. Defense mechanisms identified for counselors of color are overidentification with clients' perceived issues and identification with the oppressor in their role as counselor. Across these counselor-specific defenses, counselors' prejudices may be operative to the extent that counselors may struggle to



acknowledge their own biases or the realities of oppression (i.e., color-blindness), project racial assumptions on to their clients (i.e., counter-transference), or disown their roles in racial dynamics in the dyad (e.g., pseudo-transference or identifying with the oppressor).

### Addressing Prejudices in Counselor Training

Several techniques and educational strategies are now being employed to educate counselors and psychologists to reduce the learned prejudices and biases that are a result of growing up in a racist, sexist, and classist society. Cross-cultural or multicultural counseling techniques and strategies are a part of curricula in nearly all counseling training programs; further, the existence of competencies and guidelines by the major counseling and psychology associations have encouraged increased sensitivity, awareness, knowledge, and skills in both educators and counselors. It is recommended that education and training focus on teaching the ability to navigate among foundational theories of counseling (e.g., psychodynamic, cognitive-behavioral) to inform culturally relevant treatment approaches for clients. In addition, it is encouraged for counselors and mental health professionals to move away from deficit models to recognizing clients' strengths based on biculturality, multi-culturality, or both. To the extent that counselors' endorsement of cultural identity attitudes has been related empirically to multicultural counseling competence, training programs may employ measures of racial identity attitudes, acculturation, gender identity attitudes, and worldview in evaluating the efficacy of multicultural counseling training curricula.

It is recommended that counselors and counseling trainees examine the extent to which they have internalized a Western bias toward compartmentalizing cultural variables that are embedded in counseling theories. Namely, counseling theories tend to examine gender, race, sexual orientation, and class separately, rather than the interplay among them. Thus, the lives of people with multiple stigmatized identities are compartmentalized into fragmented cultural categories that do not mirror real life. Consequently, Eurocentric and multicultural perspectives share a limitation in that the

complex manner in which multiple stigmas operate in the lives of individuals is largely unexamined. More specifically, the degree to which counselors may hold prejudices related to multiple cultural identities (e.g., stereotypes related to women of color or lesbian, gay, bisexual, transgendered people of color) may go unapproached without addressing the realities of the intersections of social locations.

*Farah A. Ibrahim and Carmen B. Williams*

*See also* Antisemitism (v3); Bias (v3); Classism (v3); Discrimination (v3); Discrimination and Oppression (v2); Oppression (v3); Racism (v3); Sexism (v3); Stereotype (v3)

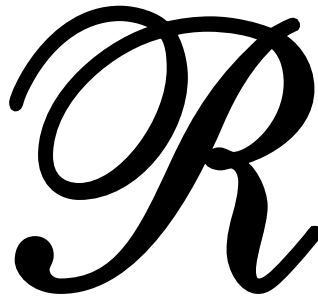
### Further Readings

- Allport, G. (1982). *The nature of prejudice* (4th ed.). Reading, MA: Addison-Wesley.
- Croteau, J. M., Talbot, D. M., Lance, T. S., & Evans, N. J. (2002). A qualitative study of the interplay between privilege and oppression. *Journal of Multicultural Counseling and Development, 30*, 239–258.
- Duckitt, J. H. (1992). Psychology and prejudice: A historical analysis and integrative framework. *American Psychologist, 47*, 1182–1193.
- Fiske, S. T. (1998). Prejudice, stereotyping, and discrimination. In D. T. Gilbert, S. T. Fiske, & G. Lindzey (Eds.), *Handbook of social psychology* (4th ed., pp. 357–411). New York: McGraw-Hill.
- Jones, J. M. (1997). *Prejudice and racism* (2nd ed.). New York: McGraw-Hill.
- Levin, J. (1982). *The functions of prejudice*. New York: Harper & Row.
- Nelson, T. D. (2002). *The psychology of prejudice*. Boston: Allyn & Bacon.
- Neville, H. A., Worthington, R. L., & Spanierman, L. B. (2001). Race, power and multicultural counseling psychology. In J. G. Ponterotto, J. M. Casas, & C. M. Alexander (Eds.), *Handbook of multicultural counseling* (2nd ed., pp. 257–288). Thousand Oaks, CA: Sage.
- Plous, S. (2003). The psychology of prejudice, stereotyping, and discrimination: An overview. In S. Plous (Ed.), *Understanding prejudice and discrimination* (pp. 3–48). New York: McGraw-Hill.
- Sidanius, J., & Pratto, F. (1999). *Social dominance: An intergroup theory of social hierarchy and oppression*. Cambridge, UK: Cambridge University Press.









---

## RACE

---

Race refers to a label that is commonly ascribed to individuals in certain societies based on their affiliation with a group of people. Members of racial groups typically share common characteristics in physical appearance or phenotype, but more significantly, they share a common stature within a given society. Although not widely regarded as such, many societies are hierarchically arranged by race, with the sociopolitically dominant group being composed of Whites and other racial groups variously (and frequently interchangeably) arrayed at lower rungs. Convention suggests that racial classification is a reflection of an objective scheme about biogenetic differences among humans (the presumption of “natural race”); however, such a conclusion is irrefutably false. According to the American Anthropological Association, race is a social construction whose origins can be traced to an ideology that associates observable physical qualities of people that serve as markers of race, with presumptions about the person’s personality, morality, temperament, or “deservedness” of prized resources in a society. These resources include entry into political and judicial arenas, access to valued academic institutions, and opportunities to enter and be promoted in various occupational settings. That biogenetic differences are found in human groups appears to relate not to race, but rather to such factors as regional differences, group sensitivity to ultra-violet light, and resistance to disease.

Race is distinguished from ethnicity in that the former evolved out of a history of racial oppression. Determining which people constituted what racial

group was influenced in part by ethnicity; yet the evolution of race appears to relate closely with the sociopolitical circumstances that surrounded the people in a society. Indeed, racial groups encompass people from different ethnicities. For example, in the United States, the White racial group category can include the multiple European ethnic groups that migrated to the country, just as the Asian/Pacific Islander American racial group includes people with ethnic origins in Cambodia, Japan, Korea, the Philippines, and the various inevitable admixtures. The other racial groups that have been constructed in the United States are African or Black American, Hispanic or Latino/a American, and Native/Alaskan/Aleutian American. People from historically marginalized racial groups can form pan-ethnic (or pan-tribal) allegiances because of the oppression they have endured. People who are visibly descended from ethnic groups often come to associate themselves as White people and, as such, become associated with the benefactor of racial entitlements in that society.

Race as a phenomenon is linked to European conquest that stems from thousands of years ago, but it began to take on greater virulence about 400 years ago. It continues to influence people’s worldviews through a process of socialization. According to Diane Hughes and her colleagues, racial socialization occurs not only from direct teachings about issues of race that are conveyed by parents to children, but also through media, formal education, discourse that is considered acceptable according to societal norms, and politically resistant efforts, as in the establishment of learning settings that promote racial awareness and understanding. Over time, ideas can shift about who constitutes what race, as in far-gone delineations of



Africans that included distinguishing those of “mixed” race (labeled mulattoes or octoroons) from those with more African appearance in skin color, nose shape, and texture of hair.

As an illustration of the questions regarding the suggestion that determinations of race are objective, *hypodescent* is a practice that originated in the earlier years of racial formation in the United States and is characterized by the automatic assignment of the children of racially different couples to a less privileged group. Another illustration of race as a social construction is the experience of a person being designated one racial group in one setting and another in another setting. Persons of mixed Black–White parentage with discernible African features most likely would be classified as Black or biracial in the United States but potentially as White in some Caribbean countries.

A more elaborate history of the origins of race follows.

### Historical Context

Shared phenotypic qualities have historically been the basis for a distinction between racial groups, and those in power have used race as a justification to identify some groups as inferior and thus to justify their mistreatment of such groups. What developed in this construction of race was an ideology of differential human worth that could be linked to observable phenotypic features. Several scholars, including J. L. Graves, presented documented evidence of how White scientists attempted to prove such a connection using an assortment of “scientific” measures and tests. Certain intrinsic qualities, such as intellectual abilities, moral fiber, aesthetic tastes, personalities, and physical abilities were “proven” to be associated with racial group membership. Positive human qualities were associated with Europeans, who labeled themselves as racially White, whereas various non-White populations throughout the world were considered to possess negative qualities.

Notably, scholars describe the emergence of a new identity among Whites in North America that paralleled the evolving construction of race. Many Whites saw themselves as having superiority in worth and being the deserving heirs of the territories inhabited by non-Whites. They viewed the colonized and exploited as inferior and deserving of their fate. In the United States, an ideology of race became reproduced over time, catalyzed by forces such as shifts in the nation’s demography—shifts that resulted not only from

increases in the population of enslaved Africans and immigrants but also from factors such as the preponderance of “mixed” racial parentages, fluctuations in the economy that were linked intricately to racial and ethnic competition in the labor force, and legal issues surrounding definitions of who constituted what race.

Also developing over time were responses to racial oppression by non-Whites. Depending on the extent of violence or, threat of violence, non-White racial groups often built alliances across ethnicities to form kinships, or, rather, networks of support and endurance. Yet another response by many oppressed racial groups was to align themselves with their White oppressors to decrease the severity of their conditions. As history has shown repeatedly that violence can breed further violence, we know from documented accounts that multiple conflicts have existed between racial groups, for example, between non-Whites and Whites during uprisings for liberation, and among similarly marginalized racial groups, as in Black cowboys’ participation in Native American massacres. The spawning of divisions within racial groups can be attributed in part to racial oppression, as well as to the confluence of other forces that pertain to unfair systems of stratification, like class exploitation and sexism.

### From History to Contemporary Contexts

Racism is perpetuated when people are unable to resolve the dehumanization that underlies its existence. A crucial step in this resolution is the need for a wider acknowledgment of its existence and the understanding of the varied meanings that people attach to race. Evidence shows that people of all walks of life are hampered by the erroneous belief that racial groupings can be associated reliably with biogenetic variation or other differences in traits presumed to be immutable. For counseling professionals, it is especially troubling that behavioral scientists seemingly carry this belief when they examine racial issues. A base of knowledge that could inform mental health practitioners about the relevance of race to psychological functioning is compromised by a preponderance of research studies in which self-identified race is used to speculate about research outcomes. A more direct approach would be to investigate the meaning that people ascribe to race as related to these outcomes. J. E. Helms, M. Jerrigan, and M. Mascher



recommend methodological strategies for studying race that can best inform mental health practice.

In the absence of forceful efforts to abrupt societal racism, there is the continued threat that racism's reach will extend to various parts of the world. C. E. Thompson, J. A. Annan, S. S. Auma-Okumu, and A. Qureshi contend that the spread of racist ideology has had an impact on *all* episodes of genocide and ethnic cleansing in the past century and in current-day Sudan. The American Anthropological Association links the adoption of an ideology of race to the extermination of 11 million "inferior" people in Nazi Germany.

Although some propose that an obliteration of "race" as a human label is necessary to this goal of the elimination of racism, most scholars seem to agree that this charge can be viewed as a manifestation of *color-blindness*, that is, the desire to ignore race for the expressed purpose of seeing people "merely as people." The problem with color-blindness ideology is that it assumes that racism can be tackled easily by an insistence that the person is not noticing something that probably, for most people, is impossible *not* to notice. In other words, people who uphold an ideology of color-blindness assume that the perceptual erasure of race is possible; yet recent studies by J. Dovidio and his colleagues show that racial cues often spark implicit biases in Whites that contradict their nonracist, verbal messages. An erasure of labels, though a laudable aspiration in view of their association with a loathsome past, would also detract from non-Whites' pride in the resiliency of their groups. Moreover, because racism is a construction that is multiply layered and given to imperceptibility, resolving its pathological manifestations would require systemic efforts and the engagement of the varied racial groups that comprise the society. Learning to acknowledge rather than deny the experiences of different racial groups can be seen as a healthy start to these strategies.

Relevant to the discussion on ways to resolve problems over, and confusions about, race is the proliferation of labels that better reflect the amalgamation of people across races and regions of the world. Terms like *Afro-Cuban*, *biracial* or *multiracial*, *Black-Indian*, and so forth, challenge ideas about the more commonly used racial categories that were indicated earlier. These labels, which are internally defined as opposed to other racial labels that were externally imposed, help identify people's multiple heritages. They therefore complicate the notion of racial classification and could very well urge people to consider

the taken-for-granted nature of established racial labels. With improved lines of research and further study on race and racism, science and theory can help better determine the extent to which the varied uses of these labels—whether for the purpose of asserting one's desire to break free of racial labels, denoting one's loyalty to certain or varied family members, building alliances with similarly labeled people, or a combination of these and/or other factors—can operate to extinguish racial pathologies.

### Implications for Counseling

In promoting positive mental health, counselors and therapists conduct assessments of individuals, groups, and families to determine client needs and strengths and the obstacles that hinder such promotion. Incorporating an understanding of race, as well as an understanding of its meaning to the client, can be helpful to the counseling process and outcome. How does this occur with so little research to guide professionals? Racial identity theory is a conceptualization in which the cognitive and affective processes associated with people's response to racism are viewed as patterned. Whites and people of color experience these patterns differently, yet they share some commonalities: People develop racial identity as they are increasingly exposed to racial stimuli, and when their abilities to cope with these stimuli are depleted, particularly with exposure to the contradictions in reality and their proneness to moral reasoning, they then are compelled to seek out newer, more complex ways to cope. Racial identity theory is a valuable template for thinking about and working through issues of race and racism in counseling. The theory can be used as a means to make assessments about a client, about the counselor-self relative to his or her understanding of racial issues in counseling, and as a road map for facilitating advanced development. Advanced racial identity development refers to characteristics about a client's way of behaving and viewing the world that include risk-taking behaviors (to move the person to more enlightened perspectives about racism and other forms of oppression) and greater complexity in thinking about others *and* the self. Racial identity theory does not concern itself with racial labels, but it may elicit information about labels to achieve a rich understanding of how the individual perceives the self and others within the racism-hierarchical scheme.

There are many cues to determine how or if matters of race are relevant to counseling. C. E. Thompson



and R. T. Carter recommend that practitioners help create a climate in which the client can assume that these matters are viewed as permissible in counseling and, therefore, *can* be relevant to counseling. Such deliberate engineering is important in view of the suppression that surrounds racial discourse. One way to create this climate is to briefly point out the racial designation the client indicated on an intake form, or simply ask him or her directly.

As noted earlier, racial socialization refers to a process of learning about racial issues. Racial identity theory more specifically examines how people come to view their worth relative to others in racialized societies. These appraisals of worth are influenced by stereotypes about racial groups, such as the stereotype of lazy Latinos/as or low-intelligent Black people. Stereotypes reduce the complexity of humans by conveying ideas about individuals based on their visible group affiliation. Stereotypes contain kernels of truth about people, yet the propensity of societal institutions to downplay and distort historical conditions of oppression, as well as continued experiences of racial discrimination in various spheres of public life, helps crystallize notions about “the way people are.” It is essential that the counselor be aware of the cognitive and affective processes that can distort his or her view about people and, especially, the view of certain groups as possessing less worth than others.

In trying to glean the meaning that clients make about race, counselors need to develop skills in inquiring about a topic that is considered fairly off-limits in polite society. Complicating matters, it is not uncommon for some people to express an indifference or rejection to race labeling, as in “I don’t refer to myself racially,” and showing some annoyance in the counselor raising issues of race during these interactions. White clients may express this racelessness as a means to express their indifference to race or deflect any embarrassment they might have about their affiliation with other Whites. Consistent with racial identity theory, responses to how clients react to racial cues will differ according to their understanding and degree of comfort with these stimuli.

The following two scenarios are presented to offer some glimpse of some of the meanings that people can ascribe to racism, notably the question: “What is your racial group?” On a preemptive note: How clients respond to racial stimuli offers useful information about the client’s worldview; however, it would be unwise to conclude anything based on very brief

responses. Determining the relevance of race of a particular client requires systematic exploration. As illustrated below, racial discourse characterized by the counselor’s attempts to determine how race and racism have been incorporated into a client’s worldview also reveals knowledge of how the person currently understands him- or herself in general, and as a person socialized in a structurally unequal and unfair world. As people talk about racial matters, a skillful assessment can help glean positive and negative ideas about the self. Constructions of race are closely linked to constructions of others; consequently, when clients in therapy share their feelings of fragility and low self-worth, the counselor potentially has clues about how their clients might relate or see others by comparison. People who need to be seen as distinct from a different group may have carved out ideas about who they want to be affiliated with as well as which group they do not want to be affiliated with.

In the first illustration is a person whose race is ambiguous and who is asked by the counselor, “Racially, how do you identify yourself?” With the response “biracial,” the counselor notices that the client exhibits discomfort. These observations are marked by the client’s rapid eye-blinking and twists of her body. The counselor may take these nonverbal cues as indications of the client’s annoyance at being asked the question. For people who appear racially ambiguous, there is some wariness to such questions because of the sense that inquirers seem to *need* to know to settle their own intolerance for the ambiguity. The skilled therapist should take note of the detected physical reactions, perhaps even explain that this is a question he asks all of his clients and that he suspects that she is bothered by it because she’s been asked many times and perhaps by those for whom the intent is not entirely known but suspected. As the client listens, she may appear to become more relaxed as she infers that the counselor’s desire to know her race is different from the others she has encountered. Over time, the client explains that her parents, one of whom is Black and the other White, raised her in a loving home in which matters of racism were addressed openly. Her family also honored their different racial and ethnic heritages—Irish, African, Chinese, and Polish—and made special efforts to celebrate the rich heritage of her African ancestors because these ancestors, and others descended from them, are seen as the “undesirables” of American society. The counselor learns, still over the course of some time, that opportunities to



interact with Black people have always been and continue to be plentiful, as with people from other backgrounds. As a result of her family, the client recognizes that deliberate efforts have to be made to relinquish negative ideas about her heritage as a marginalized member of society and that getting to know people from a range of backgrounds in ways that honor them as people is something that she constantly strives for, not only because of race but also because of how she has to come to know the host of forces that create divisions among humans in society.

Based on this information and the evolving relationship, the counselor is able to learn some important information about the client's psychological makeup. He learns that there is open communication in the family about a very difficult subject as well as deliberate efforts to go about their lives that counter mainstream ideals. He also learns that the person exudes confidence in a manner that is unapologetic. Her relationship with diverse groups of people suggests that she can traverse many situations socially and that she seeks rather than avoids close relationships with people without the barrier of stereotyping or skillful avoidance accompanied by deft justifications. What one can surmise from this client is that she functions in psychologically healthy ways in many areas of her life. With someone so advanced in racial identity, Helms noted, the race of the counselor may not matter so much as when the client's development is less advanced.

Consider this next example of a client, who appears White, and when asked about his race, quickly responds "Caucasian," then proceeds to shifting the topic to the "real" issue at hand. He may harbor some questions about why the question was even asked but is so smooth with his indifference to race that the slightly annoyed mood barely registers. As sessions proceed, he makes certain subtle yet disjointed remarks about his admiration of Native American people whom he believes "have suffered *so* much." He may even start dropping hints of his new relationships with Native Americans. His therapist is Native American, which is discerned by name, appearance, and dress in a town with a critical mass of Native Americans. The stimulus of race (i.e., the perceived race of the therapist) invokes the notion not only of difference but also of the disparities that exist between Whites and Native Americans within a society in terms of resources, living conditions, and so forth. Race also signals different experiences between groups, whereby non-Whites face everyday racism,

exoticism, and discrimination, while Whites encounter privilege, often unrecognized. The client's reference to "Caucasian" signals perhaps the notion that this term sounds official and less embarrassing than "White." What the counselor learns, at least in a tentative manner, is that the client is open to making inroads with people whom he may have formerly been indifferent to or whom he has relegated as inferior to him. But those overtures are indirect and suggestive of a lack of maturity in racial identity development. He also may have a lack of meaningful social supports to make these connections more constructive. The client may be impelled to unresolved problems related to race because he is experiencing a positive relationship with his counselor and would like the counselor to approve of him. A more authentic relationship would yield not only more mature strategies for connecting with the counselor but also an ability of the client to discover a more genuine interest in Native American people. Stated another way, the client may be restricted to viewing the therapist and other Native American people as objects that are important in helping him diminish feelings of self-worth. In promoting psychological health, the counselor would need to better assess the extent to which the client's objectification serves to feed a fictitious image of himself as good and help replace these strategies with those that reflect more genuine engagement in people in general.

Both illustrations reveal how racism establishes a *yoked* existence among individuals in society. In contrast to the interdependence that exists in creating functioning societies, racism and other unfair systems of stratification impose a twisted interdependence that thwarts the realization of these societies. According to Thompson and her colleagues, the yoke is experienced when people in racialized societies collude in belief systems about human superiority. Because of the lack of "working through" the generations-long challenges inherent in racial oppression, people invoke the yoke when they come to believe that human worth is achieved in ascending these constructed hierarchies. In some societies like Brazil, racial ascendancy can be characterized by the marriage of non-Whites to Whites or by the acquisition of wealth. Racial ascendancy can be tied to social class, ethnicity, gender, and skin color in many societies. But importantly, a striving for ascension through constructed hierarchies does little to dismantle the hierarchies. The individual ultimately responds in collusion with the distortions about humankind, thus reaffirming bias and distancing.



To break from the construction, people must recognize the need for equity, integrity, and other goals that would foster the creation of human family across stratified groups.

Counselors need to learn to disengage from the yoke and its varied proliferations. To do this, it is recommended that therapists gain an understanding of how race is dramatized locally and nationally and learn to work through it in their own lives and in the counseling process. Furthermore, and because racism is but one form of oppression in an unfortunately lengthy list of oppressive forces, counselors need to learn about the other forces that have an impact on people in conjunction with one another. In view of these forces, the focus of counseling and treatment plans should be not only to remove symptoms but also to foster more liberating worldviews in clients.

*Chalmer E. Thompson*

**See also** African Americans (v3); Alaska Natives (v3); American Indians (v3); Asian Americans (v3); Biracial (v3); Black Racial Identity Development (v3); Color-Blind Racial Ideology (v3); Critical Race Theory (v3); Demographics, United States (v3); Diversity (v3); Ethnic Identity (v3); Ethnicity (v3); Latinos (v3); Multiracial Families (v3); Racial Identity (v3); Racism (v3); Reversed Racism (v3); Visible Racial/Ethnic Groups (v3); White Racial Identity Development (v3)

### Further Readings

- American Anthropological Association. (1998). American Anthropological Association statement on "race." *American Anthropologist*, 100, 3. Retrieved from <http://www.aaanet.org/stmnts/racepp.htm>
- Dovidio, J. F., Gaertner, S. L., Kawakami, K., & Hodson, G. (2002). Why can't we just get along? Interpersonal biases and interracial distrust. *Cultural Diversity & Ethnic Minority Psychology*, 8, 88–102.
- Graves, J. L., Jr. (2001). *The emperor's new clothes: Biological theories of race at the millennium*. New Brunswick, NJ: Rutgers University Press.
- Haney Lopez, I. F. (1996). *White by law: The legal construction of race*. New York: New York University Press.
- Helms, J. E. (1995). An update of Helms's White and people of color racial identity models. In J. Ponterotto, J. M. Casas, L. A. Suzuki, & C. M. Alexander (Eds.), *Handbook of multicultural counseling* (pp. 181–198). Thousand Oaks, CA: Sage.
- Helms, J. E., Jerrigan, M., & Mascher, J. (2005). The meaning of race in psychology and how to change it: A methodological perspective. *American Psychologist*, 60, 27–36.
- Hughes, D., Rodriguez, J., Smith, E. P., Johnson, D. J., Stevenson, H. C., & Spicer, P. (2006). Parents' ethnic-racial socialization practices: A review of research and directions for future study. *Developmental Psychology*, 42, 747–770.
- Miville, M. L. (2005). Psychological functioning and identity development of biracial people: A review of current theory and research. In R. T. Carter (Ed.), *Handbook of racial-cultural psychology and counseling: Theory and research* (Vol. 1, pp. 295–319). Hoboken, NJ: Wiley.
- Root, M. P. P. (2001). Negotiating the margins. In J. G. Ponterotto, J. M. Casas, L. A. Suzuki, & C. M. Alexander (Eds.), *Handbook of multicultural counseling* (2nd ed., pp. 113–121). Thousand Oaks, CA: Sage.
- Smedley, A. (1993). *Race in North America: Origin and evolution of a world view*. Boulder, CO: Westview Press.
- Thompson, C. E., Annan, J. A., Auma-Okumu, S. S., & Qureshi, A. (in press). Building cultures of peace in post-colonial Africa: A case in point. In C. E. Thompson & R. T. Carter (Eds.), *Racial identity theory: Applications to individual, group, and organizational interventions* (2nd ed.). Mahwah, NJ: Lawrence Erlbaum.
- Thompson, C. E., & Carter, R. T. (1997). *Racial identity theory: Applications to individual, group, and organizational interventions*. Mahwah, NJ: Lawrence Erlbaum.
- Thompson, C. E., & Neville, N. A. (1999). Racism, mental health, and mental health practice. *The Counseling Psychologist*, 27, 155–223.
- Trimble, J. E. (2005). An inquiry into the measurement of ethnic and racial identity. In R. T. Carter (Ed.), *Handbook of racial-cultural psychology and counseling: Theory and research* (Vol. 1, pp. 320–359). Hoboken, NJ: Wiley.

---

## RACIAL IDENTITY

---

Racial identity is a dynamic sociopolitical construction and assists in the understanding of within-group differences of people of different races. Racial identity development is relevant to all racial groups and incorporates perspectives of a person's view of self with regard to his or her own racial group and other racial groups. Racial identity is an important construct because it is a more meaningful concept, and likely a better predictor of behavior, than racial group membership alone. In addition, the experiences of people



of color are not homogeneous and have resulted in different meanings and attributions about being a part of a specific racial group.

### Definition of Racial Identity

A number of theorists and researchers have attempted to define racial identity. Janet E. Helms described the construct as a sense of collective identity that is based on a perceived common heritage with a racial group. Helms integrated perceptions of self and others in her definition of racial identity. Robert T. Carter stated that racial identity development is a lifelong process that involves how a person interprets messages about racial groups. Additionally, racial identity has been described as the significance and meaning of race in one's life.

Independent researchers have identified various aspects of racial identity, but no one has combined them to form one single definition of the term incorporating a developmental perspective, perspectives of both dominant and minority groups, and qualitative meaning of group membership. In combination, the racial identity literature has shown that racial identity is a multifaceted construct that refers to (a) the qualitative meaning one ascribes to one's own racial group, (b) meaning attributed to other racial groups, (c) sense of group identification with one's own racial group, (d) salience of race in defining one's self-concept, and (e) perspectives regarding race over time.

### Ethnic Identity Versus Racial Identity

To understand the distinctions between racial identity and ethnic identity, it is important to distinguish the concepts of race and ethnicity. In the United States, *race* is a social construct that refers to factors such as skin color and physical features, while ethnicity refers to one's national or religious origin. *Racial identity* is comprehensively defined as the qualitative meaning and salience one ascribes to one's own and other racial groups, whereas *ethnic identity* is a dynamic construct that refers to one's sense of self as a member of an ethnic group. At their core, both constructs reflect an individual's sense of self as a member of a group; however, racial identity integrates the impact of race and related factors, while ethnic identity is focused on ethnic and cultural factors. Some authors suggest that ethnic identity development is an individual's movement toward a more conscious identification with his or her own cultural values, behaviors,

beliefs, and traditions, whereas others note that theories of racial identity tap into racial psychological development rather than ethnic development.

### History of Racial Identity Models

#### *African American/Black Racial Identity*

The concept of racial identity in the psychological literature has existed since the 1970s and was developed in response to the civil rights movement. The first models of racial identity were focused on Black American racial identity. For example, Clemmont Eyvind Vontress proposed that there were different personality types for Black Americans: Colored, Negro, and Black. This theory emphasized societal stereotypes and suggested that the personalities of these individuals were static. William E. Cross, Jr.'s Nigrescence theory was another early Black racial identity theory. The most recent version of this theory incorporates six different issues, including the structure of Black self-concept (i.e., the integration of aspects of personal and reference group orientation), the variety of Black identities, identity socialization from infancy to early adulthood, adult resocialization experiences, continued identity development and enrichment across the life span, and identity functions that incorporate the variety of Black identities that are displayed within and across situations. These and other stage models (e.g., Dizzard, 1971; Gibbs, 1974; Jackson, 1975; Milliones, 1980; Thomas, 1970; Toldson and Pasteur, 1975) suggest that individuals progress from holding negative views of themselves based on internalized racism to having a more positive view of their own and other racial groups.

#### *White Racial Identity*

White racial identity models have been proposed by a number of researchers. Rita Hardiman proposed a five-stage developmental model (no social consciousness, acceptance, resistance, redefinition, and internalization) of racial identity development for Whites born in America. Helms also described different components of White racial identity, including Phase I (abandonment of a racist identity: contact, disintegration, and reintegration) and Phase II (establishment of a nonracist White identity: pseudo-independence, immersion/emersion, and autonomy). In the contact status, people are satisfied with the racial status quo, are unaware of continuing subtle racism, and believe



that everyone has an equal chance of success. In the disintegration status, the White person may become conflicted over unresolvable racial moral dilemmas and obliviousness about the impact of race begins to break down. In the reintegration status, the White person might regress to basic beliefs about White superiority and minority inferiority; there may be an idealization of the White European American group and denigration of other minority groups in this status. In the pseudo-independence status, a person is propelled into this status by a painful or insightful encounter that jars him or her from the reintegration status and may lead him or her to identify with the plight of persons of color. There is an intellectual understanding of racial issues in this status. In the immersion/emersion status, the White person continues a personal exploration of him- or herself as a racial being, and questions focus on the meaning of Whiteness; personal meaning of racism is explored. In the autonomy status, there is an increased awareness of one's own Whiteness and reduced feelings of guilt. There is also an acceptance of one's role in perpetuating racism and a renewed determination to abandon White entitlement.

Helms noted that ego status (differentiated by a person's understanding of the concept of race) has been integrated into the concept of racial identity because the use of stages may not adequately describe attitudes, beliefs, and emotions that are exhibited from more than one stage. In addition, *stage* is a static term, and racial identity theory and measurement do not support the idea that stages are mutually exclusive or temporally stable. It has been noted that racial identity attitudes change and develop based on environmental and temporal influences, and change in identity does not necessarily imply a developmental process. In addition, stage models have been critiqued, and alternative conceptualizations such as White racial consciousness have been proposed.

### **General Racial Identity**

Models of racial identity have been applied to people of color in general in the United States. One example is Donald R. Atkinson, George Morten, and Derald Wing Sue's racial/cultural identity development model for people of color. This model was first introduced as the minority identity development model and was expanded in later years. In this model, people of color are posited to progress through different stages,

including conformity, dissonance, resistance and immersion, introspection, and integrative awareness. Each of these stages takes into account a person's attitudes toward self, others of the same and different racial groups, and the dominant racial group. Similar to the Helms's model, in the conformity stage, people of color depend on White society for definition and approval. In the dissonance stage, there may be feelings of confusion and conflict about the meaning of one's race. The person of color may encounter information or experiences that are inconsistent with culturally held beliefs and attitudes. In the resistance and immersion phase, the person of color may endorse minority-held views completely and reject dominant values. In the introspection phase, the person of color may experience feelings of discontent and discomfort with previously held rigid group views. In the integrative awareness stage, people of color develop an inner sense of security and can own and appreciate unique aspects of their own group as well as the dominant group.

Extending Helms's model, Julie R. Ancis and Nicholas Ladany's heuristic model of nonoppressive interpersonal development can be applied to a variety of demographic variables (e.g., gender, sexual orientation, socioeconomic status), including race, for which an individual is either in a position of privilege (socially privileged group [SPG]) or oppressed (socially oppressed group [SOG]). In this model of means of interpersonal functioning there are four stages. The first stage, adaptation, is reflective of complacency and conformity regarding a socially oppressive environment for both SOG and SPG members. In the second stage, incongruence, there is some dissonance or internal conflict about oppression. This stage is followed by the exploration stage in which members of SOG and SPG evaluate and explore the meaning of membership to their respective group. The last stage, integration, includes awareness of oppressive environments and situations, multicultural integrity, and commitment to advocacy for oppressed groups. This model is unique in that stages of development can be applied to both members of privileged and oppressed groups. Similar to other models of identity development, people may go through different phases in specific situations or with respect to certain demographic characteristics.

Interactional models of racial identity suggest that one's level of racial identity development impacts one's interactions with others. These models have been applied to counseling and supervision to compare the racial identity development of clients to that



of their counselors, as well as trainees compared to their supervisors. For example, in parallel-high relationships, both individuals are in later stages or statuses (i.e., Phase II) of identity development. In parallel-low relationships, both individuals have lower levels of identity development (i.e., Phase I). Progressive relationships involve either the supervisor or counselor being in Phase II, while in regressive relationships they are both in Phase I. The racial identity level of supervisors and counselors can impact the course and depth of discussions of racial issues, the formation of an authentic working relationship, and feelings of cultural trust and rapport in counseling or supervision.

## Measurement and Research

### *African American/Black Racial Identity*

Racial identity has been one of the most heavily researched areas in the psychological experiences of African Americans. One of the most widely used measures of Black racial identity is the Black Racial Identity Attitudes Scale (RIAS-B) from Thomas A. Parham and Helms. The original RIAS (Short Form A) is a 30-item self-report measure designed to assess four of the five stages of racial identity proposed by Cross's Nigrescence model: pre-encounter, encounter, immersion/emersion, and internalization. The fifth stage, internalization/commitment, was not included in the RIAS because it was conceptualized as a style of behaving with respect to identity issues that might be present in other stages.

RIAS items were developed to measure stages of Black awareness development. The RIAS was revised into two forms: Short Form B, which also consists of 30 items, and the RIAS-Long Form, which was developed to increase the subscales' reliabilities and contains 20 additional items. RIAS items are rated on a 5-point Likert scale ranging from 1 (*strongly disagree*) to 5 (*strongly agree*). Item scores on each subscale are averaged, with higher scores indicating the presence of that type of racial identity attitude.

The RIAS has been shown to be a reliable scale overall, meaning that it measures the construct of racial identity in a consistent, stable, and uniform manner over repeated measurements. However, some researchers have found low reliabilities for the subscales of the various versions of the RIAS, especially the Encounter subscale. In addition, given the low

test-retest reliability estimates for the subscales, some researchers have concluded that the attitudes measured by the RIAS-B should be considered state rather than stable trait variables. Evidence shows that the RIAS is a valid measure of the construct of racial identity because the relationships between the subscale scores and measures of other related constructs are consistent with racial identity theory.

Research using the various forms of the RIAS is extensive. It has been used to study the relationship between racial identity and other constructs, such as psychological distress and self-esteem, Minnesota Multiphasic Personality Inventory-2 scores, counselor demographic preference, and career choices. Strengths of this measure include its frequent use in published literature, the availability of both short and long forms, and strong support for its construct validity. However, the low reliability coefficients found by several authors suggest the measure requires additional psychometric investigation and improvements. Also, the measure has not been significantly updated since Cross's was revised and is therefore not consistent with the changes to the theory.

The Cross Racial Identity Scale (CRIS; Vandiver et al., 2001) was designed to measure the theoretical constructs proposed in the updated version of the Nigrescence theory. The CRIS was developed to measure six of the seven identity clusters described in the revised theory: assimilation and anti-Black (pre-encounter), intense Black involvement and anti-White (immersion/emersion), Black nationalist and multiculturalist (encounter). The CRIS is a 40-item scale that uses a 7-point Likert scale ranging from 1 (*strongly disagree*) to 7 (*strongly agree*). A pool of 250 items was developed by the authors and later reduced to 126 items which were evaluated by expert judges knowledgeable about the revised Nigrescence theory. Validity of the measure has been demonstrated through its relationships with other measures of Black racial identity and measures of self-esteem and social desirability. Statistical analysis indicates that the CRIS can be used to measure either the six individual identity clusters in the model or two general stages that are conceptualized as pre-discovery and discovery.

The CRIS has not been utilized extensively in published literature beyond studies of its psychometric properties. In one study, Afrocentric cultural values and a positive ethnic identity were found to be negatively related to a racialized identity, as measured by the Immersion-Emersion Anti-White subscale of the



CRIS. In another study it was found that racial identity attitudes were related to internalized racism. While the evidence supporting the CRIS is strong thus far, additional research is needed to further investigate its contribution to racial identity literature.

Robert M. Sellers, Stephanie A. Rowley, and colleagues developed the Multidimensional Inventory of Black Identity (MIBI; Sellers et al., 1998) to operationalize the concepts proposed in their multidimensional model of racial identity. Items were developed by combining items from previous scales on African American racial identity, ethnic identity, and social identity with original items created by the authors. The MIBI contains 56 items rated on a 7-point Likert scale ranging from 1 (*strongly disagree*) to 7 (*strongly agree*). It comprises three scales (Centrality, Ideology, and Regard), as well as subscales (i.e., Nationalist, Assimilation, Minority, Humanist, Private Regard, and Public Regard). Studies have indicated that the MIBI is an adequately reliable, valid measure of three distinct factors: centrality, ideology, and regard.

The MIBI has been used to investigate the relationship between racial identity and perceived discrimination and distress, academic performance, and personal self-esteem. Strengths of the MIBI include its potential ability to capture the multidimensional aspects of African American racial identity and be used as a complement to other stage-based measures. Additional research is needed to further validate this instrument and explore its contribution to racial identity literature.

### **White Racial Identity**

Several researchers have attempted to operationalize and measure White racial identity. Helms and Carter developed the White Racial Identity Attitude Scale (WRIAS), a 50-item inventory that includes five subscales designed to measure the extent to which a person uses the race-related schemas (i.e., Contact, Disintegration, Reintegration, Pseudo-Independence, and Autonomy) through which one interprets racial cues. Items were developed based on Helms's model of White racial identity development and are assessed on a 5-point Likert scale ranging from 1 (*strongly disagree*) to 5 (*strongly agree*). Studies of the WRIAS have suggested it is adequately reliable, while the relationship of its subscales to measures of personality constructs has indicated that it is a valid measure of White racial identity.

The WRIAS has been used extensively in research on White identity. White identity has been found to be related to cultural values, preference for counselor race, self-reported multicultural counseling competencies, self-actualization, and cross-cultural education. Several researchers have criticized the validity and reliability of the WRIAS; others have argued that it does not measure the five distinct aspects of racial identity it was designed to measure. To address the latter issue, some researchers have used the WRIAS to measure two theoretically proposed *phases* of racial identity (i.e., Phase I and Phase II) instead of five *stages*.

Sandra Choney and John Behrens developed the Oklahoma Racial Attitude Scale-Preliminary Form to measure the types of racial attitudes White individuals hold regarding their own and other racial groups. White racial consciousness has been defined as the characteristic attitudes regarding the salience of being White and the implications of this on interactions with those from other racial groups. The 50-item scale measures whether White people have achieved White racial consciousness and includes four basic *achieved* attitudes (dominative, conflictive, integrative, and reactive) and three *unachieved* attitudes (avoidant, dissonant, and dependent). Items were developed to measure the attitudes proposed in their model and are rated on a 5-point Likert scale with responses ranging from 1 (*strongly disagree*) to 5 (*strongly agree*). Scores that differ the most from the mean indicate which type of racial attitude best characterizes the individual's outlook.

N. Kenneth LaFleur, Wayne Rowe, and Mark M. Leach developed the 35-item revised Oklahoma Racial Attitudes Scale (ORAS) following initial studies of its reliability and validity and theory revisions. Investigations of the measure have suggested that the items measure their predicted factors and support the measure's reliability. Although limited, published research using the measure has found White racial consciousness to be predictive of racial prejudice. While this measure has promise as a tool to assess White racial identity, it requires additional psychometric and empirical investigation.

### **People of Color Racial Identity**

Black and White racial identity attitudes have been assessed more often in research than the racial identity attitudes of other racial groups. While some researchers have suggested that ethnic or cultural identity may be more salient than racial identity for



people of color, others argue that measures of racial identity are appropriate for people of color. In an attempt to operationalize the statuses described in her people of color racial identity model, Helms created the People of Color Racial Identity Attitudes Scale (POCRIAS). The POCRIAS contains 50 items with four subscales measuring the conformity, dissonance, immersion/emersion, and internalization/integrative awareness statuses. Items are measured on a Likert scale ranging from 1 (*strongly agree*) to 5 (*strongly disagree*), with higher scores on each subscale indicating greater levels of that racial identity attitude. Studies have supported the reliability of the measure, although published empirical support for its validity is limited. Therefore, while one of its strengths is that it is one of the only scales available to assess the racial identity of people of color in addition to that of African Americans, this measure is limited by its lack of empirical support and utilization in published literature. The limited psychometric support for this measure has led some researchers to use African American racial identity measures (e.g., the RIAS) to examine the racial identity of other individuals of color.

Although limited, empirical research on racial identity for racial groups other than White and Black individuals has been conducted. For example, Asian American racial identity has been found to be related to gender role conflict and psychological symptoms, gender role conflict and male norm roles, psychosocial development, and levels of racial adjustment. For Latinos/as, racial identity has been found to be related to gender role conflict and psychological symptoms, ego identity, and psychosocial development. Psychometric research on the POCRIAS with Native Americans suggests it is appropriate for investigating the racial identity attitudes of this group. While one study found that Native Americans endorse high internalization identity attitudes, additional research is needed on the racial identity of this population.

### Future Directions

Racial identity is one of the most extensively investigated constructs in counseling psychology and has important implications for research and practice. With the addition of recent theories and measures, racial identity is likely to continue to be widely studied. One of the largest gaps in the racial identity literature is the application of the construct to individuals of color other than African Americans. Additional research on

the measurement of racial identity is needed for these groups, as well as for biracial and multiracial individuals. More research is also needed on the psychometric properties of the measures used to operationalize racial identity. Further, practical applications of racial identity theory need to be investigated more fully.

Anju Kaduvettoor, Aimee-Nicole Adams,  
and Nicholas Ladany

**See also** Black Racial Identity Development (v3); Cross, William E., Jr. (v3); Ethnic Identity (v3); Ethnicity (v3); Helms, Janet E. (v3); Identity (v3); Identity Development (v3); Multicultural Counseling Competence (v3); Sue, Derald Wing: Contributions to Multicultural Psychology and Counseling (v3); Visible Racial/Ethnic Groups (v3); White Americans (v3); White Racial Identity Development (v3)

### Further Readings

- Ancis, J. R., & Ladany, N. (2001). A multicultural framework for counselor supervision. In L. J. Bradley & N. Ladany (Eds.), *Counselor supervision: Principles, process, and practice* (3rd ed., pp. 63–90). New York: Brunner-Routledge.
- Atkinson, D. R., Morten, G., & Sue, D. W. (1998). *Counseling American minorities: A cross-cultural perspective* (5th ed.). Dubuque, IA: William C. Brown.
- Carter, R. T. (1995). *The influence of race and racial identity in psychotherapy: Toward a racially inclusive model*. Oxford, UK: Wiley.
- Cross, W. E., Jr., & Vandiver, B. J. (2001). Nigrescence theory: Current status and challenges for the future. *Journal of Multicultural Counseling and Development*, 29, 201–213.
- Hardiman, R. (1994). White racial identity development in the United States. In E. P. Salett & D. R. Koslow (Eds.), *Race, ethnicity and self: Identity in multicultural perspective* (pp. 117–140). Washington, DC: NMCI.
- Helms, J. E. (1984). Toward a theoretical explanation of the effects of race on counseling: A Black and White model. *The Counseling Psychologist*, 12, 153–165.
- Helms, J. E. (1995). An update of Helms's White and people of color racial identity models. In J. G. Ponterotto, M. J. Casas, L. A. Suzuki, & C. M. Alexander (Eds.), *Handbook of multicultural counseling* (pp. 181–198). Thousand Oaks, CA: Sage.
- LaFleur, N. K., Rowe, W., & Leach, M. M. (2002). Reconceptualizing White racial consciousness. *Journal of Multicultural Counseling and Development*, 30, 148–152.



- Parham, T. A., & Helms, J. E. (1981). The influence of Black students' racial identity attitudes on preferences for counselors' race. *Journal of Counseling Psychology, 28*, 250–257.
- Ponterotto, J. G. (1988). Racial consciousness development among White counselor trainees: A stage model. *Journal of Multicultural Counseling and Development, 16*, 146–156.
- Pope-Davis, D. B., Vandiver, B. J., & Stone, G. L. (1999). White racial identity attitude development: A psychometric examination of two instruments. *Journal of Counseling Psychology, 46*, 70–79.
- Rowe, W., Bennett, S. K., & Atkinson, D. R. (1994). White racial identity models: A critique and alternative proposal. *The Counseling Psychologist, 22*, 129–146.
- Sellers, R. M., Smith, M. A., Shelton, J. N., Rowley, S. A., & Chavous, T. M. (1998). Multidimensional model of racial identity: A reconceptualization of African American racial identity. *Personality and Social Psychology Review, 2*, 18–39.
- Sue, D. W., & Sue, S. (2008). *Counseling the culturally diverse* (5th ed.). New York: Wiley.
- Vandiver, B. J., Fhagen-Smith, P. E., Cokley, K. O., Cross, W. E., Jr., & Worrell, F. C. (2001). Cross's Nigrescence model: From theory to scale to theory. *Journal of Multicultural Counseling and Development, 29*, 174–200.

---

## RACIAL MICROAGGRESSIONS

---

Racial microaggressions are subtle and commonplace exchanges or indignities (both conscious and unconscious) that somehow convey demeaning messages to people of color. These racial slights can be verbal, behavioral, or even environmental. The exchanges often are viewed by perpetrators as harmless and inoffensive, but racial microaggressions can be a cause of psychological distress and drain spiritual energy for people of color who experience them.

A taxonomy of racial microaggressions was proposed by Derald Wing Sue and his colleagues, and their taxonomy classified racial microaggressions into three forms: microassaults, microinsults, and microinvalidations. *Microassaults* are explicit and conscious derogatory racist epithets that are purposefully meant to hurt people of color. *Microinsults* and *microinvalidations* are the unconscious and unintentional demeaning slights made toward people of color. An example of a microinsult would be a White man

telling a person of color who is interviewing for a job, "The person who is most qualified will get this job."

## Historical Perspective

The term *microaggressions* was first introduced by Chester Pierce in 1970. According to Pierce's definition, microaggressions are interracial interactions that convey contempt, disregard, and/or ambivalence that often reflect racial slights toward people of color. They are subtle racial behaviors that act as reminders of the societally inferior racial status of people of color in the United States. Because racial microaggressions are so unpredictable and occur intermittently, they force people of color to react and remain vigilant to preserve their self-respect. In the late 1980s, Peggy C. Davis defined *racial microaggressions* as stunning automatic acts of disregard that come from unconscious attitudes of White superiority and reveal a verification of Black inferiority. Therefore, racial microaggressions have evolved over time to reflect subtle and unconscious forms of racism.

## Contemporary Views of Racial Microaggressions

### *Implications for Counseling and Supervision*

Existing research and literature today focus on different aspects of microaggressions, particularly the contexts in which they occur. Microaggressions not only occur in daily interracial interactions for people of color, but they also occur in counseling and supervision relationships.

In a therapeutic relationship, where therapists are in positions of power and clients are more likely to view their therapists in positions of authority, clients who experience racial microaggressions from their therapists are more likely to question themselves than their therapist. For example, if a client shares an experience that she or he perceived as racist and wanted to process this experience with her or his therapist, the therapist may respond by saying, "I think that you are being paranoid," thus completely invalidating the client's experience. Well-intentioned White therapists also may claim that they understand racial oppression completely in an attempt to identify with or make a connection with their clients of color. However, such an intervention could further demean clients'



experiences of racism and invalidate their identification as a person of color who experiences unique racial oppression.

Racial microaggressions also have been found to occur in cross-racial supervisory relationships involving White supervisors and Black supervisees. For example, Black supervisees have reported that White supervisors have blamed clients of color for problems stemming from oppression, made stereotypic assumptions about these supervisees and clients of color, offered culturally insensitive treatment recommendations to these supervisees, and been reluctant to give performance feedback to them for fear of being viewed as racist. These experiences have been found to be detrimental to Black supervisees and, indirectly, to the clients they serve.

### **Implications for Counseling**

Mental health practitioners must be aware of the detrimental effects that racial microaggressions have on people of color. The literature reveals that this experience of everyday racism for people of color has an effect on their intrapsychic structure. Racial microaggressions perpetuate and promote feelings of invisibility, unworthiness, and anguish among people of color. Because racial microaggressions can be so subtle, yet so powerful, people of color usually are left with feelings of disbelief about their occurrence and, in turn, question themselves as to what really happened in a microaggressive situation. It is imperative that counselors are sensitive to and aware of experiences of racial microaggressions when they are shared in a therapeutic context so that these experiences are not disregarded or invalidated through minimization.

*Madonna G. Constantine and Cristina Dorazio*

*See also* Bias (v3); Communication (v3); Constantine, Madonna G. (v3); Discrimination (v3); Discrimination and Oppression (v2); Oppression (v3); Prejudice (v3); Racism (v3); Stereotype (v3); Sue, Derald Wing: Contributions to Multicultural Psychology and Counseling (v3)

### **Further Readings**

Constantine, M. G. (2007). Racial microaggressions against African American clients in cross-racial counseling relationships. *Journal of Counseling Psychology, 54*, 1–16.

- Constantine, M. G., & Sue, D. W. (2007). Perceptions of racial microaggressions among Black supervisees in cross-racial dyads. *Journal of Counseling Psychology, 54*, 142–153.
- Franklin, A. J., & Boyd-Franklin, N. (2000). Invisibility syndrome: A clinical model of the effects of racism on African-American males. *American Journal of Orthopsychiatry, 70*, 33–41.
- Harrell, S. P. (2000). A multidimensional conceptualization of racism-related stress: Implications for the well-being of people of color. *American Journal of Orthopsychiatry, 70*, 42–57.
- Sue, D. W., Capodilupo, C. M., Torino, G. C., Bucceri, J. M., Holder, A. M. B., Nadal, K. L., et al. (2007). Racial microaggressions in everyday life. *American Psychologist, 62*, 271–286.

---

## **RACIAL PRIDE**

---

Racial pride is an attitude signifying a preference for cultural representations of one's racial group. Much of the conceptualization and research regarding racial pride has focused on the socialization experiences of African Americans, an ethnic group within the Black population. Information about racial pride among other racial groups remains relatively unknown. The definition of racial pride evolved to denote both a racial socialization message promoting heritage and culture to children and adolescents and an attitude endorsing positive racial identity among adults. Currently, racial pride contributes to furthering the multidimensional conceptualization and measurement of socialization processes and racial identity among Blacks and, potentially, other racial groups.

### **Conceptualization and Measurement of Racial Pride**

Conceptualization and measurement of racial pride evolved following decades of researchers attempting to understand the racial preferences of Black children under the reactionary premise that Blacks were an inferior and devalued group in the United States. In the 1930s, studies finding African American children's preference for White over Black dolls produced a prevailing yet flawed belief in Black self-hatred, low self-esteem, and low racial pride that endured until Black self-esteem studies in the 1960s suggested the



contrary. Marked by the pro-Black, proactive stance of that time, positive racial identity theories in the 1970s, followed by affirmative racial socialization theories in the 1980s, began to appear in the psychology literature with inclusion of the racial pride concept.

### ***Racial Identity Factor***

Racial pride is one of multiple racial identity attitudinal factors that describe how Blacks identify with their racial group. Conceptually, racial pride is the endorsement of a positive Black identity and an attitude of interest or involvement in activities related to the culture. Empirically, measures of racial pride are subsumed in racial identity scales such as the Black Racial Identity Attitudes Scale and brief scales to measure collectivism, religiosity, racial pride, and time orientation. Racial identity research based on racial pride attitudes consistently support its conceptual assumptions, and associate more positive pride attitudes with fewer general psychological distress symptoms and improvement in health-related behaviors, such as breast cancer-related knowledge and mammography screening. Conversely, racial pride's contribution to racial socialization research is more complex.

### ***Racial Socialization Factor***

As a construct in the multidimensional conceptualization of racial socialization, racial pride refers to one of the messages parents convey to their children regarding the meaning of being Black. Theoretically, like other socialization messages, racial pride is transmitted intentionally and unintentionally from parents to children in tacit and explicit ways to aid in their psychological adjustment, especially in dealing with racism and discrimination in society. Empirically based racial pride measures emerged out of qualitative data from the landmark National Study of Black Americans and subsequent racial socialization measures, such as the Cultural Pride Reinforcement subscale of the Scale of Racial Socialization; this subscale measures knowledge about African American history and culture and positive feelings about the cultural group. Growing evidence supports greater racial pride socialization among girls than boys, whereas boys are more likely to receive socialization messages related to racial barriers such as discrimination. Moreover, racial pride differentially contributes to psychological outcomes such as depression, anger,

and aggression for boys and girls. Among adolescents, racial pride has been positively associated with self-esteem, kinship social support, knowledge about one's racial group, and favorable ingroup attitudes. However, some evidence suggests negative relationships between racial pride and academic curiosity and grade point average outcomes, raising questions about whether the pride socialization comes before or after the poor academic indicators. The complex findings surrounding racial pride provide impetus for future directions of the research.

### **Future Directions**

For more than two thirds of a century, racial pride has helped explain a portion of how Blacks identify with their own racial group. Subsumed within racial identity research, positive pride attitudes are consistently associated with fewer general psychological distress symptoms and improvement in health-related behaviors. Yet complex correlational relationships with attitudinal and behavioral factors along with gender differences among females and males exist. Future research exploring the relationships among racial pride, racial identity, and racial socialization for Blacks, Asians, Hispanics, and other racial group members will aid in formulating multidimensional conceptualizations of racial issues in cross-cultural counseling theory. Longitudinal studies will help explain the directional associations between racial pride and its identity and socialization factors. Future research that examines the interactions among racial pride, gender, other demographic variables, racism and discrimination experiences, health, and educational outcomes will provide a more accurate understanding of the multiple factors that contribute to how individuals are socialized and how they identify with their racial group.

*Ma'at E. Lewis-Coles*

**See also** African Americans (v3); Afrocentricity/Afrocentrism (v3); Black Racial Identity Development (v3); Cultural Values (v3); Ethnic Pride (v3); Racial Identity (v3)

### **Further Readings**

Constantine, M. G., & Blackmon, S. (2002). Black adolescents' racial socialization experiences: Their relations to home, school, and peer self-esteem. *Journal of Black Studies*, 32, 233–335.



- Kreuter, M. W., & Haughton, L. T. (2006). Integrating culture into health information for African American women. *American Behavioral Scientist*, 49(6), 794–811.
- Neblett, E. W., Philip, C. L., Cogburn, C. D., & Sellers, R. M. (2006). African American adolescents' discrimination experiences and academic achievement: Racial socialization as a cultural compensatory and protective factor. *Journal of Black Psychology*, 32(2), 199–218.
- Neville, H. A., & Lily, R. (2000). The relationship between racial identity cluster profiles and psychological distress among African American college students. *Journal of Multicultural Counseling and Development*, 28(4), 194–207.
- Stevenson, H. C. (1994). Validation of the scale of racial socialization for African American adolescents: Steps toward multidimensionality. *Journal of Black Psychology*, 20(4), 445–468.
- Stevenson, H. C., McNeil, J. D., Herrero-Taylor, T., & Davis, G. Y. (2005). Influence of perceived neighborhood diversity and racism experience on the racial socialization of Black youth. *Journal of Black Psychology*, 31, 273–290.

---

## RACISM

---

Racial categorization is a central construct within American society and, as such, has had an enduring impact on all levels of social relations. Given the hierarchical social structure within the United States, racism has emerged as a logical outcome of a society based on and structured around race. A growing appreciation of the social and psychological costs associated with racism has led to racism being viewed as an important area of inquiry and intervention for counselors and psychologists.

*Racism*, a term coined in the 1930s, is centered on the belief that persons can be separated into categories based on physical attributes. Racism is understood to have three fundamental components. First, it is rooted in the belief that perceived group differences can be attributed to fundamental differences in biology (stereotypes); second, racism involves the negative evaluations one has of another racial group relative to one's own (prejudice); and third, racism reflects the unequal treatment of groups (discrimination). Fundamentally, racism involves the presumption that one race is superior over others in areas of aptitude, abilities, intelligence, physical prowess, and/or virtues, and it is exhibited through acts of discrimination and harassment.

Various types of racism include individual, institutional or structural, and cultural or ideological. *Individual racism* is characterized by one person's treatment toward another based on race, for example, an employer not hiring a qualified individual or a sales clerk not helping a customer. *Ideological racism* is a perception or worldview that may formulate into a personal theory about individuals belonging to a particular race (e.g., the assumption that all African Americans have inferior intelligence or the assumed superiority of European art forms over other racial groups' artistic expressions). *Institutional* or *structural racism* is located within political and economic systems and social institutions such as education and law enforcement. Institutional racism is thought to involve unfair distribution of resources and unequal participation in the above-mentioned systems based on racial categorization. Such discrimination can be seen in a financial institution's practice of consistently providing loans at higher rates of interest to persons of color.

## Racism in Historical Context

Racism as a social phenomenon and psychological reality is built entirely on the concept of race. A historical review of the word *race* indicates that from its inception, race has been associated with classification. The Latin derivative of the word *race*, *razza*, was first applied to the classification of animals into species. With the advent of European exploration and the convergence of economic, political, religious, and scientific forces in the colonialist age, the word *race* began to be applied to groups of people. This development culminated in the establishment of a racial hierarchy, with peoples of European origin forming the top of the hierarchy and people of African origin being at the base. It is easily understood then how certain groups of people began to be viewed as inherently inferior, a belief which the then scientific community supported by means of Social Darwinism and the Eugenics movement. Current thinking, largely led by anthropologists and supported by genetic research, indicates that race, as a biological construct, is in fact nonexistent. Genetic data consistently yields evidence of greater variability within so-called racial groups than across them. However, race as a social construct continues to hold much sway with unstated views of inferiority/superiority being reinforced by the existence of significant social inequalities across racial lines.



A review of various socioeconomic indicators in contemporary U.S. society reveals that, proportionately, White Americans tend to accumulate the greatest amount of wealth and have more consistent access to educational opportunities and health care than do their non-White counterparts. In the corporate world, Whites disproportionately hold the greatest percentages of managerial and executive positions, and in the political arena, Whites have been singularly represented in the positions of president, vice president, and Speaker of the House of Representatives. Furthermore, racial disparities that exist in the areas of health and health care, as well as the disproportionately higher rates of incarceration among Blacks and Latinos/as, serve to reinforce stereotypical notions of the racial hierarchy as well as provide further evidence of the institutional and structural nature of racism. Many observers have concluded that even though race is in and of itself inherently meaningless, the significance that is attached to race has made it a real and enduring concept. Perhaps the most powerful and damaging aspect of race is simply the belief that physical differences are representative of differences in traits, abilities, and aptitude, a belief that provides the core ideological foundation for the persistence of racism.

### ***Privilege***

An important correlate of racism is the notion of privilege, also referred to as unearned advantage or conferred dominance. Essentially privilege is viewed as the accrual of social power based on historical inequities. Given the history of race within the United States, the accepted understanding is that Whites currently are the racial group to whom concept of privilege most accurately applies. Before and during the time of slavery, Whites inherited certain privileges that were denied to non-White persons. These privileges included receiving an education, working for wages, having the right to vote, and having the right to own property. As a racial group, Whites continue to benefit from these types of "privileges." It is this system of unearned advantages, irrespective of individual knowledge or intent, that forms the basis of institutional and structural racism. When this system is accompanied by a personal belief in the notion of racial superiority, individual racism is the result.

## **Psychological Models of Racism**

Although racism is viewed primarily as a sociological phenomenon, it is also understood to have distinct psychological components.

### ***Theoretical Foundations***

Prejudice is viewed as a core aspect of individual racism and racial discrimination. G. E. Allport was one of the first scholars to offer a psychological model of prejudice. Allport viewed prejudice as an inflexible attitude, defined by generalizations based on inaccurate information, that could be directed toward a group or an individual of that group. Although evolutionary psychologists have suggested that prejudice is embedded in the genetic makeup of humans, social psychological theory proposes that prejudicial attitudes are habitual and learned, either through imitation of others or in the ways in which we construct our psychological reality. While initially thinking that prejudice was in fact a type of personality, Allport eventually introduced an integrated theoretical model of prejudice, which focused on the various causes of prejudice, including historical, sociocultural, situational, personality-type, phenomenological, and individual factors. In addition to concepts outlined in Allport's model, social psychologists have also viewed prejudice to be embedded in the human need for self-justification, status, and power. People's unfair treatment of others is justified if they assign derogative labels such as "inferior," "unworthy," "stupid," or "subhuman" to others who are different from themselves. The notion of prejudice is thought to be a foundational element of the larger phenomenon of racism.

### ***Current Psychological Models of Racism***

#### **Aversive Racism and Racial Microaggressions**

S. Gaertner and J. Dovidio have described aversive racism as a subtle process whereby White Americans, while holding on to egalitarian beliefs, continue to feel discomfort and negative feelings in relation to people who are racially different. Given the positive developments in race relations over the past few decades (e.g., civil rights legislation), the notion of aversive racism is now viewed as having replaced the overt racism of the Jim Crow era. For Black



Americans and other people of color, the Jim Crow era was marked by legalized racial segregation, consistent threat to their physical well-being, intimidation practices such as cross burning, and the ubiquitous loss of property and personal rights. Although these intentional and overt acts of hostility and discrimination are now disavowed, the more unintentional behaviors consistent with avoidance and minimization of racially different others continues to provide racism with a ubiquitous hold on American society.

A correlate of aversive racism is the phenomenon of racially based *microaggressions*—a term introduced by Chester Pierce. Racial microaggressions are thought to be the day-to-day demeaning and insulting messages directed toward people of color, both directly and indirectly. One type of microaggression is the experience of invisibility among African American men. The “invisibility syndrome,” as described by A. J. Franklin, is thought to be a phenomenon whereby, irrespective of accomplishments, Black men continue to be interacted with based on stereotypical notions of inferior intelligence, criminality, and danger. Hence, their individual self is lost to the stereotypical view of who they are, and a feeling of invisibility ensues. The consistent exposure to racial microaggressions is understood to have a detrimental effect on well-being.

### Racism as a Type of Stressor

Racism has become appreciated as representing a significant aspect of psychological stress for people of color. R. Clark and colleagues and S. Harrell have provided important theoretical frameworks from which the individual impact of racism can be understood. Although primarily focusing on the African American experience, their frameworks have applicability for individuals from all racial groups who are exposed to racism within the United States. Both models view racism and its effects as an interaction between the individual and his or her environment. Accordingly, various forms of racism-related stress have been identified, namely, racism-related life events, vicarious racism experiences, daily racism microstressors, chronic contextual stress, collective experience of racism, and transgenerational transmission of group traumas. Racism-related stress, therefore, can be understood as a combination of episodic stress, daily hassles, and chronic strain. How an individual evaluates

or perceives the experience of racism is considered to be a central determinant of the manner in which the individual will be impacted by the experience of racism. If an environmental stimulus is perceived as racism, an individual will employ various coping responses. The coping response in turn determines the physical or psychological outcome of the environmental stimulus, possibly leading to adverse psychological and physiological stress.

### Racism as a Type of Mental Illness

There is debate as to whether White racism is a type of mental illness. James E. Dobbins and Judith H. Skillings have argued that the dynamics of White racism are similar to those dynamics seen among individuals who experience addictions. Accordingly, it is argued that individual racism includes a specific set of behaviors and symptoms, such as a reduced racial sensitivity marked by increasing tolerance of racist behavior, denial of the presence of racism (both individual and socially), withdrawal and isolation from people of color, persistent maladaptive behavior designed to maintain distance between self and the racial other, and persistence of maladaptive behaviors irrespective of consequences. As such, it is thought that racism can be arrested through interventions such as the restructuring of distorted cognitions, the use of self-help groups to engage in antiracist dialogue, and the implementation of a 12-step model with the goal being a change in ideas, attitudes, and behaviors.

### Expanded Psychological Definitions of Racism

Psychologists have begun to call for an expanded understanding of the manner in which racism impacts people of color. Included in this call is a need to rethink the definition of *racism*. One approach is to parcel out aspects of racism in relation to racial discrimination (withholding) and racial harassment (acts of hostility). In making this distinction it is thought that the psychological and emotional impact of racism could be more efficiently explored. Additionally, preliminary evidence indicates that those individuals who report experiences consistent with racial harassment are more likely to report increased levels of psychological distress such as depression, anxiety, and intrusive thoughts. In relation to racism-related stress, researchers have commented on



the significant differences in rates of posttraumatic stress disorder (PTSD) between Whites and people of color. The offered explanation is that people of color, possibly due to chronic exposure to racism, might have a lower stress threshold when encountering traumatic events. Subsequently, it is argued that current understandings of traumatic stress might not capture the type of stress induced by consistent exposure to, and involvement with, racism. For people of color it is thought that generic or general life stress most likely includes aspects of stress that are inherently associated with living in a society structured on race and defined by racism.

## Psychological Correlates of Race and Racism

### *Mental Health*

Racism has long been viewed as having important psychological aspects. Early scholars such as Frantz Fanon spoke in terms of racism leading to alienation—alienation from self, from significant others, from one's culture and history, and from self-determination and access to various forms of social power. In the 1950s A. Kardiner and L. Ovesey introduced the notion that a defining characteristic of the "Negro personality" was the belief in their inferiority. Kenneth and Mamie Clark provided some of the first empirical evidence of the harmful psychological impact of racism when their study showed that Black children displayed a preference for White dolls over Black dolls. The notion of racism as an intrapsychic process whereby the targets of racism accept the inferior view of their racial group and, by extension, an inferior view of themselves, is referred to as *internalized racism*. More recently, Shawn Utsey and Mark Bolden have suggested that acute reactions to racism might include racism-related trauma, racism-related fatigue, anticipatory racism reaction, race-related distress, racism-related frustration, and racism-related confusion. A growing body of research indicates that experiences of racism are linked to psychological distress, decreased quality of life, and specific physiological disorders such as hypertension. With regard to psychological distress, racism is associated with experiences of depression, anxiety, increased feelings of hostility, and higher levels of paranoia. Currently, the accepted understanding is that racism is generally associated with poorer health status and that the association is the strongest for mental health.

Finally, there is a growing appreciation of the manner in which racism functions at the psychological level within the dominant racial group. Research suggests that for Whites, the psychological correlates of racism include a distorted sense of self and personal accomplishments, an irrational sense of superiority, a fear of those who are racially different, and a predominant sense of guilt.

### *Racial Identity*

The construct of racial identity is an important psychological correlate of racism. Racial identity theorists such as William E. Cross, Jr. and Janet E. Helms have been at the forefront of increasing the understanding of race as a psychological variable as exhibited by racial identity statuses and attitudes. Racial identity is understood to be an aspect of personality that reflects an individual's identity in relation to his or her racial group membership. Additionally, racial identity is believed to influence the manner in which an individual processes racial stimuli and experiences of racism and is understood to encompass affective, cognitive, and behavioral functions. Racial identity theory posits varied maturational statuses in relation to how an individual processes racial stimuli and therefore is an important construct to consider when exploring the individual impact of racism. The statuses that are viewed as more immature for people of color are pre-encounter and encounter and for Whites are contact, disintegration, and reintegration. Essentially, the immature racial identity statuses are defined by a denial of race and racism and confusion in relation to self as a racial being and racism as social reality. For Whites, the more mature statuses are re-integration, pseudo-independence, and autonomy while for people of color, the more mature statuses include immersion/emersion, internalization, and integrative awareness. These statuses are defined by a recognition and appreciation of the presence of race and racism and the acceptance of self and others as racial beings. Research has indicated that more mature racial identity statuses tend to be associated with greater degrees of psychological well-being and that racial identity statuses have a direct impact on the perception and appraisal of race-related events. Finally, there is preliminary evidence for a potentially moderating role of racial identity in relation to racism-related stress and psychological functioning. Scholars have posited that the more mature racial identity status might act as a



buffer, protecting individuals against the more harmful psychological effects of racism.

### ***Racial Socialization***

Socialization is understood to be a process by which individuals learn the beliefs, values, and behaviors that are considered to be normative within their specific reference groups—racial, ethnic, religious, and so forth. In relation to racism, racial socialization is viewed as an important element influencing how individuals both anticipate and respond to experiences of racism and discrimination. Given that people of color within the United States are raised in a negative and, at times, hostile environment, racial socialization practices are instrumental in facilitating a healthy self-concept. Through implicit and explicit messages, children are taught to value those beliefs, behaviors, and values that are specifically associated with their racial group membership. As with racial identity, racial socialization is considered to be an important construct in the development of resiliency and can also be viewed as potentially protective for individuals and groups who are consistently exposed to experiences of racism.

### **Racism and Mental Health Practice**

The importance of racism in mental health practice is understood in relation to the nature of a client's presenting concerns, the impact of race and racism on the quality of the therapeutic relationship, and factors associated with coping and resilience.

### ***Cultural Mistrust***

Perceived racism is the subjective experience of racism and discrimination. Symptoms that tend to be associated with paranoia (i.e., suspiciousness, feelings of ill will, beliefs in external control) are viewed as effects of perceived racism. However, in populations that have been consistently exposed to racism, perceived racism has been associated with a type of "cultural paranoia." Contrasted to clinical paranoia, cultural paranoia is initiated by the experience of being a racial minority in a socially hostile environment. Within counseling and psychotherapeutic services, the notion of cultural paranoia is often labeled "cultural mistrust," a distrust and attitudinal response that people of color might have toward the dominant majority, brought on by years of social and economic

oppression as well as continued everyday experiences of perceived racism, prejudice, and/or discrimination. Cultural mistrust is demonstrated in the counseling relationship, especially between a racial minority client and dominant racial majority counselor. Trust on behalf of the client toward the counselor must be established for the counseling to be effective. The client must trust that the counselor has his or her best interests in mind during treatment. Importantly, a person of color who pursues counseling wants to be ensured that the counselor is also understanding of issues related to race and racism. Hesitance to engage in the counseling process due to the notion that the counselor lacks the understanding of how one's culture plays a part in the presenting problem is often a result of cultural mistrust. Although the impact of racial similarity in counselor pairing has not yet been empirically settled, there is research to suggest racially similar dyads might have an important influence on the counseling process. For example, Black clients have been noted to report lower levels of rapport with White counselors and greater counseling satisfaction with racially similar counselors, a finding considered largely due to an increased perception of trust. More often than not, if trust is not established, there is risk for premature termination, lower amounts of self-disclosure, and increased negative attitudes about seeking help.

### ***Cultural-Specific Coping***

Using a culture-specific framework, James M. Jones developed a model that describes the manner in which peoples of African descent are able to cope with racism. Jones argues that racism is a cultural legacy that has been embedded in the psychological consciousness. Subsequently a person or group's ability to cope with racial oppression is dependent on their psychological resiliency. He theorized that one's coping strategy is heavily dependent on one's racial identity and the subscription to the cultural foundation of one's cultural African legacy. Jones's model, TRIOS—which stands for time, rhythm, improvisation, orality, and spirituality—is thought to capture the cultural resources available to, and utilized by, Black Americans. Although prejudicial attitudes from the dominant group remain, the marginalized or minority group has gained the ability to cope with prejudice by detecting and protecting themselves from racism, eliminating self-defeating perceptions, and enhancing



self-worth. Models such as these might shed light on how individuals and groups who experience racism consistently report high levels of subjective well-being and how they have developed resilience. For the mental health practitioner, an appreciation of cultural-specific coping styles, such as relying on religion and spirituality, culture-specific behaviors and rituals, is an essential requirement when working with populations who regularly experience discrimination. Finally the role of cultural enclaves (i.e., living in racially similar communities) has also been recognized as potentially providing a buffer against those negative psychological reactions experienced by individuals and groups when faced with racist incidents.

### **Implications of Racism for Counselor Practice**

The phenomenon of racism impacts counselor practice on multiple levels. Counselors are involved in assisting individual perpetrators of racism in gaining a healthier sense of self and accordingly shifting away from dysfunctional ways of perceiving racial difference. Counselors also work with individuals or groups who have experienced racism in order to facilitate the employment of more effective coping patterns as well as the development of self-efficacy and personal power. On a more systemic level, counselors work to challenge racist structures that lead to differential rates of mental illness and disproportionate access to adequate health care. Counselors work to have increased racial representation among mental health professionals. Counselors work to legitimize practices of indigenous healing that might be questioned by the dominant racial majority as being unscientific. Finally, counselors and counseling psychologists seek to challenge dominant psychotherapeutic theories that view psychological functioning from an individualistic perspective, which could be less helpful to people of color who tend to value communal ways of being and incorporate spirituality as an essential aspect of well-being.

A recent development within counseling and counseling psychology has been the focus on social justice as a core aspect of who counselors are and what counselors do. Antiracism training is therefore a critical aspect of counselor training and preparation. Effective counselors recognize that they too are products of socialization experiences and cultural upbringing. Living in a society structured around race, counselors

have also been influenced by various aspects of individual and structural racism. Counselors therefore seek to maintain an active awareness about the ways in which they participate and contribute to the maintenance of racism as a system of oppression. Antiracist attitudes and behaviors have been incorporated within the rubric of multicultural competence and therefore represent one of the baseline qualities needed for competent and effective counselor practice.

*Alex L. Pieterse and Kilynda V. Ray*

**See also** Affirmative Action (v3); Antisemitism (v3); Bias (v3); Color-Blind Racial Ideology (v3); Cultural Mistrust (v3); Cultural Paranoia (v3); Discrimination (v3); Discrimination and Oppression (v2); Multicultural Counseling Competence (v3); Oppression (v3); Prejudice (v3); Race (v3); Racial Identity (v3); Sexism (v3); Social Justice (v3); Stereotype (v3)

### **Further Readings**

- Allport, G. (1954). *The nature of prejudice*. Boston: Beacon Press.
- Carter, R. T. (1995). *The influence of race and racial identity in psychotherapy: Toward a racially inclusive approach*. New York: Wiley.
- Carter, R. T., & Pieterse, A. L. (2005). Race: A social and psychological analysis of the term and its meaning. In R. T. Carter (Ed.), *Handbook of racial-cultural psychology and counseling* (Vol. 1, pp. 41–65). Hoboken, NJ: Wiley.
- Clark, R., Anderson, N., Clark, V. R., & Williams, D. R. (1999). Racism as a stressor for African Americans: A biopsychosocial model. *American Psychologist*, 54, 805–816.
- Dobbins, J. E., & Skillings, J. H. (2005). White racism and mental health: Treating the individual racist. In R. T. Carter (Ed.), *Handbook of racial-cultural psychology and counseling* (Vol. 2, pp. 427–446). Hoboken, NJ: Wiley.
- Feagin, J. R. (2001). *Racist America: Roots, current realities and future reparations*. New York: Routledge.
- Franklin, A. J. (1999). Invisibility syndrome and racial identity development in psychotherapy and counseling African American men. *Counseling Psychologist*, 27, 761–793.
- Gaertner, S. L., & Dovidio, J. F. (1986). The aversive form of racism. In J. F. Dovidio & S. L. Gaertner (Eds.), *Prejudice, discrimination, and racism* (pp. 61–90). San Diego, CA: Academic Press.
- Harrell, S. P. (2000). A multidimensional conceptualization of racism-related stress: Implications for the well-being of people of color. *American Journal of Orthopsychiatry*, 70, 42–57.



- Jones, J. (1997). *Prejudice and racism* (2nd ed.). New York: McGraw-Hill.
- Robinson, T. L., & Ginter, E. J. (Eds.). (1999). Racism: Healing its effects [Special issue]. *Journal of Counseling & Development*, 77(1).
- Smedley, A., & Smedley, B. D. (2005). Race as biology is fiction, racism as a social problem is real. *American Psychologist*, 60, 16–26.
- Sue, D. W. (2003). *Overcoming our racism: The journey to liberation*. San Francisco: Jossey-Bass.
- Tatum, B. D. (1997). *“Why are all the Black kids sitting together in the cafeteria?” and other conversations about race*. New York: Basic Books.
- Thompson, C. E., & Neville, H. A. (1999). Racism, mental health, and mental health practice. *The Counseling Psychologist*, 27, 155–223.

---

## REFUGEES

---

Refugees are people who flee their native countries to seek sanctuary in another country as a means of escaping persecution or oppression. Typically, refugee populations are especially active in times of war, though many also leave their countries of origin to escape an oppressive government. The traditional countries that accept refugees are Australia, Canada, Denmark, Finland, the Netherlands, New Zealand, Norway, Sweden, and the United States. In certain political eras in history, the criteria for receiving refugee status and the countries that the United States aided by accepting refugees fluctuated. During World War II, when thousands of people were fleeing violence and persecution, the United States and many other countries turned away refugees because their numbers were much higher than the immigration quotas instituted at the time. The U.S. Department of State refused to increase the quotas and to relax the limits on immigration. In response to the overall failure of countries to respond to the needs of World War II refugees, the United Nations High Commissioner for Refugees (UNHCR) was created, and the 1951 Convention Relating to the Status of Refugees delineated the international obligation, which the United States accepted, to shelter people who faced death and persecution in their own countries.

In contrast to the response to refugees during World War II, during the cold war, people from Southeast Asia, the Soviet Union, and Cuba were accepted into the United States as refugees although they did not meet the criteria for being a refugee. This illustrates

how the political atmosphere—in this case, the need to “liberate” people from communism—influences which nationality groups of refugees are allowed into the country. More recently, the United States has focused on smaller refugee groups, such as Sudanese refugees, who have been victims of repression in Egypt, Ethiopia, and Kenya, and refugees from Bosnia and Kosovo who were fleeing religious persecution.

The United States traditionally has accepted more refugees than the other countries of resettlement combined. However, after the terrorist attacks on September 11, the number of refugees admitted has declined. For persons to be declared refugees in the United States, they are generally interviewed by an officer from the UNHCR and an officer of the U.S. Citizenship and Immigration Services to assess if the person is considered a refugee under U.S. law. Despite these procedures, there are still ways to allow refugees into the country who do not fit the profile of a refugee. For example, under the Widows and Orphans Act, (a) women who fear they will be harmed because of their sex and (b) children under 18 whose parents cannot provide adequate care can be admitted into the United States as refugees. Although the United States does not admit as many refugees as in the past, there is still a significant refugee population in the United States that continues to grow.

Refugees are known to suffer extensive psychological distress as a result of war experiences, flight from their native country, residence or incarceration in foreign refugee camps, and their involuntary immigration to a host country. At present, posttraumatic stress disorder (PTSD) and major affective disorders are known to be common symptom patterns within refugee populations, and there has recently been a rise in the prevalence of PTSD. However, despite the known association between refugee status and the likelihood of mental illness, diagnoses may go undetected due, in part, to culture-related presentations (e.g., somatization) and assessment biases of mental health practitioners. Thus, the combination of cultural factors in mental health presentations and new refugee groups in the United States demonstrates a need for research to better understand the problems of refugee populations and to propose effective treatment that is culturally sensitive.

## Mental Health Interventions

The task of mental health providers has been to develop programs that refugees can access and utilize,



as well as receive in their own language. Kenneth E. Miller discussed an intervention approach with an ecological perspective. He suggested identifying and training community members, who are obviously familiar with local beliefs and practices, to assist as mental health paraprofessionals and with prevention services. It is important that mental health practitioners expand the range of settings in which mental health is practiced from traditional clinic-based approaches to community-based approaches, including psychoeducation, that allow for an expansion of consumers and a network of interdisciplinary collaboration among psychiatrists, psychologists, social workers, translators, teachers, medical doctors, and stakeholders from within the community. In political persecution, perpetrators aim to destroy people's sense of belonging and their community ties. Thus, interventions for refugees should be embedded in communities. Community outreach projects serve to bring communities and families together in some collaborative effort.

Gargi Roysircar reported on specific guidelines for working with refugee populations. First, counselors should attend to refugees' immediate and concrete needs; this provides the opportunity to build rapport with refugees. Some guidelines to increase effectiveness in developing a working relationship with refugees include (a) treating them with respect and dignity, (b) determining beforehand the appropriate means of greeting in the refugee's culture, (c) finding out where the refugee can obtain food appropriate for his or her culture, (d) arranging for an interpreter, (e) locating a religious community appropriate for the refugee's faith, and (f) connecting new arrivals with other members of their ethnic community. Finally, counselors' ability to listen to the refugees will be key in the facilitation of a trusting relationship.

Roysircar also suggested several community outreach services appropriate for refugee populations. First, she advocates for the establishment of a life skills group. This educational group should be structured to teach refugees about American society. Topics of a life skills group could include using public transportation, writing a résumé, applying for benefits, understanding the school system, and learning how to enroll in English as a Second Language (ESL) classes. Another community outreach program could focus on nutrition classes. The idea behind this service is that it will teach refugees how to prepare nutritious and inexpensive meals. Another possible outreach service could be to offer a stress management

class. An example of this type of class might include Tai Chi, deep breathing, and relaxation exercises. In such a class, refugees can begin to understand trauma and its deleterious effects rather than remaining confused about PTSD or stigmatizing it. In addition, an acculturation class can relate life problems of employment difficulties, legal issues, absence of primary support group, lack of American education, housing issues, economic issues, access to health care, and social functioning problems in the challenging process of acquiring a second culture. Other types of groups include men's and women's support groups, ESL classes, and community outreach projects (e.g., a gardening project, organizing a cultural festival). Community outreach projects also can serve to bring communities and families together in some collaborative effort.

*Gargi Roysircar and Emily Pimpinella*

*See also* Acculturation (v3); Acculturative Stress (v3); Adaptation (v3); Assimilation (v3); Bicultural (v3); Bilingual Counseling (v3); Career Counseling, Immigrants (v4); Cultural Accommodation and Negotiation (v3); Culture Shock (v3); Help-Seeking Behavior (v3); Immigrants (v3); Multicultural Counseling Competence (v3); Oppression (v3); Posttraumatic Stress Disorder (v2); Second Culture Acquisition (v3)

### Further Readings

- Barnett, D. (2006, December). A new era of refugee resettlement. *Center for Immigration Studies*. Retrieved February 2, 2007, from <http://www.cis.org/articles/2006/back1006.html>
- Huynh, U., & Roysircar, G. (2006). Community health promotion curriculum: A case study of Southeast Asian refugees. In R. L. Toporek, L. H. Gerstein, N. A. Fouad, G. Roysircar, & T. Israel (Eds.), *Handbook for social justice in counseling psychology* (pp. 338–357). Thousand Oaks, CA: Sage.
- Miller, K. E. (1999). Rethinking a familiar model: Psychotherapy and the mental health of refugees. *Journal of Contemporary Psychotherapy*, 29, 283–306.
- Refugees. In *Holocaust encyclopedia*. U.S. Holocaust Memorial Museum. Retrieved February 2, 2007, from <http://www.ushmm.org/wlc/article.php?lang=en&ModuleId=10005139>
- Roysircar, G. (2007). *Disaster recovery: Counseling interventions*. Alexandria, VA: American Counseling Association.



## RELIGION/RELIGIOUS BELIEF SYSTEMS

The term *religion* comes from the Latin *religare*, which means “to bind together or to express concern.” In modern times, religion has become a visible institution that provides an organizational structure for faith in the divine, sacred, or supernatural. In addition, there frequently are moral codes, ritual practices, worship, and celebrations associated with each religion or religious belief system.

Religion and spirituality are two constructs that have become inextricably and inappropriately linked in the professional literature, despite their differences. Although religion and spirituality are not necessarily mutually exclusive, they remain separate and distinct constructs. For example, one may express her or his spirituality through religion, whereas another may feel that religion inhibits the full expression of individual spirituality. Hence, some people will find religion and spirituality to be mutually exclusive. It is important to note that there is no consensus on the definitions of the terms *spirituality* and *religion*, and many scholars continue to merge the two erroneously. People may generally have a similar lack of precision regarding their religious and spiritual self-perceptions; this presentation is most likely a reflection of their personal experiences with, and understanding of, religion and spirituality in their lives.

In the United States, there are approximately 12 major religions represented, with an unknown number of lesser-known groups as well. Of the major organized religions in the United States, the overwhelming majority of the population (77%) is Christian. The remaining major groups, with the percentage of the population in parentheses, are Judaism (2%), Islam (2%), Buddhism (1%), and Hinduism (0.5%). The rest of the 12 major American groups include Unitarian Universalist, Wiccan/Pagan/Druid, Spiritualist, and Native American religion, as well as secularism, atheism, and agnosticism; each represents less than 0.5%, except secularism (i.e., nonreligious persons), which represents 13%. It is important to note that these figures are estimates of the religious composition of the current U.S. population; the government no longer assesses religion as part of its annual census. It also bears attention that religious diversity tends to be greater near large metropolitan areas, and religious minorities tend to cluster as

communities in specific demographic areas (e.g., East Coast and West Coast).

The religions in the United States are somewhat comparable to those in the world, with a few noted exceptions. The largest world religions include Christianity (2.1 billion), Islam (1.3 billion), secularism/atheism/agnosticism (1.1 billion), Hinduism (900 million), Chinese traditional religion (394 million), and Buddhism (376 million). Recent trends include the rapid rise of Islam in the United States and worldwide, as well as a significant increase in the numbers of Buddhists and Hindus in the United States.

### Worldview

Like culture, religion provides its members with a unifying sense of identity and feeling of belonging. In addition, religious groups often espouse certain worldviews and expect that their congregations will hold similar, if not identical, views. Said another way, religion provides people with a lens through which to view the world. Related to this, religious traditions also prescribe attitudes about specific issues and behaviors related to observance. For example, there are five foundational principles of Islam: (1) the belief in monotheism and Muhammad as the final prophet, (2) prayer 5 times per day, (3) giving charity, (4) fasting and abstaining from sexual activity from sunrise to sunset during Ramadan, and (5) making a pilgrimage to Mecca.

Hinduism provides another worldview example. Hindus believe in the repetitious reincarnation of the soul after death into another body, a process called *Samsara*. *Karma*, which is essentially a tallying of one's good and bad deeds, determines whether a Hindu will be reborn at a higher or lower level in her or his next life. Hindus can escape *Samsara* by becoming enlightened. In pursuit of enlightenment, Hindus structure their lives around the four aims of Hinduism: (1) dharma (righteousness in one's religious life), (2) artha (economic success), (3) kama (sensual, sexual, and psychological enjoyment), and (4) moksha (becoming enlightened and thus liberated from *Samsara*). Of course, the degree of adherence to religious doctrine will likely guide the degree of adherence to the espoused worldview (and associated attitudes and behaviors) of the particular group. Judaism is a good example, with a variety of denominations that reflect varying degrees of adherence to traditional Jewish law.



## Family and Marriage

Religious doctrine often includes specific guidelines for families, including marriage, sexuality, roles of family members, and divorce. For example, many religions discourage intermarriages among different religious groups, and some may require conversion of one partner before the marriage can be sanctioned by the religious body. Choosing which religious rituals and customs to observe may be difficult within mixed marriages, particularly when children are involved. Within a marriage, the specific roles and rights of male and female partners may be prescribed, though the degree to which these roles are followed may depend on the couple's level of religiosity. In some religions, the children's relationship with their parents is also prescribed. In Islam and Buddhism, for example, adult children are obligated to provide care for their elderly parents. Most Western religions prohibit sexual activity outside of marriage, though the degree of adherence to this clearly varies. A recent issue of debate within both Eastern and Western religious groups is the degree to which same-sex relationships can be recognized and accepted. This has resulted in a range of responses, from ordination of gay clergy in some Protestant denominations and Reform and Reconstructionist Judaism, to varying levels of tolerance in Buddhist traditions, to expressions of stern disapproval by fundamentalist Protestants, the Roman Catholic Church, Orthodox Jews, and Islam. Once a marriage has been sanctioned by a religious body, most religions strongly discourage divorce. In some cases, such as in Roman Catholicism and Orthodox Judaism, a marriage must be dissolved by a religious body in addition to a civil divorce proceeding, before the individuals may remarry.

## Career

An emerging area for career counseling is the role of religion in career decision making. While understanding an individual's work-related values is a recognized component of career counseling, some individuals may feel called to a career by a higher power. Such a calling may arise from Christian or Muslim religious values, such as service to the poor, or from the Jewish concept of *Tikkun Olam*, which is a call to heal the world. In such cases, a client might be encouraged to go beyond traditional career choice methods, such as interest and skills inventories, and

engage in a process of "discernment," which is derived from the process used to assist individuals contemplating religious vocations.

## Counseling Implications

Because religion may affect a wide range of personal issues, counselors must consider that their clients' religious value systems may affect the presenting issues. When counseling couples and families, counselors are commonly called to resolve value conflicts, which may occur within, as well as across, religious groups and across generations. Just as importantly, counselors should seek to explore and understand the effect of their own religious values on their own lives and on their clinical judgments. Counseling is not a value-free process, but responsible counseling may be achieved if counselors are attentive to the interaction of their own values with their personal and professional lives.

Everett L. Worthington put forth a model that examines level of religious commitment as a predictor for client behavior as it relates to counseling. For example, clients with higher levels of religious commitment are more likely to want counselors with similar values. Assessing clients' level of religious commitment can also assist counselors with understanding how clients may respond to challenges in session and generally how clients will perceive the counselor. Hence, counselors may want to assess both religious identity and religious commitment in their clients. In fact, getting the identity without understanding the degree of adherence and commitment to the religion will limit the counselor to operating from stereotypes of the particular religious tradition.

There is tremendous within-group variability in all religious groups. Hence, counseling experience with a member of a particular religious group may not necessarily translate to applied work with another person from the same faith. Counseling professionals need to educate themselves about the religions of their clients yet, at the same time, allow their clients to define what religion means for them or how religion affects their lives.

*Lewis Z. Schlosser and Pamela F. Foley*

**See also** American Jews (v3); Espiritismo (v3); Indigenous Healing (v3); Spirituality (v3); Spirituality/Religion (v2); Worldview (v3)



### Further Readings

- Matthews, W. (2004). *World religions*. Belmont, CA: Wadsworth.
- Richards, P. S., & Bergin, A. E. (Eds.). (2000). *Handbook of psychotherapy and religious diversity*. Washington, DC: American Psychological Association.
- Schlosser, L. Z. (2003). Christian privilege: Breaking a sacred taboo. *Journal of Multicultural Counseling and Development*, 31, 44–51.
- Worthington, E. L. (1988). Understanding the values of religious clients: A model and its application to counseling. *Journal of Counseling Psychology*, 35, 166–174.
- Worthington, E. L., Kurusu, T. A., McCullough, M. E., & Sandage, S. J. (1996). Empirical research on religion and counseling: A ten-year update and prospectus. *Psychological Bulletin*, 119, 448–487.

---

## REVERSED RACISM

---

Reversed racism is a controversial contention in which members of a dominant racial group allege racism and discrimination targeted toward them by, or on behalf of, a subordinate or minority racial group. That is, members of a dominant racial group contend that they are being victimized on the basis of their race. Reversed racism can be considered to be a subclass of reversed discrimination, in which members of any majority group feel discriminated against by a minority group, as in, for example, reversed sexism or reversed ageism. As with other forms of reversed discrimination, individuals, groups, or governments can practice reversed racism. In the history of the United States the dominant racial group has been White people. The concept of reversed racism entails White people alleging that they are discriminated against by virtue of being White. For example, a White individual may feel that African Americans are given preferential treatment in hiring or admission criteria and thus allege that those preferences constitute reversed racism.

The concept of reversed racism has been highly controversial, with some scholars debating the validity of the construct. For some, a key component of the definition of racism entails the recognition of the socioeconomic power to put racist beliefs into action in a systemic way. This definition of racism explicitly focuses on the power differential between Whites and racial minorities. Although persons of color may hold

prejudices, they lack political, economic, and societal power, and consequently, according to this definition racial minorities, on the whole, lack the power to be racist. Further undermining the concept of reversed racism is the fact that many question the construct of race itself. For example, some scholars contend that race is a social construction that lacks a scientific basis and exists primarily to preserve power and privilege. Therefore, if racism is a social construction, then under a social constructionist definition, reversed racism is also a social construction that ultimately serves to protect and preserve the power of the dominant racial group. Often underlying the issue of race in the United States is the concept of racial salience—the belief that race is an essential part of identity of racial minorities and a nonessential, optional, and unspoken part of the identity of Whites. As a result, when racial minorities seek to overtly address the issue of racism, they are often labeled racist or as practicing reversed racism or labeled as “race baiters.”

While some may question the legitimacy and basis of reversed racism, the term seems to have prominently entered the public discourse in many arenas. For example, to address past racial discrimination and current systemic inequities in health, education, and employment, there may be a need to provide access to health care, jobs, and education previously denied to racial minorities. Such attempts to “level the playing field” mitigate the inherent advantages and privileges of White people. Systemic attempts to provide access and opportunity to racial minorities are often targeted on a systemic level yet may be perceived on an individual level by an individual White person who feels he or she personally has been denied a position or opportunity given to racial minority. Consequently, the individual may present a challenge based on the allegation of reversed racism, frequently seeking a legal remedy. An issue that is often overlooked is that the allegation of reversed racism may emanate from racist beliefs. That is, some White individuals may (consciously or not) endorse racist beliefs in the inherent superiority of Whites and resulting inferiority of other racial groups and therefore may interpret the success of racial minorities as possible *only* through means of reverse racism. This type of circular reasoning is self-reinforcing.

Federal affirmative action programs and university admissions have often been the flashpoints for allegations of reversed racism. Implemented in 1965 under the Johnson administration, affirmative action programs were created to ensure that qualified women



and racial minorities had opportunities of which they had historically been denied and that they were given equal access to educational and employment opportunities. The legislation has been criticized and incorrectly interpreted as a program that maintains a strict quota system and provides racial minorities with preferential treatment to employment, education, and housing opportunities, while excluding or preventing Whites from achieving such positions. Federal Equal Employment Opportunity laws have also been challenged in a similar manner. These allegations and the resulting litigation popularized the notion of reversed racism. Although the debate over affirmative action and Equal Employment Opportunity legislation has been cast in terms of reversed racism, often overlooked is the fact that the main beneficiaries of such programs have been White women.

Education is another arena against which the allegations of reversed racism have been leveled. Admissions policies and race-based scholarships, in particular, have come under fire. Courts have made it clear that quotas cannot be used in selecting applicants, and increasingly the courts have ruled against race as the determining factor in admissions. The University of Michigan was in the national spotlight in 1997 when it had to defend its admissions policy. Rather than defend the presence of racial minorities as a remedy to past discrimination, Michigan successfully made the case that diversity was in the best interest of all students and necessary for optimal learning. Race-based scholarships and programs have also been challenged, with several states having to disband programs or scholarships or open them to all applicants, regardless of race. Although many focus solely on the negative impact of the allegation of reversed racism (e.g., drastically lowered racial minority enrollments in higher education in California), there may have been some positive impact as well. By having to defend admissions policies and commitment to diversity, colleges and universities may have been forced to consider the essential need for diversity rather than rely on programs that may have inadvertently created an atmosphere of tokenism. In addition, a positive impact has been the focus on rural and economically disadvantaged Whites as a group in need of attention from colleges and universities.

Concerns over reversed racism are not confined to the educational and employment arenas; often the media are criticized for practicing reversed racism. For example, the National Council of La Raza and Latino/as protesting U.S. immigration policies has

been accused by some in the media of practicing reversed racism in their advocacy of undocumented Latinos/as. Often in the media, attempts by racial minorities to display racial pride are interpreted as reversed racism or equated to overt White racism such as the Ku Klux Klan.

Counselors may deal with the allegations of reversed racism as part of their work with marginalized or oppressed groups in the larger community, or they may encounter statements endorsing reversed racism in individual and group therapy. Counselors may need to keep in mind that a belief in reversed racism may be indicative of a level of racial identity development in an individual. For White clients a stated belief in reversed racism may be indicative of early stages (also termed *statuses* to reflect the dynamic and fluid nature of identity) of racial identity development (e.g., contact and reintegration) in which the client endorses a belief that race is not important and that U.S. society is fair or neutral on the subject of race. Consequently, the client may be willing to equate acts or statements about racism as having equal impact regardless of the race of the people involved. Some White clients may have experienced or perceived racism or discrimination targeted toward them and, as a result, may have considerable anger and become entrenched in racist beliefs as a matter of self-protection. The counselor's challenge is to help the White client move toward a higher level of racial identity. Likewise, a racial minority client may also endorse a belief in reversed racism, and this may also be indicative of his or her racial identity development. A necessary prerequisite for helping clients to advance their racial identity is for the counselor to have first advanced his or her own racial identity. Janet Helms has stated that a progressive relationship (in which the counselor's racial identity is more advanced than the client's) is optimal for growth in therapy.

It is also important to explore clients' experiences of reversed racism, because ineffective coping strategies and faulty beliefs could interfere with the counseling process and goal attainment. The notion of reversed racism may be very applicable for White clients who present for educational or career counseling. Reversed racism is perpetuated by the belief that for one group to advance, another must suffer. In the United States, racial minority groups today attain higher levels of education, higher incomes, and are promoted to upper management jobs more than ever before in American history. Those who support reversed racism claim that individuals of the dominant



culture unjustly suffer at the expense of advancing racial minorities. Thus a client may perceive himself or herself as a victim without acknowledging the privilege he or she has been afforded. Beyond helping clients move to a higher level of racial identity, integrating race and ethnicity with educational and career counseling can help White clients locate schools or programs and career choices that will best meet their educational and employment needs.

*Edward A. Delgado-Romero and Kimber L. Shelton*

**See also** Affirmative Action (v3); Bias (v3); Color-Blind Racial Ideology (v3); Discrimination (v3); Discrimination

and Oppression (v2); Oppression (v3); Prejudice (v3); Race (v3); Racial Identity (v3); Racism (v3); Sexism (v3); Social Justice (v3); Stereotype (v3)

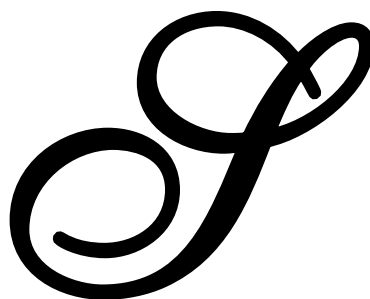
### Further Readings

- Carter, R. T., Helms, J. E., & Judy, H. L. (2004). The relationship between racism and racist identity for White Americans: A profile study. *Journal of Multicultural Counseling and Development, 32*, 2–17.
- Helms, J. E. (1990). *Black and White racial identity: Theory, research, and practice*. Westport, CT: Greenwood Press.
- Stubblefield, A. (1995). Racial identity and non-essentialism about race. *Social Theory and Practice, 21*, 346–368.









---

## SANTERÍA

---

Santería, also known as Lukumí, Regla de Ocha, or “the way of the saints,” is an Afro-Cuban and earth-centered religion transmitted primarily in oral fashion. Its main objective is to find solutions to human problems in a world that is simultaneously physical and spiritual. Its origins can be traced to the 19th century or earlier, when the Yoruba (*Yorùbá* in Spanish) people of West Africa were brought as slaves to Cuba. They are also known as Lukumí people. *Lukumí* means “friends” in the Yoruba language. The term also applies to Yoruba slaves’ descendants, their music and dance, and their dialect.

Santería is now practiced throughout the Caribbean, Mexico, Argentina, Colombia, Venezuela, and the United States. The religion was brought to the United States by Cuban exiles. Santería has been observed in Miami, Tampa, New York City, Newark, Detroit, Chicago, Atlanta, Gary (Indiana), Savannah (Georgia), and several other urban locations. Storefront botánicas provide Santería figures, incense, and herbs for nearly a million adherents.

During the colonization of Cuba, Brazil, Haiti, and Trinidad, thousands of Yoruba natives were transported there as slaves. These slaves wanted to remain attached to their religious practices and African traditions but were forced to adjust to the New World. They faced widespread persecution by slave masters who prohibited the practice of African religions within their Roman Catholic society. Thus, the religion was practiced in secret, and its survival was due primarily to the convergence of Yoruba’s religiosity and Catholicism. Many elements from the Catholic

religion and their symbols are often present in Santería rites.

Santería devotees believe in a creator who is called Olodumare (“owner of the heavens”; also known as Olorun, Oluwa Orun, or Eleda). His power, called Ashe, is the cosmic energy present in everything in the world. He created the universe and the Orishas. According to Santería devotees, everyone receives a destiny from Olodumare, which can be fulfilled with the aid and energy of the Orishas. The Orishas govern over nature. They are powerful but not immortal. Their human limitations help them understand and assist humans. For these reasons, devotees strive to establish a personal relationship with them.

Because the Orishas need food, animal sacrifice is a principal form of worship. In exchange, the deities protect and visit the houses of devotees, empowering them and dignifying their living conditions. Sacrifices are performed at birth, marriage, initiation of new members and priests, and other major celebrations, as well as for the cure of the sick and for death rites. Sacrificial animals include chickens, pigeons, doves, ducks, guinea pigs, goats, sheep, and turtles. The sacrificed animal is cooked and eaten, except after healing and death rituals.

Each Orisha has an associated Catholic saint, principle, important number, special color, favorite food, dance posture, and emblem. The following 16 Orishas are recognized in Cuba (their corresponding Catholic saint and principles are added in parenthesis): Agayu (Christopher, fatherhood), Babaluaye (Lazarus, illness), Esu/Elegbara/Eleggua/Elegua (Anthony of Padua, fate), Ibeji (twins Cosmus and Damien, children), Inle (Rafael, medicine), Obatala/Orunmila/Ifa (Mercedes,



clarity), Ogun/Gun (Peter, labor), Olokun (Regla, profundity), Orula (Francis, wisdom, destiny), Osanyin (Joseph, herbs), Oshosi (Norbert, justice), Oshun/Ochun (Caridad, love), Oya/Yasan (Therese, adversity), Shango/Chango/Obakoso (Barbara, passion), Yemoja/Yemaya (Regla, womanhood). The religion does not have a devil figure.

Priests are known as Santeros or Santeras, the high priest as Babalawo, and the second highest priest as Italo. Under the priests' guidance, initiates to the priesthood have to commit to memory the songs, incantations, laws, pharmacopoeia, and actions of all Santería rituals. Their rituals include the following:

*Divination.* This ritual is used to deal with everyday problems. Santería believers go to Santeros to get advice and to seek solutions for their problems of friendship, health, love, money, or work. Santeros manipulate coconuts, seashells, or other devices to get the Orisha to reveal the believers' needs and to provide solutions to the problem. Santeros use verses, myths, folktales, prayers, and songs to find a suitable prescription for the client's problem.

*Sacrifices and Offering.* These rituals are used to respond, express gratitude and praise, and supplicate Orishas to continue their positive work on behalf of people. Specific food offerings are recognized as appropriate for each Orisha. For example, a devotee will offer a rooster to Chango and yellow hen to Oshun.

The practice of animal sacrifice is seen by followers of Santería as a necessary part of their relationship with their Orishas; it is sometimes seen by others as abhorrent. Legal action to stop the practice of this religion in the United States failed. In 1993, the U.S. Supreme Court ruled in *Church of Lukumi Babalu Aye v. City of Hialeah* that animal cruelty laws targeted specifically at Lukumí were unconstitutional. The court indicated that religious beliefs are protected by the First Amendment even if they are not acceptable or comprehensible to others. Furthermore, the historical association between animal sacrifice and religious worship suggests that animal sacrifice is an integral part of their religion that cannot be deemed bizarre or incredible.

*Drum and Dance Festivals.* These festivals, also known as bembé, are held in the Santero's house. The purpose of these rituals is to honor those Orishas that are important in the lives of the participants. A specific drum

rhythm and dance posture are associated with each Orisha. For example, the dances for Ochosi, the Orisha of the hunt, include shouts of a hunter and the actions of using a bow and arrow. The drum rhythms and the dance postures bring participants to a sacred state of consciousness, manifested as a spirit possession. The spirit possession is wanted because it opens the channels of Ashe as the dancers merge with the deity. In addition, during this state the Orisha can give other attendants advice, warnings, and admonitions through the devotee.

### Implications for Counseling

Given the number of Latinos/as and others who adhere to Santería, counselors would benefit by becoming familiar with these beliefs. Multiculturally competent counselors are aware of the spiritual perspectives they bring to counseling and of the importance of the role religious beliefs play in the lives of their clients. The explanations clients from culturally diverse backgrounds give when explaining the causes of their psychological concerns provide insights about their worldviews and their belief systems, which affect how they relate to their personal problems and to their counselors. Exploring the spiritual beliefs of clients during intake can facilitate rather than hinder the counseling process.

Furthermore, it is important to note the varied levels of belief in Santería. Some Latinos/as may have an altar at home dedicated to a specific deity, whereas others may attend Santería ceremonies and seek guidance from a Santero. Some clients may be seeking help from a Santero while in counseling. They may discuss work-related issues with their counselor but choose to discuss family-related issues with their Santero. For this reason, it is important that the counselor assess the importance of the Santería belief for their clients as well as their level of participation. It is recommended that counselors inquire about the client's spiritual beliefs instead of introducing elements of Santería. The counselor should let the client bring up the subject of Santería; not all Latinos/as or Cubans embrace such beliefs, and some (e.g., Evangelicals) find them abhorrent or diabolical. If the client reveals his or her beliefs, then the counselor can let the client know that he or she is familiar with Santería beliefs. This may help the client feel understood and feel more comfortable in therapy.

In addition, it is also important for the counselor to explore the client's religious interpretations of his or



her current problems and not to dismiss the client's interpretations. The counselor can explore within the sessions the client's visions, dreams, and religious experiences using a culturally sensitive approach instead of prejudging them as psychopathological symptoms.

Clients who believe in Santería usually have strong spiritual beliefs and expect that their counselor will treat their beliefs with respect. Some counselors may tailor their counseling to include their client's spiritual belief as a support system and may invite the Santero to collaborate in the treatment on behalf of the client (if agreeable to the client). Many Santeros are knowledgeable about mental disorders and frequently advise clients to seek more conventional mental health treatments.

*Carlos P. Zalaquett*

**See also** Espiritismo (v3); Latinos (v3); Multicultural Counseling Competence (v3); Religion/Religious Belief Systems (v3); Spirituality (v3); Spirituality/Religion (v2); Worldview (v3)

### Further Readings

- De La Torre, M. A. (2004). *Santería: The beliefs and rituals of a growing religion in America*. Grand Rapids, MI: Eerdmans.
- Drinan, R. F., & Huffman, J. I. (1993). Religious freedom and the *Oregon v. Smith* and *Hialeah* cases. *Journal of Church & State*, 35, 19–36.
- Eliade, M. (Ed.). (1987). *The encyclopedia of religion*. London: Macmillan.
- Lefever, H. G. (1996). When the saints go riding in: Santería in Cuba and the United States. *Journal for the Scientific Study of Religion*, 35, 318–330.
- Wedel, J. (2004). *Santería healing: A journey into the Afro-Cuban world of divinities, spirits, and sorcerers*. Gainesville: University of Florida Press.

---

## SECOND CULTURE ACQUISITION

---

Second culture acquisition, an integral aspect of the acculturation process, is the adjustment of the immigrant to the dominant culture. In the new culture, immigrants must navigate through situations in which they have no experience, often without a grasp of the language. Immigrants must deal with changes such as alterations in diet, climate change, different customs

and social practices, unfamiliar clothing, new employment, and different family composition, as the majority of their family may reside in their country of origin or in another host country. Several different models have been constructed to explain the methods immigrants use to adapt to the new culture and to highlight reasons for adaptation difficulty. All these factors must be taken into consideration when counseling an immigrant client.

### Models of Adaptation

#### *Unilinear Model*

Unilinear acculturation considers adaptation to the second culture as a function of time. Individuals appear to become more acculturated the longer they are exposed to the new culture. The rate of acculturation varies depending on another aspect of time: the age of the immigrant at the time of entry. Children aged 12 and younger often become accustomed to the new culture faster than those who immigrate at an older age.

#### *Bilinear Model*

Berry postulated that immigrants grapple with two questions: Is it valuable to maintain cultural identity and characteristics (enculturation)? and Is it valuable to maintain relationships with other groups (acculturation)? Although the answers to these questions are independent of each other, they interact, leading to four qualitatively different responses to the second culture: integration, assimilation, separation, and marginalization.

In the integration mode of adaptation, also known as biculturalism, individuals value both the original culture and the host culture and are able to balance the retention of cultural identity and relationships within the dominant society. This strategy is considered the most psychologically healthy strategy for a person to use. A person's development of a bicultural identity is highly individualized and dependent on characteristics such as age, gender, personality, and socioeconomic status.

There are several aspects of biculturalism that positively influence mental health. The first is that the individual maintains positive attitudes toward both cultural groups. In this way, the individual is able to interact with, and gain support from, both groups (groundedness). For example, Kim and Omizo found in their study that Asian American participants who



engage with the majority culture both perceive themselves as being able to cope with different cultural situations and feel that people from the majority culture view the Asian American group favorably. They also expressed more cognitive flexibility and general self-efficacy. Similarly, Kosic found that immigrants who favored the integration strategy were more socioculturally adapted than those who used the separation and marginalization strategies. Engaging with the original culture is important as well because enculturation behaviors are associated with the membership dimension of collective self-esteem (the worth placed on one's cultural group).

Another factor that comes into play is bicultural efficacy, which is the sense that the person can live in the two groups without compromising his or her identity. This factor also influences personal relationships with both cultural groups in that people can interact with others without fear that they are betraying their identities. Another crucial part of biculturalism is the person's ability to communicate well in both cultures. Without this ability, it is difficult to have a positive relationship with both groups and to believe that one can function well in each of them. Another facet of biculturalism is role repertoire, in which the individual has developed a range of roles and behaviors that can differ based on situational factors. This flexibility and knowledge of roles helps the individual navigate through both cultures in appropriate ways. Kosic asserts that being able to function well in both cultures helps an individual to be more psychologically adapted, exhibiting less emotional distress and psychosomatic symptoms.

In the assimilation strategy, individuals relinquish their original cultural identity and interact only with the dominant group. People who choose the assimilation strategy of acculturation may experience psychological stress caused by the weakening of ties and support to their original culture and the new and tenuous relationship with the new culture. In this mode, there is the possibility that the person will be rejected by both their original culture and the mainstream culture. It is also difficult to learn new cultural behavior and to completely immerse oneself in another cultural way of thinking and being. Unfortunately, many immigrants feel that they must reject their cultural values and adopt the values of the mainstream to be successful. Though assimilation can have some negative effects on individuals, in some ways it is healthier than the separation and marginalization modes of adaptation. For example, Kosic found that assimilated

participants were more socioculturally adapted, had lower levels of emotional disorders, and had lower levels of psychosomatic symptoms than did participants who favored either separation or marginalization strategies.

In the separation mode, the opposite of assimilation, individuals value the original culture and avoid contact with the dominant culture. Kosic talks about how people who choose this strategy have been shown to have the lowest level of sociocultural adaptation when compared to all the other strategies, as well as higher levels of emotional disorder and psychosomatic symptoms when compared to assimilated and integrated participants.

In the marginalization mode, individuals have low connection with both cultures. Kim and Omizo speculated that marginalization may be the most psychologically harmful adaptive strategy because people who employ this strategy may feel isolated, as if they don't belong anywhere. According to Kosic, those who employ this strategy exhibit low levels of sociocultural adaptation and higher levels of emotional disorder and psychosomatic symptoms.

Ample research, such as research done by Berry, points to integration as being the best alternative for immigrants; however, integration can be achieved only in a society that values multiculturalism. Societal multiculturalism requires low degrees of discrimination and prejudice, acknowledgment of the rights of any group to live in a culturally different manner within the larger group, positive attitudes between groups, an attachment to the greater society among all groups, and recognition of cultural diversity as an asset. Program development grounded in research on acculturation and intergroup relations can help immigrants and host cultures avoid unnecessary acculturative stress and intergroup conflict and can promote positive adaptation and mutual accommodation.

### ***Nonlinear Model***

Roysircar proposed an adaptation of Berry's model that is bilinear but contextual, which makes it a nonlinear model. Essentially, individuals will move across Berry's four acculturation modes depending on the nature of the situation. This model takes into account varied human experiences; no one acts the same way consistently, and context plays a large role in behavior. A case in point is illustrated by a foreign-born female immigrant from India who has lived in



the United States for 27 years. The prejudice and racism she has experienced in the United States may influence her to lean toward the separation mode of adaptation to make herself resilient, while her identification with gender roles as a successful professional leads her to assimilate a feminist orientation of the dominant culture. However, she is very conscious that she is a feminist of color with different priorities, which sets her apart from many White American feminists. As a result, she cannot relate completely to either her original Asian Indian culture or the White dominant culture when dealing with gender issues, so she falls into the marginalization mode of adaptation. In addition, most of the time, she is able to reach out and interact with the dominant culture while still retaining her cultural identity, which shows integration. So, depending on the situation, all four acculturation modes are functional adaptations for this Indian woman. The idea of multiple options and solutions in immigrant adaptation is important in therapy, as the therapist needs to know the adaptation strategies immigrant clients use most frequently or less so, when they use these, and why. Consciously giving up the stereotyped notion that “one size fits all,” the therapist seeks from clients their cultural reasonings, while probing into aspects of the second culture that they are struggling with, as well as aspects of the old culture they wish to retain or leave behind.

### **Second Culture Acquisition and Mental Health**

Second culture acquisition is a stressful process. Acculturative stress is exhibited in the reduction of health status for those trying to navigate through new cultural experiences and it occurs when the individual has insufficient resources to adapt to the new culture. Berry found that the groups under the most stress were those who were the least similar to, but still had some contact with, the dominant group and who preferred the separation mode of adaptation.

Adapting to a new culture can also be stressful for immigrants because it may negatively impact existing mental health problems in an individual. For example, immigration can exacerbate existing posttraumatic stress disorder in political refugees because of the added stress of the person being in an unfamiliar place, feeling alienated because of prejudicial and discriminatory treatment in the host culture, feeling isolated because no one wants to listen to their story of

pain and horror or even knows about their sociopolitical history, and being separated from their own culture and kinship. As a result, therapists must treat the multiple complex stressors in the psychopathology of immigrant clients. In addition, the culturally competent therapist serves as a cultural broker and bridge for immigrant clients, advocating their access to resources and mental health care, as well as showing them how to use these resources.

### **Bicultural Stress**

Bicultural stress refers to the stress that U.S.-born second generation (and later) immigrants experience while trying to negotiate between their two inherited cultures. For example, a second-generation Asian American immigrant would be born into an Asian family and be pressured to adhere to Asian traditions while simultaneously being pressured to adopt American values and practices. This stress may cause tension in a family where the parents and children have very different strategies in dealing with the dominant culture. An example of this is if the children identify primarily with the dominant culture and favor more of an assimilation approach and the parents struggle to maintain their original cultural identity and favor an approach closer to separation. Bicultural skills are extremely important in promoting the mental health of U.S.-born second and later generation immigrants and the lack, or perceived lack, of these skills causes stress for the individual. Sodowsky and Lai described two dimensions involved in bicultural stress: the interpersonal and the intrapersonal dimensions. The interpersonal dimension, which deals with intercultural competency, is exemplified by having cultural conflicts with one's own cultural group and/or the dominant culture. The intrapersonal dimension deals with acculturative distress such as that initiated by identity crisis, sense of inferiority in one's cultural group, feeling marginalized by one or both cultures, and anger toward either group.

As implied, bicultural stress is important to consider in counseling. Therapists are cautioned against invalidating the impact of bicultural stressors, such as the stress of becoming proficient in two languages, and the incongruence between home culture and the dominant culture. For example, when a counselor says “keep your own culture,” as well as “adopt a second culture,” it leads to mixed messages for a psychologically impaired mental health client, which may lead to an unclear understanding of the counseling relationship



and unpleasant feelings toward mental health care on the part of a minority client. Because immigrant children and adults are less likely to use mental health services and have higher rates of counseling dropout compared with White clients, it becomes paramount for counselors to carefully address and consider all of a minority client's motives for seeking mental health assistance. Therefore, it is important for therapists to determine if bicultural, bilingual, and familial stressors are too great (with the potential to lead to more serious issues such as depression, suicide, substance abuse, violence, running away) before reframing contextual multiplicity as positive challenges universal for immigrants.

### **Factors That Facilitate Second Culture Acquisition**

Several different factors can make second culture acquisition easier and reduce acculturative stress. The first and perhaps most obvious factor is English proficiency. The immigrant will find it much easier to utilize services and to function in the dominant culture if he or she is able to communicate with the people in the dominant society. People of a higher socioeconomic status also have an easier time with second culture acquisition and less acculturative stress because they have more access to resources because of their financial status. Individuals' motivation for immigration also makes a difference in the stress experienced; people who immigrate voluntarily fare better than people who are forced to relocate to escape persecution or international students making only temporary contact. These factors are important to consider in therapy to determine what coping resources the individual has at his or her disposal, and knowing these factors can help the counselor better predict how the individual will adapt.

The positive complement to bicultural stress is bicultural skills. Living in and balancing two or more cultures is worthy of praise, admiration, and acknowledgment and can be demonstrative of resiliency, which in turn can assist with reducing the effects of acculturative stress. Simultaneously functioning in two distinct cultures also can help build skills that immigrant youngsters can use in the future for adjusting and thriving in a variety of systems (e.g., jobs/careers, personal relationships, new communities, college/university, etc.). For example, Feliciano studied the academic success of immigrant Asian and Latino/a students as measured by their likelihood of dropping out of high

school. She found that bicultural students, those that had not abandoned their native culture and language while accepting their need to succeed in mainstream society, were more successful in school and were more positive about their future. She indicated that it was these youngsters' skills at finding support in both cultures that led them to be better adjusted than those who were polarized toward the native culture or mainstream society. Other researchers have reported that bicultural youths demonstrate fewer conduct disorders and also less depression than their peers who are fully assimilated into mainstream society. In addition, bicultural youth may display more effective methods for functioning in various sociocultural situations than their fully assimilated peers.

### **Second Culture Acquisition and Counseling**

Second culture acquisition is a complex and often stressful process for immigrants of all ages. Therefore, it is important for the therapist to be aware of the trials and confusion an individual faces while struggling to integrate two value systems and ways of living that may be strikingly different from each other. It is also important that mental health professionals not fail to validate the cultural conflicts immigrant families may encounter at home as a result of parents who wish their children to adhere to traditional values, experiences at school or work where these immigrants may feel pressure from teachers and employers to acculturate to U.S. customs, or in social settings (e.g., after-school programs, social functions, organized sports, community activities) where peers may harass them for "being different" or "not talking right." Therefore, it is recommended that counselors implement individual and group counseling goals centered on increasing the awareness and reframing of immigrants' bicultural skills and using bicultural skills in various academic, employment, and social settings to cope with cultural conflicts.

In addition, counselors, therapists, and psychology trainers are encouraged to highlight the personal-social and cognitive skills (e.g., speaking two languages, managing different sets of nonverbal cues, understanding how cultures can coexist even if they differ on certain values and beliefs, etc.) necessary for someone to balance practices and values of two cultures. Counselors may also elect to focus on the strength and resilience of their clients in the face of juggling a traditional culture at home as well as a new



and developing American culture in their schools and jobs. For example, children can help parents understand that they are learning how to balance both their home culture and their American culture, which is more desirable in today's economy, or they may be encouraged to share with teachers and peers how their bicultural perspectives frame their views of history or even fashion trends.

*Gargi Roysircar and Emily Pimpinella*

**See also** Acculturation (v3); Acculturative Stress (v3); Adaptation (v3); Assimilation (v3); Bicultural (v3); Cultural Accommodation and Negotiation (v3); Immigrants (v3); Multicultural Counseling Competence (v3); Multiculturalism (v3); Orthogonal Cultural Identification Theory (v3); Refugees (v3)

### Further Readings

- Berry, J. (2001). A psychology of immigration. *Journal of Social Issues*, 57, 615–631.
- Feliciano, C. (2001). The benefits of biculturalism: Exposure to immigrant culture and dropping out of school among Asian and Latino youth. *Social Science Quarterly*, 82, 865–879.
- Kim, B. S. K., & Omizo, M. M. (2006). Behavioral acculturation and enculturation and psychological functioning among Asian American college students. *Cultural Diversity & Ethnic Minority Psychology*, 12, 245–258.
- Kosic, A. (2002). Acculturation attitudes, need for cognitive closure, and adaptation of immigrants. *Journal of Social Psychology*, 142, 179–201.
- Roysircar, G. (2004). Counseling and psychotherapy for acculturation and ethnic identity concerns with immigrant and international student clients. In T. B. Smith (Ed.), *Practicing multiculturalism: Affirming diversity in counseling and psychology* (pp. 255–275). Boston: Pearson.
- Sodowsky, G. R., & Lai, E. W. M. (1997). Asian immigrant variables and structural models of cross-cultural distress. In A. Booth, A. C. Crouter, & N. Landale (Eds.), *Immigration and the family: Research and policy on U.S. immigrants* (pp. 211–237). Mahwah, NJ: Lawrence Erlbaum.

oppression of women. In its most obvious forms, sexism includes conscious, deliberate, and overt discrimination against women, such as denying women the right to vote or own property, as was the practice in the United States in the early 19th century and is still seen in other parts of the world. At the other end of the continuum, it also includes subtle behaviors and attitudes that might go unnoticed in everyday life; sexism is operating anytime a woman is expected (or expects herself) to diet to extreme thinness, maintain a youthful appearance in perpetuity, downplay her own competence, accept verbal or physical mistreatment, or otherwise “know her place.” Although the conceptual isolation of sexism is useful for the purposes of discussion, it is important to note that sexism is just one part of an interlocking system of oppression that also includes racism, heterosexism, and classism, among others. So although some overarching themes can be explored with regard to sexism, these themes play out differently in the lives of women of color, lesbians, bisexual women, transgendered people, and poor and working-class women.

### Sexism, Patriarchy, and Feminism

Understanding sexism begins with understanding patriarchy, the context in which sexism occurs. In *The Gender Knot*, Allan Johnson explained that a patriarchal society is one whose power structures, values, norms, and institutions are specifically male-identified. In other words, positions of power and authority tend to be occupied by men, important resources are generally controlled by men, values tend to reflect stereotypically masculine strengths and characteristics, norms are shaped around the ways that men live their lives, and institutions and their procedures tend to advance and promote the needs and success of men. In a patriarchy, the privileged status of men is rooted deep in society's subconscious, so that well-intentioned men and women who would oppose outright gender discrimination often unintentionally hold and perpetuate sexist stereotypes. American society's continuing patriarchal nature can be seen in such realities as the nearly all-male makeup of the nation's chief executive officers (CEOs) and legislators, as well as the vast gap between the amounts of income and wealth accruing to men and women. Patriarchy places men at the center of American cultural expression, whether in music, literature, or the movies; important contributions by women film directors or composers are often singled

---

## SEXISM

---

It has been called the world's oldest oppression: sexism. Sexism is the name given to the systematic



out as being noteworthy on that basis alone. Patriarchy explains the fact that, whereas assaults against individuals on the basis of most group memberships merit special designation and prosecution as “hate crimes,” violence against women does not capture people’s attention in the same way.

The movement to end sexism is called feminism. Feminism is frequently characterized as having evolved in three “waves.” The first wave took shape in the late 1800s and focused on securing fundamental legal rights for women, culminating in the right to vote for women in 1920. Second-wave feminists moved beyond these basics in the 1960s and 1970s to work for broader personal, political, social, economic, and sexual equity among men and women. The objectives that second-wave feminists took on were, therefore, not only conceptually more complex but also more controversial: Whereas the double standard involved in disenfranchising half the American adult population was relatively clear-cut, the deconstruction of deeply held beliefs about conventional gender roles and relationships presented a much more complex challenge to mainstream understanding. Second-wave feminists elucidated and confronted sexism as manifested in such important issues as sexual harassment, images of women in the media, violence against women, pay inequities between men and women, limits on women’s reproductive freedom, and the oppressive underpinnings of conventional heterosexuality.

Even this second wave of the women’s movement, however, had thus far failed to address issues of race, class, and sexual orientation as they intersect with sexism, resulting in a feminism that spoke primarily to the experiences of White heterosexual middle-class women. Influential African American feminist authors such as Audre Lorde, bell hooks, and Angela Davis were among the scholars whose work helped to illuminate the intersections of multiple oppressions within patriarchy. In 1983, Alice Walker introduced the term *womanism* to refer to Black feminism and the feminism of women of color. Placing the experiences of women of color at its center, Walker defined womanism as emphasizing wholeness, spirit, strength, and community, a valuing of African American heritage, and a cherishing of other women of color.

The second wave of feminism, then, inspired important legal, medical, and social protections for women. It also spurred an emotionally charged, contentious response from some corners that resulted in what has been called the “backlash” against feminism

in the 1980s and 1990s. As part of this regressive trend, the word *feminism* itself was cast in a negative light; even many women who affirmed their disapproval of sexist discrimination now wished to disassociate themselves from the feminist movement. Beginning in the 1990s, however, a generation of women young enough to have benefited from feminist accomplishments all their lives advanced a third wave of feminism, which emphasized the intersectionality of sexism with other aspects of identity, broadening feminist discourse to incorporate queer theory, women-of-color feminism, and postcolonialism.

## Sexism in the United States

### *The Wage Gap*

The wage gap is one of the most obvious and enduring examples of the continuing presence of sexism in American culture. Despite the passing of the Equal Pay Act in 1963, which outlawed sex discrimination regarding pay, the U.S. Census Bureau reported in 2005 that for every dollar that a man earns, a woman earns 77 cents. The same report demonstrated that women are 40% more likely to live in poverty than are men. The National Committee on Pay Equity, a coalition of legal, educational, professional, and civil rights organizations, explained in 2005 that women workers are concentrated in low-wage paying occupations such as clerical, service, and sales positions; furthermore, as women workers become more prevalent in an occupational segment, income levels there decrease. A 2003 U.S. General Accounting Office report found that even when differences in work-related factors such as occupation, job tenure, and experience are accounted for, an unexplained 20% wage gap remains; this gap is attributable to discrimination. Intersections with racism mean that the wage gap for women of color is even more severe. In 2000, African American women’s average weekly wages were 64% of the wages of White men, while Latinas earned just 52% of that amount.

### *The Glass Ceiling*

One of the reasons that women workers tend to be found at the lower end of the pay scale is that corporate hierarchies do not advance women at the same rates as men, often promoting them only as far as the



so-called glass ceiling. First labeled as such by the *Wall Street Journal* in 1986, the U.S. Department of Labor convened the Glass Ceiling Commission in 1991 to study this phenomenon, defining it as an artificial, bias-related barrier that prevented qualified employees from advancing into management-level positions. In 1995, the Commission's final report documented the unquestionable presence of the glass ceiling with regard to women and people of color, finding that although women held more than 45% of the nation's jobs, 95% of senior managers were men. Furthermore, those women who were managers earned only 68% of what men made in similar positions. Ten years later, Catalyst, a research firm that tracks women's experiences in a wide range of workplaces reported that 50.3% of all professional and management positions and 1.4% of Fortune 500 CEOs were women. Six of these seven women were White; Andrea Jung, CEO of cosmetics maker Avon Products, is Asian American. In their 2005 study of corporate leaders titled "Men 'Take Charge' and Women 'Take Care,'" Catalyst researchers found that both men and women considered women to be more supportive but less leaderful than men and that men (but not women) believed that women are not good problem solvers.

Business is, of course, not the only workplace setting in which a glass ceiling is operational. In 2006, the *New York Times* reported that although law schools have been graduating equal numbers of men and women for roughly 2 decades, and although firms have been hiring graduates in comparable numbers, the percentage of women dwindles drastically in terms of who is promoted to the higher tiers of the firm: Approximately 17% of the partners at major law firms nationwide were women in 2005. Inadequate mentoring of women by predominantly male partners was cited as a factor, as was the fact that much of the networking and development opportunities that can advance a law career tend to take place in stereotypically male environments, such as football games or the golf course. Similarly, the American Association of Medical Colleges reported in 2001 that although 45% of medical students were women, there was an average of 21 women full professors per academic medical center, compared with 161 men at that rank. As for senior administrative positions, just 7.5% of medical department chairs nationwide were women. Women comprise one third of American journalists, according to Indiana University's 2003 American Journalist Survey, yet a 2001 study by Annenberg Public Policy Center found

that, among top media executives, women occupy only 13% of those positions.

### ***Sexual Harassment***

Another expression of sexism that can occur in a woman's place of work is sexual harassment. The U.S. Equal Employment Opportunity Commission (EEOC) describes sexual harassment as unwelcome sexual advances, requests for sexual favors, and other verbal or physical conduct of a sexual nature that explicitly or implicitly affects employment, interferes with work performance, or creates an intimidating, hostile, or offensive work environment. In 1979, feminist legal scholar Catharine MacKinnon pioneered the analysis of this issue in her book *The Sexual Harassment of Working Women*. Before MacKinnon's analysis was published, sexual harassment was often considered to be a normal, biologically based instance of "boys being boys"; MacKinnon was instrumental in explicating it as a discriminatory misuse of power within workplace culture. Today, many businesses actively educate employees about this form of discrimination, and the EEOC reports that 12,679 reports of sexual harassment were filed in 2005, as compared to a high of 15,889 in 1997.

### ***Women's Physical Health***

A nonsexist framework for understanding the prevalence of certain disorders among women locates them within a patriarchal context, bringing a focus to such issues as body image, eating disorders, sexual health, reproductive freedom, and the pathologizing of women's experiences through conventional mental health diagnostic practices. Throughout history, women's behaviors and feelings have been given various explanations and diagnostic labels by male-dominated society. Hippocrates warned that women who remained virgins for longer than was appropriate would find that their menstrual periods brought on visions, murderous rage, and a longing for death; women whose behavior did not conform to conventional expectations were hunted as witches for centuries. In the 19th century, medical textbooks portrayed women as the puppets of their ovaries and uterus, organs which were considered to be responsible for myriad mental and physical complaints as well as for the generally flighty nature and immature judgment seen as hallmarks of the feminine character.



In fact, the favorite diagnostic label for women of the late 19th century (which can still be heard today), *hysteria*, is derived from the Greek word for uterus.

Other forms of oppression also impact women's health, as evidenced by statistical data regarding the well-being of women of color. In 2002, the National Institute of Health released a report documenting the shorter life expectancies of women of color as compared with White women. Elevated risk factors were heart disease, cancer (especially African American women), diabetes (all women of color), cerebrovascular diseases (especially Native Americans), unintentional injuries, and HIV/AIDS (especially African American women). Eighty percent of all new cases of HIV/AIDS in women occurred among African American women and Latinas. Women of color were also at greater risk to give birth to low-birth-weight babies, to report unmet mental health needs, to be obese, and to be without health insurance. The cumulative impact of sexism and racism, compounded by the overrepresentation of both women and people of color among the nation's poor, leaves women of color the most vulnerable of all Americans in terms of basic health care.

Contraceptives are an important form of health care for women, enabling them to make basic decisions regarding their own fertility and sexual health. In December 2000, the EEOC moved to protect women from sexist deterrents to sexual health when it ruled that an employer's exclusion of contraceptives from its health insurance plan constituted impermissible sex discrimination. Protection of these rights has not always been consistent, however; in 2005, the Center for Reproductive Rights sued the U.S. Food and Drug Administration for violating its own procedures and statutes as it failed to approve the emergency contraceptive product Plan B for over-the-counter status. Emergency contraception, also known as "the morning after pill," reduces the risk of pregnancy when it is taken within 72 hours of unprotected intercourse. As of 2006, the federal government completed 3 years of its delay in providing a ruling on the distribution of Plan B. In a 2006 statement titled "The War on Women," Planned Parenthood explained its view that restricted access to contraceptives, the funding of medically unsound abstinence-only sex education programs, and the resulting reduction in access to family planning represented critical human rights violations regarding the health and empowerment of women.

In 1973, the Supreme Court established constitutional protection of a woman's right to choose

abortion in the well-known case *Roe v. Wade*. This ruling was in accord with advocates of women's rights and nonsexist reforms of women's health care, who pointed out that preventing a woman from exercising fundamental freedoms regarding her own body, including the rights to regulate fertility and terminate an unwanted or dangerous pregnancy, constituted a particularly overt demonstration of gender discrimination. Simultaneously, this ruling inspired the growth of the anti-reproductive rights movement, and the National Organization for Women estimates that the backlash to *Roe v. Wade* began in earnest when the Supreme Court upheld a Connecticut ban on public funding for abortion in 1977. Since 2000, the federal government has moved to limit women's reproductive freedom through such acts as the so-called Partial Birth Abortion Ban, which does not include an exception to preserve a woman's health. Most recently, the governor of the State of South Dakota signed a bill banning all abortions outright except in cases where the woman would otherwise die; survivors of rape or incest or women whose health or fertility were at risk were not protected. The citizens of South Dakota subsequently rejected the bill by a margin of 55% to 45%.

### ***Women's Emotional Health***

Feminist analysis has examined the ways that conventional psychological theory and psychopathological nomenclature are themselves derived from patriarchal constructions of femininity. Hope Landrine's work demonstrated that stereotypical assumptions about women's behavior form the basis for such personality disorders (PDs) as histrionic PD and dependent PD. In *Women and Madness*, Phyllis Chesler elaborated on this issue, explaining the double bind that women are placed in as a result: While both men and women who show these personality characteristics are considered ill, women will also be labeled as deviant if they *fail* to enact them to some degree. Along these lines, feminist psychologist and scholar Laura Brown has suggested that conceptions of mental illness derived from dominant culture norms have limited utility for understanding the difficulties experienced by members of subordinated groups, many of which might be more properly understood as "oppression artifact disorders."

Working as they do from gender-biased representations of mental health and disorder, it is not surprising that counselors' attitudes toward women clients can



be compromised by sexist stereotyping. Beginning with the work of I. K. Broverman in the 1970s, findings have demonstrated that clinicians have different standards and conceptions regarding the mental health of men and women, with typical adult women conceptualized as having characteristics incompatible with mentally healthy functioning more frequently than are typical adult men. Based on these analyses, feminist psychologists began in the 1960s to describe the ways that traditional approaches to psychotherapeutic practice were misapplied, and even oppressive, with regard to women clients. Women's experiences of living in connection to others were often pathologized by therapists schooled in the patriarchal belief that autonomy should represent the pinnacle of emotional development, and the power-over configuration of the conventional psychodynamic therapist–client dyad was shown to reproduce the subordinate position that women occupied in the larger society. Feminist counseling approaches were conceptualized to affirm the lived experiences of women, to encompass the oppression-related components of women's stories and struggles, and to facilitate empowerment within a collaborative working relationship. An example of one such approach is relational-cultural therapy, which originated with the work of Jean Baker Miller and continues to be elaborated by psychologists at Wellesley College's Stone Center. Taking women's experiences at the crossroads of multiple oppressions as a point of departure, relational-cultural theory posits that psychological connection, rather than separation, is most crucial to understanding optimal human growth and development. The counseling relationship, then, is reframed with an emphasis on mutuality, empathic connection, and power sharing.

### **Cultural Representations of Women**

Representations of women in the media, particularly in advertising, have been analyzed over the years for their sexist depictions of women. Contemporary popular culture features women in a much wider variety of roles than were seen decades ago, yet whether they are doctors, lawyers, housewives, detectives, or psychics, women are still portrayed as overwhelmingly young, thin, beautiful, White, and dressed in the latest fashions. Patriarchal emphasis on women as objects of men's attentions, combined with the bottom-line motivations of the billion-dollar fashion and cosmetics industries, compels women to conform to

this culturally prescribed feminine ideal; as Susan Brownmiller explained in her 1984 book *Femininity*, to fall short in one's achievement of "the feminine difference" is to appear not to care about men, to risk the loss of their attention and approval, and to thereby relinquish one's core identity as defined within a patriarchal context.

Culturally constructed ideals of female beauty are frequently used to sell products featured in advertisements, and the toxic environment that this creates for women has been explored by media analysts such as Jean Kilbourne, author of *Deadly Persuasion: Why Women and Girls Must Fight the Addictive Power of Advertising*. Commercial images are increasingly more unrealistic, thanks to the development of digital photo-enhancement technology, and frequently depict thin, young, partially nude White women posed in sensual or sexual contexts. Older women, when depicted at all, are also presented in ways that reinforce the predominant commercial image: Most often they appear uncommonly youthful and are selling cosmetics, drugs, or surgeries promising to offer the same. Women of color and larger-sized women are, for the most part, invisible or relegated to specific niche markets. Such images create anxiety for women, regarding the appearance of their own normal, healthy bodies, and are a factor in the development of eating disorders, body dysmorphic syndromes, and the abuse of diet regimes and medications. With regard to women of color in particular, these images simultaneously enforce a White beauty ideal, paving the way for sales of hair straighteners, skin bleaches, and colored contact lenses.

Problems with body image and eating illustrate the relationship between cultural messages to women regarding their appearance and the ways that women care for their own bodies. Susie Orbach, author of the 1978 book *Fat Is a Feminist Issue*, explored the idea that, in a patriarchal context, weight gain can be seen as a form of rebellion against these often-impossible standards. In 1991, Naomi Wolf elaborated on this theme in *The Beauty Myth*, relating the cultural obsession with smaller-sized women to a patriarchal enforcement of their diminished status in society. Pointing to a cultural backlash against feminism, Wolf demonstrated that the more equity women have achieved, the more harshly cultural prescriptions for beauty have constrained them, as seen in the upsurge in anorexia, bulimia, cosmetic surgery, and diet pills and products.



## Violence Against Women

Patriarchal oppression has life-threatening consequences when it is expressed through violence against women. Many women have experienced everyday forms of violence, such as sexual comments on the street, acquaintance rape, obscene phone calls, or sexual harassment at work, aggressions that society often sanctions by blaming the woman herself: She “asked for it,” her attire was too provocative, she has no sense of humor, and so forth. Unfortunately, significant numbers of women also face more serious threats to their safety and health. The National Organization for Women reported in 2005 that one in six women will experience rape. Half of women who report rape are under the age of 18, and 22% are under the age of 12. Estimates are that domestic violence affects from 2 to 4 million women each year, with at least 170,000 of those attacks being serious enough to require emergency room care. According to the United Nations Commission on Human Rights, pornography also represents a form of violence against women, in that it legitimizes the degradation and maltreatment of women and asserts their subordinate function with regard to men.

## Internalized Oppression

Sexism, like other forms of oppression, is learned by both dominant and subordinate members of society, with the result that women themselves, intentionally or not, participate in the enforcement of oppressive restrictions in their own lives and on other women. When women take oppressive, patriarchal definitions of femininity into the deepest levels of their own identity, it is called *internalized oppression*. In other words, when women believe in their own inadequacy, when they feel that they cannot be seen without makeup on their faces, when their speech is characterized by expressions of tentativeness and uncertainty, when they attempt to conceal their intelligence, when they disparage other women who speak up, when they wear comfortable clothing, or when they otherwise defy conventional stereotypes, they are revealing the extent to which they have internalized their own oppression. In her 2003 book *Women's Inhumanity to Women*, Phyllis Chesler explored the ways that women wound themselves and each other by gossiping and scapegoating other women, allowing their relationships with women to be competitive and transient as they prioritize obtaining the attentions of men. Women's reluctance to associate themselves with movements of women can be seen as part of this

trend, reminiscent of the old Groucho Marx line, “I wouldn't join any club that would have me as a member.” bell hooks has described the paradoxical phenomenon that is created by this reluctance: modern women who have benefited throughout their lives from feminist-generated social reforms yet go to great lengths to insist that they are not feminists.

Women of color and queer women internalize double and triple doses of oppression. In her book *Homophobia: A Weapon of Sexism*, Suzanne Pharr elucidated the linkages between homophobia, heterosexism, and sexism. Attacks and discrimination against lesbians and gay men serve to enforce the traditional heterosexual power structure, in that adults who break ranks by defying conventional sex role behaviors—women who are not dependent on men, men who do not structure their identities around difference from and dominance of women—are ostracized. To identify as a lesbian, then, is to be stigmatized as the ultimate outsider within a patriarchal context. In her book *Sister Outsider*, Audre Lorde explored the anger, suffering, and self-rejection that racism, heterosexism, and patriarchy create, dividing women of color from themselves and each other.

## Transcending Sexism

Feminists are sometimes speciously dismissed as advocating something like a reversal of dominant-subordinate sex roles as the alternative to sexism. In fact, a world beyond sexism is envisioned as one in which both men and women are free to live, learn, work, and love without the confinement, the posturing, and the damage imposed by patriarchal sex role requirements. As bell hooks explained in her book of the same title, feminism is for everybody.

Laura Smith

*See also* Bias (v3); Discrimination (v3); Discrimination and Oppression (v2); Empowerment (v3); Feminist Therapy (v1); Marianismo (v3); Oppression (v3); Pay Equity (v4); Prejudice (v3); Racism (v3); Sexual Harassment (v4); Sexual Violence and Coercion (v1); Social Justice (v3); Stereotype (v3)

## Further Readings

Albelda, R., & Tilly, C. (2005). *Glass ceilings and bottomless pits: Women's work, women's poverty*. Boston: South End Press.



- Chesler, P. (2005). *Women and madness* (Rev. ed.). New York: Palgrave Macmillan.
- Faludi, S. (1992). *Backlash: The undeclared war against American women* (Reprinted ed.). New York: Anchor Press.
- Hernandez, D., & Rehman, B. (Eds.). (2002). *Colonize this! Young women of color on today's feminism*. Emeryville, CA: Seal Press.
- hooks, b. (2000). *Feminism is for everybody*. Boston: South End Press.
- Johnson, A. (1997). *The gender knot: Unraveling our patriarchal legacy*. Philadelphia: Temple University Press.
- Lorde, A. (1984). *Sister outsider*. Berkeley, CA: Crossing Press.
- MacKinnon, C. A. (2005). *Women's lives, men's laws*. Cambridge, MA: Belknap Press.
- Miller, J. B. (1987). *Toward a new psychology of women* (2nd ed.). Boston: Beacon Press.
- Moraga, C. (1984). *This bridge called my back*. New York: Kitchen Table—Women of Color Press.
- Pharr, S. (1997). *Homophobia: A weapon of sexism* (Reprinted ed.). New York: Chardon Press.
- Walker, A. (2003). *In search of our mothers' gardens: Womanist prose* (Reprinted ed.). New York: Harvest.
- Wolf, N. (2002). *The beauty myth* (Reprinted ed.). New York: Harper.

---

## SOCIAL IDENTITY THEORY

---

Originally developed by Henri Tajfel and John Turner to understand the psychological bases of intergroup discrimination, social identity theory seeks to explain the psychological and social bases for intergroup behavior and has more recently been used to also understand intragroup processes. Social identity theory can be used in the contexts of multicultural counseling, research, and practice to understand the processes by which individuals develop and maintain social identities and groups. The theory includes three core elements: social categorization, social identification, and social comparison. Social identity theory proposes that individuals engage in a natural process of categorizing their social world into “us” and “them.” Individuals strive for a positive self-concept and maintain and enhance their self-esteem through their memberships in social groups. Individuals derive positive valuation from their ingroup (i.e., members of the group to which they belong) through engaging in social comparison of their group with other groups. To enhance their self-concept, individuals view their

social groups as unique and of higher status than other groups.

### Social Categorization

Individuals naturally categorize their social environment into those in their ingroup and those in outgroups. Tajfel and Turner suggest that this simple categorization is sufficient to trigger ingroup favoritism and outgroup discrimination. That is to say, individuals need only be aware that an outgroup (i.e., those with whom they do not share group membership) exists for them to engage in intergroup competition with those whom they perceive are part of their outgroup.

Individuals engage in categorization because it helps to simplify the social environment. Therefore, individuals will categorize people according to how similar and different they are to each other. Furthermore, individuals will accentuate these perceived differences in a stereotyped fashion, viewing people as more similar to or more different from them than they actually are.

### Social Identity

Individuals are thought to have multiple levels of identity that define who they are. On the most basic level, individuals define themselves according to individual personality traits and interpersonal relationships, and this is referred to as *personal identity*. Through social categorization, individuals also understand themselves as members of social groups and derive social identity from these group memberships. Specifically, social identity includes those aspects of a person's self-concept that are based on their perceived membership in social groups (e.g., Black, Catholic, university student).

### Social Comparison and Positive Distinctiveness

To have a positive self-concept and social identity, individuals engage in social comparison with other groups and view themselves as better than and different from members of other groups (i.e., with positive distinctiveness). The dimensions along which individuals of one group differentiate themselves from other groups depend on the social context. For example, race is a salient attribute with which ingroup and outgroup members are defined in the United States, whereas it may not be a relevant attribute in other countries. For



social comparison to take place, outgroups must be seen as similar enough to the ingroup to make social distinctions relevant, and all groups must agree that the attribute of distinction is of importance.

It has been argued that regarding one's ingroup with positive distinctiveness is essentially a form of intergroup competition because the goal of such a comparison is to assert the group's superiority over an outgroup. As such, social identity theory has been widely used to understand intergroup discrimination and conflict, as well as social changes that involve an individual's desire for mobility into a more positively regarded social group or a group's efforts to assert positive distinctiveness.

### Implications

Social identity theory aids in our understanding of intergroup social phenomena, such as stereotyping and discrimination, as well as intragroup social phenomena, such as differentiation of members within the group and within-group effects on individual attitude change.

#### *Intergroup Processes*

*Stereotypes and Discrimination.* When social identity is salient, an individual perceives his or her group to be normative and holds attitudes and behaviors consistent with perceived group norms. Self-enhancement results in individuals viewing their group favorably while holding negative stereotypes about the outgroup. Intergroup behavior can thus be understood as the collective action of individuals of an ingroup who behave similarly and treat outgroup members similarly, viewing them as stereotypically homogeneous.

Social groups organize into status hierarchies as a result of social comparison. According to social identity theory, when individuals do not derive a positive social identity from a particular group membership, they will strive to leave this group and/or act to make their group more positively distinct.

Individuals who strive for upward social mobility try to dissociate from members of the ingroup that they perceive as lower in the status hierarchy and display preferences for members of a higher-status group. An example of this phenomenon is internalized racial oppression, involving self-hate among racial minorities and their desire to emulate mainstream

White Americans. Mobility out of a lower-status group is considered an individual rather than a group endeavor, and while possibly changing the status of an individual, such individual mobility does not change the status of the groups.

Rather than attempting to leave their existing groups, some members of lower-status groups may instead try to make their group more positively distinct. They can do this by redefining how their group is being compared with others. For example, lower-status groups may attempt to emphasize another dimension for social comparison, one that casts a more positive light on them. Lower-status groups may also change the values of attributes assigned to their group from negative to positive. For example, whereas being African American was perceived to be negative, the Black nationalism movement in the 1960s and 1970s, proclaiming that "Black is beautiful," redefined being Black as positive. In addition, lower-status groups may select a different outgroup as a comparative frame of reference. This usually involves selecting a comparison group that is perceived to be of lower status than the group. These processes by which members of lower-status groups attempt to make their group more positively distinct are collective actions that attempt to change the status of the group as a whole.

Another way that an ingroup may assert their positive distinctiveness is by attempting to change the status position of their group along the valued dimension of comparison. For example, the civil rights movement was an attempt by minorities to change their status position in the United States through fighting for more rights. The result of social competition changes the status hierarchy as a whole. When competition occurs over scarce resources, social competition will lead to conflict between higher-status groups, who wish to retain their resources and social position, and lower-status groups.

#### *Intragroup Processes*

More recently, social identity theory has been applied to better understand how individuals organize themselves within groups. When individuals define themselves with a social identity, they construct and conform to the ingroup norms. However, few groups exist where all members are entirely homogeneous. According to social identity theory, differentiation among members of an ingroup may be allowed, with the nature of such differentiation dependent on the social context in which



group norms are agreed. Members of a group may agree that heterogeneous roles among members are allowed or even necessary for the group to enhance its positive distinctiveness. Individuals are allowed a level of optimal distinctiveness, or the freedom to balance the desire to be part of a group while maintaining individuality, so long as there remains a greater perceived difference between, rather than within, groups. For example, a basketball team comprises players who all identify as members of the same team, but each player contributes to help the team win games.

Attitude change is internalized by individuals through their self-categorization as group members. For example, Jim Sidanius and his colleagues have found that ethnic minority college students' membership in ethnic organizations increases not only their sense of ethnic identity but also their perceptions of discrimination.

Social identity theory informs our broad understanding of the complex social processes through which individuals interact with others as individuals and as group members. This perspective is shaped entirely by the sociocultural context in which individuals and groups reside.

*Anne Saw and Sumie Okazaki*

*See also* Bias (v3); Black Racial Identity Development (v3); Discrimination (v3); Ethnic Identity (v3); Identity (v3); Identity Development (v3); Prejudice (v3); Stereotype (v3); White Racial Identity Development (v3)

### Further Readings

- Capozza, D., & Brown, R. (Eds.). (2000). *Social identity processes: Trends in theory and research*. Thousand Oaks, CA: Sage.
- Hogg, M. A., & Abrams, D. (1988). *Social identifications: A social psychology of intergroup relations and group processes*. New York: Routledge.
- Robinson, W. P. (Ed.). (1996). *Social groups and identities: Developing the legacy of Henri Tajfel*. Oxford, UK: Butterworth-Heinemann.
- Sidanius, J., Van Laar, C., Levin, S., & Sinclair, S. (2004). Ethnic enclaves and the dynamics of social identity on college campuses: The good, the bad, and the ugly. *Journal of Personality and Social Psychology*, 87, 96–110.
- Tajfel, H., & Turner, J. (1986). The social identity theory of intergroup behavior. In S. Worchel & W. G. Austin (Eds.), *Psychology of intergroup relations* (2nd ed., pp. 7–24). Chicago: Nelson-Hall.

## SOCIAL JUSTICE

Social justice refers to the promotion of full and equal participation of all individuals and groups, allowing their needs to be met equally. Most societies around the world have fallen short of creating conditions of social justice. This is evidenced by the existence of marginalization in many societies, as evidenced by the fact that many groups do not have full participation or share equal power in society because of race, ethnicity, age, socioeconomic status, religion, disability, or sexual orientation. Because inequities exist based on these cultural differences, societies that strive for social justice often have attempted to identify and rectify the existence of oppressive structural barriers embedded in the social, economic, and political systems. Historical examples within the United States are the women's suffrage movement that led to the federal right for women to vote in 1920 and the civil rights movement in the 1960s, which was aimed at abolishing racial discrimination against African Americans.

The negative psychological effects of social injustice are numerous and include the development of symptoms such as depression and anxiety. Within the field of psychology, it has been argued that the reality of oppression and social injustices must be incorporated into the treatment plans of individuals who are members of marginalized groups (e.g., women, people of color). A failure to acknowledge the adverse effects of social injustice on individuals' mental health and functioning can be problematic for many reasons. For example, a recent immigrant who is having difficulty finding a job may benefit from having a counselor with whom to process his or her frustrations, but therapeutic processing alone may not be sufficient in helping the client understand the full range of reasons he or she has had difficulty finding work. A counselor who is not aware of the potential of societal oppression might even attribute the client's difficulty in finding work solely to individual factors (e.g., an underlying personality issue), rather than the possibility that the client is also facing workplace discrimination. As a result, the client may end up feeling as misunderstood in therapy as he or she does in other facets of life.

Because the genesis of some mental health problems can include experiences of social injustice, it has been argued that mental health professionals should expand their roles beyond that of traditional counseling.



Although the counselor can provide a place to process emotions related to oppression, of equal importance is the counselor's role as an agent of social change. Rather than changing people only through individual empowerment, a social justice framework within the mental health field encourages counselors to change the contextual variables that contribute to social inequity and oppression. Numerous scholars have suggested that client advocacy and public policy work can be infused into the skills of counselors.

Advocating for social justice requires that mental health counselors become more knowledgeable about oppression and societal inequities and how they are experienced by individuals and groups. For example, a counselor may benefit from visiting the neighborhood in which a client resides so as to learn more about the client's everyday experience. When counselors learn more about their clients' communities, they are better able to assist clients in accessing their indigenous support networks, such as religious leaders, community leaders, friendship networks, and family. Counselors must also personally reflect on issues of oppression and privilege in their own lives. An important part of being a social justice-oriented counselor is to critically examine one's experience as an oppressor, the oppressed, or both. To think critically about these experiences may influence the ways one conceptualizes and interacts with clients.

In addition to increasing knowledge of oppressive forces and gaining self-awareness regarding power and privilege, it is important that counselors strive to actively engage in the work of social justice on behalf of their clients. For example, counselors can implement and evaluate both remedial and preventive mental health intervention programs to assist marginalized populations. Preventive mental health interventions can serve as a unique way to effect change within a community. Rather than waiting until a problem occurs, prevention programs provide the possibility of protecting their stakeholders from the negative outcomes of social inequity. Counselors can become more involved in community organizations that confront social injustice as a way to not only assist the community but also extend the scope of their reach beyond individual client. Thus, a commitment to social justice requires more than becoming aware of inequity; it requires a commitment to working to end inequity.

Professionals in the field of counseling have unique insight into the detrimental effects of oppression and social injustice on individual health and well-being.

It is incumbent upon such professionals to advocate for marginalized groups to help alleviate oppression. In addition to implementing outreach and prevention programs that are aimed to alleviate the detrimental effects of oppression, counselors can also play an important role as advocates for political policies that seek to end the injustices that plague marginalized communities. This has implications for training mental health professionals to become competent with members of historically marginalized groups.

Educators must not only train counseling students to develop multicultural competence (i.e., the ability to work effectively with diverse and marginalized populations) but also encourage students to act individually and in groups to become agents of social change. In addition to teaching these important skills and encouraging discussions of political and social issues, counselor educators should encourage trainees to get involved in out-of-class activities on campus and in the surrounding community. This could include the addition of real-world experiences as a component of courses that focus on topics of oppression, prevention, outreach, and/or advocacy. Such real-world experiences might include facilitating students' creation of an action research project that examines social issues within the campus, or organizing and participating in a service project that benefits local underserved populations. Through such outreach and service activities, counseling students will develop a greater understanding of the diverse experience of others and be exposed to broader social issues.

In addition to infusing social justice teachings into counselor training programs, counselor educators must enact a combination of advocacy research and social action designed to support the oppressed rather than the powerful. Research aimed at social justice should focus, in particular, on how institutions serve to promote or sometimes prevent social changes and on how individuals and groups can overcome the consequences of an oppressive system. In addition, action-oriented research would assess the need for, or impact of, social policies within marginalized groups and communities (i.e., needs assessments or outcome studies). The delivery of research findings to policy makers through direct presentations to community members and leaders who can get involved at the policy level is imperative. A link between social justice research and its intended beneficiaries must be maintained for the



field of counseling to continue to serve as an active agent of social justice.

*Laura Dick, Kimberly Bena, and Elizabeth M. Vera*

**See also** Bias (v3); Classism (v3); Discrimination (v3); Discrimination and Oppression (v2); Multicultural Counseling Competence (v3); Oppression (v3); Power and Powerlessness (v3); Racism (v3); Sexism (v3); Social Class (v4); Socioeconomic Status (v3); Stereotype (v3); White Privilege (v3)

### Further Readings

- Constantine, M. G., Hage, S. M., Kindaichi, M. M., & Bryant, R. M. (2007). Social justice and multicultural issues: Implications for the practice and training of counselors and counseling psychologists. *Journal of Counseling & Development*, 85, 24–29.
- Prilleltensky, I., & Nelson, G. (1997). Community psychology: Reclaiming social justice. In D. R. Fox & I. Prilleltensky (Eds.), *Critical psychology: An introduction* (pp. 166–184). Thousand Oaks, CA: Sage.
- Vera, E. M., & Speight, S. L. (2003). Multicultural competence, social justice, and counseling psychology. *The Counseling Psychologist*, 31, 253–272.

---

## SOCIETY FOR THE PSYCHOLOGICAL STUDY OF ETHNIC MINORITY ISSUES

---

The American Psychological Association (APA) is organized with divisions that focus on specialty and interest areas within psychology. As one of the 56 divisions of APA to date, the Society for the Psychological Study of Ethnic Minority Issues (also known as Division 45) has its own governance structure elected by its members.

The Society for the Psychological Study of Ethnic Minority Issues serves as a means to promote the development of knowledge and understanding of ethnic minority psychology; the application of psychological principles specific to ethnic minorities; consideration of how social concerns impact ethnic minority populations; and the incorporation of the importance of cultural diversity in society. The purpose of this organization, as noted in the Division 45 bylaws, is to advance the contributions of psychology as a discipline in the understanding of issues related to people of

color through research, including the development of appropriate research paradigms; to promote the education and training of psychologists in matters regarding people of color, including the special issues relevant to the service delivery issues relevant to ethnic minority populations; and to inform the general public of research, education and training, and service delivery issues relevant to ethnic minority populations.

The formation of Division 45 can be traced to a long history of efforts by many individuals and organizations through the years, and a good account of this history can be found in an article by Lillian Comas Diaz in the division's journal, *Cultural Diversity & Ethnic Minority Psychology*. In addition, a list of Division 45 founders is provided on Division 45's Web site. The Council of Representatives of APA voted to establish Division 45 at the August 1986 annual APA meeting. An interim president and executive committee were selected to set up the organization and establish bylaws and procedures. Elections were held in 1987, and the first elected executive committee of Division 45 was formed. Division members elect representatives to the APA Council of Representatives, which is the governing body of the APA, and set policies and direction for the organizations and the field of ethnic minority psychology. Division 45 also has provided leadership in generating many policy changes within APA, as well as in contributing to the knowledge base of the field of psychology. In particular, significant inroads have been made to effect the representation of ethnic minority psychologists within the governance structure of the APA.

Division 45's journal, *Cultural Diversity & Ethnic Minority Psychology*, is regarded as one of the top APA journals in terms of utilization rate, hit rates on computerized searches, and subscriptions. The division's newsletter, *Focus*, is published twice a year and provides information about Division 45's activities and provides articles of interest to the membership of the division. Members of Division 45 have been very active in many other APA divisions and have advocated for the inclusion of multicultural issues within the field of psychology at large. This advocacy fostered the development of the *APA Multicultural Guidelines*, which were approved by the APA Council of Representatives in 2002. This document described cultural competencies for psychologists and the expected approaches for incorporating ethnic minority issues in research, teaching, psychology training, and practice. The *APA Multicultural Guidelines* represent a



central guiding source for evaluating psychologists for licensing, ethical practices, training and education, and professional advancement in colleges and universities.

Division 45 also has collaborated on various other projects with APA divisions to enhance cultural diversity training and to bring resources to a broader audience, such as state psychological associations, practitioners via online continuing education training, and conferences, to examine various issues and evidence-based practices for ethnic minority groups. For example, several APA divisions have collaborated and cosponsored a biannual Multicultural Summit conference that focuses on ways to advance the field of psychology through multiculturally sensitive and competent efforts. Other such conferences have emerged or are being planned with similar collaborations on topics such as the impact of immigration, the effect of violence in diverse communities, and evidence-based practices with ethnic minorities.

*Eduardo Morales*

*See also* Asian American Psychological Association (v3); Association of Black Psychologists (v3); Ethnic Minority (v3); National Latina/o Psychological Association (v3); Society of Indian Psychologists (v3)

### Further Readings

Comas Diaz, L. (in press). Changing psychology: History and legacy of the Society for the Psychological Study of Ethnic Minority Issues. *Cultural Diversity & Ethnic Minority Psychology*.

### Web Sites

Division 45: <http://www.apa.org/divisions/div45>

---

## SOCIETY OF INDIAN PSYCHOLOGISTS

---

The Society of Indian Psychologists (SIP) is a formal professional organization of American Indian, Alaskan Native, and non-Native psychologists, as well as other affiliated professionals, whose purpose is to promote and improve the psychological health and well-being of the indigenous peoples of the Americas. Additionally, SIP advocates for the development and application of culturally competent and

relevant psychological theory, research, education, and clinical practice with American Indian and Alaskan Native peoples.

Through biannual meetings, Internet listservs, and other venues, the society provides a forum for professionals who share these collective concerns to consult with one another. SIP also serves as a network for American Indian and Alaskan Native professionals. This network provides opportunities for professional development, advisement, mentorship, and sharing of knowledge, experience, and skills for American Indian and Alaskan Native psychological professionals and others who work with indigenous communities.

### Beginnings

The precursor to SIP was an informal group of newsletter subscribers, persons interested in sharing information about psychological services then available in indigenous communities. The newsletter, called *Network of Indian Psychologists*, was founded in 1970 and solely administered by Carolyn Attneave (Delaware/Lenni Lenape), an internationally renowned American Indian psychologist. Five years later, SIP was formally established as a professional organization for American Indian and Alaskan Native psychologists. Today, with a membership of more than 300 professionals, SIP continues to honor Attneave's revolutionary work through sponsoring a memorial scholarship fund in her name.

### Policy Making

SIP is one of five national ethnic minority psychological associations; other such organizations include the Association of Black Psychologists, Asian American Psychological Association, National Latina/o Psychological Association, and the Society for the Psychological Study of Ethnic Minority Issues (Division 45) of the American Psychological Association. Together, these organizations constitute the Council of National Psychological Associations for the Advancement of Ethnic Minority Interests.

In 1999, SIP proposed a resolution that supported the retirement of all Indian mascots, personalities, images, and other symbols in use within schools, colleges, universities, and athletic teams in the United States. In 2005, the highest governing body of the American Psychological Association, the Council of Representatives, adopted a similar resolution that



recommended immediate retirement of American Indian mascots within educational institutions, athletic teams, and organizations. Both resolutions were based on concerns about the ethical practice of psychology within these contexts as well as psychological research that had demonstrated harmful and negative effects of the use of Indian mascots and other symbols on American Indian children, communities, and students.

*Jill S. Hill and María R. Scharrón-del Río*

**See also** Alaska Natives (v3); American Indians (v3); Asian American Psychological Association (v3); Association of Black Psychologists (v3); Bureau of Indian Affairs (v3); Indian Health Service (v3); National Latina/o Psychological Association (v3); Society for the Psychological Study of Ethnic Minority Issues (v3)

### Future Readings

- Fryberg, S. (2001). *Really! You don't look like an American Indian*. Unpublished doctoral dissertation, Stanford University, Palo Alto, CA.
- LaFromboise, T. D., & Trimble, J. E. (1996). Obituary: Carolyn Lewis Attneave (1920–1992). *American Psychologist*, 51, 549.
- Perego, J. J., & Gloria, A. M. (2007). American Indians and Alaskan Native populations. In M. G. Constantine (Ed.), *Clinical practice with people of color: A guide to becoming culturally competent* (pp. 61–84). New York: Teachers College Press.

### Web Sites

Society of Indian Psychologists: [http://www.okstate.edu/osu\\_orgs/sip/](http://www.okstate.edu/osu_orgs/sip/)

---

## SOCIOECONOMIC STATUS

---

Socioeconomic status (SES) typically refers to a person's position and esteem in society based on economic and other resources. The most commonly cited indicators of SES are income, occupation, and education. In social science research, SES is often used interchangeably with the term *social class*. However, some would argue that these are different terms and that social class is determined both by the quantifiable amount of resources someone has and their relative standing in relation to others. For example, the terms

*lower class*, *middle class*, and *upper class* can be thought of as income demarcations and are often used as such in census data, but others look at these terms as descriptors of job prestige (e.g., both a college professor and a lawyer may fit into the “upper class” category though their incomes differ greatly). N. Krieger, D. R. Williams, and N. E. Moss, in their paper on measuring social class in public health research, stated that “socioeconomic position” consists of both actual resources and status (i.e., qualities related to prestige and rank). The confounding between the terms *SES* and *social class* reflects the lack of clarity of these concepts in society due to the “myth of the classless society,” which is the idea that ability and effort alone are responsible for one's class standing. Oppression by those with material and power and privilege also contributes to the confusion of these terms. This entry focuses on SES but integrates social class concepts as they are relevant to counseling psychology.

## SES Indicators and Disparities

### Income and Wealth

*Income* is defined as money received (e.g., from wages, interest, child support, Temporary Assistance to Needy Families), whereas *wealth* consists of assets accumulated. Another way to define wealth is net worth, or assets (e.g., home ownership, stocks, cars, leftover income after expenses) minus debts. Typically, when talking about SES in the United States, the media focus on income. However, wealth statistics paint a more accurate picture of SES and inequality. In addition, income cutoffs for federal programs such as food stamps do not accurately portray the amount of money actually needed for U.S. families to meet basic needs.

According to the U.S. Census Bureau, the median income of families in the United States in 2004 was \$44,389. There are significant income disparities based on race. In 2004, the median household income was \$48,977 for non-Hispanic Whites, \$30,134 for Blacks, \$57,518 for Asians, and \$34,241 for Hispanics. These figures are estimates and often omit working undocumented immigrants and intergroup differences, such as the status of Southeast Asian refugees.

There are also disparities in income between men and women. The median income for men with earnings in 2004 was \$40,798, and for women with



earnings it was \$31,223. According to this estimate, women are making almost 77 cents on the dollar compared with men. Other estimates claim that the pay gap is decreasing, and women are making about 80 cents for every dollar of men's earnings. However, part of this narrowing is due to the fall of wages for working-class men rather than increases in wages for women.

In 2004, 12.7% of the U.S. population lived below the poverty line. That year, the Department of Health and Human Services defined the poverty threshold as an income of \$18,850 for a family of four. However, many economists and social scientists question the formula used to calculate this figure. The threshold is calculated using a formula that was developed in the 1960s, based on the cost of food for a family multiplied by three. This formula fails to incorporate rising housing and healthcare costs, not to mention the need for child care in most American families. Several economists have proposed new formulas for calculating the income that families need to meet their basic needs, and the results of these formulas suggest that families in the United States need an average of 2 times the federal poverty threshold to simply survive. In some regions of the country, the difference is even greater.

Continuing to use the Department of Health and Human Services definition of poverty, glaring differences based on race are apparent. The poverty rate (percentage of the population living under the federal poverty threshold) in 2004 was 8.6% for non-Hispanic Whites, 24.7% for Blacks, 9.8% for Asians, and 21.9% for Hispanics. Two-year average poverty rates (2003–2004) were calculated for American Indians/Alaska Natives and Native Hawaiian/Pacific Islanders, respectively: 24.4% and 12.9%. There are also disparities based on citizenship status. The poverty rate for U.S.-born citizens was 12.1%, compared with 9.8% for foreign-born naturalized citizens and 21.6% for noncitizens. Female-headed households are much more likely to experience poverty. The poverty rate for female households with no husband present was 28.4%. For male households with no wife present it was 13.5%, and for married couple households it was 5.5%.

Wealth disparities are even more staggering. The median net worth (i.e., assets minus debts) for White households in 2001 was \$121,000. For Black households, the median was \$19,000, and for Latino/a households the median was \$11,500. Even as the gap in income between races decreases very slowly, wealth disparities have stayed the same or increased.

Some economists and social scientists, such as Chuck Collins and Felice Yeskel, the authors of *Economic Apartheid in America* with United for a Fair Economy and Class Action, argue that inequality is a critical social problem even if the standard of living has improved for Americans overall. They discuss inequality between racial and ethnic groups, men and women, and wealthy and poor (and, increasingly, between wealthy and middle-income people). Salaries of chief executive officers (CEOs) and other executives have increased exponentially, while workers' wages are stagnant or even decreasing. In addition, CEOs' salaries are positively correlated with downsizing, so as more and more working and middle-income people lose their jobs, the wealth of executives increases. In 2003, the average CEO made as much money as 301 workers. According to the U.S. Census Bureau in 2004, income for families in the top 5% of the population grew by 75% between 1979 and 2003, and for those in the middle 20%, income grew by only 15% during the same period. In 2001, 10% of the population owned 70% of all wealth, and 90% of the population owned 30% of all wealth. Collins and Yeskel reviewed several studies regarding inequality and public health and found that the regional gap between the rich and the poor predicts health better than poverty rates do. In the United States in particular, most working people are working longer hours and earning less; struggling to afford health insurance, higher education, and retirement; going into more debt to pay for everyday expenses; saving less; and working more temporary jobs with no security or benefits.

### Occupation

Occupation is another indicator of SES used in social science research. Some researchers simply distinguish between the employed and unemployed, and others use various job categorization schemes. Nancy Lynn Baker noted that the current terms for distinguishing between social classes (e.g., *working class*, *professional class*) are simply job descriptions and do not capture important distinctions between occupations, such as personal control and level of danger.

Occupations are sometimes grouped by income, but most schemes rely on categories based on prestige, skill, or education required. The U.S. Census groups occupations into 23 major groups, some of which are management; legal; education, training, and library; protective services; building and grounds;



cleaning and maintenance; sales and related; office and administrative support; construction and extraction; and transportation and material moving. According to the U.S. Department of Labor, in May 2005, the occupational group with the highest mean annual wage was management (\$88,450), and the occupational group with the lowest mean annual wage was food preparation and serving (\$17,840). However, understanding SES by these categories is not particularly meaningful, as management occupations include, for example, CEOs and social and community service managers, and food preparation and service-related occupations include both chefs and dishwashers. In both cases, these occupations differ greatly in terms of income, education required, prestige, and personal control over one's workday. Prestige and power are associated with such categories, as captured by the Occupation Score of the Hollingshead Index of Social Position. The original Hollingshead Two-Factor Index grouped occupations from highest prestige (which could be called business management and professionals) to lowest prestige (unskilled employees). Industrialized nations seem to have similar conceptions of occupational prestige. Michael Argyle reviewed studies of occupational prestige across various countries and found that professionals are usually held in highest esteem, whereas unskilled service workers, farmers, and farm laborers are usually regarded in lowest esteem.

In his book *The Working Class Majority: America's Best Kept Secret*, economist Michael Zweig defined social class in terms of the power workers have in different occupations. He discussed three types of power important in determining one's social class: economic power (based on earnings and wealth, and power over the means of production, including other workers), political power (the power to influence policy), and cultural power (power over the processing of information, such as the media and education). Though someone could have one type of power and not another, all three types generally reinforce one another. He divided occupations into three major classes based on the amount of power each class has: the capitalist class (which includes the ruling class), the middle class, and the working class.

The capitalist class consists of business owners, particularly owners of corporations or "big businesses." Many small business owners fit into Zweig's definition of the middle class. The distinction is that members of the capitalist class do not come into much

contact with workers or the process of production, though they have great control over the workforce through middle management. The ruling class consists of a small percentage of the capitalist class who serve on the boards of several corporations, affording them access to political and cultural leaders. Zweig defines the middle class as small business owners; supervisors and managers; and professionals, such as doctors, professors, and computer programmers. He described the middle class as caught between the competing interests of the working and capitalist classes: On the one hand, they have an interest in maintaining their privileges by limiting the power of working-class people, but on the other, they are losing control over their jobs (e.g., designing curricula, HMO policies) to the capitalist class. The working class is the largest class according to Zweig's analysis (about 60% of the U.S. workforce) and is quite diverse. Working-class people are those with the least amount of power and control in their occupations. In the U.S. Census categories, they are typically found in sales, administrative support services, production, and technical occupations. Zweig estimates that 75% of the unemployed are working-class people actively looking for jobs.

## Education

Education is often used as a descriptive indicator of SES, distinguishing between those who have not completed high school, those who have completed high school or have obtained a general equivalency diploma, those who have 2-year or vocational degrees, and so on. Education is considered a major vehicle of upward social mobility, as higher education is tied to occupations with higher incomes and prestige. However, the education and income of one's family of origin are highly predictive of future educational opportunities. Income, occupation, and education appear to be intertwined and mutually reinforcing. In the United States in 2003, the median annual income for non-high school graduates was \$15,610. This figure was \$30,936 for those with associate degrees, \$40,588 for those with bachelor's degrees, \$51,116 for those with master's degrees, \$70,985 for those with doctorate degrees, and \$81,833 for those with professional degrees.

In the United States, there are stark racial/ethnic disparities in education. According to the U.S. Census Bureau in 2004, 89.2% of non-Hispanic Whites ages 18 and older had a high school diploma or more,



compared with 79.5% of Blacks, 86.8% of Asians, and 58.9% of Hispanics. More striking disparities are found in higher education. Twenty-eight percent (28.2%) of non-Hispanic Whites age 18 and older had a bachelor's degree or higher, compared with 15.6% of Blacks, 45.6% of Asians, and only 10.3% of Hispanics. Note that data were not available for American Indians, Alaska Natives, or Native Hawaiians and other Pacific Islanders, who typically fare worse than other groups on SES indicators.

### ***Classification Schemes Based on Prestige***

Two of the most popular classification schemes for SES are August B. Hollingshead's Index of Social Status and Otis Dudley Duncan's Socioeconomic Index. Both of these methods rank occupational categories based on prestige. These methods are based on census data from 1970 and 1950, respectively, and are thus outdated. The Hollingshead Index combines education, occupation, gender, and marital status into one social status score. The Duncan Socioeconomic Index classifies occupational prestige based on the income of, and education required for, the occupation. Another classification method is the Nam-Powers Socioeconomic Status Score, which uses a definition of occupational status based on median income and education of those employed in that occupation, combined with educational level and family income. Problems with these measures include few studies on validity and reliability, the combination of highly intercorrelated SES indicators into one measure, and equating socioeconomic resources with prestige.

## **SES and Health**

### ***SES and Physical Health***

There is a clear relationship between SES and health, as indicated by studies that have found evidence of a gradient where low SES is correlated with most (but not all) diseases, and the likelihood of contracting or experiencing disease decreases as SES increases. Relationships between various socioeconomic indicators and physical diseases have been found, including cardiovascular disease, hypertension, and certain types of cancer. Level of education alone has been cited as a predictor of mortality and morbidity in the United States and other countries.

SES is highly correlated with physical health for various reasons. Access to health care, safe workplace conditions, and supportive social networks contribute to the health of those with higher SES. In addition, lower SES is associated with a greater likelihood to engage in risky behaviors, such as smoking and alcohol consumption. Individuals coping with the stress of a low SES environment are also less likely to engage in healthy behaviors such as exercise. The physical environment of low SES neighborhoods can also directly impact health. Impoverished neighborhoods are often exposed to pathogens, carcinogens, and environmental hazards. People in poor communities are also more likely to be exposed to, or experience, violence and may have less social support than people living in higher SES communities.

Nancy E. Adler, Elissa S. Epel, Grace Castellazzo, and Jeannette R. Ickovics conducted a study in which they found strong correlations between subjective SES and health, by asking 157 healthy White women to rank their social status on a 10-rung ladder. Significant negative correlations were found between subjective SES indicators of poor health (e.g., body mass index). The researchers also measured psychological health and found significant negative correlations between subjective SES and negative affectivity, chronic stress, subjective stress, pessimism, and passive coping. Significant positive correlations were found between subjective SES and control over life and active coping. This is one of several studies demonstrating relationships between SES and both physical and mental health.

### ***SES and Mental Health***

People living in low SES communities face multiple stressors and often do not have the material or social resources to cope with the resulting stress. Aside from severe financial crises that poor families face (hunger, threats of eviction, etc.), they face more hassles in their daily living than do families in higher SES communities. Those of higher SES have more access to high-quality housing, shops, banks, health care, and transportation. These resources alone can be buffers against stress.

Citing national epidemiological studies, Yan Yu and David R. Williams stated that in 1994, individuals who did not complete high school were almost two times more likely to be diagnosed with a major affective disorder than individuals who had a college education or more. In addition, people of low SES were almost



2 times more likely to suffer from a substance abuse disorder than people in the highest SES group. Though these disparities may be the result of the stressors described above, it is possible that classism, racism, and other forms of oppression affect rates of diagnosis in people of low SES. Considering the SES disparities between races in the United States, it is clear that racial/ethnic minorities are more likely to be diagnosed with a psychiatric illness than are White individuals.

Depression has been linked consistently with poverty in adults and children. According to Deborah Belle and Joanne Doucet, adults in poverty are at double the risk for experiencing a new episode of major depression than are other adults. This compounds children's risk for depression and other mental health problems. Poor household economic conditions increase the risk for childhood depression and the poor physical health correlates of depression. Other risk factors for childhood depression that are linked to SES are living in a single-parent home, parental unemployment, and low educational attainment by parents. A recent meta-analysis by Vincent Lorant and colleagues concluded that there is a moderate to strong relationship between SES and depression, and this is especially true for persistent depression.

## SES and Counseling

### *Classism and Counseling Psychology*

Bernice Lott and Laura Smith have called attention to the classism that exists in psychological research and practice. Classism, like other forms of oppression, results from those with unearned class privilege exerting their power over others. Lott discussed notions of class superiority and inferiority that result in psychologists and others distancing themselves from poor people through cognitive means such as stereotyping; exclusion of low SES individuals from institutions such as education, housing, and politics; and interpersonal means such as blatant discrimination and invalidation.

Smith traced the history of psychotherapy's treatment of the poor, including the political backlash against community mental health centers and therapists' expectations of clients based on White middle-class norms. Current therapeutic models are most likely not addressing the needs of those from lower SES groups, as evidenced by higher treatment dropout rates. An example of an attitudinal barrier is counselors seeing their interventions as less significant

because poor clients are facing multiple stressors. As the multicultural counseling competencies have helped to address counselors' attitudes regarding race and ethnicity, identification of attitudinal barriers to working with low SES clients will begin to increase counselors' competence to work across socioeconomic groups.

### *The Social Class Worldview Model*

William M. Liu developed the Social Class Worldview Model (SCWM) to address the definitional problems surrounding class and SES and to analyze the complexity of within-group differences (i.e., not all people within a certain class or SES are assumed to share the same characteristics). This model specifically addresses the subjective experience of SES most often known as social class. This has important implications for counseling, as clients' and counselors' perceptions of both their own and the others' SES impact the counseling relationship and process.

Liu chose a worldview model because the underlying construct he is describing reflects people's subjective experience of belonging to a specific group. The subjective context of the SCWM is one's perceived class and status position. This influences saliency, consciousness, and attitudes toward social class issues, which interact with referent groups, material objects, lifestyle, and behaviors. Though all aspects of the SCWM influence one another, saliency, consciousness, and attitudes are placed at the center of the model. *Perceived class and status position* is a person's answer to the question, "What is your social class background?" *Saliency* indicates a level of awareness of an SES system in which there are differential opportunities for people in different classes. *Consciousness* refers to the level of awareness an individual has about belonging to, and being influenced by, a social class system. *Attitudes* refer to feelings, beliefs, attributions, and values about social class. Social class attitudes are shaped by one's early socialization experiences.

*Referent groups* are groups that inform one's socialization experiences. They influence the development of the SCWM and one's behaviors. The three referent groups that Liu names are the *group of origination* (e.g., caretakers, relatives, early peers), *cohort group* (those with whom one spends the most time and are most similar to him or her in their own worldview and behavior), and *group of aspiration* (the group that one would like to belong to). *Material objects*,



*lifestyle*, and *behavior* can be considered “performance” variables, as they are the visible indicators of class and status. Liu discussed the objective SES measures of income, occupation, and education as limits on one’s SCWM. One’s class aspirations may not match one’s resources.

Because of the paucity of research on the subjective experience of social class, this is a preliminary model that has not been validated. The SCWM places a person’s subjective interpretations of social class in ecological context by considering cultural values, social comparison groups, and other important systemic variables. It is a promising paradigm for understanding how people make sense of social class.

Lott, Smith, and Liu each have made significant contributions to the understanding of the relevance of SES to counseling. In U.S. society, the ideology of the “American dream” reinforces a cultural myth that there is no class stratification and that anyone can climb the social class ladder with effort. An understanding of class-based oppression is crucial for counselors who may be working with individuals from different SES groups. More often than not, counselors hold a relatively high SES in U.S. society because of their education and occupational prestige. It is crucial for counselors to examine their SES and social class biases, in addition to examining biases based on race, gender, and other social identities. Liu’s model offers a helpful framework for counselors to ask themselves questions about their SES-related beliefs, attitudes, and behaviors. It also provides a model for understanding how social class may be related to clients’ presenting concerns. Because social class and SES are complex and often misunderstood constructs, models such as the SCWM can provide structure to the examination of these issues.

### Future Directions

SES and social class are inadequately defined in social science research, including counseling research. Socioeconomic indicators such as income, wealth, occupation and occupational prestige, and education have clear implications for health and mental health and will benefit from further research. In addition, counseling psychologists have begun to address the subjective meaning of social class and how it plays out in their lives, including in counseling relationships. An important aspect of this research will focus on understanding discrimination and oppression

based on SES and how it affects the work of counselors and psychologists.

*LeLaina Romero*

**See also** Academic Achievement (v2); Classism (v3); Part-Time Work (v4); Physical Health (v2); Poverty (v3); Social Class (v4); Third World (v3); Vocational Identity (v4); Worldview (v3);

### Further Readings

- Adler, N. E., Boyce, T., Chesney, M. A., Cohen, S., Folkman, S., Kahn, R. L., et al. (1994). Socioeconomic status and health: The challenge of the gradient. *American Psychologist*, 49, 15–24.
- Adler, N. E., Epel, E. S., Castellazzo, G., & Ickovics, J. R. (2000). Relationship of subjective and objective social status with psychological and physiological functioning: Preliminary data in healthy White women. *Health Psychology*, 19, 586–592.
- Argyle, M. (1994). *The psychology of social class*. London: Routledge.
- Baker, N. L. (1996). Class as a construct in a “classless” society. In M. Hill & E. D. Rothblum (Eds.), *Classism and feminist therapy: Counting costs* (pp. 13–23). New York: Haworth.
- Belle, D., & Doucet, J. (2003). Poverty, inequality, and discrimination as sources of depression among U.S. women. *Psychology of Women Quarterly*, 27, 101–113.
- Boushey, H., Brocht, C., Gundersen, B., & Bernstein, J. (2001). *Hardships in America: The real story of working class families*. Washington, DC: Economic Policy Institute.
- Collins, C., & Yeskel, F., with United for a Fair Economy and Class Action. (2005). *Economic apartheid in America: A primer on economic inequality & insecurity*. New York: New Press.
- Krieger, N., Williams, D. R., & Moss, N. E. (1997). Measuring social class in U.S. public health research: Concepts, methodologies, and guidelines. *Annual Review of Public Health*, 18, 341–378.
- Liu, W. M. (2001). Expanding our understanding of multiculturalism: Developing a social class worldview model. In D. B. Pope-Davis & H. L. K. Coleman (Eds.), *The intersection of race, class, and gender in multicultural counseling* (pp. 127–170). Thousand Oaks, CA: Sage.
- Liu, W. M., Ali, S. R., Soleck, G., Hopps, J., Dunston, K., & Pickett, T., Jr. (2004). Using social class in counseling psychology research. *Journal of Counseling Psychology*, 51, 3–18.



- Lott, B. (2002). Cognitive and behavioral distancing from the poor. *American Psychologist*, 57, 100–110.
- Smith, L. (2005). Psychotherapy, classism, and the poor: Conspicuous by their absence. *American Psychologist*, 60, 687–696.
- Taylor, S. E., Repetti, R. L., & Seeman, T. (1999). What is an unhealthy environment and how does it get under the skin? In I. Kawachi, B. P. Kennedy, & R. G. Wilkinson (Eds.), *The society and population health reader: Vol. 1. Income inequality and health* (pp. 351–378). New York: New Press.
- Yu, Y., & Williams, D. R. (1999). Socioeconomic status and mental health. In C. S. Aneshensel & J. C. Phelan (Eds.), *Handbook of the sociology of mental health* (pp. 151–166). New York: Kluwer Academic/Plenum.
- Zweig, M. (2000). *The working class majority: America's best kept secret*. Ithaca, NY: ILR Press.

---

## SOJOURNER

---

A sojourner is a person who resides in a country other than his or her country of origin for an extended time. Sojourners leave their home country for a specific purpose (e.g., teaching, studying, working, military service, humanitarian aide) but have no intentions of applying for citizenship or moving permanently to the host country. International students, peace corps volunteers, military personnel, missionaries, and people who temporarily work overseas are all examples of sojourners. Usually this temporary move is purely by choice; however, in certain cases, like that of military personnel, their service may be voluntary but their requirement to move may be a demand of their service and thereby not totally of their own accord. Sojourning has become increasingly popular as technology and communication have advanced to create a global economy.

Sojourning can be considered a major life stressor and individuals may see a counselor for assistance in adjusting to their relocation. Cognitive, behavioral, and emotional adjustment will be necessary. Upon arrival in their host country, many sojourners describe a variety of symptoms such as fatigue, isolation, numbness, irritability, confusion, a sense of loss and/or violation, frustration, anger, exhaustion, depression, and reduced confidence. These tend to be most prevalent upon their arrival in the host country and dissipate over time. A failure to recover from the transition into another culture may result in an early

return to their native country, difficulties performing their duties in the host country, and prolonged distress. This failure to adjust may have long-term effects on their career path and interpersonal relationships. Counselors can assist their clients by helping them adjust to their new environment and normalizing their feelings. Counselors must be respectful of their unique worldview and not suggest they change to fit in with the culture of the new country. It is important to understand what the sojourner's expectation is for counseling and how counseling is viewed in his or her country of origin. This will be critical in determining the client's expectations of the counselor. Sojourners may present many challenges to the counselor, such as less fluency in the host culture language, different nonverbal behaviors, and different customs. It is necessary for counselors to familiarize themselves with the customs of their culture of origin to facilitate a multiculturally sensitive approach to treatment.

If sojourners are able to negotiate the adjustment into their host culture, they may return to their native country having gained a new understanding of international relations and an increased appreciation for both their native country and their host country.

Jennifer L. Lemkuil

*See also* Acculturation (v3); Acculturative Stress (v3); Adaptation (v3); Assimilation (v3); Cultural Values (v3); Culture (v3); Culture Shock (v3); Enculturation (v3); Occupational Stress (v1); Second Culture Acquisition (v3); Stress Management (v2)

## Further Readings

- Sussman, N. M. (2000). The dynamic nature of cultural identity throughout cultural transitions: Why home is not so sweet. *Personality and Social Psychology Review*, 4(4), 355–373.
- Ward, C. (1996). Acculturation. In D. Landis & R. S. Bhafat (Eds.), *Handbook of intercultural training* (Vol. 2, pp. 124–147). Thousand Oaks, CA: Sage.
- Ward, C., Bochner, S., & Furnham, A. (2001). *The psychology of culture shock* (2nd ed.). Philadelphia: Taylor & Francis.

---

## SPIRITUALITY

---

Spirituality, from the Latin *spiritus*, refers to a sense of, or belief in, something bigger than, beyond, or outside oneself. Individual spirituality is often seen as a



connection among oneself, others, and that which is beyond oneself and others. In addition, some scholars have referred to spirituality as a holistic connection with the divine or the breath that animates life. Some see spirituality in terms of people's attempts to understand the ultimate nature of things in the universe; in this way, spirituality shares commonalities with some philosophies. Finally, others relate spirituality to psychological health; that is, the person on a spiritual path is also seeking psychological balance and well-being.

Spirituality is often combined and/or confused with religion. There is a lack of consensus among professionals regarding the similarities and differences where spirituality and religion are concerned, which has resulted in a frequent merging of the two constructs. There are, however, some agreed-upon ways to articulate the differences between spirituality and religion. For example, spirituality has been seen as encompassing religion; that is, religion is a form of spirituality. In addition, spirituality is typically seen as a construct that resides within an individual and connotes a personal relationship with a higher power. In contrast, religion is a social institution, with rules and hierarchies for salvation. As a result of this difference, religions tend to proscribe a path to enlightenment or nirvana, while the spiritual person would suggest that there are many ways to achieve the desired goals regarding psychological and spiritual well-being.

### **Manifestations of Personal Spirituality**

There is no one "right" way to be spiritual. To that end, spirituality can be demonstrated in a variety of ways. Some examples of personal manifestations of spirituality include prayer, meditation, yoga, physical exercise, laughter, breathing exercises, worship, rituals, fasting, imagery creation, Bible/Qur'an/Talmud study, pastoral counseling, and quoting sacred texts. It is important to note that this list is not meant to be exhaustive.

### **Spirituality in the Counseling Process**

Like many things in a counseling relationship, the spirituality of the counselor and client can significantly impact the therapeutic process. The spiritual beliefs of both the therapist and the client should be viewed as important characteristics that may affect counseling.

For clients, their spirituality should be considered as important to the therapeutic process as any other salient variable, especially clients for whom spirituality is

central to their identity or cultural self-description. For some clients, spirituality provides a lens or worldview with which they see and interact with others in their environment. For highly spiritual clients, then, counselors should be sure to attend to the client's spiritual orientation, as it is likely to facilitate the client's exploration of the problem(s) that brought him or her to counseling. In addition, counseling professionals will obtain a more complete understanding of their clients by attending to the client's spirituality. Of course, some clients might not feel comfortable talking about spirituality with their counselor because they might assume that spirituality is a taboo topic in counseling.

For counselors, there are two conditions in which spirituality affects the counseling process. First, the counselor can facilitate the client's disclosure by welcoming, and perhaps even inquiring about, the client's spirituality in session. In this way, the counselor must provide a safe environment for the client to discuss his or her personal spirituality. Honoring the client's spirituality can be as effective as being empathic and sensitive to the client's other aspects of identity, such as race, ethnicity, gender, sexuality, religion, and socioeconomic status.

Second, the personal spirituality of the counselor can also assist in the development and strengthening of the counseling relationship. For example, many counselors endorse having spiritual beliefs that serve as guiding principles for their lives. This view of self and others can be facilitative with regard to the counselor's understanding and conceptualization of the client's behavior, history, and worldview. The counselor who understands the role of spirituality in his or her own life, even if that means no spirituality, will be better prepared to attend to the client's personal spirituality as it might emerge in the counseling process.

Effectively discussing spirituality between the counselor and client has the potential to establish a sound working alliance, especially where there is some shared perceptions regarding spirituality. Through the counselor's welcoming of spirituality into the treatment room, the client may feel more comfortable in disclosing those aspects of him- or herself, especially as they relate to the presenting problem(s). At the minimum, counselors should attend to the client's spirituality if and when the client raises that issue as part of the counseling process. To ignore a client's sense of spirituality is to deny what could be a vital, if not central, aspect of the client's identity. In sum, clients will be better served by counseling professionals who attend to spirituality in their clients



and who have sought to understand what role, if any, spirituality plays in their own lives.

### Spirituality in the Lives of People of Color

It is important to attend to spiritual concerns in all clients; however, with clients of color it may be even more critical to understand the role that spirituality plays in their lives. Continuous experiences with social intolerance (i.e., prejudice, racism, discrimination, and oppression) have been primary forces causing a deepened level of spirituality for many people of color. These forces, both powerful and harmful, often have negative psychological impacts; some examples include heightened levels of anxiety, frustration, depression, and identity confusion. As a result, people of color seek refuge from this intolerance through spirituality; this is done to comfortably connect their internal selves with the surrounding world and a self-defined higher power or higher being. Through personal spirituality, people of color find ways of transcending difficult social situations and recognizing the positive aspects of unfortunate circumstances. Hence, spirituality plays an integral part in the lives of people of color by empowering them with renewed hope and strength to endure despite daily personal and social struggles.

### Spirituality as a Coping Mechanism

Spiritual practices and beliefs are relevant across all racial and cultural groups, providing coping mechanisms for a variety of stressors. The use of spiritual techniques may help people view difficult or challenging situations in a more positive light by identifying personal meaning in the face of adversity. This could, in turn, lead to acceptance and possibly appreciation of negative experiences. Belief in a higher power may also serve as a powerful resource for clients in terms of feeling supported in the face of struggles. In sum, embracing spirituality can be a powerful tool for building personal strength and enhancing resiliency for the challenges of daily living.

*Lewis Z. Schlosser, Raymond D. Brock-Murray,  
and Tonisha Hamilton*

**See also** Coping (v2); Espiritismo (v3); Multicultural Counseling Competence (v3); Religion/Religious Belief Systems (v3); Spirituality/Religion (v2); Worldview (v3)

### Further Readings

- Cashwell, C. S., & Young, J. S. (Eds.). (2005). *Integrating spirituality and religion into counseling: A guide to competent practice*. Alexandria, VA: American Counseling Association.
- Cervantes, J. M., & Parham, T. A. (2005). Toward a meaningful spirituality for people of color: Lessons for the counseling practitioner. *Cultural Diversity & Ethnic Minority Psychology, 11*, 69–81.
- Curtis, R. C., & Glass, J. S. (2002). Spirituality and counseling class: A teaching model. *Counseling and Values, 47*, 3–12.
- Fukuyama, M. A., & Sevig, T. D. (1999). *Integrating spirituality into multicultural counseling*. Thousand Oaks, CA: Sage.
- Griffith, J. L., & Griffith, M. E. (2002). *Encountering the sacred in psychotherapy: How to talk with people about their spiritual lives*. New York: Guilford Press.
- Richards, P. S., & Bergin, A. E. (Eds.). (2000). *Handbook of psychotherapy and religious diversity*. Washington, DC: American Psychological Association.
- Richards, P. S., & Bergin, A. E. (2005). *A spiritual strategy for counseling and psychotherapy* (2nd ed.). Washington, DC: American Psychological Association.

## STEREOTYPE

Stereotype is generally defined as a consciously or unconsciously held rigid belief or expectation about a group that does not easily permit exceptions. Stereotyped beliefs are held by a group (commonly called the ingroup) and involve an agenda that benefits the ingroup at the expense of the stereotyped group (commonly called the outgroup or target group). Stereotypes help the ingroup members feel good about their group and themselves relative to the target group. A stereotype often concerns a trait that is important to the ingroup's identity and emphasizes the distinctness and inferiority of the outgroup. Relatedly, stereotypes maintain sociopolitical hierarchies in society. They can serve as a justification for believing that certain groups are superior to others and as a rationale for oppressing target groups.

While the phenomenon of stereotyping has been defined and explored primarily in social and cognitive psychology, it has many implications for counseling and has been taken up and discussed by many scholars in counseling psychology. These discussions often focus on the sociopolitical aspects of stereotypes,



including the relevance of stereotypes to prejudice and to counseling training, competence, and process.

### History of the Term

The term *stereotype* comes from two Greek words meaning “solid” and “a model.” In English, it first meant a metal printing plate. The term evolved to become associated with the act of stamping out the same image or text over and over; by the beginning of the 20th century, it connoted rigid, repetitive behavior. Soon thereafter it was applied to cognitive processes of categorization that were consistent and predictable. Early discussions of categorizing objects asserted that stereotypes were useful but also resulted in a certain number of errors. When applied to the social domain in the 1930s, *stereotype* came to denote the misattributions commonly applied to ethnic groups (e.g., Germans are scientific minded; Turks are cruel). Thus, stereotypes became linked to prejudice and discrimination and were often considered negative. At this time stereotypes ceased to involve exclusively errors in cognition and became a social phenomenon resulting more from cultural influences than from individual experience.

In the latter 1970s and the 1980s scholars began exploring the cognitive processes of stereotyping, relating stereotypes to cognitive schemata or theories. Using general principles of cognitive processing to illuminate how stereotyping occurs, the discussion at times ignored the sociopolitical context of the phenomenon. In contrast, when the field of counseling took up the term in examining the impact of prejudice and ethnocentrism on counseling process and training, scholars consistently focused on the sociopolitical underpinnings of stereotyping.

### Perspectives on Stereotyping

In discussing stereotyping, counseling scholars often draw heavily on conceptualizations generated by other fields. A discussion of these perspectives can flesh out the phenomenon’s meaning for counseling.

#### ***Stereotyping as a Social-Cognitive Phenomenon***

Stereotypes have been explored a great deal in terms of the cognitive processes of attending to, organizing, and interpreting social information or stimuli encountered in everyday life. Social psychologists have done the majority of this work, applying principles

of cognitive psychology to social stereotyping. The premise is that people do not have the capacity or resources to consider and analyze every new stimulus as if it were the first piece of information ever received. To process all incoming stimuli efficiently and effectively, people create sorting mechanisms, expectations, and assumptions, often called *cognitive schemata*. Schemata are systems that help people make sense of the complex sets of stimuli that constantly confront them. Schemata are organizing principles that prioritize what to focus on and that categorize and organize the information for interpretation. For example, we have a schema that helps us efficiently differentiate a table from a chair based on multiple expectations about the attributes of each of these objects. From a social-cognitive perspective, stereotypes are a type of schema—rules and expectations we have about people from different groups.

Schemata often become automatic and unconscious. Thus, stereotype holders are not often aware of the expectations and assumptions that influence their thinking, emotions, and behavior. When asked explicitly, they deny holding these stereotypes, but the stereotypes manifest their influence in implicit ways.

Often, the experiences that give rise to stereotyped beliefs are also implicit and embedded in a society’s culture. Implicit messages that give rise to stereotypes are broadcast by societal institutions. For example, the media do not explicitly state that Whites or men are superior to people of color or women, but they present a preponderance of heroic characters that are White men, while presenting people of color and women in secondary and supporting roles. This imbalance in portrayals communicates stereotypes about racial and gender hierarchy, including that White men have greater abilities and are more important than people of color and women. As a result, many members of the society unconsciously hold such stereotypes.

To understand stereotypes, social-cognitive scholars have drawn on rules for how unconscious cognitive sorting and organizing processes function. For instance, based on rules of human cognition, groups that stand out (e.g., groups who are in the minority and are judged to be different from the majority) and traits that stand out (e.g., traits that are not often seen in mainstream experience) are often paired to form stereotypes. In the example, Blacks stand out as a minority group visibly distinguishable from Whites, and criminality stands out as an infrequent, deviant trait, so the two can be connected easily in the White person’s mind. Even though the connection does not



exist in reality, the distinctiveness of both the group and the trait creates fertile ground for them to be paired in a stereotype.

Of course, stereotyping is a social as well as a cognitive process. The culture, characteristics, and views of the ingroup are important in the development of stereotypes. Fertile ground for a stereotype is increased if the target group is viewed as deviating from the ingroup on the trait in question. It is also increased when the trait is one that the ingroup deems important to its identity. To most Whites, not being a criminal means that one has the favor and help of society's institutions (e.g., the police), and thus one has more value and power in society. Thus, the stereotype that Black and Latino males are criminals can serve to make Whites feel more valuable and powerful by creating a false contrast on an attribute or status that is important in White culture.

Stereotypes also have an emotional component. If an ingroup has strong negative feelings about a trait they perceive in a target group, a stereotype is likely to develop. The in-group's emotions about the target group also come into play: Greater negative feelings toward the group can result in more negative stereotypes about the group. In fact, simply putting people in a bad mood has been shown to elicit more stereotyped judgments of others.

This emotional component of stereotyping contributes to a vicious cycle. When ingroup members experience what they perceive as a negative encounter with target group members, they develop negative feelings about the target group and what they perceive as its undesirable traits. This gives rise to increased negative feelings and expectations (stereotypes), which influence their interpretation of and reaction to future encounters, resulting in further affirmation of the stereotype.

The social-cognitive approach also helps explain why stereotypes are rigid and hard to change. People are more likely to process accurately and remember information that is consistent with stereotypes they hold. Many studies have shown that stereotype-consistent information is easily remembered and readily accepted without question. People also tend to remember (but with a different purpose) information that is contrary to the stereotypes they hold. They pay very close attention primarily to figure out how to explain or interpret the information so that their stereotype remains unchallenged. The new information may be distorted or misperceived to fit the stereotype.

Of course, new information can cause a person to modify or even abandon a stereotype, but this happens

only rarely. From a cognitive perspective, people tend to see what fits with what they expect, and they often misperceive what is there, to fit their expectations. This happens in categorizing or characterizing objects as well as people. When this cognitive tendency is added to the emotional component of stereotypes and to the individual and group dividends gained by maintaining a stereotype, it is clear why contrary information often does not produce a change in a stereotype.

One way in which evidence contrary to a stereotype is absorbed without threatening the hold of the belief involves the process of subtyping. People create a slightly different subcategory of the larger target group to hold an individual member of the group who presents with traits that are inconsistent with the stereotype. For example, to absorb the fact that many Blacks are successful and law-abiding, Whites create subtypes (Black businessperson, educated Black), while maintaining the general negative stereotype that Blacks are criminals.

Contrary information may also be processed as extreme: The perceiver may tend to exaggerate the level of the unexpected trait or behavior. Thus, a woman who is competitive or ambitious is seen as extremely (and negatively) so, whereas a man with the same level of these traits is seen as normal. Similarly, stereotypes may create what is called a *shifting standard* for judging the behavior of individuals from different groups. For example, if a teacher who holds the stereotyped expectation that Blacks are less intelligent than Whites sees the same test score from a Black and a White student, the Black student may be perceived as highly intelligent and the White student as of average intelligence. Due to the stereotype, the teacher maintains a lower standard for considering a Black student intelligent than for considering a White student intelligent. The Black student will be perceived as very smart *for a Black person*.

The social-cognitive perspective helps counselors understand the functioning and even some of the motivation behind stereotypes, but it is also limited because it more or less views stereotyping in a political vacuum, as if no power hierarchy of social groups existed. Stereotypes play a role in rationalizing and maintaining this hierarchy, and the hierarchy influences the nature of stereotypes.

### ***Stereotyping as a Sociopolitical Phenomenon***

Counselors draw upon the social-cognitive approach to stereotypes but often integrate it into a



larger context. Sociopolitical factors and cognitive factors interact in both developing and maintaining stereotypes. Stereotypes emerge from the sociocultural context and are driven by power differentials between groups. As noted earlier, the distinctions between groups that are inherent in stereotyping can make the ingroup feel better about itself. To push further on this point, counseling has tended to look at the role of stereotypes in reinforcing power hierarchies between reference groups.

From the sociopolitical perspective, stereotypes grow out of a need to rationalize oppression and subjugation rather than simply out of cognitive processes and errors. For example, in the service of enslavement and genocide, stereotypes emerged that Blacks were childlike and Native Americans savage. Thus, sociopolitical expediencies influence the traits misattributed to a group.

Sociopolitical influence is illustrated by the change in stereotypes held about Blacks before and after slavery was abolished. Before abolition, Blacks were stereotyped as docile, dependent, and incapable of independent thought or action, that is, a group seen as benefiting from enslavement. After slavery was abolished, however, the Whites' stereotype of Blacks tended toward aggressive, dangerous, wild, and uncontrollable. The belief in these traits played a role in justifying brutal treatment of Blacks by Whites both by law (e.g., Jim Crow statutes) and outside the law (e.g., lynching). Thus, the existence and nature of stereotypes can change based on the ingroup's requisites for protecting its privilege and access to power and resources.

Such change suggests that stereotypes may not originate in experience. An initial negative encounter with a target group may not be necessary for a stereotype to develop. Some argue that sociopolitical forces give rise to stereotypes first, and then social-cognitive processes come into play, contributing to their maintenance and rigidity. Power differentials between groups, and the need to rationalize them, may be the starting point for the vicious cycle discussed earlier.

## Implications for Counseling

### ***Impact of Stereotypes on the Counseling Process***

Among other things, counseling involves evaluating clients and their experiences, to gain an empathic understanding and choose appropriate interventions. Stereotypes have a deleterious effect on this process in several ways. First, they set expectations that limit the

counselor's openness to who clients are and what they are experiencing. If a counselor expects a female client to be weak and submissive, the counselor is more likely to ignore or misinterpret information suggesting the opposite. The counselor will misunderstand the client and impose this expectation on her. Such a response can invalidate the client's experience and even negatively influence her sense of who she is. If, due to a counselor's stereotype, a certain trait or experience of a client is always ignored, while evidence of another trait is always emphasized and focused on, the client may start to believe and behave as if the stereotype were true. Counseling scholars have noted that this is a form of oppression and must be avoided in counseling practice.

Even when counselors recognize information contrary to a stereotype, they may distort the information and the relationship. A counselor who holds stereotypes about female gender roles (that women are "feminine" by nature) and encounters "masculine" traits in a female client may perceive those traits as exaggerated, resulting in a distorted view of the client. Or a counselor may not take seriously a successful Black client's vocational concerns if the counselor perceives that the client has achieved great success *for a Black person*. Holding this lower standard for certain groups has broad implications in areas within the counseling realm. At the individual level a school counselor may not encourage a Black student to pursue college, and at the institutional level, the allocation of resources to these groups will match the low standard of performance expected from them.

Stereotyping can lead to nongenuine and condescending relations between counselor and client. Because it is socially unacceptable to stereotype openly, White guidance counselors may evaluate the performance of Black students less critically in an attempt to avoid being perceived as stereotyping. Although this behavior may even come out of a desire to counteract racism (though it may also arise out of a motivation not to *appear* prejudiced), in essence it perpetuates prejudice and the stereotype by implying that the target group should be held to a lower standard.

Most people are not aware of the stereotypes they hold. Because stereotypes are unconscious, a counselor will perceive the aforementioned evaluations of clients as objective and perhaps not even linked to group membership. Thus, communication of the stereotype from counselor to client may be implicit and highly subtle, making it hard for either party to identify and counter. In fact, stereotypes often set off



subtle, unconscious interactive patterns between the stereotype holder (counselor) and the target (client). The counselor's expectations create both a cognitive and an emotional disposition toward the client that may be subtly communicated to the client through nonverbal and other behavior. The client may well respond to these cues in ways that the counselor interprets negatively according to the stereotype. The counselor, unaware of the impact the stereotype has already had on the client's behavior, concludes that the client's behavior represents clear evidence for the truth of the stereotype. Again, the vicious cycle ensues.

### ***Stereotypes and Multicultural Counseling Competence***

The multicultural counseling competencies specifically mandate that counselors be aware of the stereotypes that they hold and the impact these beliefs have on their work with clients. This implies that most, if not all, counselors hold stereotypes and must become aware of them and avoid their negative effects.

Some counseling scholars note that counselors must eliminate the negative effects of stereotypes to become culturally sensitive, an attribute mandated by the American Counseling Association's code of ethics. The inverse relationship between cultural sensitivity and stereotyping can be seen when one considers stereotypes as a type of cognitive schema.

Schemata can be seen in two ways. On the one hand, they are flexible hypotheses that can be influenced by information coming in. For instance, when a piece of information is not accounted for by an existing schema, the schema may change and adapt to incorporate the new information. If a schema for chair is flexible, a newly encountered bean bag may be considered a chair. Scholars assert that flexible schemata about social groups characterize cultural sensitivity.

On the other hand, schemata can be rigid expectations that influence what is perceived and how it is interpreted. They can impose a selective focus on incoming stimuli and prioritize information that poses no threat to the schema. Such schemata also affect how stimuli are interpreted, so even contradictory information may be interpreted in a way that supports the schemata, and the meaning of the information is distorted. Counseling scholars note that such rigid information processing is the basis of stereotyping.

Some counseling scholars state that, if counselors apply any stereotype of a particular group to all its individuals, the counselors are likely to misperceive

and misunderstand the clients and fail to be culturally sensitive. Stereotypes block interpersonal communication and rapport; they can lead clients to early termination, alienation from the counseling process, and cultural oppression. To avoid these errors and outcomes, scholars suggest that counselors work to become more conscious of their information processing in client encounters and treat expectations as hypotheses whose fit with the particular client must always be evaluated. Such caution should be exercised even when counselor and client are members of the same group, as within-group variance may make automatic expectations erroneous.

In overcoming the negative impact of stereotypes on the counseling process, and promoting culturally sensitive counseling, counselors critically need self-awareness of their own cultural and group memberships and their influences on their expectations. Self-analysis should include exploring the origins of, and possible motivations behind, each expectation, bringing these to consciousness. Only then can they be held as hypotheses to understand others' experiences and behaviors rather than rigid stereotypes kept in place by unknown agendas.

A self-aware counselor can be purposive and active in applying schemata to work with clients. An unexamined, passive, automatic application of schemata is likely to result in stereotyping the client. Counselors must actively explore and intentionally direct what stimuli they attend to, how they interpret the information, and what they do based on the information. Because many counselors have been socialized not to attend to group membership issues, inattention is the default. Inattention allows unexamined stereotypes to hold sway over what is acknowledged and how it is responded to.

Some counseling scholars, noting that stereotyping provides the ingroup with a self-definition distinct from and superior to that of the target group, assert that asking counselors to stop their stereotyping behavior is akin to asking them to give up a source of positive self-regard. They suggest that such work must be done in a safe environment and must include help in breaking down the connection between anti-target group sentiment and beliefs and positive self-construal.

### ***Impact of Stereotypes on the Target Group: Stereotype Threat***

Another effect of stereotyping on the counseling process is the impact on targets. Counselors must be



aware of how stereotyping affects the ways both counselors and their clients present. Such understanding can help counselors develop interventions, especially at the programmatic level, that can mitigate the negative impact of stereotypes.

One impact that has been extensively explored is the phenomenon of stereotype threat. Stereotype threat is a situationally triggered phenomenon in which a target group member's efforts to avoid confirming a stereotype lead to performance deficits. Stereotype threat can arise when a target group member approaches a task for which a stereotype expects poor performance by the target group. The individual tends to experience pressure to disconfirm the stereotype. Cognitive resources are marshaled to deal with this pressure, so they are not available for completing the task, and this negatively impacts performance. For example, when a female science student takes a biology exam she may be hampered by pressure to disconfirm the stereotype that women are not good in science.

The negative effect of the stereotype goes beyond the poor performance. It can cause target individuals to avoid domains in which a stereotype exists and their behavior may be evaluated. This can cause targets to avoid certain majors or fields, or even avoid speaking in class.

Thus, simply by their existence, stereotypes can produce the behaviors that they predict in target group members. An ingroup member need not react to a target based on a stereotype for the target to experience a negative effect. To mitigate these negative effects, counselors must do more than simply be aware of the stereotypes they hold and limit the negative effects of those on counseling. Scholars suggest that programs and interventions must reduce the stereotype threat experienced by targets. First, counselors must avoid ascribing clients' difficulties exclusively to internal processes such as the internalization of stereotypes by targets. Modification of contextual and situational factors must also be considered important avenues for intervention. Second, programs and interventions must avoid being a source of stereotype threat themselves. Threat can occur when a program or intervention is presented as remedial, suggesting that those who need this intervention are inferior. Targets may often be identified as having a problem and be referred to programs created to help them. Participation in the program can then be seen as a confirmation of a stereotype. One suggestion is that programs and interventions be modified to challenge participants sensitively, rather than

lowering the expected standard. Participation, too, must be reframed as an earned privilege, showing that the client is up for the challenge, rather than a punishment for poor performance. Such programs and interventions actively counter the stereotypes in the air and create an environment where participants can feel proud of both their group membership and their efforts in the domain of their choice. Pride can create a positive linking of these two in the perception of all, countering stereotypes as well as their negative impact.

Noah M. Collins

**See also** Antisemitism (v3); Bias (v3); Classism (v3); Cross-Cultural Training (v3); Discrimination (v3); Discrimination and Oppression (v2); Model Minority Myth (v3); Multicultural Counseling Competence (v3); Oppression (v3); Prejudice (v3); Racism (v3); Sexism (v3); Social Class (v4); Social Discrimination (v4); Social Identity Theory (v3); Stereotype Threat (v3)

### Further Readings

- American Counseling Association. (1995). *Code of ethics and standards of practice*. Alexandria, VA: Author.
- American Psychological Association. (2003). Guidelines on multicultural education, training, research, practice, and organizational change for psychologists. *American Psychologist*, 58, 377–402.
- Arredondo, P. (1999). Multicultural counseling competencies as tools to address oppression and racism. *Journal of Counseling & Development*, 77, 102–108.
- Biernat, M. (2003). Toward a broader view of social stereotyping. *American Psychologist*, 58, 1019–1027.
- Davies, P. G., Spencer, S. J., & Steele, C. M. (2005). Clearing the air: Identity safety moderates the effects of stereotype threat on women's leadership aspirations. *Journal of Personality and Social Psychology*, 88, 276–287.
- Dovidio, J. F., & Gaertner, S. L. (1999). Reducing prejudice: Combating intergroup biases. *Current Directions in Psychological Research*, 8, 101–105.
- Jones, J. M. (1997). *Prejudice and racism* (2nd ed.). New York: McGraw-Hill.
- Ridley, C. R., Mendoza, D. W., Kanitz, B. E., Angermeier, L., & Zenk, R. (1994). Cultural sensitivity in multicultural counseling: A perceptual schema model. *Journal of Counseling Psychology*, 41, 125–136.
- Schneider, D. J. (2004). *The psychology of stereotyping*. New York: Guilford Press.
- Smedley, A. (1999). *Race in North America: Origin and evolution of a world view* (2nd ed.). Boulder, CO: Westview Press.



- Steele, C. M. (1997). A threat in the air: How stereotypes shape intellectual identity and performance. *American Psychologist*, 52, 613–629.
- Sue, D. W., Carter, R. T., Casas, J. M., Fouad, N. A., Ivey, A. E., Jensen, M., et al. (1998). *Multicultural counseling competencies: Individual and organizational development*. Thousand Oaks, CA: Sage.
- Thompson, C. E., & Neville, H. A. (1999). Racism, mental health, and mental health practice. *Counseling Psychologist*, 27, 155–223.

---

## STEREOTYPE THREAT

---

In 1995, Claude M. Steele and Joshua Aronson coined the term *stereotype threat*. The cornerstone of the phenomenon of stereotype threat is the pressure to not conform to a given expectation of poor performance. This results in an activation of negative and internalized stereotypes. In other words, the pressure to not conform to a known negative stereotype about the group with which one identifies can result in compromised performance on a said task.

Steele and Aronson first examined stereotype threat among African Americans. One negative stereotype toward African Americans is low intelligence; when intelligence is defined as fixed, it creates a belief that innate or biological limitations may be to blame for poor performance. Unfortunately, these stereotypes have been applied wrongly to explain the achievement gap between African Americans and Caucasians on standardized test scores. Steele and Aronson's 1995 study created a scenario characterized by stereotype threat, where this stereotype was made salient by telling the treatment group that the test they were taking measured intelligence. The control group was told that the test was a measure to study problem solving. When stereotype threat was absent, the scores of the African American students only differed to the degree that would be expected on the basis of their prior Scholastic Aptitude Test (SAT) scores. When stereotype threat was present, the African American students performed worse than the Caucasian students. The difference was beyond what prior SAT scores would predict for individual differences in skill level. Stereotype threat was shown to be a condition where negative stereotypes about a group identity are evoked and individuals are in a situation where they could conform to that stereotype. In the previous

example, the suggestion that the test was a measure of intelligence invoked the stereotype that African Americans have lower intelligence for the African American students and under the pressure of the possibility of confirming this stereotype, they actually performed worse than would have been expected. The stereotyped group does not have to believe the stereotype for this effect to materialize.

## Generality

Stereotype threat can be generalized to populations where stereotypes are present. Numerous studies have confirmed the presence of stereotype threat among diverse racial groups, ethnicities, genders, socioeconomic statuses, and age groups. In an article published in 1999, Aronson, Michael Lustina, Catherine Good, and Kelli Keough demonstrated that stereotype threat can be present in groups that do not have a history of stigmatization or internalized feelings of inferiority. Their study found that White males performed worse on a math test than their control group counterparts when it was suggested that Asians are better at math. It seems reasonable that all groups have a negative stereotype that can be made salient in circumstances where there is pressure to perform.

Much of the research focuses on test performance; however, there have been studies confirming that stereotype threat could be induced in other domains as well. For example, a 2005 study done by Paul Davies, Steven Spencer, and Steele confirmed that exposure to gender stereotypes about leadership affected female participants' interest in taking on a leadership role. Women who had been exposed to the negative stereotypes about women's abilities in leadership were less interested in assuming a position of leadership on the task.

## Consequences

Consequences of stereotype threat are numerous. It can create a setting where a socially constructed concept can interfere with the measurement of constructs such as intelligence. Currently, high-stakes testing is used as a gatekeeper to many educational opportunities. Stereotype threat may have a role in lower test scores, which in turn may function to keep people from gaining access to opportunities. Although the concept of stereotype threat has been studied most in the area of academic achievement and the achievement gap, stereotype threat may evidence in other



contexts such as work performance. Second, this concept demonstrates how powerful stereotypes are and what the impact of internalized negative stereotypes is. Stereotype threat may create a scenario where there is now a vicious cycle. For example, a person knows of a stereotype for his or her group and, feeling pressured to not conform to a negative expectation for this reference group, the person's performance on a given task suffers: The person may be denied entrance to the school of his or her choice, or the person may miss other opportunities like jobs or community leadership roles. This denied opportunity can contribute to social inequities, including the achievement and wage gaps. In essence, this concept is critical to understanding the complex effects of stereotyping on performance. There are also effects on self-esteem and confidence for those who perform under their expectations. Many people may not be aware of stereotype threat and may begin to believe that their lower performance was a result of personal characteristics.

### Mediators

Aronson and Steele published a chapter in 2005 that explored potential mediators of stereotype threat on test performance. Anxiety has been found to be a mediator as negative stereotypes are posited to create more anxiety. The knowledge of a negative stereotype can produce anxiety, which can hinder performance. Stereotype threat can be enacted most powerfully by individuals who care strongly about doing well in a particular domain. Stereotype threat poses a particular jeopardy because it seems to be present even in situations where the student is actually motivated and interested. For example, a female student who wants to attend the best university to study math can do poorly on the math section of an entrance exam because of stereotype threat (i.e., the negative expectation that is operative is that women are not adept at math).

Individuals who have a strong identification with their group are more likely to be aware of the stereotypes about their group. Thus, research has found that people who are the most identified with their group are more affected by stereotype threat. For example, a Latino/a who is highly identified with his or her ethnic group is affected more by stereotype threat than a Latino/a student who does not identify highly with the group. However, that same student may identify highly with being lesbian or female, and therefore

stereotype threat may be more salient for the stereotypes about lesbians or females.

In the context of competition among reference groups, stereotype threat can be induced in individuals who believe they are good at the particular exercise. For example, Steele and Aronson showed that stereotype threat can be evoked for White males if they are being compared to a group, such as Asian Americans, who are stereotyped to excel at math. See Aronson and Steele (2005) for a comprehensive review of some of the research results that led to these conclusions.

### Relevance to Cross-Cultural Counseling

The phenomenon of stereotype threat is relevant to cross-cultural and multicultural counseling in several ways. First counselors need to be aware of the stereotype threat and how it works, as they may evoke stereotype threat through subtle words and/or behaviors when administering tests or during the actual process of counseling. Also, counselors may be in a position to educate those that they come in contact with about the phenomenon so that steps can be taken to reduce the likelihood of stereotype threat occurring.

*Jennifer L. Lemkuil*

**See also** Academic Achievement (v2); Academic Achievement, Nature and Use of (v4); Achievement, Aptitude, and Ability Tests (v4); Achievement Gap (v3); Bias (v3); Cross-Cultural Training (v3); Discrimination (v3); Ethnic Identity (v3); Intelligence Tests (v3); Multicultural Counseling Competence (v3); Racial Identity (v3); Stereotype (v3)

### Further Readings

- Aronson, J., Lustina, M. J., Good, C., Keough, K., Steele, C., & Brown, J. (1999). When White men can't do math: Necessary and sufficient factors in stereotype threat. *Journal of Experimental Social Psychology*, 33, 39–46.
- Aronson, J., & Steele, C. M. (2005). Stereotypes and the fragility of academic competence, motivation, and self-concept. In A. J. Elliot & C. S. Dweck (Eds.), *Handbook of competence and motivation* (pp. 436–456). New York: Guilford Press.
- Davies, P. G., Spencer, S. J., & Steele, C. M. (2005). Clearing the air: Identity safety moderates the effects of stereotype threat on women's leadership aspirations. *Journal of Personality and Social Psychology*, 88(2), 276–287.



- Martens, A., Johns, M., Greenberg, J., & Schimel, J. (2006). Combating stereotype threat: The effect of self-affirmation on women's intellectual performance. *Journal of Experimental Social Psychology*, 42, 236–243.
- Steele, C. M., & Aronson, J. (1995). Stereotype threat and the intellectual test performance of African Americans. *Journal of Personality and Social Psychology*, 69(5), 797–811.
- Steele, C. M., & Aronson, J. (1998). Stereotype threat and the test performance of academically successful African Americans. In C. Jencks & M. Phillips (Eds.), *The Black-White test score gap* (pp. 401–427). Washington, DC: Brookings Institution.

---

## SUE, DERALD WING (1942– ): CONTRIBUTIONS TO MULTICULTURAL PSYCHOLOGY AND COUNSELING

---

Derald Wing Sue is a pioneer and leader of multicultural psychology, counseling, and therapy. He is professor of psychology and education at Teachers College, Columbia University, and contributes extensively to the field through his teaching, publications, research, consultation, and organizational work.

Sue graduated with a Bachelor of Science degree in psychology from Oregon State University in 1965 and received his Ph.D. in counseling psychology from the University of Oregon in 1969. He was formerly professor at California State University East Bay (then California State University Hayward) and at Alliant International University (then California School for Professional Psychology).

Sue's extensive body of work has been pivotal in transforming psychology to be inclusive of cultural considerations in multiple domains, including theory, research, education, training, and practice. Sue has been honored numerous times for his contributions and work on multiculturalism and cultural diversity, and he has received awards from many organizations, including the American Psychological Association, the Association for Multicultural Counseling and Development, the Asian American Psychological Association, the Society for the Psychological Study of Ethnic Minority Issues, the American Counseling Association, and the American Academy of Counseling Psychology. In addition, Sue is a Fellow of the American Psychological Society, the American

Association of Applied and Preventive Psychology, and the American Psychological Association (Divisions 1, 17, and 45), as well as a member of the American Counseling Association.

### Research and Teaching

Sue's research and writings on multicultural issues in psychology have led and challenged the field of psychology to examine and critique the Eurocentric basis and assumptions of its fundamental theories, concepts, frameworks, and practices. Before the early 1970s, cultural variables were generally ignored in the field of psychology, and there was scarce research on Asian American psychology. During this time, Sue was a pioneer in the study of Asian American mental health when he collaborated with other researchers to study different aspects of Asian American psychology.

Sue's research efforts span his earliest work in Asian American psychology, to his contributions to multicultural competencies and multicultural theory, and, most recently, his research on racial microaggressions (i.e., the brief and everyday exchanges that send denigrating messages to people of color because of their racial minority status). Sue argues that racial microaggressions sap the spiritual and psychological energies of people of color and create disparities in education, health care, and employment.

Sue also has been a trailblazer in the arena of multicultural counseling teaching and training. As a young professor in the early 1970s, he developed multicultural counseling courses and infused multicultural content into other counseling courses. These courses were initially met with heavy opposition at multiple levels but have now become standard requirements in graduate clinical and counseling psychology training programs.

Sue's teaching contributions are not limited to academia, as he has provided cultural diversity training and consulted for many organizations, from Fortune 500 companies to nonprofit mental health agencies all over the world. Most notably, Sue served as a consultant and invited panelist on President Clinton's Race Advisory Board on the National Dialogue on Race in 1997, in which he called for individual, institutional, and societal efforts to confront and address racism, injustice, and discrimination. Sue also participated in a congressional briefing on the psychology of racism in 1995.



## Writing and Publications

In 1981, Sue wrote and published the seminal textbook, *Counseling the Culturally Diverse*; his brother David Sue joined him as coauthor of subsequent editions. Initially criticized for its sociopolitical content, the book has become a classic in the field and is the textbook of choice for almost 50% of graduate counseling psychology programs. Now in its fifth edition, the book also has the distinction of being one of the most frequently cited references in multicultural counseling and therapy. Sue also has authored and coauthored many articles and books that have been the impetus for the field of psychology to adopt the multicultural competencies as guidelines. These books include *A Theory of Multicultural Counseling and Therapy* (cowritten with Allen Ivey and Paul Pedersen in 1996) and *Multicultural Counseling Competencies: Individual, Professional and Organizational Development* (coauthored with members of the Division 17 and Division 45 multicultural committees in 1998). Sue's 2003 book *Overcoming Our Racism: The Journey to Liberation*—a trenchant and hard-hitting call to Whites to acknowledge and take responsibility for their racism—was the direct result of his testimony before President Clinton's Race Advisory Board.

Sue also has written 13 textbooks on personality theory, introductory psychology, racism, and abnormal behavior. These textbooks are distinctive in presenting the subject of psychology through a multicultural framework. Most notably, Sue has challenged prevailing notions of universals of mental health, instead advocating for an understanding of cultural variables in the conceptualization, assessment, and treatment of mental illness. His work also has been featured in other media formats; for example, he has produced several videotapes on racism and psychology, including *The Psychology of Racism: Where Have We Gone Wrong?*; *What Does It Mean to Be White?*; *The Invisible Whiteness of Being*; and *Overcoming Our Racism: What Can I Do?*

## Contributions to Professional Organizations

Sue has played an active role in the leadership of many professional organizations, including serving as president for the Society for the Psychological Study of Ethnic Minority Issues (Division 45) from 1998 to 1999 and the Society of Counseling Psychology (Division 17) of the American Psychological

Association) from 2003 to 2004. With his brother Stanley Sue, Sue cofounded and became the first president of the Asian American Psychological Association (AAPA) in 1972. AAPA's mission was to promote the study of Asian American mental health and culturally appropriate interventions and to support the training and education of Asian American mental health professionals. Since its inception in 1972, AAPA has grown into a sizeable organization with more than 400 members.

In the 1980s and 1990s, Sue chaired two committees working to develop multicultural competencies for the counseling field. The work of these two committees was published in 1982 and 1998, and the competencies generated by these committees formed the foundation for the adoption of multicultural guidelines by the American Psychological Association in 2002. The concept of multicultural counseling competencies has been profoundly influential in shaping the training, education, and accreditation of counselors, therapists, and psychologists. As a result of these competencies, graduate psychology training programs have been revamped to include multicultural counseling courses in their curricula and to infuse cultural considerations into existing coursework.

In addition to his leadership contributions to various professional organizations, Sue also has held numerous editorial posts, including serving as the first Asian and non-White editor of the *Personnel and Guidance Journal* (now the *Journal of Counseling & Development*). As the editor for the *Personnel and Guidance Journal*, he was innovative in his efforts to include articles that were culturally inclusive, systemically oriented, and prevention focused. These unprecedented efforts were met with tremendous support from some groups and deep resistance from others.

Sue also played a key role in the collaborative effort to organize the National Multicultural Summit in 1999, a conference focused on issues of multiculturalism and diversity. The creation of the summit was one of Sue's presidential initiatives when he was elected president of the Society for the Psychological Study of Ethnic Minority Issues (i.e., Division 45 of the American Psychological Association) in 1998. This was a historic moment in the history of psychology because Sue was one of four people of color that year elected to leadership positions within the American Psychological Association. (Sue was elected as president of Division 45, Rosie P. Bingham was elected president of Division 17, Melba J. T. Vasquez



was elected president of Division 35, and Richard Suinn was elected president of the American Psychological Association.) Sue, Bingham, Vasquez, and Suinn acted on the momentum of this historic occasion by deciding to create a national multicultural summit as a celebration of their combined presidencies. Now a biennial event, the National Multicultural Summit has been attended by as many as 1,000 participants and is an important venue for the discussion and dissemination of multicultural research.

Anne Chan

**See also** Asian American Psychological Association (v3); Asian Americans (v3); Cross-Cultural Psychology (v3); Cross-Cultural Training (v3); Culture (v3); Multicultural Counseling Competence (v3); Multiculturalism (v3); Racial Microaggressions (v3); Society for the Psychological Study of Ethnic Minority Issues (v3); Sue, Derald Wing (v1); Sue, Stanley (v3)

### Further Readings

- Sue, D. W. (1998). A personal look at psychology in my life. In L. T. Hoshmand (Ed.), *Knowledge, creativity, and moral vision* (pp. 106–125). Thousand Oaks, CA: Sage.
- Sue, D. W. (2005). The continuing journey to multicultural competence. In R. K. Conyne & F. Bemak (Eds.), *Journeys to professional excellence: Lessons from leading counselor educators and practitioners* (pp. 73–84). Alexandria, VA: American Counseling Association.
- Sue, D. W., Arredondo, P., & McDavis, R. J. (1992). Multicultural counseling competencies and standards: A call to the profession. *Journal of Multicultural Counseling and Development*, 20, 64–88.
- Sue, D. W., Carter, R. T., Casas, J. M., Fouad, N. A., Ivey, A. E., Jensen, M., et al. (1998). *Multicultural counseling competencies: Individual, professional and organizational development*. Thousand Oaks, CA: Sage.
- Sue, D. W., Ivey, A. E., & Pedersen, P. B. (1996). *A theory of multicultural counseling and therapy*. Pacific Grove, CA: Brooks/Cole.
- Sue, D. W., & Sue, D. (2008). *Counseling the culturally diverse: Theory and practice* (5th ed.). Hoboken, NJ: Wiley.

the third son of Chinese immigrant parents. He received his Bachelor of Science degree from the University of Oregon in 1966 and his doctoral degree in clinical psychology from the University of California, Los Angeles (UCLA) in 1971. He completed his dissertation research on cognitive dissonance under Bertram Raven's guidance but soon turned his scholarly attention to mental health issues facing ethnic minorities.

Sue was an assistant professor and associate professor of psychology at the University of Washington between 1971 and 1981, professor of psychology at UCLA between 1981 and 1996, and since 1996 has been professor of psychology and Asian American Studies at the University of California, Davis. In addition to his faculty appointments in psychology, Sue has served as associate dean of the graduate division at UCLA and as the director of the Asian American Studies Program at University of California, Davis. Sue's influence on Asian American psychology and ethnic minority psychology spans a wide range with respect to scholarship, service, and public policy.

### Scholarship

Sue has made significant theoretical and empirical contributions in the areas of ethnicity and mental health, cultural competency, and effective delivery of mental health services. His first major contribution was to document treatment disparities in mental health services for ethnic minorities. In his early collaboration with Herman McKinney in the 1970s, Sue analyzed the utilization patterns of nearly 14,000 clients seen in 17 community mental health agencies serving King County in the state of Washington. They found that ethnic minority clients tended to drop out from treatment at a higher rate and to have fewer average number of sessions than White clients. Based on this research, as well as on the consensus of other Asian American mental health providers, Sue made several policy recommendations to improve services for ethnic minorities, such as training therapists to be more knowledgeable about cultural bases of mental health, to recruit and hire more ethnic minority psychologists, to develop ethnic-specific mental health service centers, and to create new therapies and services that better meet the needs of ethnic minorities. These recommendations became fundamental building blocks for increasing cultural competence in mental health service delivery.

Sue's groundbreaking studies, which suggested that inadequate services were being provided to ethnic

---

## SUE, STANLEY (1944– )

---

Stanley Sue is a pioneering scholar in the field of Asian American psychology and ethnic minority psychology. He was born in 1944 in Portland, Oregon, as



minorities, were initially challenged by the Washington State Department of Social and Health Services and Sue was asked to testify before the Washington State Senate subcommittee on mental health. After his successful defense of the scientific basis for the findings, many of Sue's policy recommendations were implemented in many areas of the country. In fact, Sue directed the training for the National Asian American Psychology Training Center in San Francisco in 1980, which was established specifically to train service providers in culturally competent practice with Asian Americans.

The early work documenting treatment disparities led Sue to pursue research on culturally competent services. In a 1987 paper, Sue and Nolan Zane proposed a theoretical model for treatment outcome based on various forms of match between therapists and clients. Sue and Zane contended that ethnic match between therapists and clients is important because ethnically matched therapists tend to have higher ascribed credibility with clients, but other factors (e.g., therapist–client match on problem conceptualization and goals, therapist behavior during the first session) contribute to achieved credibility that lead to better retention in treatment and more positive outcomes. In his 1998 paper, Sue articulated his hypotheses about three essential ingredients of cultural competency. In this paper, he argued that although *culture-specific knowledge* (e.g., making direct eye contact with an elder person would be considered disrespectful in a Chinese culture) was a necessary component, a culturally competent clinician must also demonstrate *scientific mindedness* (i.e., to treat such cultural-specific knowledge as a hypothesis rather than as a given in a particular client) and practice *dynamic sizing* (i.e., to know when to apply or not apply a particular culture-specific knowledge to assess and treat a particular client).

Finally, Sue has played a critical role in fostering cutting-edge research in Asian American psychology. He directed the National Research Center on Asian American Mental Health, a research center funded by the National Institute of Mental Health, between 1988 and 2001. Sue and his collaborators at the research center produced some of the major empirical work in Asian American mental health. For example, Sue was critically involved in the first large-scale psychiatric epidemiological study of Asian Americans in the United States, which was headed by David Takeuchi

and conducted out of the National Research Center on Asian American Mental Health in Los Angeles. This study documented population estimates for the prevalence of major mental disorders among Chinese Americans.

## Service and Advocacy

As a pioneer in the field of Asian American psychology, Sue was instrumental in creating a professional organization to provide scholarly network and public advocacy for the needs of this population. Together with his psychologist brother Derald Wing Sue and other Asian American mental health professionals in the San Francisco Bay Area, Sue founded the Asian American Psychological Association (AAPA) in 1972. In the formative years of the AAPA, Sue and other leaders sought to advocate nationally on behalf of Asian American mental health issues through the American Psychological Association (APA) boards and standing committees that were sympathetic to concerns of Asian Americans and ethnic minorities. Sue and other AAPA leaders also formed coalitions with the leading ethnic minority psychologists of the time to push the APA to move toward more diversification and inclusion.

With encouragement from Patrick Okura, the then executive assistant to the director of the National Institute of Mental Health (NIMH), Sue wrote a conference grant proposal to the NIMH to convene a national conference on the training of mental health service providers to serve Asian American communities. After 2 years of planning, the National Asian American Psychology Training Conference was held in Long Beach, California, in the summer of 1976. This historic conference was critical to the grassroots movement for Asian American psychology in gaining the momentum toward visibility and influence.

Sue's research on mental health of ethnic minorities has impacted public policy on a national scale as well. Sue has served as a task panel member for the President Carter Commission on Mental Health in 1978, planning board member for the Surgeon General's Report on Mental Health in 1999, participant in the White House Conference on Mental Health in 1999, and science editor of *Mental Health: Culture, Race, and Ethnicity* in 2001—a supplement volume to the 1999 Surgeon General's Report on Mental Health.



In recognition of his work and achievements, Sue has won numerous awards and recognitions in all areas of his work. Of note, he has received three major awards from the APA, making him one of a handful of psychologists to be awarded multiple times by the organization. Among the many prestigious awards he has garnered are the APA Distinguished Contributions to Psychology in the Public Interest Award in 1986; the APA Distinguished Contributions to Research in Public Policy, the Distinguished Contributions to Research in Ethnic Minority Psychology from the Society for the Psychological Study of Ethnic Minority Issues (APA Division 45), and the Distinguished Contribution Award from the AAPA in 1990; the Janet E. Helms Award for Mentoring and Scholarship in Psychology from Teachers College, Columbia University, in 1993; the Distinguished Contributions to the Psychological Study of Diversity from the American Association of Applied and Preventive Psychology in 1995; the Dalmas A. Taylor Award for Pioneering Leadership, Scholarship, and Aggressive Advocacy for Ethnic Minorities at the National Multicultural Summit and Conference in 1999; the APA Distinguished Contributions to Applied Research and the Society of Clinical Psychology's (APA Division 12) Stanley Sue Award—which was established to recognize a psychologist who has made distinguished contributions to the understanding of human diversity—both in 2003; the Distinguished Research Contributions to Ethnic Minorities from Section IV of the Society of Clinical Psychology (APA Division 12);

and the Davis Prize for Teaching and Scholarship from the University of California, Davis, in 2005.

*Sumie Okazaki*

**See also** Asian American Psychological Association (v3); Asian Americans (v3); Cross-Cultural Psychology (v3); Cross-Cultural Training (v3); Cultural Values (v3); Culture (v3); Multicultural Counseling Competence (v3); Multiculturalism (v3); Sue, Derald Wing (v1)

### Further Readings

- Sue, S. (1998). In search of cultural competence in psychotherapy and counseling. *American Psychologist*, 53, 440–448.
- Sue, S., & McKinney, H. (1975). Asian-Americans in the community mental health care system. *American Journal of Orthopsychiatry*, 45, 111–118.
- Sue, S., & Zane, N. (1987). The role of culture and cultural techniques in psychotherapy: A critique and reformulation. *American Psychologist*, 42, 37–45.
- Takeuchi, D. T., Chung, R. C., Lin, K. M., Shen, H., Kurasaki, K., Chun, C., et al. (1998). Lifetime and twelve-month prevalence rates of major depressive episodes and dysthymia among Chinese Americans in Los Angeles. *American Journal of Psychiatry*, 155, 1407–1414.
- U.S. Surgeon General. (2001). *Mental health: Culture, race, and ethnicity. A supplement to Mental health: A report of the Surgeon General*. Rockville, MD: U.S. Department of Health and Human Services.









---

## THIRD WORLD

---

Many authors concur that the *third world* is a term used to describe countries and nations who are poor, in political crisis, contending with pollution, and in debt. Berger believes these differences between developed and underdeveloped nations have also been described as a North–South conflict wherein the developed nations are the North and the underdeveloped are the South. It is assumed that the third world represents a stable set of countries, nations, and territories, but the geographic boundaries between first, second, and third world countries is vague. The *third world*, as a term, has also been used in political movements. Blauner suggests that during the anti–Vietnam War and civil rights movements, a number of organizations used *Third World* to identify themselves as liberation oriented, anticapitalist, and anticolonialist or postimperialist. Because there are many uses and connotations for the term *Third World*, this chapter attempts to clarify the origin of the term and identify how psychologists may better understand its function among individuals.

### Origination of the Third World

In 1952, Alfred Sauvy, a French sociologist and demographer, coined the term *Third World*. Originally, the term was *tiers monde*, and was used to describe the “third estate” of commoners who aspired to be similar to the first estate, or society’s wealthy and elite. Hobsbawm posits that the notion of a third estate was later used to describe nations that did not belong to either the capitalist and postcolonial nations representing the first

world or the socialist and communist nations comprising the second world. More specifically, Sachs shows that the first world represented countries that were either already industrialized as of 1945 or newly industrialized. These countries are generally described as capitalist or proto-capitalist. For instance, the representatives of the G8 (United States, England, Germany, Italy, France, Russia, Japan, and Canada) are considered the first world. The second world are either current or former communist and socialist countries and are characterized by state ownership of production, central planning, one-party rule, and economic connections with other second world countries.

In 1955, the Bandung Conference in Indonesia created the Non-Aligned Movement. During this conference, the term *Third World* became widely accepted to describe the members of the Non-Aligned Movement. The participants in the conference represented nations who considered themselves non-aligned with either the first or second world. These countries opposed colonialism and neocolonialism and were often newly emancipated from colonial powers. Representatives from countries such as China, India, Vietnam, Egypt, and Ghana agreed that they would develop economically through partnerships with each other, would nurture their own industries and infrastructure, protect and subsidize their businesses, refuse aid from foreign multinationals and countries, and limit international trade.

Although the original intent of these non-aligned countries was to become independent from first and second world hegemony, this vision of autonomy quickly evaporated. First, starting around the 1940s, global decreases in mortality rates due to such things



as the use of DDT and pharmaceutical advances contributed to a population explosion in some countries. Historically, in some countries, high fertility rates were countered by high mortality rates; but as mortality rates decreased, birth rates did not decrease. Additionally, Hobsbawm shows that the population increases were often not matched with economic development in some third world countries.

Second, Sachs argues that by isolating themselves to global developments in technology, industry, and trade, some third world countries were unable to sustain themselves economically. To help their economies, some countries turned to assistance from the first and second world nations. As third world countries became less aligned and committed to each other, they became more reliant on political and economic assistance from first and second world nations. Consequently, third world countries became politically polarized and economically dependent. Chomsky shows that first and second world nations used third world countries as political proxies and sometimes increased political instability to meet political, economic, and military goals. A coup d'état, for instance, came to symbolize political instability in many third world countries, and Latin American governments were often derogatorily referred to as "Banana Republics." Additionally, many third world countries started to borrow monies, thereby increasing their foreign debt. Consequently, foreign debt came to be the single largest economic problem for many third world countries.

Third world development was often treated differently from European or Japanese postwar development. Rather than provide grants, as the Marshall Plan did for post-World War II Europe, many third world nations were given loans. The United States learned that European debt after World War I created a financial crisis that contributed to the Great Depression and indirectly to the rise of fascism and eventually World War II. But this lesson was not applied to the economic situation in many third world countries. Instead, loans were given to some third world governments that were corrupt and/or inept, and these countries incurred debts that were impossibly high and could never be repaid. For many countries, the only solutions are debt relief or forgiveness, combined with better free-trade agreements.

### The Third World and Mental Health

For psychologists and other mental health care providers, the *Third World* is often used to describe

conditions and settings of abject poverty or other settings of extreme deprivation. The term may be used to connote, even within the United States, situations of severe poverty, poor health conditions, and economic inequality. The term has moved away from describing nation-states, as originally coined. In current use, it communicates about people and situations with dire need and intervention by mental health care providers.

For mental health care providers, multiculturalists, and those interested in social justice, the Third World represents countries and those individuals who have experienced extreme deprivation. Along with economic inequalities, many of these individuals may have experienced poor treatments by these governments, such as jailing, torture, and other traumas. Comas-Diaz and Padilla believe that individuals from many Third World countries may have comorbid posttraumatic stress related to their experiences in their country of origin. Because many of these individuals are immigrants from other countries, mental health care providers need to be aware of the aggregate affects of migration, trauma, and poverty on the migrant or refugee. When working with these communities and individuals, acculturative stress related to the lack of psychological and economic resources may be especially acute. Along with being attuned to adjustment disorders, mental health care providers need to be conscious of other possible sequelae of migration from the Third World such as depression, anxiety, and posttraumatic stress.

William Ming Liu

*See also* Career Counseling, Immigrants (v4); Classism (v3); Colonialism (v3); Cross-Cultural Psychology (v3); Immigrants (v3); Multicultural Counseling Competence (v3); Multiculturalism (v3); Poverty (v3); Refugees (v3); Social Class (v4)

### Further Readings

- Berger, M. T. (2004). After the third world? History, destiny and the fate of third worldism. *Third World Quarterly*, 25(1), 9–39.
- Blauner, R. (1987). Colonized and immigrant minorities. In R. Takaki (Ed.), *From different shores: Perspectives on race and ethnicity in America* (pp. 149–160). New York: Oxford University Press.
- Chomsky, N. (1991). *Deterring democracy*. New York: Hill & Wang.
- Colburn, F. D. (2006, Spring). Good-bye to the "third world." *Dissent*, 38–41.



- Comas-Diaz, L., & Padilla, A. (1990). Countertransference in working with victims of political repression. *American Journal of Orthopsychiatry*, 60, 125–134.
- Dornbusch, R., & Fischer, S. (1986). Third world debt. *Science*, 234, 836–841.
- Hobsbawm, E. (1994). *The age of extremes: A history of the world, 1914–1991*. New York: Pantheon.
- Irogbe, K. (2005). Globalization and the development of underdevelopment of the third world. *Journal of Third World Studies*, 22(1), 41–68.
- Randall, V. (2004). Using and abusing the concept of the third world: Geopolitics and the comparative political study of development and underdevelopment. *Third World Quarterly*, 25(1), 41–53.
- Sachs, J. D. (2005). *The end of poverty: Economic possibilities for our time*. New York: Penguin.
- Wiarda, H. J. (1990). The politics of third world debt. *Political Science and Politics*, 23, 411–418.

---

## TOKENISM

---

Tokenism involves the symbolic involvement of a person in an organization due only to a specified or salient characteristic (e.g., gender, race/ethnicity, disability, age). It refers to a policy or practice of limited inclusion of members of a minority, underrepresented, or disadvantaged group. The presence of people placed in the role of token often leads to a misleading outward appearance of inclusive practices. The term *token* is derived from the Old English word *taken*, which means “to show.” Thus tokenism exists because inclusion of the person or group is required or expected, not because of inherent value.

Psychological research suggests that tokenism may occur when members of the underrepresented group comprise less than 15% of the total environmental organizational context they are a part of. Furthermore, when there is only a single representative of a given group in an organizational environment, he or she is considered to have what is termed *solo status*.

Historically psychological research has focused on the experiences of (White) women as they tried to achieve full participation in the workplace. However, in recent years racial and ethnic minorities, people with disabilities, gay men, lesbians, and the elderly have been increasingly the focus of research regarding the effects of tokenism in the workplace. Tokenism, or the role of one as a token, does not necessarily

indicate mistreatment or injustice. However, as a result of unfair and inequitable practices, tokenism is associated with several negative outcomes.

## Consequences

Tokenism has both individual and organizational impacts. On the individual level a person in the role of a token may feel dehumanized, stereotyped, marginalized, and depersonalized. Quality of life, mental and physical health, and potential for success in the organization may be compromised. For example, this person may begin to question his or her qualifications or abilities, and negative outcomes may result, such as pressure to conform, feelings of isolation, lowered morale, or depression. A person in the role of a token may experience a “glass ceiling” in the organization; that is, his or her success or ability to advance is limited by unseen forces because they are symbolic rather than full participants in the organization.

Token status is more likely to have negative consequences for members of groups that are lower in status or are more culturally stigmatized. Research has indicated that people who feel like tokens may experience challenges as underrepresented members of their specific social context. Three of these challenges are visibility, role encapsulation, and contrast. Visibility entails the perception that others pay a disproportionate amount of attention to people who feel like tokens and are hypervigilant concerning their actions and behaviors. Consequently, those who are in the position of token may feel they are constantly being examined or evaluated. Persons who feel like tokens in an organization may feel intensely self-conscious about how they react to their environment because of the expected and/or internalized pressure to represent their entire minority group.

Role encapsulation entails the group dynamic where a person is forced to play a role based on stereotypes of their group. For example, a racial/ethnic minority psychology faculty member may be expected to only teach classes related to multiculturalism, regardless of their area of expertise. Token status may produce negative consequences for members of traditionally underrepresented and stigmatized groups by increasing feelings of distinctiveness based on group membership, which can increase the salience of negative stereotypes or stereotypical expectancies.

The third challenge, contrast, emphasizes the majority group’s established differences between



themselves and the people who are tokens that lead to unclear and inauthentic boundaries among the groups. These boundaries, although aimed to protect the majority group members, end up causing the identified tokens in the groups to isolate themselves as a means of protection from mistreatment or expectations of mistreatment by majority members (e.g., being perceived as intelligent when other group members are perceived as uneducated).

For the organization, tokenism may negatively impact morale, lead to high rates of turnover of people from underrepresented groups, and, most pointedly, tokenism eventually may deprive the organization of the full contribution (i.e., diversity) that the individuals in the role of token might have made to the organization. Thus tokenism itself is limiting and can potentially inhibit an organization from developing and competing in a diverse and global marketplace. Of course it should be noted that practices such as tokenism are intended to prevent change from occurring and to preserve the status quo.

### Implications for Psychologists

Psychologists are specifically directed toward knowledge of tokenism to facilitate multicultural organizational development in the 2002 American Psychological Association *Guidelines on Multicultural Education, Training, Research and Organizational Change for Psychologists*. Psychologists have an ethical imperative to combat tokenism on the individual and organizational level. On the individual level psychologists can help empower clients who feel like tokens in their environments by helping the client adopt a systemic perspective on tokenism. A full range of options (leaving the organization, attempting to change the organization, adapting to the organization) can be explored. Special care should be taken so as not blame clients for their feelings (in essence, blaming the victim).

On the organization level, psychologists can serve in the role of change agents, consultants, and/or advocates. With knowledge of multicultural organizational development, psychologists can aid organizations in making substantive change. First, the psychologist can help motivate the organization to desire change based on both the benefits of change and a comprehensive evaluation of current and past discriminatory practices. Psychologists can help organizations recognize that a single individual should not be expected to represent an entire population group. Because of the increasing diversity in the population and culturally

diverse backgrounds represented in today's workforce, organizational culture may need to change to become inclusive at all levels and to be competitive in a diverse marketplace.

The development of innovative strategies that would incorporate the ideas and beliefs of all members of the group will help to ensure equality and a more inclusive environment for all involved. Although the identified tokens may overcome these negative experiences and the stereotypical beliefs of majority group members, the process can be slow.

The organization can reduce tokenism by avoiding assumptions (stereotypes) associated with the minority group. Combating stereotypes may include implementing advocacy and outreach education into institutional practices. Additionally, working to reduce the difficulties associated with token or solo status requires there be a diverse representation in the power structure of any group. Also, organizations can ensure that underrepresented groups are represented beyond a demographic or symbolic level. Beyond the issues of representation, true organizational change includes the issue of equity in outcomes (salaries, promotions, leadership opportunities).

*Edward A. Delgado-Romero  
and Eliza M. Wells*

**See also** Affirmative Action (v3); Change Agent (v3); Discrimination (v3); Diversity (v3); Diversity Issues in Career Development (v4); Ethnicity (v3); Multicultural Counseling Competence (v3); Organizational Diversity (v3); Prejudice (v3); Race (v3); Stereotype (v3)

### Further Readings

- Niemann, Y. F. (1999). The making of a token: A case study of stereotype threat and racism in academia. *Frontiers: A Journal of Women Studies*, 20, 111–135.
- Niemann, Y. F. (2003). The psychology of tokenism: Psychosocial realities of faculty of color. *Handbook of racial and ethnic minority psychology* (pp. 100–118). Thousand Oaks, CA: Sage.

---

## TRANSLATION METHODS

---

The language barrier is one of the biggest obstacles to effective cross-cultural research, testing, and counseling. Translation methods are specialized procedures



designed to make possible the communication between people who speak or read different languages. Four translation methods have been identified. The first two are oral methods: (1) simultaneous oral translation, also known as interpretation, and (2) language switching. The other two are written methods: (3) written translation, and (4) back translation. These methods are implemented in three main contexts in the field of counseling. First, translation methods are utilized to communicate with clients in the context of a clinical counseling relationship. To communicate verbally with non-English-speaking clients during intakes, assessment interviews, and early interventions, the most efficient method is the use of trained interpreters who use a simultaneous translation method also known as interpretation. For treatments, a common method utilized in an ongoing clinical situation is the oral translation method known as language switching. Second, translation methods are utilized to turn research and testing material originally conceived in one language into another language. The most researched translation method for research and testing is the method known as back translation. Third, translation methods are utilized in counseling agencies and other institutions to translate written materials from one language into another. The consensus is that institutional forms, such as informed consent, HIPAA (Health Insurance Portability and Accountability Act), and other written materials, need to be translated by a professional translator.

## Historical Background

Translation methods grew out of the intercultural and cross-cultural communication needs that expanded toward the second half of the 20th century in the United States. The services of professional translators and interpreters became common in a variety of settings, including business, industry, health care, law, and education. In the clinical counseling field, translation and interpreting was incorporated as immigration from Asia, Latin America, and Eastern European countries increased the number of clients requesting help at counseling agencies. Increases in demand for non-English-speaking counseling in the United States, coupled with a shortage of non-English-speaking counselors, have forced organizations to become responsible for offering interpreters and translators as part of their intake, assessment interviewing, and short-term intervention services. The high expense of hiring professional interpreters has led to the need to incorporate the utilization of paraprofessional foreign language interpreters. The

increased need of translators continues to pose challenges. Few counseling organizations hire certified interpreters, and many erroneously utilize the services of bilingual staff not trained in translation methods or mental health, or the relatives of the clients requesting services. The American Counseling Association's ethical guidelines of 2005 include the new recommendation of providing interpreters or translators for non-English-speaking clients.

The initial attention paid to the role of language and translation in long-term clinical counseling comes from the psychodynamic tradition. In the 1970s, authors argued that accessing certain material is more difficult for people who have had an early encoding in a different language and that bilingual clients have different experiences of self according to which language they use. Recent contributions to the psychodynamic literature posit that bilinguals may have two different language codes and that each language system may be related to different experiences of the self. Treatment proposals include analyzing the dual experience of language by utilizing a translation method called language switching.

The method of back translation used in research and testing has its origins in the fields of health and nursing, which, in turn, influenced the field of psychiatry. Most assessment and research instruments were developed originally in English. Researchers and practitioners in other parts of the world who wish to use certain instruments use the back translation method. In 1990, the National Institutes of Health in the United States enacted a policy requiring the inclusion of minorities in study populations, which prompted translation of research instruments. Though there continue to be challenges in the attempts to standardize back translation principles for tests, questionnaires, and assessment instruments, translation of instruments from one language to another for cross-cultural use has become a widespread activity.

## Interpretation

Bilingual capabilities are not sufficient for providing interpreting services. The ability to speak a second language is sometimes confused with the ability to interpret. However, when language match cannot be ensured, the services of an interpreter are required. Simultaneous translation, also known as interpretation, is a professional activity. In the counseling field, both professional and paraprofessional interpreters are used in a variety of clinical situations, including psychiatric,



substance abuse, forensic, and other assessments and in short-term interventions. According to scant literature on the subject, working with foreign language interpreters is an acceptable, beneficial, and common use of bilingual paraprofessionals who can be trained to deliver appropriate, ethical services provided that each party in this three-way communication process can agree on some basic procedures. When counselors are trained to work with an interpreter, they learn how to ask one question at a time, speak in short sentences, and wait for the interpreter to finish sentences. When interpreters are trained in the field of counseling, they learn to be the transparent mediator between the client and the counselor. The interpreter's role needs to be inconspicuous and provide a direct and simultaneous translation of counselor's and client's words, without analyzing, summarizing, or explaining but rather directly and literally translating utterances. The interpreter, thus, needs to be able to translate what has been heard, without correcting, improving, or changing the client's words. It is recommended that the interpreter use first person when translating, as if he or she were speaking for him- or herself, instead of in third person.

Counselors need to develop alliances with interpreters and learn to communicate effectively with an interpreter in the room. For example, clients and counselors can be encouraged to speak directly to each other, engaging in direct eye contact with each other. For optimal effectiveness in the use of interpreters, time should be allowed for pre-session orientation between the counselor, the interpreter, and the client to clarify the roles in the process, to orient the client, and to answer any questions the clients may have regarding confidentiality or any other aspect of the process of engaging in a session with the presence of an interpreter.

With non-mental health paraprofessionals used as interpreters or with professional interpreters who do not have the clinical mental health background, prior meetings between the counselor and the interpreter are needed to discuss areas of possible difficulty, identify specialized vocabulary that might be needed during the session, and voice ethical concerns.

### **Language Switching**

With few exceptions, long-term counseling relationships between non-English-speaking clients and English-only-speaking counselors is difficult, if not impossible, to sustain. It is possible, however, for the

monolingual counselor to work with bilingual clients provided that they have the capabilities to engage in an intimate conversation in English. It is in these treatment situations that the method of language switching has been proposed as a form of oral translation. Clients who have had encoding in more than one language often have different ways of accessing affective reactions depending on which language they are using. Researchers recommend assessing the language acquisition history and current usage to find out what experiences are associated when each language is encoded and how the languages are currently used. Language switching is a method whereby a client can be encouraged to say something in English first and then switch to say the same thing in the language in which the experience was encoded, even if the counselor cannot understand it. The counselor can then ask about affect, memory, or other differences that are elicited by the use of two languages. Bilingual clients' language switching can serve to disclose traumatic or emotionally charged content that may not be accessible otherwise. Also, language switching offers the opportunity to explore clients' different sense of self in both languages and the different cognitive and affective components of each.

### **Written Translation**

Written translation is a professional occupation that requires native written fluency in the target language and the ability to render a cultural adaptation of the original text into a new version that is coherent, well written, and culturally accurate. Bilingual capabilities are not sufficient credentials for providing written translation services, and oral proficiency in one language does not guarantee written proficiency. Professional translators are writers who can effectively render the message of the original text with accurate style and terminology. Bilingual individuals may speak two languages fluently but may not necessarily know how to move information between the two in writing. When counseling organizations do not use professional translators for their written material, translation mistakes can ensue that may be costly, embarrassing, and disrespectful.

### **Back Translation**

Back translation is used when researchers use testing instruments with populations in non-English-speaking



countries or with linguistic or cultural groups that differ from the population used to develop the instruments. Back translation methods are also used to translate instruments into American Sign Language. The goal of the back translation method is to ensure that the original and the translated versions of the instrument are semantically and culturally equivalent. The translation of concepts across cultures poses challenges to the researcher interested in adapting instruments for use in languages other than the original. There is evidence that suggests that an inadequate translation and cultural adaptation of an instrument can result in one that is less reliable or valid than the original version. The most widely used translation model in research consists of a series of repeated forward translation and back translation exercises conducted by a team of bilingual translators blind to the previous translations. This process continues until the back translation is considered to reflect congruence of meaning between the original version and the translated one. A challenge to the researcher is to ensure that the assessment tools are equivalent across groups, that the questions capture the same constructs, and that the instruments are culturally equivalent in both languages. Care needs to be taken to ensure that a systematic method of translation renders content and conceptual equivalency, in addition to semantic equivalency. To achieve cross-cultural adaptation more fully, researchers may also rely on committees of expert panels, field testing, and pilot studies, in addition to back translation.

Sara Schwarzbaum

**See also** Barriers to Cross-Cultural Counseling (v3); Bicultural (v3); Bilingual Counseling (v3); Bilingualism (v3); Career Counseling, Immigrants (v4); Communication (v3); Cross-Cultural Training (v3); Cultural Equivalence (v3); High-Context Communication (v3); Immigrants (v3); Low-Context Communication (v3); Multicultural Counseling Competence (v3); Second Culture Acquisition (v3)

### Further Readings

- American Translators Association. (n.d.). *Translation: Getting it right*. Retrieved March 22, 2007, from [http://www.atanet.org/docs/Getting\\_it\\_right.pdf](http://www.atanet.org/docs/Getting_it_right.pdf)
- Amodeo, M., Grigg-Saito, D., & Robb, N. (1997). Working with foreign language interpreters: Guidelines for substance abuse clinicians and human service practitioners. *Alcoholism Treatment Quarterly*, 15(4), 75–87.
- Bradford, D. T., & Munoz, A. (1993). Translation in bilingual psychotherapy. *Professional Psychology: Research and Practice*, 24, 52–61.
- Marcos, L. R., & Urcuyo, L. (1979). Dynamic psychotherapy with the bilingual patient. *American Journal of Psychotherapy*, 33(3), 331–338.
- Matias-Carrelo, L. E., Chavez, L. M., Negron, G., Canino, G., Aguilar-Gaxiola, S., & Hoppe, S. (2003). The Spanish translation and cultural adaptation of five mental health outcome measures. *Culture, Medicine and Psychiatry*, 27, 291–313.
- Perez-Foster, R. (1998). *The power of language in the clinical process: Assessing and treating the bilingual client*. Northvale, NJ: Jason Aronson.
- Santiago-Rivera, A. L. (1995). Developing a culturally sensitive treatment modality for bilingual Spanish-speaking clients: Incorporating language and culture in counseling. *Journal of Counseling & Development*, 74, 12–17.

---

## TRANSRACIAL ADOPTION

---

Transracial adoption refers to the placement of children with parents who are racially and ethnically different from the children. The practice of transracial adoption has a long and complex history. Throughout the history of transracial adoption, it has been referred to as *interracial adoption* or *cross-cultural adoption*. Traditionally, the term *transracial adoption* referred to the adoption of Black children by White parents in the United States. However, over time, all transracial placements where the adoptive parents and children were racially different were included in this terminology. Thus, various forms of domestic and international adoption (also referred to as *intercountry adoption*) can result in transracial adoption when the children and parents differ racially and ethnically (e.g., Korean children adopted by White parents). Transracial adoption is the most visible form of adoption due to the phenotypic or visible differences between the adoptive parents and children. In the United States and abroad, the vast majority of transracial adoptions have consisted of White parents adopting children of color or children who are racial/ethnic minorities in the United States. Some estimates suggest that approximately 8% of all adoptions are transracial in nature.



## History

Transracial adoption has a long and complex history. Poverty, war, oppression, cultural practices, and social taboos have frequently been core explanations for the rise of both domestic and international adoptions. Although world history may have a sparse sprinkling of stories of transracial placements, transracial adoption was not formally practiced on a large scale until after World War II, and those transracial adoptions were primarily international in nature. Despite the common adoption strategy of matching (e.g., religion, race, appearance) used in adoption practice at that time, domestic transracial adoption began to serve as an option for couples looking to adopt during the 1960s.

## Domestic Transracial Adoption

The earliest recorded transracial adoption took place in 1948 in Minnesota. Transracial adoptions on a larger scale took place later; some of the earliest cases of domestic transracial adoption placed American Indian children into White families as a result of the Indian Adoption Project that took place between 1958 and 1967. This project was intended to place these children with families from the dominant culture and away from Indian reservations, and it led to 395 American Indian children being placed in what were both domestic and international transracial placements. Criticisms of this practice ensued, resulting in the 1978 passage of the Indian Child Welfare Act, which made adoption by non-native Americans very difficult.

To begin to move the large numbers of orphaned African American children out of institutional settings (i.e., orphanages), domestic transracial adoption was instituted, challenging a widespread belief that race-matching was vital to the formation of family bonds. However, the extreme difficulty in placing African American children in adoptive homes prior to transracial adoption led to the designation of African American children available for adoption as meeting the criteria for “special needs” at that time. The Open Door Society, “Operation Brown Baby” in Oregon, Minnesota’s Parents to Adopt Minority Children, and the Council on Adoptable Children advocated for transracial placements, and more than 2,500 domestic transracial placements of African American children with Caucasian families took place in 1970. Within a few years, however, criticisms of transracial adoption were levied by prominent adoption

advocates. In 1972, the National Association of Black Social Workers predicted poor psychological adjustment and problematic racial identity for transracially adopted children as results of this practice that opponents referred to as “cultural genocide.” In response to their criticisms, the Child Welfare League of America reversed the changes it had made to the adoption standards and supported the perspective that same-race placements were preferable for orphaned children.

To attend to the concerns of opponents to transracial adoption, empirical research studies were conducted to assess the psychological adjustment and racial identity development of the children who had been transracially adopted. Using Black, transracially adopted children and comparing them to their non-adopted peers, the first studies (as well as many subsequent studies) used combinations of measures, interviews, parent reports, and teacher reports to conclude that the transracially adopted children were generally adjusting as well as their nonadopted peers. Estimates suggest that 70% to 80% of transracial adoptees were adjusting as well as their nonadopted peers. These findings were complicated by reports of increased referral rates and disproportionate ratios of adopted persons in psychiatric treatment. More recent research explains the higher rates of psychological problems among adoptees in comparison with their nonadopted peers as due to a skewed distribution where the majority of adoptees were adjusting well and in the middle of the distribution, but at the extremes, there were substantially higher rates of adoptees than nonadoptees.

After a series of studies was conducted to disprove the criticisms of transracial adoptions, legislation was passed that allowed resurgence in transracial adoption placements (e.g., the Multiethnic Placement Act of 1994). Subsequent research has worked to clarify these concerns, and legislation (e.g., Interethnic Placement Act of 1996) has prevented restrictions in adoptive placements based on these concerns. The Multiethnic Placement Act of 1994, sponsored by Senator Howard Metzenbaum (D-Ohio), banned agencies that received federal funding from denying or delaying transracial placements of orphans on the basis of race alone. However, this act did allow the use of race as one of several factors that could be considered in foster and adoptive placements. In 1996, this law was revised in the Interethnic Placement Act. This law prohibited the consideration of race in any



way when federally funded agencies made placement decisions.

### International Transracial Adoption

International adoption was utilized to care for orphans from war-torn Europe after World War II, but the Korean War in the 1950s led to a more widespread and visible form of international adoption. In practice, South Korean orphans were placed with White American adoptive parents, thus constituting some of the earliest transracial placements. Since that time, international adoptions have taken place from a wide array of countries. In 2005, 7,906 visas were issued to orphans adopted from China to the United States. Other countries from which children have been adopted by U.S. citizens include Guatemala, South Korea, Kazakhstan, Ethiopia, India, Haiti, and Colombia. International adoption has also faced criticism and opposition with references to it serving as a clear example of American imperialism and as a result of colonialism. Despite these criticisms and changes in the availability of children and policies for international adoption, international transracial adoption continues to be an increasingly popular option for couples seeking infants for adoption. Historically, as the availability of White infants in the United States decreased due to the increased social acceptability of single-parenthood and pregnancy out of wedlock, families seeking to adopt have turned to international adoption. Poverty, wars, political crises, population control policies, and social taboos in countries around the world have continued to provide children for adoption. In 2005, 21,968 children were adopted internationally and the vast majority of those adoptions would also be considered transracial in nature.

### Transracial Adoption and Counseling

Transracial adoption and counseling have a brief and inconsistent history. Recent issues of *The Counseling Psychologist* have given brief attention to counseling issues for transracial adoptees, but no systematic study of clinical issues, counseling skills or techniques, or counseling process has focused on transracial adoptees. Adoption advocates and more counselors and psychologists have drawn attention to the need for “adoption sensitive” or “adoption competent” counseling skills. Nationally, several U.S. states (e.g., Oregon, New Jersey, Connecticut, New York, and

Washington) have developed certificate programs in therapy with adoptive families. Despite the dearth of studies on the counseling process with adoptive families, research, anecdotal reports, and case studies reflect that common concerns for transracial adoptees tend to center on racial and ethnic identity.

### Identity Development for Transracial Adoptees

Given that one of the chief concerns of opponents to transracial adoption is racial/ethnic identity, identity issues among transracial adoptees must be explored. The research studies that examined racial/ethnic identity for transracial adoptees have generally concluded that they identify with their racial/ethnic group differently than do nonadopted individuals from their same racial/ethnic background. However, that different identification has not been systematically or empirically demonstrated to be associated with psychological maladjustment or self-esteem difficulties.

One model to address these issues was created by Amanda L. Baden and Robbie J. Steward and is called the cultural-racial identity model. The cultural-racial identity model serves as a framework for understanding and attending to racial and cultural differences among parents and children and by considering the impact that the experiences and the attitudes of parents, peers, extended family, social support networks, and the larger community have on identity development. This model accounts for transracial adoptees’ shifting affiliation or connection with their adoptive parents’ culture (e.g., often White, American, middle-class culture), their birth culture (e.g., the culture into which they were born), people from their parents’ racial group (e.g., often White Americans), and people from their own racial/ethnic background. Transracial adoptees navigate the cultures and racial/ethnic groups with which they are familiar and those with which they want to become more familiar, adept, and at ease. In essence, the process of developing an identity around culture and race is often a primary task for transracial adoptees throughout their lives.

Amanda L. Baden

*See also* Acculturation (v3); Acculturative Stress (v3); Black Racial Identity Development (v3); Ethnic Identity (v3); Family Counseling (v1); Identity (v3); Identity Development (v3); Multiracial Families (v3);



Parent–Adolescent Relations (v1); Parenting (v1); Racial Identity (v3)

### Further Readings

- Baden, A. L., & Steward, R. J. (2000). A framework for use with racially and culturally integrated families: The cultural-racial identity model as applied to transracial adoption. *Journal of Social Distress & the Homeless*, 9(4), 309–337.
- Hollingsworth, L. D. (1997). Effect of transracial/transethnic adoption on children's racial and ethnic identity and self-esteem: A meta-analytic review. *Marriage & Family Review*, 25(1), 99–130.
- Javier, R. A., Baden, A. L., Biafora, F. A., & Camacho-Gingerich, A. (Eds.). (2007). *The handbook of adoption: Implications for researchers, practitioners, and families*. Thousand Oaks, CA: Sage.
- Lee, R. M. (2003). The transracial adoption paradox: History, research, and counseling implications of cultural socialization. *The Counseling Psychologist*, 31(6), 711–744.
- McRoy, R. G., & Freeman, E. M. (1986). Racial-identity issues among mixed-race children. *Social Work in Education*, 8(3), 164–174.
- Miller, B. C., Fan, X., Christensen, M., Grotevant, H. D., & van Dulmen, M. (2000). Comparisons of adopted and nonadopted adolescents in a large, nationally representative sample. *Child Development*, 71(5), 1458–1473.

---

## TRIMBLE, JOSEPH E. (1938– )

---

Joseph E. Trimble is a pioneer and distinguished psychologist widely known for his work in cultural diversity, multicultural counseling, and issues related to culture and psychology. He has published extensively in peer review journals, books, and technical reports and has an extensive list of presentations at professional conferences. His contributions to service are extensive, and he is heavily sought out for his expertise and eloquence as a speaker. He has received numerous awards and citations for his career achievements and contributions.

Trimble is a social psychologist who is located at the Center for Cross-Cultural Research, Department of Psychology, at Western Washington University in Bellingham, Washington. He is also a research associate at the University of Colorado Health Sciences

Center and the National Center for American Indian and Alaska Native Mental Health Research. He is a scholar and adjunct professor of psychology at the Tri-Ethnic Center for Prevention Research at Colorado State University. Trimble received his B.A. degree from Waynesburg College in 1961, with concentrations in psychology, natural science, English literature, and French. He obtained an M.A. in general psychology from the University of New Hampshire in 1965, and in 1969, he received his Ph.D. in social psychology at the University of Oklahoma. His concentration was in interdisciplinary studies in psychology and sociology at the Institute of Group Relations.

### Awards

Trimble's extensive list of awards, honors, and fellowships include the Allen L. Edwards Lecturer Fellowship at the University of Washington; Radcliffe Fellow at Radcliffe Institute for Advanced Study at Harvard University; Peace and Social Justice Award given by the American Psychological Association's (APA) Division of Peace Psychology; Distinguished Psychologist Award in 2002, awarded by the Washington State Psychological Association; Janet E. Helms Award for Mentoring and Scholarship in Professional Psychology at Teachers College, Columbia University; Paul J. Olscamp Outstanding Faculty Research Award, Western Washington University; Lifetime Achievement Award from Division 45 (Society for the Psychological Study of Ethnic Minority Issues) of the APA; Excellence in Teaching Award from the Western Washington University; election to Fellow status from the APA; and Fellow of the National Science Foundation. These awards were based on Trimble's scholarly contributions together with his extensive service contributions within psychological associations, university settings, and committees that set policy in, and direction for, the field of psychology.

### Service

Among his numerous service contributions, Trimble served as president of Division 45 of the APA; chaired the Committee on Ethnic Minority Recruitment, Retention and Training Task Force Textbook Guidelines Initiative of the APA; served as a member of the APA Council of Representatives; and chaired numerous committees of the APA related to ethnic



minority issues and Native Americans. As a university professor, Trimble has served on various committees of governance and issues related to ethnic minorities, and he has taught courses in psychology, human services, and occasionally in curriculum theory and instruction. To date, he has chaired over 30 master's theses and several doctoral dissertations, and he has served on more than 30 additional master's-level thesis and doctoral-level dissertation committees.

## Publications

Trimble has written 91 peer-reviewed journal articles, chapters, and monographs; 15 authored or coauthored books; and 75 technical reports. He has given more than 130 professional presentations. He has been associated with 23 different journals throughout his career as an associate editor, editorial board member, reviewer, and consulting editor. Besides his professional contributions, Trimble's personal journey in achieving these accomplishments has shaped his thinking and perspectives.

## Personal Journey

Trimble's formal training, career achievements, and significant contributions did not let Trimble sway from understanding and appreciating his cultural, ethnic, and familial roots. In a chapter he wrote for the second edition of the *Handbook of Multicultural Counseling*, he describes his personal journey as a psychologist in training and in the profession. The struggle of managing two or more cultures with polarizing perspectives is similar to that of many minority psychologists of that time and even today. On the one hand he was raised with a perspective about life that is seen as more holistic, that emphasizes cooperation and collaboration, and that integrates the interrelationships, commonalities, and interconnectedness of all factors that influence behavior. On the other hand, the field of the social sciences and the mainstream U.S. culture tend to emphasize competition over cooperation, to prefer methods of thinking that reduce factors to a few variables of importance over the interrelatedness of factors, and to view unexplainable phenomena,

such as culture and social influences, as extraneous factors of minimal importance.

The opposing perspectives in psychology generated a determination to seek out others who had similar concerns about linking culture and psychology. With the support of an Arapaho elder and his grandfather, these conflicts only motivated him to provide the scholarship and research that was missing in the field demonstrating the connection and the importance of examining context that includes culture and ethnicity. As a true pioneer, Trimble has paved the way for others to join and build the body of knowledge, while at the same time advocate for the perspectives of appreciating diversity and integrating culture and ethnicity within the field of psychology.

*Eduardo Morales*

**See also** American Indians (v3); Bureau of Indian Affairs (v3); Cross-Cultural Psychology (v3); Cross-Cultural Training (v3); Indian Health Services (v3); Multicultural Counseling Competence (v3); Multicultural Psychology (v3); Racism (v3); Society for the Psychological Study of Ethnic Minority Issues (v3); Society of Indian Psychologists (v3)

## Further Readings

- Bernal, G., Trimble, J., Burlew, K., & Leong, F. (Eds.). (2002). *Handbook of racial and ethnic minority psychology*. Thousand Oaks, CA: Sage.
- Pedersen, P., Draguns, J., Lonner, W., & Trimble, J. E. (Eds.). (2002). *Counseling across cultures* (5th ed.). Thousand Oaks, CA: Sage.
- Trimble, J. E. (2001). A quest for discovering ethnocultural themes in psychology. In J. G. Ponterotto, J. M. Casas, L. A. Suzaki, & C. M. Alexander (Eds.), *Handbook of multicultural counseling* (2nd ed., pp. 3–21). Thousand Oaks, CA: Sage.
- Trimble, J. E., & Fisher, C. (2006). *Handbook of ethical considerations in conducting research with ethnocultural populations and communities*. Thousand Oaks, CA: Sage.
- Trimble, J. E., Stevenson, M. R., & Worell, J. P. (2003). *Toward an inclusive psychology: Infusing the introductory psychology textbook with diversity content*. Washington, DC: American Psychological Association.









---

## UNIVERSALISM

---

Universalism is defined as the principle that a given value, behavior, theory, or treatment will be the same across all groups independent of culture, race, ethnicity, gender, and other social identities. This principle has been a core philosophical assumption within the fields of counseling, psychology, medicine, and many other social sciences. This foundational tenet has maintained a stronghold on theories, research, and practice within the counseling profession. In addition to being a core belief within counseling, universalism has also become one of the central philosophical perspectives in defining multiculturalism.

### **Core Belief Within the Counseling Field**

Historically, the dominant view within counseling has been that theories and practices are to be viewed as universal hypotheses that require empirical examination to test their veracity, meaningfulness, and effectiveness. Developmental theories examining moral and cognitive development as well as counseling theories such as behaviorism and Gestalt are just a few examples of theories that purport to address the concerns and realities of all individuals. Even though attention to individual differences has always been a core belief within the counseling profession, the universal assumptions within many of these theories were not rigorously challenged until multicultural

scholars identified them as being culturally insensitive and not inclusive of alternative worldviews. This etic point of view suggests that it is possible and productive to fully understand all aspects of psychology, and even a particular culture, from a universal standpoint. Examples of such universal assumptions include how we define what is “normal,” what is “effective” counseling, and who is a “good” client. Another universal assumption is the belief that all disorders occur in all cultures and present in similar ways.

Fields such as counseling, psychiatry, and assessment have all experienced the effects of universal assumptions and biases that have led to discussions, sometimes controversial, about their effects on theories, diagnosis, norm groups, and standardized testing. The ultimate effect of universalism on theories and practice can be ethnocentric, androcentric, and even counterproductive when human complexity and diversity are not actively incorporated.

Cultural relativism is an alternative approach to understanding the behaviors, beliefs, and perspectives of others. Rather than presume that the experiences, beliefs, and developmental processes are the same for all others, examining specific cultural and individual realities help to inform this alternative perspective. This belief does not presume that having a global understanding has no value but rather that universal and cultural realities can be mutually considered and applied to bridge cultural, political, and other group differences and further our understanding of human behavior.



## Universalism and Cultural Differences Within Multicultural Counseling

Within multicultural counseling, various philosophical assumptions about multicultural perspectives in counseling have been used to organize the assumptions and strategies used for multicultural counseling and training. Descriptions of those diverse perspectives vary depending on an author's point of view. A universalistic or etic definition of multiculturalism encourages a transcendental perspective that is grounded in human commonalities. This universal approach tends to emphasize within-group differences as being greater than between-group differences. In other words, differences within groups (like unique aspects of American Indians) are more significant than differences between groups (like African Americans and Latino/a Americans). Some proponents of the universal perspective have expressed concern that focusing on cultural differences can lead to stereotyping, overgeneralization of group perspectives, or a type of cultural determinism that takes away both individually unique and universal aspects of a person. Universalism within the multicultural movement has a different perspective than the universal perspective present in the larger field of psychology. Individuals within the multicultural movement who embrace universalism do not deny culture but rather choose to focus on the human bond that connects all individuals. They believe many aspects of psychology, such as emotion, may be universally present in all cultures, but they manifest differently across cultures.

Most other perspectives could be classified within the cultural differences point of view, which is typically viewed as an alternative to universalism. The cultural difference approach, whether it focuses specifically on race or a broader understanding of difference (e.g., gender, sexual orientation), typically emphasizes incorporating the ideographic experiences of a particular cultural group as the basis for interpreting their behavior and offering psychological services. This emic point of view suggests that a culture's perspective is best understood from within that culture. Individuals who embrace the cultural difference perspective suggest that the universal point of view ignores the crucial realities of racism and other forms of oppression and their impact on the sociopolitical histories, power dynamics, and identity of various cultural groups. Issues of cultural bias and avoidance of cultural realities may be more likely to occur in a perspective that does not specifically value and embrace

cultural differences as core. The cultural difference point of view does not deny that there are universal realities that connect individuals but rather chooses to view such universal connection as less central to understanding individuals who have been historically underserved and misunderstood by the counseling profession.

## Future Directions

The universal versus cultural difference discussion is inevitably dichotomous. Although these diverse perspectives acknowledge and embrace some aspects of the other beliefs, they approach the issue of human difference from unique standpoints. Within the multicultural field there has been some discussion of the need to reconceptualize such dualistic thinking away from either/or perspectives and embrace a more unifying dialectic point of view.

Many multicultural scholars articulate the need to combine the universal and cultural relativistic perspectives to counteract their weaknesses and accentuate their strengths. The possibility of integrating a universal and inclusive perspective that honors the various social identities experienced by all (e.g., gender, social class, sexual orientation, religion) with a race-based approach that honors the unique history of race and racism in the United States would be an alternative approach that moves beyond the either/or dichotomy of universal versus culture specific. Discussions about universal and cultural relativism represent an important and ongoing conversation that is occurring within the multicultural counseling field.

Universalism will continue to be a core belief within psychology as a whole and within the specific field of multicultural counseling as counselors struggle to fully understand and explain human beings and their behaviors. However, the continued existence of cultural differences as well as cultural biases will create the need for a cultural differences perspective. Undoubtedly, such definitions will evolve as counselors attempt to appreciate and integrate the complexity of individual, cultural, and universal perspectives, and it is likely that universalism and the similarities that link human beings will remain a significant point of view.

*Amy L. Reynolds*

*See also* Cross-Cultural Psychology (v3); Cross-Cultural Training (v3); Cultural Accommodation and Negotiation (v3); Cultural Encapsulation (v3); Cultural Equivalence



(v3); Cultural Mistrust (v3); Cultural Paranoia (v3); Cultural Relativism (v3); Cultural Values (v3); Culture (v3); Etic–Emic Distinction (v3); Multicultural Psychology (v3); Pluralism (v3); Worldview (v3)

### Further Readings

- Carter, R. T., & Qureshi, A. (1995). A typology of philosophical assumptions in multicultural counseling and training. In J. G. Ponterotto, J. M. Casas, L. A. Suzuki, & C. M. Alexander (Eds.), *Handbook of multicultural counseling* (pp. 239–262). Thousand Oaks, CA: Sage.
- Draguns, J. G. (2002). Universal and cultural aspects of counseling and psychotherapy. In P. B. Pedersen, J. G. Draguns, W. J. Lonner, & J. E. Trimble (Eds.), *Counseling across cultures* (5th ed., pp. 29–50). Thousand Oaks, CA: Sage.
- Fukuyama, M. (1990). Taking a universal approach to multicultural counseling. *Counselor Education and Supervision, 30*, 6–17.
- Schwartz, S. H. (1994). Are there universal aspects in the structure and contents of human values? *Journal of Social Issues, 50*, 19–45.
- Speight, S. L., Myers, L. J., Cox, C. I., & Highlen, P. S. (1991). A redefinition of multicultural counseling. *Journal of Counseling & Development, 70*, 29–36.
- White, D., & Wang, A. (1995). Universalism, humanism, and postmodernism. *American Psychologist, 50*, 392–393.









---

## VISIBLE RACIAL/ETHNIC GROUPS

---

*Visible racial/ethnic groups* is a euphemism for racial/ethnic classification in the counseling profession when discussing American racial/ethnic groups that are non-Caucasian or not of European descent. This terminology, coined by Janet E. Helms and Donelda A. Cook, for African, Latino/a, Asian and Pacific Islander, and Native/Indigenous Americans, is an alternative to the term *racial/ethnic minority groups*. Identifying visible racial/ethnic groups as “minorities” in research and counseling implicitly compares these groups to Caucasians/European Americans as the standard, thereby disempowering them. Additionally, the term *minorities* connotes subordinate social status. The use of the terms *minority* for visible racial/ethnic groups and *majority* for Caucasian/European Americans reinforces the existing racial power differences in societal relations in the United States.

The term *visible racial/ethnic groups* signifies two aspects of American racial socialization of peoples of African, Asian, Latin, and Indigenous North American descent. The first aspect focuses on common cultural characteristics, norms, values, attitudes, and behaviors that stem from cultures of origin and are transmitted across generations. For example, cultures of Africa, Asia, Latin America, and Indigenous North America typically stress the importance of the collective society, emphasizing interdependence and connectedness. Secondly, the term *visible racial/ethnic groups* recognizes the ways in which the aforementioned groups have been subject to unequal social, economic, legal, and political power in American society, based on

visible racial characteristics, such as skin color, facial features, and native language.

### Implications of Racial/Ethnic Labels

#### **Professional Mandate**

The *Publication Manual of the American Psychological Association, Fifth Edition*, calls for the appropriate identification of research participants and clientele by specifying major demographic characteristics such as sex, age, and race/ethnicity. Language for racial/ethnic designations changes over time, and members of designated racial/ethnic groups perceive some terms negatively. It is recommended that racial/ethnic designations reflect the preferred nomenclature of the groups discussed. It is important to use terminology that empowers racial/ethnic groups in their collective social identities, as well as in their psychological well-being.

#### **Historical Evolution of Racial/Ethnic Labeling**

During the early 20th century, psychological research (i.e., intelligence research) and counseling practice recognized racial differences by comparing Caucasians with non-Caucasians (typically Black Americans) and interpreting any differences between groups against Caucasians as the standard or normative group. Thus, non-Caucasian groups were labeled deviant or deficient when found to differ from Caucasians as research participants and as counseling clientele.



As the representation of visible racial/ethnic group counselors and psychologists increased in the 1960s, they began to confront the deficit models of diversity in the profession, moving toward affirming diversity in racial/cultural identity. That is, research and practice began to examine cultural characteristics of African, Asian, Latin, and Indigenous Americans, to develop normative standards common to each racial/ethnic group. Research of within-group differences rather than between-group differences was promoted. The positive aspects of each racial/cultural group were affirmed by within-racial-group research.

In the 1970s, the social and psychological influences of racial oppression on members of visible racial/ethnic groups came to the forefront in counseling research and practice. The influence of racial socialization on the counseling process examined White counselor–Black client relationships and expectations for counseling. William Cross's theory of psychological Nigrescence introduced the role of oppression as a critical factor in shaping the stages of Black racial identity, emphasizing the impact of Blacks' encounters with the White normative standard in the development of Blacks' sense of their social and psychological identities. In the 1980s and 1990s racial identity theory in research and practice was expanded to all racial/ethnic groups. Racial identity theories are concerned with how individuals abandon the effects of oppression (as either oppressed or the oppressor) and develop respectful and equitable attitudes toward their own racial group and other racial groups.

Research in the 21st century recognizes race/ethnicity in the United States as a social construction rather than a biological entity, with racial/ethnic designations reflecting how society perceives individuals and how individuals come to perceive themselves due to racial socialization. Racial classifications are not precise measures: Self-designations of race or racial designations by others (i.e., researchers, counselors) are based on societally defined categories and societal racial positive and negative stereotypes.

The term *visible racial/ethnic groups* is an attempt to recognize the differential societal status of the socio-racial classifications for Blacks/African Americans, Asian and Pacific Islanders, Latinos/as, and Native/Indigenous Americans. This terminology also retains the cultural heritage transmissions of the respective ethnic groups.

Donelda A. Cook

*See also* African Americans (v3); American Indians (v3); Asian Americans (v3); Ethnic Identity (v3); Ethnicity (v3); Ethnic Minority (v3); Helms, Janet E. (v3); Latinos (v3); Pacific Islanders (v3); Race (v3)

### Further Readings

- American Psychological Association. (2001). *Publication manual of the American Psychological Association* (5th ed.). Washington, DC: Author.
- Cook, D. A., & Helms, J. E. (1988). Visible racial/ethnic group supervisees' satisfaction with cross-cultural supervision as predicted by relationship characteristics. *Journal of Counseling Psychology, 35*, 268–273.
- Cross, W. (1971). The Negro to Black conversion experience. *Black World, 20*, 13–27.
- Cross, W. (1978). The Thomas and Cross models of psychological Nigrescence: A review. *Journal of Black Psychology, 5*, 13–31.
- Helms, J. E. (1990). *Black and White racial identity theory: Theory, research, and practice*. Westport, CT: Greenwood Press.
- Helms, J. E., & Cook, D. A. (1999). *Using race and culture in counseling and psychotherapy: Theory and process*. Boston: Allyn & Bacon.
- Helms, J. E., Jernigan, M., & Mascher, J. (2005). The meaning of race in psychology and how to change it: A methodological perspective. *American Psychologist, 60*, 27–36.
- Helms, J. E., & Talleyrand, R. M. (1997). Race is not ethnicity. *American Psychologist, 52*, 1246–1247.
- Sue, S. (1991). Ethnicity and culture in psychological research and practice. In J. Goodchilds (Ed.), *Psychological perspectives on human diversity in America* (pp. 51–85). Washington, DC: American Psychological Association.
- Trickett, E. J., Watts, R. J., & Birman, D. (Eds.). (1994). *Human diversity: Perspectives on people in context*. San Francisco: Jossey-Bass.
- Yee, A. H., Fairchild, H. H., Weizmann, F., & Wyatt, G. E. (1993). Addressing psychology's problem with race. *American Psychologist, 48*, 1132–1140.

---

## VONTRESS, CLEMMONT EYVIND (1929– )

---

Clemmont Eyvind Vontress, American counselor educator and psychologist, is recognized generally as a pioneer in cross-cultural counseling. He first used the



concept of cross-cultural counseling in a speech at the University of Virginia in 1968. He has contributed to the literature on the impact of culture on counseling, existential psychotherapy, and traditional healing in Africa for nearly 5 decades. Early in his career, he focused his attention on problems that Anglo-Americans encountered in counseling Black Americans. After researching the national culture and its subsystems in the United States, Vontress examined how cultural differences affect the entire counseling process, regardless of the client's background. Today, he is considered one of the leading writers on culture and counseling. During the past 2 decades, Vontress has contributed significantly to the literature on traditional healing in Africa and its implications for counseling culturally different clients in the West. Living and learning in a primarily racially segregated society in the first half of the 20th century, he was influenced significantly by the ethos of the civil rights movement in the United States. His strong feelings about human rights and the equality of people were evident in his writings during the latter half of the 20th century. His concerns about counseling Blacks in segregated and integrated school systems culminated in *Counseling Negroes*, the first book to explore the topic. By the 1970s, race and culture were dominant themes in the counseling field. Vontress was in the forefront of the increasing number of counselor educators who wrote and spoke often at national, state, and local professional conventions about cultural, ethnic, and racial differences as barriers in the counseling enterprise. It was in the late 1970s, 1980s, and the 1990s that Vontress began to explicate existentialism, the philosophy underpinning his personal approach to counseling. In 1979 he outlined his philosophical approach to counseling in the article "Cross-Cultural Counseling: An Existential Approach." In writing and speaking about how existential philosophy can be used as a therapeutic modality, Vontress established himself in the counseling field as a leading advocate of existential philosophy in counseling in general and cross-cultural counseling in particular. After several research and study trips to West Africa where he met with traditional healers and some of their clients, he began to explain in his writings and discourses how spirituality is necessarily a part of the counseling process. He came to respect the efficacy of traditional healing and viewed African healers as partners in the helping profession and in helping people, especially those in developing countries. Starting in

the 1990s, his keen interest in and respect for traditional healing have been reflected in his writings.

## Background

Vontress was born in Alvaton, Kentucky, in 1929, the year the stock market crashed and the Great Depression began. After graduating from high school in Bowling Green, Kentucky, he attended and graduated in 1952 from Kentucky State University with a B.A. in French and English. Shortly after enrolling in graduate school at the University of Iowa, he was drafted into the U.S. Army and spent a tour of duty in Hammelburg, Germany. While there, he made several trips to Paris. On one of these occasions, he saw and heard Jean-Paul Sartre and Simone de Beauvoir holding forth in a brasserie. This was his first exposure to existentialism. Later, he would read *Existentialism: With or Without God*, by Catholic priest Francis J. Lescoe. He indicated that one of his graduate students, Morris L. Jackson, steered him in the direction of existentialism by recommending Lescoe's book.

Having grown up in legally segregated Kentucky, in Europe he was astonished to see the racial harmony there and wondered why it could not exist in the United States. His experiences abroad would change his outlook on the human condition. He became increasingly focused and filled with new meaning in life and was more optimistic about his future. He was determined to achieve in spite of the social conditions that hindered his development and that of his fellows. He completed the M.S. degree in 1956 and the Ph.D. in 1965 in counseling at Indiana University in Bloomington, Indiana. As a graduate student, he studied the counseling theories of Carl Rogers and E. G. Williamson, well-known counseling theorists at the time. It was while working on his Ph.D. that Vontress had the opportunity to engage Carl Rogers in a question-and-answer dialogue. The study of counseling and human behavior was, in part, due to the influence of his mother from whom he learned by example empathy, striving for perfection, perseverance, quietude, stoic endurance, and unselfishness. The experiences in Europe changed his outlook on life from pessimism to progressive optimism, which manifested itself as an inner driving force that spurred him to achieve. People who entered into his life space recognized that life seemed to have a mission for him. Upon listening to one of his Ph.D. professors' lectures about people being culturally deprived, culturally disadvantaged, or



disadvantaged, he decided to focus aspects of his writing on culture and its impact on counseling. Throughout his professional career, Vontress has been an English teacher, high school counselor, counselor educator, and psychologist.

### Cross-Cultural Counseling

Culture as an important factor in the counseling relationship always has been a centerpiece of Vontress's writings. He considered culture to be the sum total of a people's belief and procedures for negotiating environments sustaining and affecting their existence. He maintains that it is simultaneously visible and invisible, conscious and unconscious, cognitive and affective. A major shift in his understanding of culture took place when he espoused existential philosophy. Within this philosophical framework, he viewed culture as encompassing five concentric and intersecting cultures: (1) universal, (2) ecological, (3) national, (4) regional, and (5) racio-ethnic. He posited that the universal culture was the most foundational because it influenced all others.

People are more alike than they are different and are similar and dissimilar at the same time. Vontress views cross-cultural counseling as a human-to-human encounter. Therefore, culture, per se, is not necessarily an impediment in a counseling relationship. The key factor contributing to an effective counseling relationship is the ability of the counselor to accept the client as a co-equal human being. The essential therapeutic ingredient is the humanness of the counselor and his or her ability to connect with others in need of help. Vontress recommends that counselors resist the temptation to focus on cultural differences and focus instead on human similarities. In the human-to-human encounter, counselors need to understand their own humanness and that of their clients who have come to them for understanding and resolution of concerns.

Cross-cultural counseling has been the primary focus of Vontress's life work. It was in the late 1960s at an American Personnel and Guidance (now the American Counseling Association) meeting that he presented a paper titled "Cultural Barriers in the Counseling Relationship." It was later published under the same title. In it, Vontress introduced the concept "cross-cultural counseling." Counseling becomes cross-cultural whenever the counselor is unable to understand the humanness of the client and tries to engage from a culturally different perspective. Cultural,

racial, ethnic, and other visible differences become impediments to effective intervention. Because differences are perceived as well as real, a cross-cultural dyad may consist of almost any two individuals who fail to recognize their common humanity.

### Existential Cross-Cultural Counseling

Existentialism is a philosophy that advocates that people recognize the reality of human existence. Basic to this reality is the continuous movement toward death. Frequent national and international travel caused Vontress to develop a global perspective of humankind. It also contributed to his development of an existential approach to cross-cultural counseling. According to him, existentialism develops and enhances our relationships with ourselves, others, nature, and spirituality. He recommends that counselors use the Socratic dialogue as the basic technique in cross-cultural counseling. Vontress's existential cross-cultural counseling approach was influenced and inspired by Ludwig Binswanger. Central to existential cross-cultural counseling is an understanding of the existential concepts *Umwelt* (physical world), *Mitwelt* (public world), *Eigenwelt* (private world), and *Uberwelt* (spiritual world). It is also important to understand that ideally the worlds interact harmoniously to ensure a balanced existence for human beings. Vontress's existential cross-cultural counseling approach requires the individual to fully grasp the concepts of existentialism and his or her significance at different stages in the counseling relationship.

### Traditional Healing

Vontress's study of traditional healing in Africa was simultaneously a study of his historical roots. The visits to Africa provided a deeper understanding of himself and his own humanity. The paradigm shift in his worldview was made evident by his interest to document in writing his newly found understanding of humanity. It was in 1991 that he wrote his first article on Africa. Vontress continues to write about existential cross-cultural counseling and traditional healing in Africa, and he nurtures his understanding of humanity by interacting authentically with colleagues and by mentoring countless students, many of whom come from Africa.

*Morris L. Jackson*



*See also* Cross-Cultural Psychology (v3); Cross-Cultural Training (v3); Cultural Relativism (v3); Indigenous Healing (v3); Multicultural Counseling (v3); Multicultural Counseling Competence (v3); Universalism (v3); Worldview (v3)

### Further Readings

- Binswanger, L. (1962). *Existential analysis and psychotherapy*. New York: Dutton.
- Binswanger, L. (1975). *Being-in-the-world: Selected papers of Ludwig Binswanger* (J. Needleman, Trans.). London: Souvenir Press.
- Binswanger, L. (1991). Existential analysis and psychotherapy. In J. Ehrenwals (Ed.), *The history of psychotherapy* (pp. 374–379). Northvale, NJ: Aronson.
- Lescoe, F. J. (1974). *Existentialism: With or without God*. New York: Alba House.
- Vontress, C. E. (1969). Cultural barriers in the counseling relationship. *Personnel and Guidance Journal*, 48, 11–17.
- Vontress, C. E. (1971). *Counseling Negroes*. Boston: Houghton Mifflin.
- Vontress, C. E. (1973, August 27). *Racial and ethnic barriers*. Paper presented at the 81st annual convention of the American Psychological Association, Montreal, Canada.
- Vontress, C. E. (1979). Cross-cultural counseling: An existential approach. *Personnel and Guidance Journal*, 58, 117–122.
- Vontress, C. E. (2003). On becoming an existential cross-cultural counselor. In F. D. Harper & J. McFadden (Eds.), *Culture and counseling* (pp. 20–30). Boston: Allyn & Bacon.
- Vontress, C. E. (2005). Animism: Foundation of traditional healing in sub-Saharan Africa. In R. Moodley & W. West (Eds.), *Integrating traditional healing practices into counseling and psychotherapy* (pp. 124–137). Thousand Oaks, CA: Sage.
- Vontress, C. E., Epp, L. R., & Johnson, J. A. (1999). *Cross-cultural counseling: A case book*. Alexandria, VA: American Counseling Association.









---

## WHITE, JOSEPH L. (1932– )

---

Joseph L. White, born in 1932 in Lincoln, Nebraska, is a well-known African American professor, psychologist, activist, scholar, researcher, consultant, educator, and mentor who revolutionized traditional European American psychology by setting the stage and foundation for what is now known as cross-cultural psychology and multicultural counseling. White received his undergraduate and master's degrees in psychology in 1954 and 1958 from San Francisco State University and graduated with a Ph.D. in clinical psychology and developmental psychology in 1961 from Michigan State University. White has held positions of psychologist, dean, director, assistant vice chancellor, and professor at institutions such as Washington University; California State University, Long Beach; San Francisco State University; and most recently the University of California, Irvine (professor emeritus of psychology and psychiatry). As a luminary in the cross-cultural psychology field, White—respectfully and endearingly known as “Joe,” “The Godfather,” and the “Father of Black Psychology”—has been challenging theories of psychology, academics, clinical agencies, organizations such as the American Psychological Association (APA), and numerous university and psychology boards for more than 40 years.

White graduated during the groundswell of the 1960s civil rights movement and quickly emerged as a leader of social justice, diversity, and equality in psychology and in the community. White's formal education, talent, intellect, and social and political connectedness brought him into the company of

individuals such as Malcolm X, Stokely Carmichael, Eldridge Cleaver, and other members of the Black Panthers and brought him appointments to work with California Governor Edmund G. Brown, San Francisco Mayor Willie Brown, and presidential candidate Robert F. Kennedy.

In September 1968, White and a small group of African American psychologists founded the Association of Black Psychologists (ABPsi) at the San Francisco meeting of the APA. White's initial steps to revolutionize psychology began in 1968 when he and other members of the fledgling ABPsi confronted members of the APA and the convention planning committee regarding the absence of Black programming in psychology. Their truth was reality—that the struggles, strengths, science, practice, and psychology of Black Americans were not reflected in the largest organization of scientist-practitioners educating America on psychology, research, and therapy. Disheartened, angry, and driven by scholarship, White was determined to shift the paradigm of thinking on how psychology defines ethnic minority individuals. Until the 1960s, Black and other minority individuals were conceptualized according to European American and Western standards of living and psychology. In 1970, White published his seminal and groundbreaking article “Toward a Black Psychology” in *Ebony* magazine. His article provided validation to African Americans and ethnic minorities from a Black American perspective and inspired individuals to question psychology and ask questions such as “How does traditional psychology address the mental health needs of ethnic minority individuals?”

White's pioneering work propelled individuals, such as Derald Wing Sue and Stanley Sue, to form other



ethnic psychological organizations such as the Asian American Psychological Association, the National Latina/o Psychological Association, and the Society of Indian Psychologists in the following years. ABPsi served as the forerunner of more ethnic organizations and of the creation of Division 45 (Society for the Psychological Study of Ethnic Minority Issues). White's trailblazing actions gave support to others committed to social justice who also went on to become prominent leaders in the field of multicultural psychology (Wade Nobles, Allen Ivey, Stanley Sue, Derald Wing Sue, Thomas Parham, and William Parham to name a few).

White continued to expand traditional American psychology toward a cross-cultural psychology as evident in his commitment to improving the mental health treatment for people of color. Again, his scholarship flourished in his writing and cowriting of several editions of *The Psychology of Blacks: An African American Perspective*, *The Troubled Adolescent*, *Black Man Emerging: Facing the Past and Seizing a Future in America*, and, most recently, *Black Fathers: An Invisible Presence in America*, all of which have been instrumental in the creation and current discourse of cross-cultural psychology and the fourth force of multicultural psychology. Underlying White's contributions to psychology are concepts including the historical realities of people enduring the physical and psychological pains of racism, discrimination, and prejudice. He has taught that throughout history in psychology, the poor, the minority, and the non-White have endured the emotional pains resulting from being compared with their European American/White counterparts and being conceptualized as inferior. White's writings and teachings clearly shifted the paradigm of thinking in bringing awareness to counseling and in the application of differing cultural conceptualizations needed into a psychology developed and normed primarily for middle-class European Americans. Furthermore, the core of and development of Black psychology and much of White's theoretical and practical concepts have focused on human strengths, highlighting resilience, "healing in the broken places," and recognizing the positive aspects of one's life course rather than the dysfunction and pathology that one has experienced. Thus, Black psychology needs to be acknowledged as a psychology originally rooted as a psychology of strengths and positive psychology in its theoretical underpinnings and practical application.

White's contributions to cross-cultural psychology and multicultural psychology are not limited solely to

his writings and activism. Over the past 4 decades, he has taught, inspired, advised, guided, mentored, and spiritually touched hundreds of individuals, encouraging them to be change agents, to seek social justice, and to make a difference for one individual, which, in turn, will make the larger society a smaller, more manageable place. White truly believes if people make a difference in one person's life and they then make a difference in five people's lives, then this world will be a better place. White's consummate mentoring has been witnessed and experienced by many and has earned him the status of "The Conductor of the Freedom Train," a supportive pipeline for undergraduates in the tracks of aspiring to earn a Ph.D. in psychology. White created opportunities for minority and ethnic students and other students alike to experience the mentorship from beginning to end, as undergraduates to doctoral graduates in psychology. He carefully crafted such opportunities to ensure success and support in pursuit of graduate school in psychology. His pipeline and "Freedom Train" started at the California State and University of California systems and has continued for decades now with students earning Ph.D.s from reputable institutions including Southern Illinois University, Carbondale; University of Maryland, College Park; University of Missouri, Columbia; Washington State University, Pullman; and more. White's teaching abilities, his presence at conferences, his ability to connect with diverse people, and his genuine care to increase the numbers of ethnic minorities who pursue Ph.D.s in psychology are precisely why it has been believed that White has mentored more Ph.D. students in psychology than any other individual in the field, with the majority being individuals from diverse racial-cultural backgrounds.

White has gone beyond making *psychology* a household word and has encouraged individuals to apply their psychology education and diversity knowledge to other fields. Administratively, White worked toward increasing the numbers of ethnic minorities entering college. In addition to mentoring graduate students through counseling/clinical/school/child psychology programs, he was involved in the founding of the Educational Opportunities Program (EOP) at California State University, Long Beach (which led to the development of EOP systemwide). Additionally, White was active in both Head Start and Upward Bound programs in Southern California. In addition to diversifying the educational system, White also was



appointed by Governor Brown to serve as chair of the Psychology Examining Committee, State of California, where he fought to integrate and represent the interests of diverse people in the statewide system, in clinical work, supervision, on the Exam for Professional Practice in Psychology, and toward the overall practice of psychology. White has served on numerous committees to create diversity on campuses and has done more than his share in applying his psychological knowledge to diversify the American educational system and psychology. Along the way, he has guided professionals in law, government, business, higher education, political administration, academia, private practice, and medicine with regard to minority mental health. Each generation taught by White continues to advance the field of ethnic minority psychology in some capacity.

Those who know White know of his legacy and pioneering work in the field of Black psychology and multicultural counseling. As reflected in his history, White has had a lifetime of achievements that have advanced the field of ethnic minority psychology. White's several articles and books have served as roots and will continue to serve as the branches to an evolving cross-cultural psychology. White's contributions have been acknowledged through numerous awards, including the 2000 Lifetime Achievement Award from APA Division 45 (Society for the Study of Ethnic Minority Issues), the 2007 Henry Tomes Award for Distinguished Contributions to the Advancement of Ethnic Minority Psychology, and a 2007 honorary doctorate from the University of Minnesota, Twin Cities, for his life contributions to the field of psychology. He was also chosen as one of psychology's senior men of color at the National Multicultural Conference and Summit in 2001.

As a 75-year-old African American licensed clinical psychologist and professor emeritus in America, White has reached all walks of life, people, races, sexual orientations, and color in leading by example and incorporating cross-cultural psychology in his daily life. White's contributions have, without doubt, advanced ethnic minority and cross-cultural psychology as we know it today; his impact has been profound.

Nita Tewari

*See also* African Americans (v3); Afrocentricity/ Afrocentrism (v3); Association of Black Psychologists (v3); Black Psychology (v3); Career Counseling, African Americans (v4); Cross-Cultural Psychology (v3);

Cross-Cultural Training (v3); Cultural Values (v3); Multicultural Counseling (v3); Multiculturalism (v3); Multicultural Psychology (v3)

### Further Readings

- Connor, M., & White, J. L. (Eds.). (2006). *Black fathers: An invisible presence in America*. Mahwah, NJ: Lawrence Erlbaum.
- White, J. L. (1969). Guidelines for Black psychologists. *The Black Scholar*, 1, 52–57.
- White, J. L. (1970, August). Toward a Black psychology. *Ebony*, 25, 44–45, 48–50, 52.
- White, J. L. (1984). *The psychology of Blacks: An Afro-American perspective*. Englewood Cliffs, NJ: Prentice Hall.
- White, J. L. (1989). *The troubled adolescent*. Elmsford, NY: Pergamon Press.
- White, J. L., & Cones, J. H., III. (1999). *Black man emerging: Facing the past and seizing a future in America*. New York: Freeman.
- White, J. L., & Parham, T. A. (1990). *The psychology of Blacks: An African-American perspective* (2nd ed.). Englewood Cliffs, NJ: Prentice Hall.
- White, J. L., Parham, T. A., & Ajamu, A. (2000). *The psychology of Blacks: An African centered perspective*. Upper Saddle River, NJ: Prentice Hall.

---

## WHITE AMERICANS

---

The identity of White Americans can be described along a number of dimensions. Perhaps the most basic is the statistical portrait derived from numerical data as compiled by the U.S. Census Bureau; however, a more nuanced understanding of this group emerges from consideration of their history, culture, and social location.

### White Americans by the Numbers

White Americans are one of the five racial designations defined by the U.S. government, the others being Black/African American, Asian, Native American/Alaskan Native, Native Hawaiian/Pacific Islander (and Other). Whites are defined by the U.S. government as comprising people of European, Middle Eastern, or North African descent. The U.S. Census conducted in 2000 found that 77.1% of the American population indicated that they were White, alone or in combination with another race, with 75.1%



reporting that they were White only. Whites also had the opportunity to indicate their family ancestry, the most commonly reported being German (with 15.2% of the total population), followed by Irish (10.8%) and English (8.7%). With regard to place of residence, Whites are distributed fairly evenly throughout the United States, with the largest total numbers of Whites living in the South (34%) and the Midwest (25%) relative to the West (21%) and the Northeast (20%). The highest concentrations of Whites can be found, however, in the populations of the Midwest (85%) and the Northeast (79%).

### Sociopolitical Location

In terms of their social, political, and economic standing, White Americans are the dominant racial group in the United States. The United States has had White presidents and vice presidents exclusively, and as of the November 2006 elections, Whites held approximately 94% of seats in the U.S. Senate and 83% percent of those in the House of Representatives. With fewer than 10 exceptions throughout history, all elected governors of all 50 states have been White. Whites occupy the overwhelming preponderance of corporate executive positions, serving as chief executive officers at about 495 of the 500 largest corporations as represented by *Fortune Magazine* in 2006. White people are overrepresented in every powerful and highly paid profession: Overwhelmingly, American lawyers, judges, physicians, bankers, college professors, and journalists are White. The vast majority of American wealth resides in White hands, as documented by Meizhu Lui and her colleagues in their 2006 book *The Color of Wealth*. For every dollar of wealth owned by a White family, people of color own less than a dime. Family median net worth (i.e., assets minus debts) provides another way of looking at this disparity. According to the Federal Reserve Bank, the median net worth for White American families in 2001 was \$120,900, whereas for people of color it was \$17,100. In short, in nearly every walk of life, the lists of the wealthiest, the most powerful, and the most influential feature a preponderance of White Americans.

### The Origins of Whiteness

Another way of understanding White Americans involves the origins of Whiteness itself as a collective group identity. Race in general has been declared a

biological myth by bodies such as the American Association of Anthropology; rather, racial groupings are understood to be socially constructed, historically contingent identities that arise from a particular confluence of social, cultural, political, and/or economic forces. More specifically, the notion of Whiteness as a meaningful way to categorize human beings is a fairly recent development that did not exist at the time the first European settlers ventured onto this continent. The first colonists, therefore, would likely have called themselves English, Dutch, German, or perhaps Christian rather than White. As described by such historians as Howard Zinn, the socioeconomic forces that initiated the creation of Whiteness in the 1700s derived from the emergence of one of the most important economic engines of the new American nation: the transatlantic slave trade. Not only were the profits to be made from the importation and sales of African people considerable, the developing plantation system relied completely upon slave labor. In response to the necessity of justifying these practices, Whiteness materialized as a new group identity that collectively privileged the new American owning class by establishing a racial hierarchy in which Whites could claim superiority. Whiteness, therefore, provided a rationale for the buying and selling of Africans and their children, their subsequent lifelong enslavement, and the appropriation of all profits from their labor.

Africans were not the only people to find that Whiteness—or more specifically, the occupation of a social location outside and beneath it—bore important consequences in their lives. Conquered people of color throughout Central and South America and the Caribbean lost their land and resources to White colonialists, while Asians in the United States saw their wealth-building opportunities legislated away by White lawmakers. Such legislation had its foundation in the Naturalization Law of 1790, which stated that only “a free White person” was eligible for American citizenship. In the century that followed, Asians of every ethnicity filed suits in state and federal courts claiming that they had the right to be considered White and thus were among those allowed to own property and be protected by law. These included, for example, Takao Ozawa, who emigrated from Japan in the late 1800s, attended the University of California, and raised a family in Hawai‘i where he worked for an American company. He appealed the repeated denials of his naturalization requests all the way to the Supreme Court, where, in 1922, he was denied a final



time for the stated reason that he was not Caucasian. Finally, in the 1940s, racist laws such as the Chinese Exclusion Act of 1882 and the Alien Land Law of 1913 were repealed.

By law, therefore, Whiteness constituted the legally sanctioned platform for social and economic dominance in America well into the 20th century. White Americans' historical control of political power, property ownership, and wealth creation, in addition to all the other rights of full citizenship, sheds light on the contemporary concentration of wealth and power in White American hands. Moreover, it is from this historical context that Whiteness derives meaning; for this reason, psychologist Ruth Frankenburg has conceptualized Whiteness itself as an artifact of sociocultural dominance production.

### The Culture of White Americans

Many White Americans would be surprised by the idea that they have a culture. The notion of culture is often associated in the minds of Whites with people of color and the ways in which their ethnic traditions, food, and music are seen as different or exotic. In fact, White Americans do have cultural traditions and norms, even though they are largely invisible as such to Whites themselves. This invisibility derives from the fact that Whites tend to see White culture not as a culture at all but as "just the way things are"—as the standards, customs, and values that describe the essential human experience. White culture, then, gains power through its invisibility, in that it becomes the standard against which all others are judged.

The terms *White culture* and *Eurocentric culture* have been used to describe the culture of White Americans and the worldview according to how they live and perceive reality. Accordingly, the word *Eurocentrism* refers to the tendency to order and understand reality according to the tenets, beliefs, and values of White/Eurocentric culture. Psychologist Judith Katz has explicated the components of White culture, which begin with the value of individualism, as opposed to prioritizing collective or community well-being. In keeping with this value, the individual is understood to be the primary social unit, autonomy is highly valued, and individuals are expected to master the environment and exercise control over the circumstances of their lives. Closely related is the value placed upon competition: All situations can be understood as win/lose propositions, and winning is

all-important. Status is accorded to individuals on an economic basis; money and property ownership are important symbols of status, along with titles and credentials. Communication is characterized by direct eye contact, limited emotional expressiveness, and little physical contact. Whites' sense of time is characterized by a future orientation and delay of gratification; time is viewed as a commodity and strict adherence to schedules is valued. Family structure is typically patriarchal, with the male as the traditional head of the nuclear family unit and the female subordinate to him. Beauty ideals for women are based on White physical characteristics (e.g., light skin, blue eyes, blonde hair) along with a thin body and youthful appearance; men are understood to be attractive primarily on the basis of their economic status and sociopolitical power. Musical and artistic aesthetics are derived from European models, and accepted histories are based on the perspective of Europeans who colonized the North American continent. Christian religion is foundational to White American culture, with most holidays deriving from either Christianity or White accounts of North American history.

Psychologist Derald Wing Sue has written about the culture of White Americans, their worldview, and ethnocentric monoculturalism. Ethnocentric monoculturalism refers to (a) the conviction that one's own culture is superior to any other; (b) a sense of entitlement to promulgate one's own beliefs, values, and traditions at the expense of others; and (c) the sociopolitical power to do so. Cultures are not, in and of themselves, either bad or good, and all cultures tend to privilege their own beliefs over others; therefore, it is the latter of these aspects—power—that is the key to ethnocentric monoculturalism and what makes it harmful to outgroups. In the United States, this means that groups other than White Americans, and those whose cultures and worldviews differ from Whites, are often seen as inferior, deviant, alien, and incapable, even if exotic and interesting. The fact that power resides almost exclusively with White Americans means that this negative evaluation damages the life opportunities and well-being of people of color in a White-dominated culture.

Another construct that helps illuminate the operations of Whiteness and White culture in America is hegemony. Hegemony refers to the capacity for powerful groups to maintain dominance not only through institutional, political, economic, and/or military displays of power but also through their



ability to shape cultural norms, ideals, systems of understanding, and conceptions of “common sense” in a way that supports their dominance. According to the Italian political theorist Antonio Gramsci, hegemony functions so that dominant groups exercise power from within subordinated people themselves, in that subordinated people internalize ideas and structures that define the dominant group’s power as natural and preordained. The culture of White Americans, then, can be said to be hegemonic in the United States in that many of the tenets of White culture have a natural, “of course” quality to them. Celebrations of the “rugged individual,” the symbolic display of personal purchasing power, and beauty pageant contestants of various races whose features correspond to White beauty ideals are unremarkable, taken-for-granted features of American life. Along these lines, author Toni Morrison has noted that the phrase “White Americans” itself has a redundant quality; the word *American* contains notions of Whiteness within it.

### White Americans and Privilege

Open commentary by White Americans regarding Whiteness has been infrequent, although Black scholars such as W. E. B. Du Bois have written influentially about Whiteness since before the turn of the 20th century. One of the best-known White expositors of Whiteness and its privileges in recent decades is Peggy McIntosh. In her Wellesley College working paper, first published in the late 1980s, McIntosh explored her identity as a White American and the unconscious privileges associated with it, calling it “an invisible knapsack” of assets and advantages that she carried with her into every situation. For example, McIntosh observed that, as a White woman, she nearly always had the opportunity to be interviewed and evaluated by people of her own race, that history told her that people of her race created civilization as she knew it, and that bandages and other products were made to match her skin tone. McIntosh also explored the personal and moral ramifications of allowing oneself to become aware of White privilege, noting that such awareness had direct implications regarding social justice and meritocracy: If certain people acquire unearned advantages simply by being White, then this is not a society where everyone gets what she or he deserves, and Whites who acknowledge their privilege must also acknowledge that any

success that they have enjoyed has been furthered because of it.

### Marked White Americans

As mentioned, the hegemonic nature of Whiteness in the United States means that Whiteness is, for the most part, unmarked. In other words, anything that does not correspond to White cultural ideals *is* marked as discrepant—as different, ethnic, foreign, or unusual—but Whiteness itself goes unnamed as the accepted standard according to which “differentness” is judged. One group of White Americans, however, occupies a social location slightly outside the unmarked heart of White American culture and therefore requires a label to indicate their outsider status: poor Whites, variously called White trash, trailer trash, rednecks, or hillbillies. Anthropologist John Hartigan has discussed the meaning inherent in the name-calling directed toward poor White Americans. Specifically, the fact that the “Otherness” of poor Whites requires demarcation points to the classist and racist underpinnings of White American culture. Hartigan also discussed the various shades of meaning among these labels. *Redneck* is a label that poor or rural Whites sometimes embrace, in that it conveys a defiant attitude in the face of mainstream social rejection, whereas *white trash* is an identity that no poor White wants to own, in that it corresponds to the nadir of the class spectrum and conveys the lowest point of social contempt. *Hillbilly*, on the other hand, has more specific regional connotations and encompasses the complexity of the Appalachian mountain experience: an identifiable cultural heritage of music, food, art, and love of the land, experienced within a context of shaming poverty and social isolation.

### Antiracist White Americans

One of the ways that White culture maintains its hegemonic dominance is by “erasing” White antiracist thought from history. This silence supports the impression that Whiteness has always been an accepted part of American life; moreover, those White Americans who wish to question or challenge White hegemony are left with no models of how such a thing might be done. In fact, there have always been White Americans who comprehend Whiteness and the corresponding oppression of people who are not White and who oppose the oppression outright. For



example, Thomas Paine is widely studied by American schoolchildren who learn about his influential pamphlet *Common Sense*, which advocated the emerging American Revolution against the British. What is not as frequently mentioned is that he was also emphatically opposed to slavery and wrote tracts on the slave trade that were certainly read by influential White slave masters of the day such as Thomas Jefferson and George Washington. Radical pre-Civil War abolitionists such as William Lloyd Garrison receive scant, if any, acknowledgment, while John Brown, who was hanged in 1859 for treason after attempting to instigate antislavery insurrections, is cast by history as a zealot. History instead presents White Americans with Abraham Lincoln as the Great Emancipator, a man who was politically neutral on slavery although personally opposed to it. In a letter to the *New York Tribune* in 1862, Lincoln stated that his priority was saving the Union and if he could save it without freeing any slaves, he would do so. This trend continues to the present day; White antiracists such as Robert Jensen, Judith Katz, Tim Wise, Jeff Hitchcock, and David Roediger are virtually unknown in mainstream White American culture or scholarship.

### Changing Demographics: White Americans in the Future

Since the 1990 U.S. Census, the White population has grown more slowly than the population as a whole, having increased by 5.9% as compared with the growth of 13.2% for the U.S. population as a whole. This pattern of slowing growth has led to the widely accepted view that by approximately 2050, Whites will no longer be the single most populous racial group. It remains to be seen how these changing numbers will impact the social location of White Americans or their awareness of it.

Laura Smith

**See also** Classism (v3); Color-Blind Racial Ideology (v3); Demographics, United States (v3); Ethnocentrism (v3); Eurocentrism (v3); Helms, Janet E. (v3); Power and Powerlessness (v3); Race (v3); Racial Identity (v3); Racial Pride (v3); Racism (v3); Sue, Derald Wing; Contributions to Multicultural Psychology and Counseling (v3); White Privilege (v3); White Racial Identity Development (v3); Worldview (v3)

### Further Readings

- Bonilla-Silva, E. (2003). *Racism without racists*. Lanham, MD: Rowman & Littlefield.
- Doane, A., & Bonilla-Silva, E. (Eds.). (2003). *White out: The continuing significance of racism*. New York: Routledge.
- Frankenburg, R. (1993). *White women, race matters: The social construction of race*. Minneapolis: University of Minnesota Press.
- Hartigan, J. (2005). *Odd tribes: Toward a cultural analysis of White people*. Durham, NC: Duke University Press.
- Jensen, R. (2005). *The heart of Whiteness*. San Francisco: City Lights Books.
- Katz, J. (2003). *White awareness*. Norman: University of Oklahoma Press.
- Lui, M., Robles, B., Leondar-Ross, B., Brewer, R., & Adamson, R. (2006). *The color of wealth*. New York: New Press.
- Roediger, D. R. (1991). *The wages of Whiteness*. New York: Verso.
- Sue, D. W. (2003). *Overcoming our racism*. San Francisco: Jossey-Bass.
- Zinn, H. (2005). *A people's history of the United States*. New York: Harper Perennial.

## WHITE PRIVILEGE

White privilege is the concept that European Americans benefit from specific advantages—denied to people of color—solely because of their nonminority status. These are unearned benefits derived not from merit, and these benefits are often taken for granted, if even acknowledged at all. White privilege generally refers to White, male, Anglo-Saxon, middle to upper class, heterosexual, able-bodied individuals.

The concept of White privilege has been evident in discussions of prejudice for some time, but Peg McIntosh articulated it in a way that was able to reach European American counseling students and scholars of all backgrounds. McIntosh, a feminist author writing in the area of male privilege, began to speculate, not about how she was oppressed as a woman, but whether she herself was privileged due to her status as a White person. She used the analogy of a backpack filled with unearned privileges that White persons are given at birth. Her work was seminal and formed much of the subsequent discussions on this topic.

White privilege is best understood when examined in the context of power and oppression. Individuals as



well as groups of people can be the victims of classism, sexism, racism, and other forms of oppression. Multicultural competency, a cornerstone of the contemporary counseling paradigm, involves integrating this understanding into practice. However, to achieve this end, it is important for researchers and practitioners to grasp a firm understanding of the dynamics of oppression and its underlying structural components.

Oppression denotes a feeling of being weighed down and kept down by an unnecessary or unjust use of power: Oppression exists symbiotically with power. For oppression to be present, there has to be a stratified system of power differential among people in a society. That is, one person or one group needs to be on top or in a position of power, while another person or group of people is subjugated or kept in a position without power, or at least in a position without as much power as the other group. An integral aspect in the examination of the dynamics of oppression and White privilege is the often overlooked notion that people benefit from oppression without even realizing they are doing so. Many privileged members of the group with power in society do not want to think that they are living their lives in a manner that is oppressing anyone, yet every day they directly and indirectly benefit from the dynamics of oppression.

These dynamics of oppression continue to exist in society because it is difficult to enact systemic change when people are comfortable where they are in their current state of existence. The transaction of empowerment requires a power reallocation; that is, for change to occur, the people with privilege have to surrender some degree of their power. Historically, examinations of oppression have focused on the victims. However, to best understand White privilege, there needs to be an honest and thorough examination of the people who are benefiting from this power, with an emphasis on how it is highly advantageous for them to maintain their power and privilege.

### **Tripartite Model**

The transformation of this definition of racism can be conceptualized by James Jones's tripartite model of contemporary racism, and this model is quite helpful in illustrating the manifestations of White privilege in society. Three levels of racism (i.e., individual, institutional, cultural) comprise this model. The first level, individual racism, can be defined as any action or attitude—conscious or unconscious, intentional or

unintentional—that subordinates a person or group because of their race. While hate crimes and other highly visible overt acts fall into this category, individual racism also includes the beliefs and behaviors of well-intentioned people who are unaware that their attitudes and actions may oppress people of color.

The second level, institutional racism, resides in the organizations and institutions of society. Institutional racism is defined as any organizational practice or policy in business, government, schools, churches, courts, and law enforcement agencies that is enacted to unfairly subjugate persons of color, while allowing other groups to profit from these policies and procedures. The third level of racism in the tripartite model is cultural racism, which is the individual and institutional expression of the superiority of one group's cultural heritage over that of another. Cultural racism can be conceptualized as the superordinate umbrella that influences and permits both the levels of individual and institutional racism to exist and flourish.

Evidenced in each level of this model of contemporary racism, the manifestations of White privilege are often subtle, and their hegemonic nature makes them all the more powerful—and insidious. Rarely (if ever) contested, these seemingly invisible incidents of privilege allow White persons to make unlimited withdrawals from the White Privilege bank account without ever having to make deposits or even balance the checkbook.

### ***Individual Level***

White privilege at the individual level manifests itself in many forms. It may be a subtle microaggression, perhaps even an unintentional slight, which benefits a White person at the expense of a person of color. One example, from the perspective of a person of color, is the act of a White person being waited upon first even though he or she has come to the counter last.

If the White waiter takes the opportunity in an ambiguous situation to choose to wait on this White customer before the customer of color, it is difficult to discern intentionality. Perhaps the waiter legitimately didn't see the Black person enter first. Perhaps the waiter was having a bad day. Perhaps the waiter doesn't like Black people or thinks that White patrons tip better. On the other hand, if a White patron were to see another late-arriving patron waited upon first, the race-based explanation would most likely not occur to him.



However, sifting through these explanations causes a person of color to expend cognitive energy on the distinct possibility that the waiter chose to disregard societal conventions of “first come, first serve” in favor of extending an unearned privilege to a White person because of their shared racial group membership.

A microaggression is a subtle insult or small act of racism. A microaggression, such as the one in the previously mentioned example, can cause a person of color to mentally rehearse defensive scripts and actions. If the instance is brought up to a friend, colleague, or perhaps even the waiter, a person of color has to prepare to verbally defend himself against the anticipated minimization of the experience (e.g., “You’re being too sensitive and reading too much into it”). Or the person may have to defend against the flat out denial of such a race-based explanation (e.g., “The ‘60s are over. People don’t think like that any more”). Alternately, the person of color may rehearse a defensive script wherein he directly confronts the waiter about the slight, thus taking the chance that he incorrectly attributed a racially based explanation (e.g., the waiter doesn’t like Black people) when a potentially benign explanation was more accurate (e.g., the waiter didn’t see the Black person come in first).

Other examples can be seen throughout the culture of the United States. These examples include store detectives specifically following people of color when they enter a store because the store detectives believe people of color shoplift more than White people; automatic denial of loans for automobiles or homes for people of color; or even realtors who do not show homes to people of color that are in predominantly White neighborhoods. Examples such as these contribute to the physiological and psychological distress that people feel. Lack of trust underlies the anxiety and stress people may feel, and anxiety and stress contribute to increased high blood pressure, increased heart disease, and an increase in chronic health problems.

Scenarios like these can cause unnecessary stress and duress for a person of color, whether it is an actual incident occurring or just the prospect that such a situation may occur. This race-related stress can be defined as the race-related transactions between individuals or groups and the environment that emerge from the dynamics of racism. Race-related stress can tax or exceed existing individual and collective resources or threaten well-being. Exposure to race-related stress can have psychological and physiological consequences to a member of a discriminated-against

group. The exposure to chronic forms of discrimination has been implicated in the development of several stress-related diseases prevalent in the African American community and among other persons of color.

White privilege at the individual level of racism is the ability to arrive at an explanation—benign or otherwise—to an ambiguous social interaction without legitimately considering a race-related explanation. Thus, White privilege provides White persons with a buffer from the physiological and psychological consequences of race-related stress. This buffer is not readily available to persons of color who, at some level, have to at least contemplate the possibility of a racially based explanation (e.g., skin color contributed to the waiter’s decision to wait on the White person first).

### ***Institutional Level***

At the institutional level of the tripartite model of racism, White privilege may be even more difficult to discern because the unearned benefits afforded to Whites at this level do not originate in one-on-one interactions. Rather, these privileges are embedded within societal institutions and organizations. Having had these benefits denied to them, persons of color may be acutely aware of this dynamic. However, having been raised on the dominant ideologies of rugged individualism and meritocracy, White persons may have difficulty acknowledging racism as a system that structurally benefits White persons at the expense of persons of color because doing so would threaten long-standing beliefs about society and beliefs about one’s own accomplishments.

To illustrate the nature of White privilege at the institutional level, a series of compelling questions are offered here. For example, if a White employee makes an unpopular decision at his job, does he worry that his coworkers or customers will assume that a policy such as affirmative action ensured that other more qualified candidates were passed over because his race obscured an assumed lack of ability or qualifications? Is it perceived that his merit or his skin color is the main contributor to his success (or lack thereof)?

If a White person is a defendant in court, is there a good chance that a jury of his peers shares his values or even his racial characteristics? Do these peers make implicit assumptions about his guilt or innocence based on preconceived stereotypical notions about other people who look like him? Furthermore, are



these notions based on a critical mass of real-life interactions with others who look like him, or are these notions instead based on isolated incidents or derived from movies, news reports, and other popular culture representations?

Extending beyond these issues of merit, consider assumptions that are made about the protection afforded by law enforcement agencies. Is there a systemic manner in which law enforcement is provided to members of different races? Does it take police officers a comparatively longer time to respond to 911 calls in Black neighborhoods? When teaching their adolescent son how to drive, how many White parents need to include instructions on keeping his hands in plain sight on the steering wheel in the event that he is pulled over by the police?

In contemplating the answers to these questions, the subtle and subversive nature of White privilege illustrates how institutional policies and practices unfairly subjugate persons of color, while allowing other groups to benefit. An unopened backpack of White privilege ensures that these unearned institutionally based privileges are neither acknowledged nor articulated, thus ensuring their continued receipt.

Research has shown that serious educational, occupational, economic, and health disparities exist between persons of color and White persons. In the counseling domain, there is a high rate of clients of color underutilizing mental health services and not returning for second sessions. Reasons for these include economic constraints, service access barriers, and cultural mistrust attitudes toward White counselors. When clients leave counseling early, this results in an increase in underdiagnosis and misdiagnosis, which, in turn, does not allow clients to get the help they need. In addition, psychological testing has been developed and based on the majority culture and does not always meet the needs of the client, specifically for a person of color. Testing is not always culturally sensitive, culturally appropriate, or adequate for the care of diverse clients.

Further research in the counseling literature acknowledges these disparities and highlights these institutional practices in terms of microaggressions against clients of color. These microaggressions are often perpetuated by well-intentioned White counselors, even those with extensive multicultural training. These subtle exchanges convey demeaning messages to clients of color, causing damage to the therapeutic alliance and the client's psychological well-being.

Blaming the victim, dysfunctional helping, and self-righteous assertions of being nonracist are all examples of ways that clients of color can be disserved and even victimized in therapy by White counselors. To clarify, blaming the victim involves a White counselor employing an intervention wherein the counselor assigns responsibility to the client of color for his presenting concern (e.g., depressive symptoms surrounding current unemployment). This microaggression serves to minimize or ignore the reality of White privilege, perpetuate cultural mistrust, and ignore the role of societal racism as a salient contributing factor in the presenting concern of the client of color.

Institutional practices and policies contribute to these disparities. However, because explicitly racist laws, such as Jim Crow laws, are no longer legal, it is difficult for White persons to acknowledge the systemic nature by which institutions subjugate persons of color. Instead, when disparities are observed, individual attributions are made that are congruent with majority values, and corresponding solutions (e.g., work harder, pull yourself up by the bootstraps, stop feeling sorry for yourself) serve to blame persons of color while effectively absolving institutional policies and practices of any responsibility in the matter. Thus, misattribution and denial allow institutional racism to effectively function without interruption.

### **Cultural Level**

At the cultural level of the tripartite model of racism, examples of White privilege may occur in the form of subtle societal messages that are omnipresent in society and are conveyed through myriad media (e.g., television, radio, newspapers, Internet). These messages perpetuate the belief that White culture is superior and that other cultures are subordinate. A prime example is the societal standard for beauty—blonde hair, blue eyes—that favors predominantly Caucasian characteristics. Those who do not conform to this culturally exclusive standard are not fully represented in media and popular culture and thus do not achieve the same level of beauty.

Furthermore, if an attractive African American woman is acknowledged for her beauty—beauty that deviates from this cultural norm—she may be described as an *attractive Black woman*. On the other hand, an attractive blonde-haired blue-eyed Caucasian woman may be described as an *attractive woman* rather than an *attractive White woman*. This example



of asymmetric racial marking sets the beauty of the White woman as the default standard. Her beauty does not require a specific racial designation because it is understood that this beauty (i.e., blonde-haired, blue eyed, *White*) inherently conforms to the dominant cultural standard.

### Color-Blind Approach

White privilege can be thought of as the mechanism driving the color-blind approach to race relations. A color-blind approach is the position often endorsed by members of mainstream White society wherein they purport not to see race-based differences in people. Instead, they see everybody as equals and treat them accordingly. At the surface level, this is a socially desirable perspective because it conveys the sense of a progressive belief in only one race, the human race, a belief that aligns with the perspective of encouraging people of different cultures to assimilate.

However, embracing a color-blind approach is difficult because in doing so, one neglects to acknowledge the role of power in society, insinuating that we live in a purely egalitarian society wherein the American dream is equally accessible to all members of the human race, if only they work hard enough. Furthermore, it assumes that everybody has the luxury to choose not to see differences based on color. Ignoring racial group differences can validate assumptions that minority groups share the same values as those in the majority, thus leading to maintenance of the status quo. Perpetuating this societal status quo preserves the hierarchical system of racial stratification prevalent in American society, thus denying the reality of people of color—a reality wherein racism is very real to them, despite contentions to the contrary by White persons who have the power to purport not to treat people differently based on race.

White privilege is exemplified in this ability to deny another person's reality without having to acknowledge the ramifications of doing so. This invalidation can be driven by malice, but more often than not, it is driven by naïveté or even apathy when the ramifications do not appear to directly affect White persons. Power is the benefit acquired from deciding which reality is valid, and mainstream American society affords this unearned privilege of power to White persons at the expense of persons of color.

Although the colorblind strategy may appear noble and egalitarian on the surface, it conceals the reality of

contemporary racism. Examples of overt racism represent only the tip of the racist iceberg. These examples may include the internment of people of Japanese descent living in the United States during World War II, forcing African American people to ride in the back of the bus, or dousing blankets with disease to trade to Native American people. An exclusive focus on these visible acts obscures the emergence of racism's insidious modern transformation into the invisible default standard of covert racism. Arguing against the color-blind strategy, Eduardo Bonilla-Silva reports that the United States is a racist country and due to the benefits experienced by White privilege, people continue to support racism by continuing to benefit from privilege. He also reports that seemingly innocent comments such as "I am not racist, but . . ." are more passive-aggressive in nature and continue to provide people with a forum to make racist remarks.

The use of American Indians as mascots for school and sports teams provides another poignant yet rarely acknowledged example of White privilege at the cultural level. Indian-themed mascots, such as the Cleveland Indians' Chief Wahoo, exhibit distorted versions that do not encapsulate or even accurately represent how real American Indians act or what they look like. In the absence of any (or, at best, limited) contact with real-life American Indians, mascots are the image that drives society's perceptions of who American Indians are.

White privilege is the ability to ignore the perspective of those without power or voice and to honor them on terms other than their own. Furthermore, even in the most optimistic scenario, White privilege is manifest in getting all of the facts together, listening to all relevant perspectives, and receiving overwhelming evidence and reasons to make a change. Yet White privilege grants the power to disregard all of this. White persons can rationalize their actions and prioritize other concerns (e.g., tradition, convenience, money) over the denigration of another group of people, even when the implicit becomes explicit and the hegemony of cultural racism starts to unfold. White privilege thrives in this space between.

### Extension to Other Groups

Theorists have extended the concept of group-based privilege beyond race. As stated earlier, the notion was first developed within the context of male privilege and then extended to race. Now it has been used to describe



Christian privilege. An example of Christian privilege would be the ability to assume that an individual will not be required to work on a holiday that is celebrated in your religion. It has also been extended to nondisability privilege. A graphic example of nondisability privilege is the fact that an amniocentesis test showed that you did not have Down's syndrome, so you were allowed to be born, as opposed to some people who may decide to discontinue a pregnancy because of the existence of a disability. In addition, it has been extended to heterosexual privilege. A salient example of heterosexual privilege is the fact that, if you are a heterosexual individual, you are allowed to marry and benefit from all of the legal and social positive aspects of the recognition of such a union.

*Jesse A. Steinfeldt, Janice E. Jones, and  
Paul E. Priester*

**See also** African Americans (v3); American Indians (v3); Barriers to Cross-Cultural Counseling (v3); Color-Blind Racial Ideology (v3); Cultural Mistrust (v3); Discrimination (v3); Diversity (v3); Ethnic Identity (v3); Ethnic Pride (v3); Oppression (v3); Power and Powerlessness (v3); Racial Identity (v3); Racial Pride (v3); Racism (v3); White Americans (v3); White Racial Identity Development (v3); Worldview (v3)

### Further Readings

- American Psychological Association. (2003). Guidelines on multicultural education, training, research, practice, and organizational change for psychologists. *American Psychologist*, 58, 377–402.
- Bonilla-Silva, E. (2006). *Racism without racists: Color-blind racism and the persistence of racial inequality in the United States*. New York: Rowman & Littlefield.
- Constantine, M. G. (2007). Racial microaggressions against African American clients in cross-racial counseling relationships. *Journal of Counseling Psychology*, 54, 1–16.
- Harrell, S. P. (2000). A multidimensional conceptualization of racism-related stress: Implications for the well-being of people of color. *American Journal of Orthopsychiatry*, 70, 42–57.
- Jones, J. M. (1997). *Prejudice and racism* (2nd ed.). New York: McGraw-Hill.
- McIntosh, P. (1989). White privilege: Unpacking the invisible knapsack. In P. S. Rothenberg (Ed.), *White privilege* (pp. 97–102). New York: Worth.
- Neville, H. A., Worthington, R. L., & Spanierman, L. B. (2001). Race, power, and multicultural counseling

psychology: Understanding White privilege and color-blind racial attitudes. In J. G. Ponterotto, J. M. Casas, L. A. Suzuki, & C. M. Alexander (Eds.), *Handbook of multicultural counseling* (2nd ed., pp. 257–288).

Thousand Oaks, CA: Sage.

- Ridley, C. R. (1995). *Overcoming unintentional racism in counseling and therapy*. Thousand Oaks, CA: Sage.
- Sue, D. W. (2001). Multidimensional facets of cultural competence. *The Counseling Psychologist*, 29, 790–821.
- Sue, D. W. (2003). *Overcoming our racism: The journey to liberation*. San Francisco: Jossey-Bass.
- Sue, D. W. (2005). Racism and the conspiracy of silence. *The Counseling Psychologist*, 33, 100–114.
- Sue, D. W., Bingham, R. P., Porche-Burke, L., & Vasquez, M. (1999). The diversification of psychology: The multicultural revolution. *American Psychologist*, 54, 1061–1069.
- Tatum, B. D. (1997). *Why are all the Black kids sitting together in the cafeteria? And other conversations about race*. New York: Basic Books.

---

## WHITE RACIAL IDENTITY DEVELOPMENT

---

White racial identity development (WRID) theory describes how White individuals develop a sense of themselves as racial beings, acknowledge the realities of structural racism and White privilege, and come to accept race as a healthy aspect of themselves and others. *Structural racism* is defined here as the policies and practices in the fabric of U.S. society that disadvantage non-White individuals; *White privilege* refers to the rights, advantages, exemptions, and/or immunities granted to White individuals that non-Whites are not provided. WRID is a specific derivation of the more general cultural/racial identity development theory. It is consistent with cultural/racial identity development theory in that it assumes that (a) people have varying levels of awareness about their group identity, (b) the level of awareness is influenced by sociopolitical factors, and (c) the level of awareness has important implications for counseling practice and training.

### Models

William Cross developed a Nigrescence model to explain the process of Black racial identity development. This Nigrescence model was later applied by Judy Katz and Allen Ivey to understand how Whites



deny their own race and the existence of structural racism. Cross's model, combined with these early investigations of how Whites understand their own race and racism, led to the development of the first WRID models.

There are several models that have been proposed to explicate WRID, and although these models differ in their description and sequence, they generally progress as follows: a minimization of oneself as a racial being and of racism; dissonance created by cross-racial experiences that challenge this naïveté; a recognition of oneself as a racial being and Whites' perpetuation of racism; and the internalization of an integrated White racial identity and comfort in cross-racial interactions. Historically, WRID models referred to *stages* of racial identity development; this term has been replaced with *statuses* to refer to the more fluid boundaries between different racial identity statuses and the dynamic processes by which individuals progress and regress between racial identity statuses.

### Helms's Model

Janet Helms's model of White racial identity development is the most researched and applied of the WRID models. Helms's model has given rise to an assessment instrument, the White Racial Identity Attitude Scale (WRIAS), to measure WRID. Helms's WRID model has received some support from psychometric scrutiny of the WRIAS. Helms's model describes six statuses that may be divided into two meta-processes: (1) abandonment of racism and (2) defining a nonracist White identity.

Lack of awareness of oneself as a racial being and obliviousness to racial issues characterize *contact status*. Here, a White person is naïve regarding the sociopolitical implications of race. During *disintegration status*, the minimization of race and racism is challenged by witnessing racial oppression or acknowledging one's own racist thoughts and behaviors. This challenges the naïveté of the previous status and creates dissonance. This dissonance may result in feelings of guilt, sadness, or anxiety and may lead a White person to avoid contact with persons of color. *Reintegration status* is marked by recourse to pro-White, antiminority attitudes to deal with the dissonance of disintegration status. One condones White supremacy and blames minorities for their own problems.

Helms's second process—defining a nonracist White identity—begins with *pseudo-independence*

*status*. When racial oppression and a racist White identity are challenged, White people make an effort to understand racial differences. The motivation for multicultural learning is present, but understanding of diversity is immature, and cross-racial interactions may be paternalistic. In *immersion/emersion status* White people search for a personally meaningful definition of Whiteness. Intentionally learning about one's contribution to racism is an important task for this status. Less emphasis is put on trying to change others as one turns inward to address personal racist beliefs and tendencies. *Autonomy status* represents an individual's acceptance of his or her Whiteness and role in racial oppression. Here, the person's reference group is multiracial and the person selects and nurtures those aspects of White culture that "feel right." Finally, the autonomous individual moves beyond intellectualization of antiracism to take action against racial oppression.

### Sue and Sue Model

Derald Wing Sue and David Sue have recently proposed a five-phase WRID model, in which individuals fluidly regress and progress across phases. This model differs from Helms's model in the way in which White individuals are theorized to address the dissonance from acknowledging racial inequality and Whites' role in racial oppression. Rather than a movement forward into a "reintegration" phase, as in Helms's model, individuals recycle back to the beginning "conformity" phase before reaching the later phases of WRID in the Sue and Sue model. The five phases of this model are discussed next.

During the *conformity phase*, a White person is highly ethnocentric, one's self-conception as a racial being is minimal, there is a conscious or unconscious belief that White culture is superior, and one professes a nonracist identity. The *dissonance phase* occurs when an individual experiences incongruence between his or her nonracist self-image and contradictory behavior. One's Whiteness and concomitant bias is acknowledged, and there is a dilemma about how to cope with this incongruence. Here, White people may return to the conformity phase or move into the *resistance and immersion phase*, characterized by a confrontation with one's own racism. In this phase, an individual becomes disillusioned to racial oppression, may reject his or her own Whiteness, and identify strongly with non-White groups. The *introspection*



*phase* is a compromise between the preceding two phases, in which one questions and reformulates what it means to be White. The person accepts his or her Whiteness and role in perpetuating racial oppression but seeks to define a new racial identity. The formation of a nonracist White identity is the hallmark of the *integrative awareness phase*. Now, an individual has an understanding of him- or herself as a racial being, appreciates diversity, is aware of oppression, and actively works to confront it.

### **Applications for Training and Counseling**

Because the majority of counseling practitioners are White, WRID scholarship has focused upon the context of understanding counselors' racial identity status in multicultural counseling and training situations. By contrast, non-White racial identity scholarship has focused upon its implications for clients rather than counselors.

From a training perspective, becoming aware of one's own White identity is an important part of multicultural counseling competency, an imperative for working with non-White client populations. Relatedly, Helms argued that White counselors with a greater degree of WRID have a greater capacity to confront and address structural racism and the racial dynamics and racial identity of their clients. Sue and Sue recommended that graduate programs assess WRID status to tailor multicultural training experiences, with the goal of making Whiteness visible and integrated into trainees' self-concept in a nonracist fashion.

Haresh Sabnani and colleagues articulated a WRID model with concomitant training goals for each racial identity status. This model incorporates aspects of the aforementioned models to create five WRID statuses: (1) pre-exposure/precontact, (2) conflict, (3) prominority/antiracism, (4) retreat into White culture, and (5) redefinition and integration. For each of these statuses, Sabnani prescribed objectives for the development of counselors' beliefs and attitudes, knowledge, and skills, with the overall goal of facilitating the counselors' movement to the next racial identity status. Their hypothesis is that counseling trainees will be differentially primed for multicultural training experiences based on their racial identity status. As Helms also argued, targeting training and educational experiences to racial identity status is critical in facilitating

White students' racial identity, their capacity to recognize their own contributions to societal racism, and their capacity to counsel non-White individuals.

WRID also has important applications to counseling. Because WRID appears to influence cross-racial interpersonal relationships, White counselors can consider how their racial identity status may influence therapeutic relationships with non-White clients. Helms advanced a complex dyadic model for this purpose; cross-referencing WRID statuses with Black racial identity statuses. The result is a description of the relational dynamic for every potential White-non-White encounter, according to each individual's racial identity development status. This understanding of dyad combinations can attenuate confusion in clinical work and may motivate White counselors to nurture their racial self-concept to maximize the efficacy of their service to non-White populations.

Research examining the impact of WRID upon aspects of the counseling and supervisory relationship has yielded mixed results. For example, Madonna Constantine found that racial microaggressions, subtly racist messages and/or behavior by White counselors with African American clients, adversely affected the therapeutic alliance in counseling. Shawn Utsey and Carol Gernat found that White trainees with less advanced racial identity statuses relied upon more primitive ego defense mechanisms in racially provocative situations within counseling and supervisory dyads. However, Alan Burkard and colleagues did not find that WRID was associated with the capacity to form a working alliance in counseling by White participants.

### **Future Directions**

Helms's WRID model has had a significant impact upon the understanding of Whites' racial identity development and in conceptualizing its impact upon counseling and supervisory dynamics. Although the WRIAS has been widely used, there has been some debate as to the correspondence between the WRIAS and Helms's White racial identity statuses. However, the Helms model and other models of racial identity development have profoundly influenced the Association for Multicultural Counseling and Development multicultural competencies and culturally informed theories of counseling. Future research could build upon the strong theoretical base of WRID to further clarify the impact of



identity status upon the working alliance and other aspects of counseling, supervision, and training.

*Matthew A. Diemer and Adam M. Voight*

*See also* Black Racial Identity Development (v3); Cross-Cultural Training (v3); Helms, Janet E. (v3); Identity (v3); Identity Development (v3); Interracial Comfort (v3); Multicultural Counseling (v3); Racial Identity (v3); Sue, Derald Wing (v1); Sue, Derald Wing: Contributions to Multicultural Psychology and Counseling (v3); White Americans (v3); White Privilege (v3)

### Further Readings

- Behrens, J. T. (1997). Does the White Racial Attitude Scale measure racial identity? *Journal of Counseling Psychology, 44*, 3–12.
- Burkard, A. W., Juarez-Huffaker, M., & Ajmere, K. (2003). White racial identity attitudes as a predictor of client perceptions of cross-cultural working alliances. *Journal of Multicultural Counseling and Development, 31*, 226–236.
- Constantine, M. G. (2007). Racial microaggressions against African American clients in cross-racial counseling relationships. *Journal of Counseling Psychology, 54*(1), 1–16.
- Cross, W. E. (1971). The Negro-to-Black conversion experience. *Black World, July*, 13–27.
- Hardiman, R. (1982). White identity development: A process-oriented model for describing the racial consciousness of White Americans. *Dissertation Abstracts International, 43*, 104A.
- Helms, J. E. (1984). Toward a theoretical explanation of the effects of race on counseling: A Black and White model. *The Counseling Psychologist, 12*, 153–165.
- Helms, J. E., & Carter, R. T. (1990). Development of the White Racial Identity Inventory. In J. E. Helms (Ed.), *Black and White racial identity: Theory, research and practice* (pp. 67–80). Westport, CT: Greenwood Press.
- Ivey, A. E., D'Andrea, M., Ivey, M. B., & Simek-Morgan, L. (2007). *Theories of counseling and psychotherapy: A multicultural perspective*. Boston: Pearson Education.
- Katz, J. H., & Ivey, A. (1977). White awareness: The frontier of racism awareness training. *Personnel and Guidance Journal, 55*, 485–487.
- Pope-Davis, D. B., Vandiver, B. J., & Stone, G. L. (1999). White racial identity attitude development: A psychometric examination of two instruments. *Journal of Counseling Psychology, 46*(1), 70–79.
- Roysircar, G., Arredondo, P., Fuertes, J., Ponterotto, J., & Toporek, R. (2003). *Multicultural counseling*

*competencies, 2003: Association for Multicultural Counseling and Development*. Alexandria, VA: American Counseling Association.

- Sabnani, H. B., Ponterotto, J. G., & Borodovsky, L. G. (1991). White racial identity development and cross-cultural counselor training. *The Counseling Psychologist, 19*, 76–102.
- Sue, D. W., & Sue, D. (2008). *Counseling the culturally diverse: Theory and practice* (5th ed.). New York: Wiley.
- Utsey, S. O., & Gernat, C. A. (2002). White racial identity attitudes and the ego defense mechanisms used by White counselor trainees in racially provocative counseling situations. *Journal of Counseling & Development, 80*(4), 475–484.

---

## WORLDVIEW

---

The human psyche represents a complex constellation of activity that impacts how people perceive and respond to reality. Culture firmly impacts the human experience, and worldview is subsequently one of the most studied constructs in the field of cultural, cross-cultural, and multicultural psychology. Worldview has been defined as a person's perception of his or her relationship with the world. More specifically, worldview is a by-product of the way in which a person is socialized to perceive, think, feel, and experience the world. It attempts to make sense of life experiences that might otherwise be construed as chaotic, random, and meaningless. Worldview articulates the basic philosophical assumptions, values, and beliefs underlying culture and is expressed through its various structural or institutional manifestations. Moreover, worldview is a by-product of culture that affects, and tends to determine, behavior.

### Historical Synopsis

The construct of worldview is one of the earliest cultural variables to be integrated into psychological research, theory, and practice. Worldview represents a unifying thread in the psychological literature that suggests practices to guide culturally competent research and psychotherapy with culturally diverse communities. In 1970, J. L. White wrote the first article—"Toward a Black Psychology"—that questioned the utility of applying mainstream psychology



toward African Americans. This article, which was published in *Ebony*, argued that it was difficult—if not impossible—to understand the African American experience by using traditional psychological theories that were developed by European American psychologists to explain European American behavior. Implicit in this assertion was the position that worldview differences exist between these two groups and that a psychology that is rooted in Western philosophy could lead to conclusions that could be harmful in the scientific research, clinical diagnosis, and prescribed treatment of African Americans.

This investigation into the implications of worldview differences was advanced more broadly by D. W. Sue and his colleagues. In 1982, they published a position paper in *The Counseling Psychologist*. Ten years later (1992), Sue and his colleagues followed up with a call to the profession, which was published in the *Journal of Counseling & Development*. This body of work represented an initial step toward articulating a set of competencies that each culturally skilled psychologist should be able to wield in psychotherapy. Such competencies were organized along the dimensions of beliefs, knowledge, and skills. For the first time, the implications of worldview differences in psychotherapy were clearly delineated and therapist self-exploration was promoted. Two decades after the original position paper was published, in 2002, the American Psychological Association Council of Representatives adopted a set of guidelines on multicultural education, training, research, practice, and organizational change for psychologists. These guidelines noted that awareness of the research participant's—or client's—worldview is not sufficient to actualize cultural competence in research—or psychotherapy. Psychologists must also be aware of their own worldview and have the skills to work through worldview differences in research, training, and psychotherapy in a culturally sensitive and meaningful manner.

### Conceptualization of Worldview

Contemporary debates about the construct of worldview are focused more on how it is conceptualized and less on its utility in the field of psychology. It is widely understood that the construct of worldview can be used to understand interpersonal dynamics in a therapeutic relationship. Furthermore, some counseling psychologists have argued that therapists who work with

culturally different clients will increasingly be exposed to clients who exhibit different worldview orientations. To the extent that these views diverge, services may be viewed as unacceptable and unnecessary and may influence the underutilization of psychotherapy by various ethnic groups in our society. Given the mental health-related help-seeking disparities that plague such populations, several counseling psychologists have articulated a need for a comprehensive characterization of worldview that can be applied to psychological assessment and psychotherapy.

### Perspectives

To date, there are two primary perspectives that are driving the evolving conceptualization of worldview. The most prominent perspective is an existential approach that is rooted in cultural anthropology. Alternatively, some psychologists have tried to provide a more comprehensive articulation of worldview by investigating the depths of culture through the interrogation of various dimensions of philosophy.

### Cultural Anthropology

Traditionally, conceptions of worldview in psychology have been grounded in cultural anthropology. In 1961, F. R. Kluckhohn and F. L. Strodtbeck articulated an anthropological model of value orientations that focused on five existential categories: human nature (what is the character of human nature?), activity orientation (what is the modality of human activity?), social relationships (what is the modality of people's relationships?), person-nature (what is the relationship of people to nature?), and time orientation (what is the temporal focus of human life?). Furthermore, each existential category was thought to vary among three potential options: human nature—bad, good and bad, or good; activity orientation—being, being in becoming, or doing; social relationships—lineal/hierarchical, collateral/mutual, or individualistic; person-nature—harmony, subjugation and control, or power of nature; and time orientation—past, present, or future.

Psychologists have used this model to conceptualize various dimensions of worldview orientations and have hypothesized that the beliefs and values along each dimension are shaped by the individual's cultural context. It is important to note that researchers have also operationalized worldview according to other value dimensions such as justice beliefs, sense of



coherence, and cultural attitudes. A value-based conceptualization of worldview was the basis of several assessment instruments, including the Value Orientations Questionnaire (Green & Haymes), the Value Orientations Scale (Szapocznik & colleagues), and the Scale to Assess World View (Ibrahim & Kahn). These scales were designed to be applied to psychological research and to improve cultural competence in psychotherapy. In 1991, R. T. Carter provided a comprehensive summary of worldview studies based on this existential values conceptualization. F. A. Ibrahim, G. Roysircar-Sodowski, and H. Ohnishi later updated this review in 2001. Readers may consult these summaries for more detail.

## Philosophy

Conceptions of worldview in psychology have also been grounded in the discipline of philosophy. Psychologists such as W. C. Banks, L. James-Myers, K. K. K. Kambon, and W. A. Nobles argued that cultural phenomena—like worldview—could best be captured through the deep structure of culture. According to this conceptualization, worldview is organized into several philosophical constructs: *cosmology*—nature of the universe, *epistemology*—theory of knowledge, *ontology*—connection of psychological facts with reality, *axiology*—science of values, and *teleology*—theory that things act for an end purpose. This method of conceptualizing worldview encompasses the values-based approach, while adding a layer of complexity by including additional culturally influenced dimensions that have the capacity to deepen the breadth of the worldview literature.

Historically, the aforementioned philosophical constructs have been traced back to KMT (or Ancient Egypt) and the definitions of these constructs have been debated by philosophers such as G. Berkeley, R. Descartes, G. W. F. Hegel, M. Heidegger, D. Hume, I. Kant, J. Locke, K. Marx, and Plato, to name a few. In 2005, L. James-Myers and colleagues advanced the cosmology, epistemology, ontology, axiology, and teleology model for analyzing worldview systems. More specifically, they provided potential questions that could be used to gain insight into a person's worldview orientation. Examples of such questions included (a) How was the universe created? (b) What powers animate life and gives it form? (c) What can be accepted as truth? (d) How is knowledge obtained and transmitted? (e) What is the nature of reality?

(f) What exists in reality? (g) What are some values that can be used to guide human interactions? (h) What is the purpose of life?

Several behavioral scientists have used these philosophical dimensions of worldview to conceptualize the notion of *self* and *consciousness* for diverse ethnic groups. Additionally, several categorizations have been illustrated to delineate differences and similarities between different ethnic groups along these philosophical dimensions of worldview. A philosophically based conceptualization of worldview was the basis of several assessment instruments, including the Worldview Scale (Baldwin & Hopkins) and the Worldview Analysis Scale (Obasi, Flores, & James-Myers).

## Measuring Worldview

Although there is a multitude of psychological literature addressing the implications that worldview differences may have in conducting culturally competent psychotherapy, psychologists have been less adamant in investigating this issue in the domain of research. Within the field of psychology broadly, complex formulations of cultural phenomena often are relegated to race-based stereotypes. Whereas there are various theoretical formulations that conjecture the existence of worldview differences among various ethnic groups, there is a dearth in the amount of empirical evidence to substantiate such claims. In part, this is due to conceptual incarceration where Western science dictates what epistemology and methodology are deemed credible for uncovering such ontological relationships. In light of the imposed etic (cultural universals) methodology that is often inherent in Western science, limitations in researching cultural deep thought become inevitable when epistemological and ontological relationships rooted in various non-Western worldview orientations come into conflict with research methods that are grounded in a Western worldview.

For various reasons, this has bearing on the lack of instruments that can be used to research such theoretical formulations. When race-based instruments represent the closest alternative, researchers interested in cultural phenomena are faced with the alternative of pounding a square construct into a round hole. Research on racial constructs—such as racism, racialism, stereotypes, and race-related stress—is very much needed to address the stimulus value that physical features might have on attitude formulation or well-being. However, a racial paradigm will have



little to no utility when the researcher is interested in cultural factors that influence spiritual, psychological, and/or behavioral phenomena.

The measurement of worldview is crucial to advancing psychological theory, research, training, and practice. Specifically, worldview is an important cultural variable that has the capacity to effectively assess between- and within-group differences so that individuals can be understood within a broader ethnocultural context. Scholars also have highlighted the importance of assessing the relationship of cultural factors (e.g., worldview, acculturation, cultural identity) to other psychological variables in research studies. Moreover, investigating the influence of a client's worldview in both process and outcome variables in psychotherapy may provide important data regarding effective modes of psychotherapy for culturally diverse populations.

One characteristic of the culturally competent therapist is awareness of personal assumptions, values, and biases. An important dimension of therapist self-awareness includes understanding one's own worldview and how worldview perspectives are shaped by the processes of enculturation and socialization. A worldview assessment instrument can serve as a tool for training programs in helping graduate students become more aware of the lens through which they perceive and interpret events around them. Furthermore, worldview assessment can help therapists understand the client's perception of her or his presenting concerns. In addition to assisting in conceptualizing and assessing the problem, knowledge of the client's worldview can also aid the therapist in establishing methods and goals for psychotherapy that are consistent with the client's worldview and determining the roles the therapist might serve in the context of the therapeutic relationship.

Finally, worldview assessment is invaluable to psychological research. In 1995, A. J. Marsella and F. T. L. Leong identified several methodological problems that contribute to errors in validity in psychological research. Of importance to worldview assessment is the "error of commission." In summary, this error describes conducting psychological research on diverse ethnic groups without regard of their worldview. Not having a valid worldview assessment tool would force the researcher to make stereotypical inferences (e.g., African Americans are spiritual and communalistic people), which were not assessed in the research study, to inform their results.

Moreover, uncovering empirical differences in worldview may serve as a catalyst toward deriving much needed research methods that are obligatory for culturally competent research to be actualized.

As a result of the increased focus within psychology on providing effective services to culturally diverse populations that is informed by the research literature, and the recognition that culturally competent therapists and ethically responsible practice necessitate the assessment of worldview, researchers, trainers, and therapists are in need of measurement tools to assess worldview. To date, there are a few instruments to assess worldview orientation that are used in the psychology literature: Scale to Assess World View (Ibrahim & Kahn), Worldview Scale (Baldwin & Hopkins), and the Worldview Analysis Scale (Obasi, Flores, & James-Myers).

### **Scale to Assess World View**

The Scale to Assess World View consists of 45 items and was developed to assess individual and group beliefs, values, and assumptions regarding (a) views of human nature, (b) interpersonal relationships, (c) nature, (d) time, and (e) activity. Human nature is categorized as being either bad (3 items), good and bad (3 items), or good (3 items). The modality of an individual's relationships is categorized as being lineal-hierarchical (3 items), collateral-mutual (3 items), or individualistic (3 items). The relationship of people to nature is categorized as being in harmony (3 items), subjugation to control (3 items), or power of nature (3 items). The temporal focus of human life is categorized into the past (3 items), present (3 items), or future (3 items). Finally, the modality of human activity is categorized as being (3 items), being-in-becoming (3 items), or doing (3 items). Each item is rated on a 5-point Likert scale ranging from *strongly agree* (5) to *strongly disagree* (1). Responses to each item are trichotomized into "no," "neutral," or "yes." A factor analysis was conducted on the Scale to Assess World View and a four-factor solution was reported. These factors were named Optimistic, Traditional, Here and Now, and Pessimistic.

### **Worldview Scale**

The Worldview Scale (WVS) consists of 37 items assessing three broad philosophical-conceptual orientations of African and European worldview: (1) orientation toward nature, (2) orientation toward the



physical and the nonphysical/metaphysical realms, and (3) orientation toward other human beings. Additionally, items are included that assess the six bipolar conceptual components of harmony versus antagonism toward nature, spiritualism versus materialism, collectivism versus individualism, strong versus weak religious orientation, interdependence versus separateness, and humanism versus racism. Part I of the WVS consists of 24 items to which participants respond using a 4-point Likert scale ranging from *strongly agree* (4) to *strongly disagree* (1). In part I, 15 items are positively worded for the African worldview, and 9 items are positively worded for the European worldview. Part II consists of 9 items in a forced-choice format that alternates randomly from an African worldview response set to a European worldview response set. The WVS score is computed based on the total scale score; high scores correspond to an African worldview orientation, and low scores correspond to a European worldview orientation.

### **Worldview Analysis Scale**

The Worldview Analysis Scale is a 55-item questionnaire based on the philosophical dimensions of cosmology, epistemology, ontology, axiology, and teleology. These philosophical dimensions serve as a theoretical framework to operationalize measurable dimensions of worldview, such as perceptions of the universe, spirituality, immortality, communalism, knowledge of self, reality, reason, and indigenous value systems. Individual perceptions of these dimensions exist in the fabric of culture and are believed to influence cognitions, decisions, and behaviors. Factor analysis confirmed a seven-factor structure that included Materialistic Universe, Tangible Realism, Communalism, Indigenous Values, Knowledge of Self, Spiritual Immortality, and Spiritualism. The Worldview Analysis Scale hypothesizes several assumptions with regard to worldview assessment.

1. Worldview is a schema that is used to establish meaning consistent with a person's cultural framework.
2. Each culture possesses both universal and particular dimensions of worldview that are similar to and different from other cultures; thus, the measured dimensions should be able to differentiate between-group and within-group similarities and differences.

3. Cultures are constantly in contact with other cultures. Through these interactions, dimensions of worldview can be either borrowed and transformed in a meaningful fashion or rejected altogether.
4. Worldview is a construct that has the capacity to go beyond superficial race-based models to explore cultural phenomena.

### **Future Directions**

Historically, the majority of people of color (African American, Asian American, Native American, Mexican American, etc.) residing in the United States in need of some type of psychological intervention do not seek professional psychological help for their personal dilemmas. Of those who seek therapeutic assistance, an estimated 50% or more prematurely discontinue treatment after the initial session. Factors cited as reasons for this premature termination include traditional psychological paradigms that reflect the worldview of the dominant culture, diagnosis and treatment by a culturally different therapist, differential expectations between clients and their therapists, and lack of resources and lack of availability of services.

People of color are more likely to rely on traditional support networks (e.g., relatives, spiritual advisors, community organizations, and friends) rather than professional psychological services. This growing body of scientific literature consistently identifies common implications (e.g., diagnosis and treatment of the culturally different, differential expectations, and lack of resources in culturally diverse communities) that the field of psychology must address to improve therapeutic practice with diverse groups. Furthermore, these studies hypothesized that factors such as worldview, values associated with the counseling process, and cultural differences between the counselor and client can negatively impact an individual's willingness to seek professional psychological services.

In addition to the cross-cultural/multicultural discourse, it is imperative to look at the impact that worldview can have on designing empirically supported treatment modalities and training competent service providers to administer such interventions. Specifically, it is important to understand the factors that influence worldview and how differences are manifested between and within ethnic groups. For example, which dimensions of worldview predict counselor preferences, treatment modality preferences,



conceptualizations of health, help-seeking attitudes and behaviors, and so on? Are culture-specific treatments needed to address worldview differences, or are adjustments to current treatment modalities sufficient? It is anticipated that the construct of worldview will continue to influence the future of psychotherapy while solid empirical evidence continues to accumulate in this area of research.

*Ezemenari M. Obasi, Vivian L. Tamkin,  
and Taisha L. Caldwell*

**See also** Acculturation (v3); Afrocentricity/Afrocentrism (v3); Collectivism (v3); Cross-Cultural Training (v3); Cultural Relativism (v3); Cultural Values (v3); Culture (v3); Individualism (v3); Locus of Control (v3); Multicultural Counseling (v3); Multicultural Counseling Competence (v3); Multiculturalism (v3); Multicultural Psychology (v3); Religion/Religious Belief Systems (v3); Spirituality (v3); Sue, Derald Wing: Contributions to Multicultural Psychology and Counseling (v3); Universalism (v3); White, Joseph L. (v3)

### Further Readings

- American Psychological Association. (2002). *Guidelines on multicultural education, training, research, practice, and organizational change for psychologists*. Washington, DC: Author.
- Baldwin, J. A., & Hopkins, R. (1990). African-American and European-American cultural differences as assessed by the worldviews paradigm: An empirical analysis. *Western Journal of Black Psychology, 14*(1), 38–52.
- Carter, R. T. (1991). Cultural values: A review of empirical research and implications for counseling. *Journal of Counseling & Development, 70*(1), 164–173.
- Constantine, G. C., & Sue, D. W. (2005). *Strategies for building multicultural competence in mental health and educational settings*. New York: Wiley.
- Dana, R. H. (1993). *Multicultural assessment perspectives for professional psychology*. Boston: Allyn & Bacon.
- Ibrahim, F. A., & Kahn, H. (1987). Assessment of world views. *Psychological Reports, 60*(1), 163–176.
- Ibrahim, F. A., Roysircar-Sodowski, G., & Ohnishi, H. (2001). Worldview: Recent developments and needed directions. In J. G. Ponterotto, J. M. Casas, L. A. Suzuki, & C. M. Alexander (Eds.), *Handbook of multicultural counseling* (2nd ed.). Thousand Oaks, CA: Sage.
- Kluckhohn, F. R., & Strodtbeck, F. L. (1961). *Variations in value orientations*. Evanston, IL: Row Paterson.
- Sue, D. W. (1978). World views and counseling. *Personnel and Guidance Journal, 56*, 458–462.
- Sue, D. W., Bernier, J. E., Durran, A., Pederson, P., Smith, E. J., & Vasquez-Nuttall, E. (1982). Position paper: Cross-cultural counseling competencies. *The Counseling Psychologist, 10*(2), 45–52.
- White, J. L. (1970, August). Toward a Black psychology. *Ebony, 25*, 44–45, 48–50, 52.





---

## XENOPHOBIA

---

*Xenophobia* is derived from the terms *phobos* (meaning “fear”) and *xenos* (“strangers”). Thus, *xenophobia* is defined as fear of strangers or of the unknown or of anything that is different. The fears are unwarranted and triggered by unfounded beliefs and generalizations. These fears sometimes incite hostile behavior and attitudes toward the unknown target.

Some scholars suggest that xenophobia is at the root of racism such that individuals see themselves as part of a superior racial ingroup of similar individuals and see other people as part of an inferior outgroup. The outgroup members are perceived as physically and psychologically dissimilar. Thus, prejudiced attitudes and discrimination toward the outgroup member are by-products of a xenophobic climate. Expressed preferences for ingroup familiarities are problematic and reinforce intolerance in a supposedly pluralistic society. In most societies, there are individuals who are socially, culturally, or otherwise different from the majority.

Xenophobia can lead to either overt discrimination or subtle exclusion of certain individuals. This exclusion is also problematic. Persons who present an unbiased attitude but act in subtle ways that reflect implicit biases regarding race are characterized as aversive racists. The subtlety is in justifying the racist behavior based on some factor other than race. Beyond racism, xenophobia is believed to underlie heterosexism or homophobia. These irrational and irreconcilable fears of human beings based on sexual behavior and

practices are also based on gross overgeneralizations and misunderstanding.

Xenophobia is important in the context of counseling in that practitioners and clients are atypically matched by race, gender, sexual orientation, nationality, or a number of fixed factors. Xenophobia potentially contributes to racial microaggressions, subtle verbal and nonverbal communications that demean others as a function of their membership in some stereotyped group. On an implicit level, subtle behavior negatively affects therapeutic experiences and may contribute to the underuse of professional mental health services by certain groups.

People are believed to naturally categorize themselves, preferring similar others and minimizing those who are different. Although this process allows individuals to reduce complex human characteristics to simplified categories, the side effect is demeaning attitudes and behavior toward underrepresented persons across multiple contexts.

*Rheeda L. Walker*

**See also** Cultural Mistrust (v3); Cultural Paranoia (v3); Discrimination (v3); Ethnocentrism (v3); Pluralism (v3); Prejudice (v3); Racism (v3); Stereotype (v3)

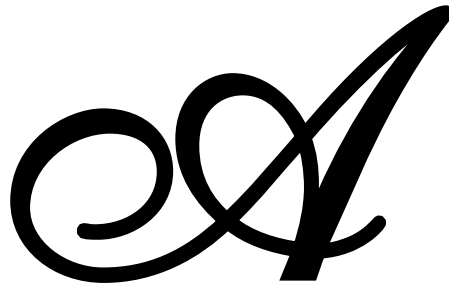
### Further Readings

Constantine, M. G. (2007). Racial microaggressions against African American clients in cross-racial counseling relationships. *Journal of Counseling Psychology*, 54, 1–16.



- Dollard, J. (1938). Hostility and fear in social life. *Social Forces*, 17, 19–38.
- Dovidio, J. F., Gaertner, S. L., Kawakami, K., & Hodson, G. (2002). Why can't we just get along? Interpersonal biases and interracial distrust. *Cultural Diversity & Ethnic Minority Psychology*, 8, 88–102.
- Jones, J. M. (1997). *Prejudice and racism*. New York: McGraw-Hill.
- Tajfel, K. (1969). Cognitive aspects of prejudice. *Journal of Social Issues*, 25, 79–97.





---

## ACADEMIC ACHIEVEMENT, NATURE AND USE OF

---

Academic achievement is axiomatic to career development processes. In people's lives, academic choices, barriers, or opportunities occur early and frequently, and they have a pervasive and lasting influence on career development. For example, a middle school student's choice of or opportunity for educational curricula limits or broadens the student's subsequent opportunity for learning experiences; a high school graduate's postsecondary educational opportunity and choice opens some occupational fields and closes others.

Academic achievement has been defined in a seemingly infinite number of ways, and some definitions are more valid, useful, and less harmful than others. In defining academic achievement, there are three salient dimensions to consider: equity, development, and meaning.

### **Equity**

Academic achievement is the main means of social mobility for people outside the mainstream of the U.S., Western, and increasingly global socioeconomic system. Yet barriers to academic achievement remain, and these barriers perpetuate the chronic achievement gaps evident in the United States and other countries. These achievement gaps produce continuing social and economic inequity and stratification. Many authors writing in the career development field have made the point that much of career development theory,

research, and practice has little use or meaning for those outside the mainstream of the U.S. socioeconomic system. That is, because many people outside the mainstream have limited opportunity—including limited opportunity-to-learn—they have no choice; and choice is frequently an explicit or implicit assumption in career research, theory, and practice.

Thus, defining academic achievement is an educational, career development, professional, ethical, social, economic, and political issue. Any definition of academic achievement that does not take into account many students' lack of opportunity-to-learn serves to perpetuate inequity. For example, in the late 1980s, several U.S. states rewarded and punished schools based on students' average scores on basic skills tests. Students in more wealthy schools had higher scores than students in poorer schools where there was less access to a quality curriculum and quality instruction. In the mid-1990s, this perpetuation of inequity was recognized, and states moved to a system based on students' degrees of improvement on basic skills tests. This current system, however, is not without fault, and no definition of academic achievement is perfect.

### **Development**

Academic achievement is naturally developmental and hierarchical. One developmental educational milestone opens opportunities for the next academic achievement endeavor. Thus, any definition of achievement must take into account the developmental nature of academic achievement. Paying attention to developmental



phenomena helps counselors and educators focus on students' and clients' past and future learning experiences in a dynamic way. A developmental perspective helps professionals see academic achievement choices, opportunities, and barriers through an equity and cultural-experiential lens.

### Meaning

The meaningfulness of academic achievement definitions, measures, or indicators is related to the equity dimension and the developmental dimension. Some developmental accomplishments have more meaning and bearing on subsequent achievement than others. If achievement outcomes have some functional meaning in terms of educational, social, and economic advancement, they are meaningful. Governments and educational institutions, however, have historically bestowed high levels of meaning on particular academic achievement outcomes that have dubious functional meaning (e.g., scores on tests with limited validity, invalid college admissions criteria).

### A Positive Example

The following is an example of a definition of academic achievement that accounts for the equity, development, and meaning dimensions: The National Center for Transforming School Counseling (NCTSC) is a component of the foundation The Education Trust. The Education Trust focuses on educational reform, educational equity issues, and closing achievement gaps. One goal of the NCTSC is for all students to graduate from high school college ready and work ready—using one intensive high school curriculum. Current school counselor training done by the NCTSC focuses on transcript analysis, with particular attention to the academic intensity of courses students complete across their middle and high school careers. Based on students' course-taking patterns, they are placed into categories representing degrees of *behind*, *on target*, or *advanced* (toward college ready and work ready). This definition of academic achievement in high school is meaningful because longitudinal national research has shown that the strongest mutable determiner of postsecondary educational success is the curriculum that students experience in middle and high school. This definition is developmental in focus, and it also takes equity issues (e.g., opportunity for an

intensive curriculum, institutional barriers, high school curriculum tracking practices) into account.

*Jerry Trusty*

**See also** Academic Achievement (v2); Achievement, Aptitude, and Ability Tests (v4); Achievement Gap (v3); Assessment (v4); Career Counseling in Schools (v4); Career Education (v4); Intelligence (v2); School Counseling (v1)

### Further Readings

The Education Trust. (2007). *The National Center for Transforming School Counseling*. Retrieved from <http://www2.edtrust.org/EdTrust/Transforming+School+Counseling/main>

Trusty, J. (2004). *Effects of students' middle-school and high-school experiences on completion of the bachelor's degree* (Research Monograph No. 1). Center for School Counseling Outcome Research, University of Massachusetts-Amherst. Retrieved from <http://www.umass.edu/schoolcounseling/PDFs/ResearchMonograph1.pdf>

### Web Sites

The Education Trust: <http://www2.edtrust.org/edtrust>

---

## ACHIEVEMENT, APTITUDE, AND ABILITY TESTS

---

Many psychologists use labels such as *achievement test*, *aptitude test*, and *ability test* imprecisely, and nonpsychologists use them as synonyms. This lack of precision is understandable because in actual practice, tests bearing these labels often appear to be quite similar and are used for similar purposes. This entry explains the theoretical distinction among achievement, aptitude, and ability tests; describes the primary uses of these tests; and provides a brief overview of the types of subscales widely used in these tests and the constructs they measure.

### Theoretical Distinction

Achievement tests are designed to assess the extent to which a person has developed a specific motor skill or



learned a specific body of knowledge. Typically, an achievement test is administered following a period of instruction designed to teach the motor or cognitive skill to be examined. The prototypical achievement test is the periodic classroom exam that is administered to determine how much the student has learned. Other examples include the written and driving tests taken to secure a driver's license, the Scholastic Assessment Test (SAT) and American College Test (ACT) taken by high school students contemplating college, and the Graduate Records Examination (GRE) taken by college students who want to go to graduate school.

Theoretically, the purpose of the achievement test is descriptive—to measure the extent to which an examinee has mastered a motor skill or area of knowledge. In practice, however, achievement test results often are interpreted as an indicator of future performance. For example, while achievement tests such as the SAT and GRE evaluate the knowledge examinees have accrued as a result of their educational experiences, scores on those tests are used to predict the likelihood of success in more advanced and challenging programs of study. This common practice confounds the performance assessment (i.e., descriptive) function of achievement tests with the prediction goals of aptitude tests.

Many achievement and aptitude tests are very similar in appearance, but the primary purpose of aptitude tests is prediction. They are designed to obtain information that can be used in predicting some aspect of the person's future behavior. Aptitude tests assess the examinee's ability to learn both cognitive and motor skills. Often, scores on a broadly based test of verbal comprehension are used to predict the examinee's potential to learn (and use) new cognitive skills. In fact, the most common use of aptitude tests is to predict future performance in an educational program or occupational setting. However, some aptitude tests measure motor skills (e.g., eye-hand coordination or the time it takes to run a 40-yard dash). Scores on aptitude tests such as these are used to predict the examinee's ability to learn (and use) desirable motor skills.

The distinction between aptitude and ability tests is subtle, and many psychologists and test publishers use the terms interchangeably. In general, however, ability tests assess cognitive and motor skill sets that have been acquired over a long period of time and that are not attributable to any specific program of instruction. For example, intelligence tests such as the Wechsler

Adult Intelligence Scale—Third Edition (WAIS—III) and the Stanford-Binet Intelligence Scales, Fifth Edition (SB5) measure verbal comprehension, working memory, perceptual organization, and processing speed. These abilities are not the result of any specific program of instruction. Instead, they are believed to be a function of the person's native ability to learn from life experiences. Ability tests are descriptive in that they assess people's knowledge and skills, but they are also predictive because they measure qualities that are presumed to influence the person's ability to learn new skills and to solve novel problems.

In summary, psychologists distinguish among achievement, aptitude, and ability tests at a theoretical level. Achievement tests describe people's present status, aptitude tests predict their future behavior, and ability tests assess their innate potential. In practice, however, achievement, aptitude, and ability tests are often similar in form and used for similar purposes.

### Common Variations Among Tests

Psychologists have created such a variety of tests that even developing a system to classify them is challenging. Most tests measure cognitive aptitudes (e.g., the Kendrick Cognitive Tests for the Elderly and the Peabody Individual Achievement Test), but many tests also measure motor skills (e.g., the O'Connor Finger Dexterity Test and the USES General Aptitude Test Battery [GATB]). Most tests require the use of verbal and reading abilities (e.g., the Multidimensional Aptitude Battery [MAB] and the Differential Aptitude Test [DAT]), but a few use nonverbal means of measuring aptitudes (e.g., Tests of Non-Verbal Intelligence, Second Edition and the Peabody Picture Vocabulary Test). In addition, tests differ in the number of aptitudes they measure, their standardization, and the manner of administration.

### Number of Aptitudes

Some tests measure a single aptitude (e.g., the Electrical and Electronics Test and the Personnel Assessment Selection System) but many measure multiple aptitudes (e.g., the Armed Services Vocational Aptitude Battery [ASVAB] and the Ball Aptitude Battery [BAB]). Both approaches have advantages.

Multi-aptitude batteries obtain information about a broad array of cognitive and motor skills and allow



comparisons of the examinee's relative strengths and weaknesses. These instruments are useful when individuals or organizations are seeking information to guide vocational and educational decisions. Although numerous multi-aptitude and multi-ability test batteries exist, all generally measure a relatively standard set of constructs.

More specialized instruments that measure a single construct are useful when more focused predictions are desirable. Obtaining information about constructs like creative and artistic potential often requires the use of specialized instruments designed for that specific purpose. Furthermore, a single aptitude instrument designed to measure reading, math, spatial, or mechanical skills may measure those skills more precisely than a multi-aptitude battery.

### Standardization

Standardized tests are those that have been administered to a group of people (referred to as the norm group) to obtain information about the likelihood of each possible score on the test. Comparing the score of an examinee to the scores obtained by the people composing the norm group allows psychologists to interpret the score. Scores on standardized tests typically are reported in terms of a standard score, an age equivalent score, or a grade equivalent score.

It is critically important that the norm group used to interpret an examinee's score provides a meaningful basis for comparison. For example, it would be misleading to interpret a high school student's achievement test score using a norm group composed of middle school students. Although the problem identified in this example is obvious, more subtle problems have only recently begun to be avoided. For example, comparing the scores a female obtained on a test to the scores obtained by a norm group composed exclusively of males yields a questionable interpretation in many instances. However, this practice was standard not too many years ago.

For this reason, many tests have more than one norm group. A test used with elementary school children, for example, might have a norm group composed of first-grade students, a second norm group composed of second-grade students, and so on up to a norm group composed of sixth graders. In addition, separate norm groups for girls and boys might be available for each grade level. Additional examples of the types of norm groups that could be developed for a test include female college graduates, successful

carpenters, African American lawyers, and enlisted males.

Accurate normative interpretation of a test is not possible without a relevant norm group, but the development of norm groups is costly and time-consuming. This creates two problems. First, many tests have only one or a few norm groups. This practice forces users to base their interpretation on the most relevant norm group rather than on a directly relevant norm group. Sometimes a relevant norm group that matches the gender, cultural background, or ethnic heritage of an examinee is not available, so the user is forced to make the best interpretation possible under the circumstances. Second, the expense of obtaining norm groups also means that some published norm groups are not current. Each cohort of examinees is born into a world that differs in important respects from the preceding cohort. The accuracy and usefulness of normative interpretations of test results declines as the norm group becomes more and more dated.

While almost all aptitude and ability tests are standardized, the typical classroom achievement test is nonstandardized. Generally, scores of nonstandardized tests are reported in terms of the percentage of items answered correctly and are interpreted in terms of a predetermined standard (e.g.,  $A > 90\%$ ,  $B = 89\%–80\%$ ;  $> 70\% = \text{Pass}$  and  $< 69\% = \text{Fail}$ ). Tests that are interpreted by comparing the examinee's performance to a predetermined standard rather than to a norm group are called *criterion-referenced*. Two advantages of criterion-referenced tests are that the scores obtained on such tests are inherently meaningful and no artificial constraints are imposed on the number of examinees that can perform at a given level.

### Test Administration

Most achievement, aptitude, and ability tests can be administered to a single person or to a group of individuals. Historically, the option to administer the test to a group was essential for tests such as the SAT, ACT, and GRE that are taken by hundreds of thousands of people each year. However, in some instances the information that can be obtained from behavioral observations made by a psychologist while administering the test to an individual is quite important. Although more costly and time-consuming, the option of an individualized administration of the test is important. This option is more likely to be desirable when administering a test to children, adolescents,



and individuals with learning disabilities or other problems that might interfere with their performance on the test. Some tests, particularly intelligence tests designed to measure cognitive abilities, are designed exclusively for individual administration.

In the last decade, an additional option for test administration has emerged: computer administration of the test. Computer administration combines the advantage of economic administration to large numbers of individuals with the possibility of some behavioral observations during the administration of the test. For example, response latencies (i.e., the amount of time it takes the examinee to answer the question) can be recorded during computer administration of the test. Furthermore, tests based on item response theory can tailor the test to the ability level of the examinee.

Computer administration is now the primary option for some tests. For example, the GRE is administered by computer to examinees in the United States, Canada, and many other areas of the world unless special arrangements are made for a paper-based administration. This trend will likely accelerate, and it is likely that most widely used standardized tests will provide an option for computer administration within a decade.

## Skills Measured

Hundreds of scales have been developed to measure various facets of achievement, aptitude, and ability. Numerous tests focus on specific content areas such as spatial, mathematical, verbal, and motor skills. Many tests that measure a single cognitive or motor skill provide an alternate (and in some instances a more precise) measure of the skills measured by the multi-aptitude batteries and intelligence tests. Despite this amazing variety of options, most of the leading tests assess the same select set of skills. Although the specific name of the skill varies from test to test and subtle differences exist among similarly named tests, the constructs measured by the various tests are quite similar.

The following sections describe some of the most frequently measured cognitive and motor skills and some of the composite scores obtained by combining information about these skills.

### Cognitive Skills

*Verbal Aptitude:* The ability to understand the meanings of words, sentences, and paragraphs and to use them

effectively. Measures of this skill assess how well an examinee understands ideas expressed in words and how clearly he or she can reason with words. Some tests include separate subscales to measure components of verbal knowledge. For example, the ASVAB includes tests of word knowledge and paragraph comprehension. The WAIS-III, MAB, and SB5 contain vocabulary tests. The SB5 also includes the test Verbal Relations. The DAT contains the following tests: Verbal Reasoning and Language Usage: Spelling and Grammar.

*Numerical Aptitude:* The ability to understand ideas expressed in numbers. Tests include some combination of items that assess numerical computation (i.e., the ability to add, subtract, and perform other arithmetic calculations) and numerical reasoning (i.e., how well an examinee can think and reason with numbers). Scales that assess aspects of this skill are variously titled Arithmetic, Equation Building, Numerical Ability, and Quantitative, among others.

*Spatial Aptitude:* The ability to visualize or form mental images of solids from looking at plans on a flat piece of paper. Some items require people to look at a diagram and determine how an object would look in three-dimensional space if it were completed. Others ask respondents to look at a picture or drawing of a completed object and visualize in three-dimensional space how that object would look if it were rotated into a different position. Related skills are measured in tests titled Block Design, Matrix Reasoning, Matrices, Paper Folding and Cutting, Pattern Analysis, Space Relations, and Spatial.

*Abstract Reasoning:* The ability to understand ideas that are presented without using words or numbers. Tests of abstract reasoning present problems in terms of size, shape, position, or quantity using pictures, shapes, patterns, or some other nonverbal, non-numerical form. Scales measuring spatial aptitude measure one aspect of this ability. Other scales measuring aspects of this ability are titled Form Perception, Object Assembly, Picture Completion, and Picture Arrangement, among others.

*Comprehension:* The ability to use deductive reasoning (and, to a lesser extent, inductive reasoning) to derive solutions for socially relevant problems and issues. These tests assess examinees' practical judgment and common sense and their ability to deal



with their social and cultural environment. Other scales measuring aspects of this aptitude are titled Absurdities and Similarities.

### **Motor Skills**

In a sense motor skills represent the output function of human ability. Understanding and problem solving occur unobserved inside the human brain, but the product of that mental activity is expressed either in words or through some physical activity. Many motor skills tests require people to use their cognitive skills prior to making some physical response. For example, tests of clerical speed and accuracy (i.e., scanning lists of names or street addresses to see if they match or are in alphabetical order) require people to use both cognitive and motor skills. Other examples include block design (i.e., arranging blocks to make a designated design) and digit symbol (i.e., translating randomly arranged symbols into numbers using a key that matches the symbols and numbers).

The following three tests provide purer assessments of motor skills. The tasks they require people to perform are simple and do not require cognitive skill to understand. As such, they provide a clear measure of the individual's ability to perform the physical task.

*Motor Coordination:* The ability to coordinate the eyes and the hands or fingers in quick, precise, accurate movements. Tests of motor coordination present people with a page of small boxes and require them to make a mark in as many boxes as possible within a brief designated time.

*Finger Dexterity:* The ability to make small, rapid, and accurate movements with the fingers such as in typing and to move small objects quickly and accurately such as in assembling two or more objects. Tests of finger dexterity require people to assemble simple objects such as putting a washer on a rivet and to disassemble objects such as taking washers off of rivets and returning the washers and rivets to their storage location.

*Manual Dexterity:* The ability to make coordinated movements with the hands quickly and skillfully. Tests of manual dexterity require people to place objects in designated positions or to turn objects from one position to a designated position.

### **Composite Scores**

Composite scores are scores obtained by combining the scores obtained on two or more tests. Often, test scores are interpreted both in terms of their meaning as a stand-alone score and as part of a composite. The concept of intelligence is probably the best-known composite. Many intelligence tests yield three composite scores: a verbal intelligence, a performance intelligence, and an overall or full-scale intelligence score. Another way to conceptualize intelligence is in terms of the mental processes that form the basis of cognitive behavior. This perspective suggests that intellectual behavior involves understanding, organizing, thinking, and remembering. Important composite scores obtained from tests of cognitive ability that reflect this view of intelligence are verbal comprehension, perceptual organization, processing speed, and working memory.

*Verbal Intelligence:* Obtained by combining scores on measures of verbal, numerical, and spatial aptitude. This composite provides an overall measure of people's abstract reasoning ability and ability to comprehend and learn new skills. This composite is heavily influenced by verbal skills.

*Performance Intelligence:* Obtained by combining scores on measures that require both abstract reasoning and the manipulation of objects such as blocks, beads, pictures, or puzzle pieces. This composite provides a measure of abstract reasoning ability that relies less heavily on the use of words and verbal skills. The ability to understand nonverbal material figures more prominently in this composite.

*Intelligence:* Obtained by combining scores on verbal intelligence and performance intelligence. In tests such as the WAIS-III, MAB, and SB5, this composite incorporates information from verbal and performance composites of five or six tests each. In multi-aptitude batteries such as the DAT and USES GATB, this composite incorporates information from measures of verbal aptitude, numerical aptitude, and spatial aptitude.

*Verbal Comprehension:* This composite provides an overall measure of the individual's ability to understand and work with verbal information. It is obtained by combining scores on measures that assess



vocabulary, general information, and the ability to work with ambiguous information to solve problems when presented in verbal form.

**Perceptual Organization:** This composite provides information about the individual's ability to analyze information that is presented in a nonverbal form and to organize it into a meaningful pattern. It is obtained by combining scores on measures that require the individual to work with pictures, blocks, or matrices.

**Processing Speed:** This composite provides information about the speed with which the person can work with abstract symbols. It is obtained by combining scores on tests that assess the ability to work with abstract symbols that do not have any readily accessible verbal meaning.

**Working Memory:** This composite provides information about the person's ability to hold information in memory and work with it to solve problems. It is obtained by combining scores on tests that require the individual to remember patterns formed by pictures of beads, numbers, and letters.

### Enduring Contribution

The development of the psychological test is one of the most important and enduring contributions of psychology to civilization. Indeed, noted psychologists René V. Dawis and David Lubinski regard psychological tests as serving the same function for psychologists that the microscope and telescope serve for microbiologists and astronomers. Tests provide psychologists with the ability to see phenomena that would otherwise be invisible. Many of the enriching benefits psychology has contributed to modern day society would not have been possible without the use of psychological tests.

Early psychologists began work on the first tests of achievement, aptitude, and ability in the late 1800s. Research and innovation up to World War II focused largely on the development of methods for measuring vocational interests and cognitive and motor skills. The modern science of psychological measurement is attributable to decades of research on tests, as is the fruitful diversity of tests developed by psychologists. Although psychologists have conscientiously developed tests to address the full range of social needs,

their productivity in the area of achievement, aptitude, and ability testing is unsurpassed.

*Howard E. A. Tinsley*

**See also** Academic Achievement (v2); Academic Achievement, Nature and Use of (v4); Armed Services Vocational Aptitude Battery (v4); Assessment (v4); Computer-Assisted Testing (v2); General Aptitude Test Battery (v4); Intelligence (v2); *Journal of Career Assessment* (v4); Psychometric Properties (v2); Test Interpretation (v2); Thurstone, Louis L. (v2); Tyler, Leona E.: Human Multipotentiality (v2); Wechsler, David (v2)

### Further Readings

- American Educational Research Association, American Psychological Association, and National Council on Measurement in Education. (1999). *The standards for educational and psychological testing*. Washington, DC: American Educational Research Association.
- American Psychological Association, Joint Committee on Testing Practices. (2005). *Code of fair testing practices in education*. Washington, DC: Author.
- Anastasi, A., & Urbina, S. (1997). *Psychological testing* (7th ed.). Upper Saddle River, NJ: Prentice Hall.
- Hambleton, R. K., Robin, F., & Xing, D. (2000). Item response models for the analysis of educational and psychological test data. In H. E. A. Tinsley & S. D. Brown (Eds.), *Handbook of applied multivariate statistics and mathematical modeling* (pp. 553–581). San Diego, CA: Academic Press.
- National Council on Measurement in Education. (1995). *Code of professional responsibilities in educational measurement*. Madison, WI: Author.
- Spies, R. A., & Plake, B. S. (Eds.). (2005). *The sixteenth mental measurements yearbook*. Lincoln, NE: Buros Institute of Mental Measurements.
- Walsh, W. B., & Betz, N. E. (1995). *Tests and assessment* (4th ed.). Upper Saddle River, NJ: Prentice Hall.

---

## ACTION THEORY

---

Action theory is based on a school of thought in philosophy, social and cognitive psychology, neurology, and organizational behavior as well as in counseling and career development. This school of thought addresses the intentional, goal-directed nature of



human behavior. It has historical roots in the works of George Herbert Mead, Talcott Parsons, and Lev Vygotsky, among others. Action theory has been referred to as a language for how people engage themselves in their daily lives by focusing specifically on processes across time. It takes a teleological perspective of human behavior, thus seeking explanations primarily in the goals of behavior rather than in their causes. Furthermore, action theory is not a theory in the traditional sense, whose purpose is to generate specific hypotheses that can be tested and subsequently accepted or rejected as part of the canon of science. Rather, it is more like a metatheory that provides a guiding framework for understanding human behavior.

Action theory has been applied to counseling and career development and has been found to be heuristic for several reasons. Counseling is essentially a practice that has goal-directed behavior at its center. Career development also involves goals, intentions, plans, and emotional and cognitive processes over time, all of which are addressed in action theory.

In providing a comprehensive framework, action theory recognizes that action can be seen from three perspectives: social meaning; internal processes, that is, the cognitions and emotions that guide and steer action; and the specific behavioral elements that actually comprise the external behavior, including language. For example, one can readily see that writing an e-mail message or having dinner has social meaning. These actions are readily understood by both participants and observers. They are socially meaningful in that society has constructed various norms, rules, and institutions that serve to construct their meaningfulness. People use cognitive and emotional processes to steer their behavior in these actions and rely on language, skills, habits, and resources to actually implement the action. Action theory also reflects the notion that goals are hierarchically ordered across time—that is, some goals are more important than others and may persist for longer periods of time.

### **Application of Action Theory to Counseling and Vocational Psychology**

Action theory has been applied to counseling and vocational psychology by providing new understandings of career development, creating new research capabilities, and developing new and enhancing existing interventions.

### ***An Alternative Epistemology***

The most important epistemological shift that action theory provides is that our understanding of career behavior is not primarily represented by a series of causal statements. Rather it is based on an epistemology that knowledge and meaning are induced and constructed through action, particularly as researchers and practitioners focus on processes and base knowledge generation on language that reflects everyday experience. Specifically, in this epistemology, new knowledge is generated by interpreting for meaning, analyzing for function, and observing for behavior.

### ***Focus on the Social***

Action theory represents part of the substantial shift in counseling and career development, given the emphasis on cultural and contextual perspectives, that focuses on the social rather than on the individual. Specifically, a radical departure from the understanding of vocation as an individual process was operationalized in the contextual action theory of career by directing attention to the joint actions and projects of those centrally involved in each other's lives. For example, in several studies in the past few years, action theory researchers have illustrated how the relationship between parents and adolescents figures centrally in the joint career processes, and indeed career projects are subsumed by relationship and communication goals.

### ***Conceptualizing Action-Project-Career***

One of the contributions of action theory is the conceptualization of the connection among *action*, *project*, and *career*. Here action refers to short-term, goal-directed behavior, and project to a series of actions with a common goal over a midterm time period. When projects coalesce or are constructed as having a common or overarching goal over the long term, they can be considered as career. Projects and careers can be both prospective and retrospective. This conceptualization places action as central to career, and it does not isolate career as strictly an occupational construct. Thus, this conceptualization does not represent the application of psychology to career, but is a psychology in which career has a central place.



## **The Action-Project Method**

In recent research in vocational psychology, action theory researchers have developed a qualitative research method, identified as the action-project method, that has broad applications for use in research in counseling, vocational psychology, and other areas that involve human action. This method has unique units of analysis and data gathering procedures that, when used together in the study of human social processes, can generate findings that speak to the systems of action (i.e., actions, projects, and career), to the ways actions are organized (i.e., as goals, functional steps, and behavioral elements), and to the commonalities and discrepancies between them.

Although researchers have used this method as a qualitative method, it is not exclusively limited to qualitative data. There are aspects of data gathering that are subject to systematic observation and thus are amenable to quantitative analyses. Other aspects of the data are interpretative and depend on subjective reports and interpretation within a meaning community. Data from all perspectives on action, that is, manifest behavior, internal processes, and social meaning, are critical as each contributes to understanding action. This method is enhanced by the use of a video recall procedure, called the *self-confrontation interview*, in which participants have the opportunity to see a videotape of and recall internal process during a recent action.

## **Context**

In action theory, context is represented in and through actions, projects, and career. Actions are embedded in their contexts. They are the person's agentic engagement with the circumstances of his or her own life and more specifically the joint actors' agentic engagement with the circumstances of their lives together.

## **Developing New and Enhancing Established Interventions**

### **Connecting Theory and Practice**

A long-standing issue in vocational psychology is that, while there have been theories of career development, there have not been explicit theories of career counseling. Simply put, theory and practice have

developed separately. Contextual action theory is equally an approach to career counseling practice as it is to knowledge generation about the career process. It allows the counselor and client to address goals in counseling without being too rational, to address cognitive-emotional processing without subscribing simply to an information processing approach, and to address habitual behavior and automatic processes without relying too much on physiological or unconscious processes.

## **Joint Action and Self-Confrontation in Counseling**

Anecdotal evidence suggests that participating in joint action and self-confrontation in counseling can make a difference in the lives of clients. These procedures seem to help clients make joint goals explicit and recognize that they are shared. Clients also appear to appreciate the opportunity to see themselves in action during the video recall and in a sense construct that narrative of that action through recalling their internal processes.

## **Working With Projects**

The concept of joint project adds significantly to practice in the field of vocational psychology. Because project is more time limited, it is more accessible and perhaps more under the control of the client than the construct of career is. In addition, project has the advantage of capturing the agency of the person. It is linked to career, and it is the level that best reflects the joint action between the counselor and the client.

Richard A. Young

*See also* Career Construction Theory (v4); Career Counseling (v4); Constructivist Theory (v2); Fatalism (v3); Person–Environment Interactions (v2); Qualitative Methodologies (v1); Quantitative Methodologies (v1)

## **Further Readings**

- Brandtstädter, J., & Lerner, R. (Eds.). (1999). *Action and self-development*. Thousand Oaks, CA: Sage.
- Valach, L., & Young, R. A. (2004). Some cornerstones in the development of a contextual action theory of career and counseling. *International Journal of Educational and Vocational Guidance*, 4, 61–81.



- Valach, L., Young, R. A., & Lynam, M. J. (2002). *Action theory: A primer for research in the social sciences*. Westport, CT: Praeger.
- von Cranach, M., Kalbermatten, U., Indermuehler, K., & Gugler, B. (1982). *Goal-directed action*. London: Academic Press.
- Young, R. A., Marshall, S., Domene, J. F., Arato-Bolivar, J., Hayoun, R., Marshall, E., et al. (2006). Relationships, communication, and career in the parent-adolescent projects of families with and without challenges. *Journal of Vocational Behavior*, 68, 1–23.
- Young, R. A., & Valach, L. (2000). Reconceptualizing career psychology: An action theoretical perspective. In A. Collin & R. A. Young (Eds.), *The future of career* (pp. 181–196). Cambridge, UK: Cambridge University Press.
- Young, R. A., & Valach, L. (2004). The construction of career through goal-directed action. *Journal of Vocational Behavior*, 64, 499–514.
- Young, R. A., Valach, L., Ball, J., Paseluikho, M. A., Wong, Y. S., DeVries, R. J., et al. (2001). Career development as a family project. *Journal of Counseling Psychology*, 48, 190–202.
- Young, R. A., Valach, L., & Collin, A. (2002). A contextual explanation of career. In D. Brown & Associates, *Career choice and development* (4th ed., pp. 206–250). San Francisco: Jossey-Bass.
- Young, R. A., Valach, L., & Domene, J. F. (2005). The qualitative action-project method in counseling psychology. *Journal of Counseling Psychology*, 52, 215–223.

---

## ADULT CAREER CONCERNS INVENTORY

---

The career concerns presented to counselors by adults vary widely. Some clients are making new career choices, others are coping with adjustment problems, and still others are planning retirement. To identify the career issues that most concern an individual, Donald Super, Albert Thompson, and Richard Lindeman constructed the Adult Career Concerns inventory (ACCI). The ACCI contains 61 items and takes approximately 20 minutes to complete. The first 60 items ask individuals to indicate their degree of concern about coping behaviors that address a sequence of vocational development tasks. The final item inquires about the individual's current career change status.

The ACCI operationally defines Super's model of career adaptability in adulthood. This model postulates that individuals are likely to progress through

four stages as they cycle through an occupational position or job. The length of an occupational cycle can last 30 months (called a minicycle) or 30 years (called a maxicycle) depending on the circumstances of the individual's career pattern. The four major stages in either a mini- or maxicycle are exploration, establishment, maintenance, and disengagement. For each stage, the ACCI measures 15 coping behaviors that deal with progressing through that stage. The 15 coping behaviors in each of the four stages are further divided into subscales consisting of five items each that measure three specific tasks for each stage.

The three tasks of the exploration stage are crystallization, specification, and implementation. These tasks of exploration require that an individual crystallize his or her vocational self-concept and translate it into a general preference for a group of similar occupations, then reduce that group to specify a single specific occupational choice, and eventually to implement the specified choice by gaining employment in that occupation. The three tasks of the establishment stage are stabilizing, consolidating, and advancing, where one is required to adapt to the culture of the organization and show competence in one's job-related tasks, develop a conscientious and disciplined work ethic while establishing friendly and collaborative relationships, and show initiative in order to gain promotion. The three tasks of the maintenance stage are not characterized by progress; rather, they deal with preservation. As such, the tasks deal with the manner in which an individual seeks to maintain his or her current position. The three styles of maintenance are upholding, updating, and innovating, and involve maintaining one's work-related responsibilities, updating one's knowledge and skills, and seeking new ways to complete tasks more efficiently. Finally, the disengagement stage involves the tasks by which an individual leaves one job or occupation in order to transition to another job or eventually into retirement living. Disengagement involves deceleration as one manages her or his time between fulfilling current work responsibilities and exploring new possibilities.

The ACCI is copyrighted to Vocopher and is available free in electronic format via the Internet at [www.vocopher.com](http://www.vocopher.com).

Kevin W. Glavin

**See also** Adults in Transition (v4); Adult Development (v1); Career Counseling (v4); Career Decision-Making Difficulties Questionnaire (v4); Career Exploration (v4);



Career/Life (v4); Career Transitions Inventory (v4); Coping (v2); Super, Donald Edwin (v4); Super's Theory (v4); Transition Behavior Scale (v4)

### Further Readings

- Glavin, K. W., & Reh fuss, M. (2005, June). *Using the Adult Career Concerns Inventory to measure career planning and one's concerns with career development tasks at various life stages*. Paper presented at the National Career Development Association conference, Orlando, FL.
- Niles, S. G., Anderson, W. P., Jr., Hartung, P. J., & Staton, A. R. (1999). Identifying client types from Adult Career Concerns Inventory scores. *Journal of Career Development, 25*, 173–185.
- Super, D. E., Thompson, A. S., & Lindeman, R. H. (1988). *Adult Career Concerns Inventory: Manual for research and exploratory use in counseling*. Palo Alto, CA: Consulting Psychologists Press.

---

## ADULTS IN TRANSITION

---

Adults experience a wide variety of transitions including shifting from school to work, marriage, divorce, birth of a child, death of a loved one, adjustments to serious injuries, relocations, and, particularly, career transitions. Since the latter part of the 20th century, a rapidly changing global economy and technological advances have demanded that people adjust to the changing context affecting their work lives. Coping with these challenges requires increased awareness of one's self, of the world of work, and of adaptive strategies for making wise career decisions. The following sections emphasize various career-related transition types, theories, stages, special populations, and implications for career counseling.

### Types of Transition

Transitions may be categorized as anticipated, unanticipated, or even nonevents. Moreover, these events can occur abruptly, such as in the case of accidents, or more gradually, such as adjustment to planned promotions or career transitions. A transition may be defined as an event or nonevent resulting in a change of assumptions about self and the environment and thus requires corresponding change in one's behavior and relationships. For career counselors, it is important to understand the nature and context of the transition.

### Anticipated Career Transitions

Some transitions occur at expected times and can be approached strategically. The initial planned career transition that most adults face is switching from school to work, with other transitions including searching out and changing careers and retirement. Unlike in other career transitions, the individual asserts great control in initiating change. This process typically involves gains, losses, and significant role shifts across the life span. Being able to think about and rehearse these changes in roles can increase one's level of preparation, thus allowing for successful transitions.

### Unanticipated Career Transitions

Unanticipated career transitions often involve a sense of crisis and are not usually associated with planned life cycle transitions. These unanticipated events can happen as a result of being fired or demoted, of sudden illness, of a premature death of a spouse, or of a natural disaster. Sudden plant closures or reductions in force (RIF) exemplify unanticipated career transitions. Although a plant closure may be announced and support for the transition provided, a RIF may result in a notice shortly prior to termination.

### Nonevents

Nonevents are those events that a person has planned for and expected, but do not materialize, such as a marriage that did not occur, a promotion that failed to happen, or an unrealized dream. Another example of a nonevent is if a person planned to retire at age 62, but was not able to do so due to financial limitations. Nonevents can be categorized as personal, ripple, resultant, or delayed. Personal nonevents are individualized nonevents, such as a job change that never happened. A ripple nonevent results as a consequence of another person's nonevent such as a spouse losing a job, hindering a planned retirement. The resultant nonevent occurs when either an anticipated or unanticipated event develops, causing a nonevent such as failing to graduate, effectively blocking a planned career. Delayed events represent a situation where a nonevent occurs, but the person continues to hope that the event is only delayed and will eventually happen, such as a delayed promotion. Theories have been developed over the last century to help individuals cope with these types of transitions.



## Theoretical Background

Career theories have been continually updated since Frank Parsons's early work on vocational choice. These changes were driven by industrialization, urbanization, immigration, and globalization. Parsons is credited as the father of vocational psychology. Prior to Parsons's time, occupational choice and satisfaction related more to a person's social class than to his or her choice. Industrialization allowed more individuals the opportunity and volition to engage in personally satisfying careers that provided a sense of security, dignity, and that matched their interests and values. Over a century since Parsons's time, parallel issues affect today's workers, though globalization presently is the main driving force instead of industrialization. Whereas the vocational issues that Parsons addressed involved a changing emphasis from agricultural to industrial opportunities within the United States, rapidly developing technologies and the increasing pressures of a global economy are presently paramount. Today, occupations are not simply shifting from one industry or area within the country, but the work is being sent to areas around the world. While new opportunities have opened up for workers, most continually struggle to cope and adapt to situations over which they have little or no control.

Career transition concerns and coping strategies are likely to vary across a life span. Theories such as Donald Super's life-span, life-space vocational developmental theory are intended to cover a person's career and life roles across the life span. His integrative theory was established during an era in which a person predictably and uniformly left school, obtained employment, and eventually retired. Although Super recognized the necessity of being ready to cope with work environments and occupations that are likely to change, his term *career maturity* implied a typical or natural progression from school, to work, to retirement.

To address the changing nature of careers, theorists have updated the concept of career maturity, considering it more appropriately as career adaptability, which has been placed at the core of career construction theory. Career adaptability is a psychosocial construct that denotes an individual's readiness and resources for coping with current and imminent vocational development tasks, occupational transitions, and personal traumas. Insights from this concept provide a framework for dealing with unplanned changes. Individuals who are able to adapt and navigate through educational and

career transitions do so along dimensions of concern about one's future work life, control over one's career future, curiosity to explore future selves and scenarios, and the confidence to seek one's career goals.

## Transition Stages

Career transitions inherently involve a process that occurs over time. Therefore, any consideration of transitions must address the complex interactions between the individual, significant others, and the cultural context of the transition. Theorists have proposed that individuals experience four stages in career transitions—moving in, moving through, moving out, and moving in again. Research indicates that people experience a variety of issues related to each stage. During the moving in stage, many employers will fail to provide sufficient job orientation. As a result, 50%–60% of newly hired individuals leave their job in the first 7 months. This stage of starting a new job requires knowing the expectations of peers, subordinates, supervisors, and job tasks. Moreover, workers must recognize that openness to this new information can help them embrace the new system and environment. In order to accomplish this, the person needs to understand the expectations regarding his or her new position and the culture of the environment, understanding the explicit and implicit norms and being aware that he or she is likely to feel marginalized initially.

As the person adjusts, he or she enters into the moving through stage. At this point some people may feel that their careers have reached a plateau. A person may also fear being stuck in a dead-end job, feel loneliness or that he or she is lacking in competence, or be concerned about managing competing demands. Strategies for addressing demands of this stage can be organized into three approaches. *Forming* is a way for individuals to gather information through exploration, innovation, and invention. *Norming* allows the individual to extend and improve upon what has been done in the past. Finally, *fulfilling* is a type of transformation involving integration of old and new ideas.

The third stage is the moving out stage. This is a common experience for a variety of reasons, such as a reduction in force, retirement, planned career change, or a layoff. It is both a time of distress as well as an opportunity for a new beginning, depending on how one approaches the change. Working through this stage is similar to working through the grief process, which is characterized by denial and isolation, anger



and resentment, bargaining, preparatory depression, and finally acceptance. Individuals must recognize the importance of moving through stages and not getting stuck. Some may not even be aware of the stages or the nature of what happens in the stages.

The fourth stage, moving in again, involves the individual's attempts to find and adapt to a new occupation or setting. It is helpful for support systems, such as family, friends, and even former coworkers, to find ways to cope with the unemployment during this stage. Coping strategies can involve joining support groups, keeping busy with other productive activities, and taking an active approach to career and educational exploration. During this stage, it is likely that individuals and their families will experience moments of despair or frustration. Instead of moving into a new job, many individuals transition into an educational setting. Although starting a new job, changing careers, going back to school, or retiring involve unique concerns and outcomes, the transitional issues remain the same: Individuals need to understand the culture of the educational setting, expectations for performance, technology and skills involved in returning to school, and seek strategies for feeling connected to the community again.

### Implications for Counseling

To assist individuals with transitions, it is important to conduct an adequate assessment of their values, interests, skills, and personality and to note the importance of coping, social support, and so on. For coping resources, it may be useful to understand the four S's of Situation, Self, Support, and Strategies, which address the current situation, the person's unique patterning of traits and identity, the available resources, the social support, and the coping styles employed. Both emotion-focused and solution-focused approaches can be beneficial in helping the individuals and families process their emotions as well as retain a positive focus on identifying solutions in moving in a new direction. For example, the initial stages of transition may include anger at the company, the situation, or even government policies. Counselors can help dislocated workers understand and appropriately express these emotions. A solution-focused strategy may include a shift from dwelling on what went wrong in the past situation to proactively identifying steps, such as returning to school, to plan for the future.

Counselors can incorporate strategies from career construction theory or the career pathing model to

benefit people in transition. Career construction uses narrative and constructivist approaches to help the person understand his or her career decision influences and choices across the life span. Career construction gives counselors a way to view clients in a broader and integrated fashion that emphasizes human agency through the context of their work and other life themes.

Career pathing starts with a clarification of goals and then utilizes assessments to help the client understand how his or her skills, experience, and personal style align with the skill requirements, performance expectations, and available occupational opportunities. The information gathered can be used to identify the actions and environments, such as training, coaching, additional education, or mentoring, that will be needed to prepare the person for a new occupation.

People naturally seek meaning and order in today's complex world, especially those who have experienced a great deal of change. Because people who have gone through forced or unplanned career changes may experience a sense of loss and reformation of goals, it may be helpful for them to search for a sense of meaning and purpose in the transition. For some, this involves seeking spiritual support and guidance, which can also be another means of engaging social support.

### Special Populations

Because career transitions affect the lives of individuals in such a holistic and sometimes dramatic fashion, it is important to consider how the transition process affects one's personal and emotional well-being. Although certain aspects of transitions are universal (e.g., confusion, adjustment), the unique nature of different transition types can interact with personal and cultural factors to create additional challenges or to buffer the transitional experience. Career transitions might be experienced differently by people depending on gender, age, socioeconomic status, education, race/ethnicity, region of the country, sexual orientation, disability status, and so on. Following are a few examples of special populations.

With regard to women's career development, women may experience barriers in career transition related to work-family stressors, discrimination, or lack of support. For workers transitioning into retirement, the concepts of selection, optimization, and compensation may be particularly relevant. Selection



can involve identifying new goals and choosing plans for retirement. People may shift their allocation of funds to optimize their financial resources and even compensate by choosing activities that are commensurate with changes in health. Similarly, health-related changes in older adults are resulting in families that are sandwiched between trying to take care of their own children while taking on the role of caregiver for aging parents, resulting in additional life stressors. Immigrants may have other stressors based upon their level of acculturation, language skills, discrimination, and cultural differences in their views of occupations and dedication to family.

With the rapid changes involved in globalization, workers need to have an increasing level of adaptability to keep up with the dynamics in the world of work. This involves understanding the occupational requirements as well as having an awareness of their own goals, resources, interests, abilities, and coping style. The associated global changes demand a more educated and nimble workforce. Similarly, career counselors need to keep up with these changes and have the appropriate tools to adequately assist individuals transitioning into a better future. Effective transition interventions can result in improved post-transition adjustment, which allows individuals to navigate future transitions with greater ease and confidence.

*Charles K. Hees and Patrick J. Rottinghaus*

**See also** Adult Development (v1); Career Construction Theory (v4); Career Counseling (v4); Career/Life (v4); Career Transitions Inventory (v4); Coping (v2); Job Loss (v4); Life Transitions (v2); Parsons, Frank (v4); School-to-Work Transition (v4); Super, Donald Edwin (v4); Super's Theory (v4); Transition Behavior Scale (v4)

### Further Readings

- Baltes, P. B. (1997). On the incomplete architecture of human ontogeny: Selection, optimization, and compensation as foundation of developmental theory. *American Psychologist*, 52(4), 366–380.
- Betz, N. E. (2005). Women's career development. In S. D. Brown & R. W. Lent (Eds.), *Career development and counseling: Putting theory and research to work* (pp. 253–277). Hoboken, NJ: Wiley.
- Bobek, B. L., & Robbins, S. B. (2005). Counseling for career transition: Career pathing, job loss, and reentry. In S. D. Brown & R. W. Lent (Eds.), *Career development*

*and counseling: Putting theory and research to work* (pp. 625–650). Hoboken, NJ: Wiley.

- Goodman, J., Schlossberg, N. K., & Anderson, M. L. (2006). *Counseling adults in transition: Linking practice and theory* (3rd ed.). New York: Springer.
- McAdams, D. P., Josselson, R., & Lieblich, A. (Eds.). (2001). *Turns in the road: Narrative studies of lives in transition*. Washington, DC: American Psychological Association.
- Parsons, F. (2005). *Choosing a vocation*. Broken Arrow, OK: National Career Development Association. (Original work published 1909)
- Savickas, M. L. (2005). The theory and practice of career construction. In S. D. Brown & R. W. Lent (Eds.), *Career development and counseling: Putting theory and research to work* (pp. 42–70). Hoboken, NJ: Wiley.
- Schlossberg, N. K. (1981). A model for analyzing human adaptation to transition. *Counseling Psychologist*, 9(2), 2–18.

---

## ARMED SERVICES VOCATIONAL APTITUDE BATTERY

---

The ASVAB, shorthand for the Armed Services Vocational Aptitude Battery, anchors the Career Exploration Program (CEP) offered free to schools by the Military Enlistment Processing Command through teams of Educational Services Specialists. The CEP encourages exploration through OCCU-Find, which integrates vocational interests with ASVAB scores and Occupational Information Network. This entry is based on available documentation for the ASVAB and CEP, including journal articles and technical reports. Many issues identified by reviewers of the ASVAB have been addressed, some remain.

### Test Purposes and Scoring

Test purposes served by the ASVAB include career counseling, enlistment screening, and placement. Scores are provided for eight tests, as well as numerous composites including verbal, math, and science–technical; the tests are administered by trained individuals in high schools that make voluntary requests. The ASVAB is rooted in a rich tradition. The Army Alpha test, developed to screen recruits during World War I, evolved into the Army General Classification Test administered to recruits in World



War II. Differentiation of testing occurred across the services until conformance to the ASVAB and the Armed Forces Qualifying Test composite became mandatory. Testing for secondary students began in 1968 as a value-added purpose. Computer-adaptive testing is available, but only for enlistment testing.

Currently, eight tests make up the ASVAB. The raw scores are formed into composites for multiple purposes. The tests, number of items, and content are as follow: General Science (25 items; knowledge of life science, earth and space science, and physical science), Arithmetic Reasoning (30 items; ability to solve basic arithmetic word problems), Word Knowledge (35 items; ability to understand word meaning through synonyms), Paragraph Comprehension (15 items; ability to obtain information from written material), Mathematics Knowledge (25 items; knowledge of mathematical concepts and applications), Electronics Information (20 items; knowledge of electrical current, circuits/devices, and electronic systems), Auto and Shop Information (25 items; knowledge of auto maintenance and repair, wood-metal shop), Mechanical Comprehension (25 items; knowledge of mechanical devices, structural support, and properties of materials). The composition of the ASVAB should be continually scrutinized across purposes and populations.

The focus here is the paper-and-pencil ASVAB used for counseling within the CEP versus the distinct purposes of military testing. A recent refocusing, guided by an expert panel, resulted in enhanced ASVAB scoring moving from a single to a three-construct model and support materials delivered via the Internet. Score reports are well laid out, but may require support to be discussed in family settings after postinterpretation sessions. During the refocusing, a measure of work values was dropped and a measure based on Holland's theory (Interest Finder) was replaced by a scale called Find Your Interests (FYI) delivered by paper or by Web. The FYI is described in the 2005 Counselor's Manual. OCCU-Find, with passcode access generated by a third party, provides test takers, who input their scores, with links to civilian and military jobs aligned with the Occupational Information Network. An update of OCCU-Find to create alignments to more occupations is under way.

The ASVAB is an intersection among societal institutions, namely testing and occupational information; the armed services; and education. Testing as an institution creates consequences for individuals.

Harley E. Baker noted in 2002 that the goal of the CEP program is to present appropriate norm information for secondary and postsecondary career counseling. Norms by grade and gender are derived from the regularly updated Profile of American Youth surveys. Two important aspects of the ASVAB and CEP are the validity of score interpretations for multiple purposes and receptiveness in the test-user and test-taker populations. Baker's research showed reductions in career indecision for a group of Student Testing Program participants compared to two control groups. Score interpretations would be enhanced by investigating distal career outcomes for civilian and military jobs. As a voluntary tool, patterns of requests over time should be informative to developers and users. And despite concerns, according to CEP staff less than 5% of test takers use their scores for enlistment. Schools are given substantial latitude in dictating post-ASVAB contact, although No Child Left Behind regulations grant access unrelated to the ASVAB, which might explain misperceptions.

## Evaluation of the ASVAB

Resources, diminishing though they may be, are invested in the CEP and thus meeting objectives, trade offs, and return on investment become legitimate evaluation questions. The ASVAB-CEP is valuable for school districts and especially for those who cannot afford to purchase off-the-shelf tests of abilities and interests and for the development of occupational linkages. The technical characteristics as described in the *Counselor's Manual* seem solid on reliability and validity with known gender differences. Further, due to a misnorming of the ASVAB (admittedly, long ago) that led to acceptance of lower-scoring recruits, substantial attention is paid to quality assurance. A recent technical review by a committee of experts presented 22 recommendations for the ASVAB. The final paragraphs of this review indicated the quality of the research base with acknowledgment of slow acceptance of innovations by the Department of Defense. The ultimate effect of this review on the CEP is unknown because of its focus on the military testing program. The ASVAB can still be improved for all its purposes.

James T. Austin



*See also* Achievement, Aptitude, and Ability Tests (v4); Career Counseling in Schools (v4); Career Exploration (v4); General Aptitude Test Battery (v4); Holland's Theory of Vocational Personalities and Work Environments (v4); Occupational Information Network (v4); Trait-Factor Counseling (v4)

### Further Readings

- Baker, H. E. (2002). Adolescent career indecision: The ASVAB Career Exploration Program. *Career Development Quarterly*, 50, 359–370.
- Campbell, J. P., & Knapp, D. (Eds.). (2001). *Exploring the limits in personnel selection and classification*. Mahwah, NJ: Lawrence Erlbaum.
- Drasgow, F., Embretson, S. E., Kyllonen, P. C., & Schmitt, N. (2006, December). *Technical review of the Armed Services Vocational Aptitude Battery (ASVAB)*. Alexandria, VA: HumRRO.
- Edwards, J. E., Scott, J. E., & Raju, N. (Eds.). (2003). *The human resources program-evaluation handbook*. Thousand Oaks, CA: Sage.
- Sands, W. A., Waters, B. K., & McBride, J. R. (Eds.). (1997). *Computerized adaptive testing: From inquiry to operation*. Washington, DC: American Psychological Association.
- Yerkes, R. M. (Ed.). (1921). Psychological examining in the United States Army. *Memoirs of the National Academy of Sciences*, 15, 1–890.

---

## ASSESSMENT

---

The assessment of different measures, such as an individual's interests or personality, can influence career development and counseling, giving both the individual and the career counselor useful information for decision making. This entry discusses three central points regarding career assessment: (1) career assessment has a long and distinguished history forged by some of the leading test developers in psychology; (2) the reliability, validity, and usefulness of career assessment measures are unsurpassed in psychology; and (3) comprehensive and multivariate assessment with a variety of high-quality and specific measures will best reflect the individuality that underlies career development.

### Standing on the Shoulders of Giants

Modern psychological assessment began just over 100 years ago when Alfred Binet created the first

intelligence test in 1905. Some 15 years later at Carnegie Institute of Technology, a number of pioneering psychologists were devising ways to measure vocational interests. From that work emerged in 1927 E. K. Strong's Vocational Interest Blank, a powerful and practical measure that has been revised and expanded over its 80-year history by leading psychologists. Today, the Strong Interest Inventory (Strong) is an icon of career assessment, and it illustrates many of the important ways that individuality can be measured to give meaning to career decisions.

People's responses to career inventories matter. Career assessment, as well as work life, has undergone sea changes since those early beginnings. The world of work is very different now than it was 80 years ago when the Strong began. Strong's first samples were often Stanford undergraduates, and they were exclusively male. His early work with working adults was exclusively with men; and in fact, he did not believe that women's interests were well focused. Today, women are the majority in many professional schools such as veterinary medicine, human medicine, and law. Women's scores on scales for leadership and academic achievement equal or exceed those of men. The validity, meaning, and implications of career measures for women are every bit as good as they are for men. Moreover, many career assessment tools appear to have good cross-cultural validity, both globally and across U.S. ethnic and minority groups.

Also, in the past 30–40 years, the kinds of constructs that can be usefully measured in career inventories have greatly expanded beyond interests. What interests (or disgusts) a person is still centrally important to career life, but there are also many other important things. Assessment across diverse domains is the keystone of vocational psychology. Most revolutionary has been Nancy Betz and Gail Hackett's 1981 adaptation of Albert Bandura's ideas of social agency to the theory and constructs of career self-efficacy. Moreover, personality measures are now recognized for their close links to educational and work life. There are many hints that some early personality dispositions may be causal for the development of other career inclinations, such as interests, self-efficacy, and satisfaction.

### Robust Psychometrics in Career Assessment

The quality of measures in career assessment is as good as any area of psychological assessment. The meaning



of a measure for career counseling derives from its reliability and validity. Meaning rests on scale quality. The pioneers in career assessment 70 years ago, such as Strong, Frederic Kuder, and D. G. Paterson, were astutely attentive to reliability and validity. Developers of career measures since then have stood on the shoulders of these giants. Strong launched the empirical, criterion-based occupational scale and showed with decades-long longitudinal studies that interests of adults are quite stable. Kuder pioneered the concept of internal consistency underlying content scales with high homogeneity. In the late 1960s, David Campbell merged these kinds of scales in the Strong as he brought John Holland's content-based concepts to Strong's empiricism. In the current 2005 revision of the Strong, the internal consistency reliabilities for those Holland scales are all .90 or more.

Career measures are robust because career constructs are robust. People differ tremendously in how they see themselves and their work lives. If test developers ask physicists if they *like* calculus, 90% will say yes, but an equal number of car salespeople will say they *dislike* calculus. In other words, how people feel about mathematics, whether they enjoy it or can do it, comprises potent dimensions of individual differences. Most people develop these math cognitions and emotions in their youth and persist with these reactions to math throughout their lives. They become part of one's persona and sense of personal agency. Test developers can readily construct measures of math interests or self-efficacy with high reliability. These measures in turn have potent validity and meaning for both practice and science. One's reactions to math cascade throughout the career development space. They determine how one chooses to embrace or flee a college major in accounting, physics, engineering, or actuarial science. Such college majors in turn have lifelong effects on the course of careers. Reactions to math tend to have high test-retest reliability and high predictive validity for many of career life outcomes. An accountant, physicist, or actuary who hated or feared math would certainly be an outlier.

How one feels about math is one of the most potent dimensions of individuality in career space. There are many other practically significant dimensions. The number of individual differences variables in the self-report realm that importantly affect career life probably exceeds 50. This assertion, based on the trend of recent research, clearly flies in the face of Holland's triumphal advocacy for six career types. Certainly, those six Holland dimensions are an effective and

efficient summary of one's career persona. (They have reliabilities of .90 on the Strong partly because they are long scales.) So if one is an enterprising type, looking toward business and leadership is the right first step. However, within the enterprising domain are crucial facets such as management, entrepreneurship, sales, marketing and advertising, public speaking, law, and politics. Those facets are moderately correlated for a group of people, but individuals with an enterprising bent often differ tremendously on those specific facets. Those facets add very substantially to the meaning and validity of career assessment of individuals. Courses of study, such as college majors, are closely tied to those facets, so a student is well served to have knowledge about those facets. A marketing and advertising major is quite different from a political science major, as are the people moving into careers from those majors.

### **Toward Comprehensive and Multivariate Assessment**

Quite paradoxically, the simplest assessment systems, such as Holland's six broad scales, have prevailed in the last 4 decades along with complex systems with specific scales. The best example is the Strong, as revised by Campbell. The Strong, since then, has contained six broad Holland scales as well as 23–30 Basic Interest Scales (BISs) arrayed under the Holland scales. In the Strong, simplicity of broad scales coexists with complexity of specific BISs. The Holland scales enable a three-letter code that has proved enormously popular in understanding Holland's theory and simplifying career counseling. At the same time, multivariate research (e.g., Donnay & Borgen, 1996) has shown that specific scales such as the BISs increase validity severalfold over the Holland scales for specific criteria such as college major and adult occupation. Campbell's Interest and Skill Survey is similarly structured so that the same conclusions apply to it. The simple six-dimensional system is practically efficient and easy to apply, even though important additional valid variance resides in the specific facets. The same phenomenon has occurred in personality assessment where the simplest systems have become the most popular and widely applied even though there is more valid and meaningful variance remaining in specific facets. The clear examples here are the Myers-Briggs Type Indicator and measures of the Big Five personality dimensions.



In the past decade there has been a surge of studies showing how personality, interests, and self-efficacy are interwoven and linked to career development. The evidence shows not only that these domains overlap substantially, but also that they contribute incremental validity in explaining important career outcomes. When specific scales are constructed as homogeneous content scales, it is possible to combine them in linear composites that predict complex, heterogeneous criteria, such as membership in a college major or occupation. Thus, for example, the ingredients of marketing and advertising are a combination of artistic creativity, writing, public speaking, management, and marketing. These are likely the ingredients of Strong's traditional occupational scale for marketing and advertising; but because occupational scales are actuarial, constructed with blind empiricism, their content has always been opaque. Now, with a multivariate approach to content scales, counselors can match people to college majors and occupations and also make transparent the ingredients of that process. That enables useful career interventions. For example, a student aspiring to a career in marketing, but with low public speaking scores, can seek life experiences to enhance those scores.

Among the 50 plus dimensions a career counselor might have in a comprehensive tool kit are such diverse assessments as introversion–extraversion, optimism, anxiety, risk taking, academic orientation, teamwork, leadership, creativity, career maturity, career indecision, career decision-making self-efficacy, well-being, construal of possible selves, religiosity, altruism, profit-orientation, mechanical activities, athleticism, teaching, music, artistic creativity, selling, accounting, investing, and information technology. Only the most data-driven counselor will want to integrate so many measures. Test developers must organize this cornucopia in a computer-based system that is user friendly and coherent in highlighting the salient scores for counselor and client. Aided by the Holland classification, many comprehensive inventories, such as the Strong and the Campbell Interest and Skill Survey, go a long way toward doing this. Test developers and other researchers also need to demonstrate the incremental validity of this large number of measures to show that a new measure brings utility not already present in prior measures. This is a large and continuing endeavor.

## Top 10 Tools for the Career Counselor's Toolkit

Here are several kinds of measures that are likely to be useful in career assessment, dependent to some degree on the setting. These are all subjective self-report measures. Some of these inventories have very long histories; others are recently developed or are still being refined and have yet to be widely accepted. Some counselors in some settings may equally need objective measures of cognitive skills, or even behavioral samples.

- Comprehensive interest inventory with broad and specific measures
- Comprehensive personality inventory identifying strengths in normal people
- Comprehensive confidence inventory with broad and specific measures
- Measure of work and life values
- Measure of career indecision
- Life satisfaction or well-being measure
- Job or college satisfaction measure
- Measure of career maturity
- Measure of career decision-making self-efficacy
- Career goal-setting inventory

## CAPA Assessment System

The CAPA Assessment System of Nancy Betz and Fred Borgen exemplifies a comprehensive, computer-based system that incorporates measures of interests, self-efficacy (confidence), and personality strengths. The CAPA Interest Inventory includes 47 broad and specific scales, and the parallel CAPA Confidence Inventory includes 39 broad and specific scales. These inventories also contain Life Engagement Scales, measuring such dimensions as academic achievement, extraversion, leadership, and risk taking. These two inventories have been combined in a computerized, online system that assists college students in exploring majors that best match their interests and confidence. Finally, the Healthy Personality Inventory provides 17 scales measuring strengths such as creative, outgoing, and relaxed.

The Betz and Borgen CAPA Assessment System has college majors scales that are linear composites of specific interests and confidence. These new scales, based on modern multivariate methods, can predict



a complex criterion, as can Strong's venerable occupational scales. They have psychometric properties (namely, heterogeneity and diverse content) that are similar to Strong's occupational scales of 1927, yet they are created in an entirely different way. They are based on specific content dimensions known to be the ingredients of a particular major. Thus, students can be shown quite transparently how their individuality matches the typical characteristics of a major. A similar approach can be devised for occupations and for clusters of similar occupations. All of this can be implemented in an online system that provides sophisticated interpretation and links instantly to other sources of information or exploration.

Fred H. Borgen

**See also** Campbell Interest and Skill Survey (v4); Career Counseling, History of (v4); Career Decision Self-Efficacy Scale (v4); Career Indecision (v4); Career Maturity (v4); Career Maturity Inventory (v4); Holland's Theory of Vocational Personalities and Work Environments (v4); Job Satisfaction and General Well-Being (v4); *Journal of Career Assessment* (v4); Kuder, Frederic (v4); Life-Role Balance (v4); Multicultural Career Assessment Models (v4); Personality Assessment and Careers (v4); Strong, Edward Kellogg, Jr. (v4); Test Interpretation (v2)

### Further Readings

- Bandura, A. (in press). An agentic perspective on positive psychology. In S. J. Lopez (Ed.), *The science of human flourishing*. New York: Praeger.
- Betz, N. E. (2007). Career self-efficacy: Exemplary recent research and emerging directions. *Journal of Career Assessment*, 15, 403–422.
- Betz, N. E., & Hackett, G. (2006). Career self-efficacy theory: Back to the future. *Journal of Career Assessment*, 14, 3–11.
- Borgen, F. H., & Betz, N. E. (in press). Career self-efficacy and personality: Linking the Career Confidence Inventory and the Healthy Personality Inventory. *Journal of Career Assessment*.
- Borgen, F. H., & Lindley, L. D. (2003). Individuality and optimal human functioning: Interests, self-efficacy, and personality. In W. B. Walsh (Ed.), *Counseling psychology and optimal human functioning* (pp. 55–91). Mahwah, NJ: Lawrence Erlbaum.
- Brown, S. D., & Lent, R. W. (Eds.). (2005). *Career development and counseling: Putting theory and research to work*. Hoboken, NJ: Wiley.
- Campbell, D. P. (2002). The history and development of the Campbell Interest and Skill Survey. *Journal of Career Assessment*, 10, 150–168.
- Chaney, D., Hammond, M. S., Betz, N. E., & Multon, K. D. (2007). The reliability and factor structure of the Career Decision Self-Efficacy Scale-SF with African Americans. *Journal of Career Assessment*, 15, 194–205.
- Donnay, D. A. C., & Borgen, F. H. (1996). Validity, structure, and content of the 1994 Strong Interest Inventory. *Journal of Counseling Psychology*, 43, 275–291.
- Donnay, D. A. C., Thompson, R., Morris, M., & Schaubhut, N. (2005). *Strong Interest Inventory manual: Research, development, and strategies for interpretation*. Palo Alto, CA: Consulting Psychologists Press.
- Gasser, C. E., Larson, L. M., & Borgen, F. H. (2007). Concurrent validity of the 2005 Strong Interest Inventory: An examination of gender and major field of study. *Journal of Career Assessment*, 15, 23–43.
- Hansen, J. C., & Dik, B. J. (2005). Evidence of 12-year predictive and concurrent validity for the SII Occupational Scale scores. *Journal of Vocational Behavior*, 67, 365–378.
- Hartman, R. O., & Betz, N. E. (2007). The Five Factor model and career self-efficacy: General and domain specific relationships. *Journal of Career Assessment*, 15, 145–161.
- Holland, J. L. (1997). *Making vocational choices: A theory of vocational personalities and work environments* (3rd ed.). Odessa, FL: Psychological Assessment Resources.
- Larson, L. M., Rottinghaus, P. J., & Borgen, F. H. (2002). Meta-analyses of Big Six interests and Big Five personality factors. *Journal of Vocational Behavior*, 61, 217–239.
- Nauta, M. M. (2007). Career interests, self-efficacy, and personality as antecedents of career exploration. *Journal of Career Assessment*, 15, 162–180.
- Ozer, D. J., & Benet-Martinez, V. (2006). Personality and the prediction of consequential outcomes. *Annual Review of Psychology*, 57, 401–421.
- Ralston, C. A., Borgen, F. H., Rottinghaus, P. J., & Donnay, D. A. C. (2004). Specificity in interest measurement: Basic Interest Scales and major field of study. *Journal of Vocational Behavior*, 65, 203–216.
- Rottinghaus, P. J., Lindley, L. D., Green, M. A., & Borgen, F. H. (2002). Educational aspirations: The contribution of self-efficacy, interests, and personality. *Journal of Vocational Behavior*, 61, 1–19.
- Strong, E. K., Jr. (1927). Vocational interest test. *Educational Record*, 8, 107–121.
- Walsh, W. B., & Heppner, M. (Eds.). (2006). *Handbook of career counseling for women* (2nd ed.). Mahwah, NJ: Lawrence Erlbaum.



- Walsh, W. B., & Savickas, M. L. (2005). *Handbook of vocational psychology* (3rd ed.). Mahwah, NJ: Lawrence Erlbaum.
- Zytowski, D. G. (2001). Kuder career search with person match: Career assessment for the 21st century. *Journal of Career Assessment*, 9, 229–241.

---

## ATTACHMENT THEORY

---

Attachment theory provides a useful theoretical framework for understanding how relationships function to facilitate or hinder developmental progress, such as progress in career development. A central tenet of this theory concerns the central role of attachments as enduring emotional bonds of substantial intensity that influence healthy development and participation in satisfying relationships. Regularities in interactions with caregivers provide children with a sense of security. As individuals mature, cognitive representations (schemas)—or internal working models of attachment relationships—develop and become essential to the experience of security throughout the life span and are predictive of a number of adaptive outcomes. These models become activated and essential during times of stress. Continued participation in mutually satisfying relationships plays a significant role in healthy human development across the life span. Individuals at any age are better adjusted when they have confidence in the accessibility and responsiveness of a trusted other.

Anxiety generated by new situations, such as those encountered when engaging in career tasks, can be alleviated through the experience of attachment to a significant person in one's life who can provide emotional security. This relationship, referred to as the *secure base*, can provide some of the necessary ingredients for successful adaptation to a wide range of new contexts. The transition to a new work environment, which is undoubtedly even more complex for young people leaving school, represents the sort of challenge for which the experience of a secure base would be particularly important.

Much of the research on family relationships has investigated the role of attachment on various career behaviors. Specifically, attachment has consistently been found to be positively related to college students' degree of vocational exploration, career decision making, educational and career aspirations,

expectations and orientation, and effective and healthy transitions.

Similarly, research has found that high school students who anticipated parental support for certain careers, also valued those careers. There also is support for the role of attachment on other career variables including adult adjustment to work, adaptive relationships at work, and career maturity. In the following sections, more information on career exploration, career decision making, occupational aspirations, expectations, and career orientation, and transitions is provided.

### Career Exploration

Career exploration is an important component in identifying, evaluating, and deciding on vocational alternatives. Career exploration has generally been defined as a process wherein individuals seek out information about themselves and the educational and occupational environment to facilitate progress in career development. It is thought that the experience of felt security within secure attachment relationships facilitates the exploration process, which frequently evokes anxiety.

Research suggests that parental attachment is positively related to vocational exploration. In particular, researchers have found that attachment to both peers and mother (but typically not father) is positively associated with environmental exploration, progress in committing to career choices, and career search self-efficacy. In a sample of high school students, other researchers found that a secure attachment to both parents was positively related to the frequency with which girls engaged in exploratory activities and the diversity of the activities that they engaged in. For boys, no relationship was found between parental attachment and exploratory behaviors. For girls, but not for boys, support has been found for the positive association between attachment to mother and satisfaction with exploration in terms of feeling well informed. The results of these studies suggest that attachment with parents facilitates vocational exploration.

### Career Decision Making

The literature on career decision making includes career decidedness, career commitment, and career decision-making self-efficacy. Progress in moving from an undecided position to a committed position with



respect to career choice is a developmental process that is thought to be influenced by contextual factors such as attachment relationships. It has been suggested that the experience of the secure base fosters the risk taking and experimentation that are integral to the process of deciding on and committing to a career choice. Research suggests that for female college students, attachment to both parents is positively related to commitment to career choices and negatively related to the tendency to foreclose on a career choice (i.e., committing to a career decision without adequately engaging in exploration). For college males, only attachment to father is typically related to commitment and tendency to foreclose. Other research has found that attachment to mother was positively related to committing to a career choice, but to a lesser extent than attachment to peers for both men and women.

Attachment to mother, father, and peers also has been shown to be negatively related to fear of commitment to career choices and positively associated with career decision-making self-efficacy. Other evidence indicates that students who experience greater levels of attachment anxiety (i.e., fear of abandonment coupled with the desire for extreme closeness) also report less vocational self-concept crystallization (i.e., degree of clarity and certainty of self-perception with respect to vocationally relevant attitudes, values, interests, needs, and abilities) and greater global career indecision. The literature on attachment and career decision making suggests that attachment influences the various aspects of the career decision-making process for adolescents, such as career commitment and self-efficacy.

### **Occupational Aspirations, Expectations, and Career Orientation**

Several investigations have provided evidence to suggest that adolescent girls' attachment with their mothers contributes to their career orientation. In a longitudinal study of female high school seniors, researchers have found that attachment to mother during high school contributed to the career aspirations of these women 5 years later, but the effect was mediated through career self-efficacy. Most of the research in this area was conducted on a relatively homogenous sample of predominantly middle- to upper-middle-class European American girls. Research is needed with males and participants who are representative of diverse racial, ethnic, and socioeconomic groups.

## **Transitions**

A number of investigators have argued that an adaptive level of attachment between late adolescents and their parents may be beneficial for developmental progress and adjustment in transitions. Evidence suggests that attachment to parents at the end of high school predicts positive changes in expectations of support and socio-emotional adjustment across the transition to college. Research also has shown that parental attachment is positively related to college student adjustment. One study found that for women, attachment to both parents was related to academic autonomy, and for men, attachment to mother was related only to academic autonomy and academic and personal adjustment. In a related study, college student adjustment was positively related to a secure adult attachment style and was negatively related to fearful and preoccupied attachment styles. Other research demonstrated that the relationship between attachment and college student development was mediated by separation-individuation from parents. Implications of this research suggests a model of individuation-within-relatedness for understanding adolescent development.

## **Summary**

The current literature on attachment relationships and career development is suggestive of a positive relationship between a secure attachment to parents and progress in career development. Although only attachment research was reviewed here, research also implicates the importance of separation-individuation from parents as an important construct that may work in tandem with attachment. In summary, attachment relationships seem to have a particularly significant influence on career progress. It also should be stressed that relational influences on career outcomes should not be examined in isolation from gender, race, ethnicity, and socioeconomic status.

*Donna E. Palladino Schultheiss*

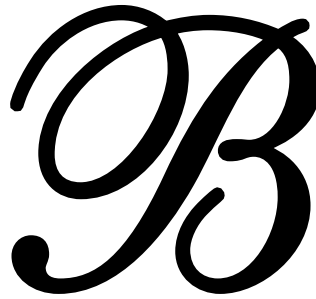
*See also* Career Counseling (v4); Career Decision Self-Efficacy Scale (v4); Career Development Inventory (v4); Career Exploration (v4); Decision Making (v4); Developmental Counseling and Therapy (v2); Parent-Adolescent Relations (v1); Parenting (v1); School-to-Work Transition (v4); Self-Efficacy/Perceived Competence (v2)



**Further Readings**

- Blustein, D., Prezioso, M., & Schultheiss, D. (1995). Attachment theory and career development: Current status and future directions. *The Counseling Psychologist*, 23, 416–432.
- Blustein, D., Walbridge, M., Friedlander, M., & Palladino, D. (1991). Contributions of psychological separation and parental attachment to the career development process. *Journal of Counseling Psychology*, 38, 39–50.
- Bowlby, J. (1982). *Attachment and loss: Vol. 1. Attachment* (2nd ed.). New York: Basic Books.
- Ketterson, T. U., & Blustein, D. L. (1997). Attachment relationships and the career exploration process. *The Career Development Quarterly*, 46, 167–178.
- O'Brien, K. M., Friedman, S. M., Tipton, L. C., & Lin, S. G. (2000). Attachment, separation, and women's vocational development: A longitudinal analysis. *Journal of Counseling Psychology*, 47, 301–315.
- Whiston, S. C., & Keller, B. K. (2004). The influences of the family of origin on career development: A review and analysis. *The Counseling Psychologist*, 32, 493–568.





---

## BIODATA

---

Biodata, or biographical data, are paper and pencil measures that ask respondents to reflect or report on their life experiences. Scores from biodata are typically used in conjunction with other employment measures for predicting individual performance in a given job. Biodata have been used across a wide range of occupations as an indicator of the likelihood of job success, where success may be defined as task-specific job performance, teamwork, or other organizationally relevant outcomes. Biodata can therefore be a useful tool for organizations seeking to examine job applicants' backgrounds in a consistent, transparent, and fair manner. The fundamental premise underlying the use of these measures is that past experience should be a reasonable predictor of future work behavior. That is, it is assumed that individuals shape their life experiences, and they are also shaped by these experiences. Given these processes are relatively continuous over time, having critical information about an individual's previous experiences should allow for making more accurate predictions about future behavior—even above and beyond predictions one could make from measures of cognitive ability, personality, motivation, and interests.

Biodata items can vary substantially in content and specificity. For instance, some items may be relatively personality oriented, making the underlying experiences of interest difficult to identify (e.g., "To what extent does your happiness depend on how things are going at work?"). On the other hand, they may be more situation specific or overt, making it relatively

easier to identify the purpose of the item (e.g., "Approximately how many books have you read in the past three months?"). In all cases, however, biodata items require the respondent to recall and report their characteristics and experiences. Therefore, the usefulness of these items depends in part on the extent to which individuals are able to accurately perceive, store, and recall this information and their willingness to report it truthfully. It is known from the cognitive psychology literature that individuals vary widely in the efficiency and effectiveness of their memory storage and retrieval processes, and it is known from the organizational psychology literature that faking answers to items that have no right answer (such as biodata and personality items) is a serious concern in the employment setting.

In addition to items being covert or overt in nature, the underlying personal characteristics tapped by biodata instruments also vary widely across forms. Either implicitly or by design, biodata items typically reflect specific experiences tied to constructs such as ability, personality, motivation, interpersonal skills, and interests. In some cases, these items may be fairly pure measures of a given construct, but in other cases, the items may relate to several constructs. This clearly has implications for empirically examining and interpreting the underlying factor structure and reliability of biodata instruments. Both test-retest reliability and internal consistency (coefficient alpha) should be considered when examining biodata reliability, with test-retest reliability being more sensible when no strong factors exist in the measure.

Although biodata instruments vary widely in terms of many characteristics (e.g., content, length, scoring),



these measures have consistently been found to demonstrate criterion-related validity across occupations. Correlations between scores on these measures and indices of job performance (e.g., supervisor ratings) tend to be approximately .30. Furthermore, these measures have demonstrated incremental validity above and beyond measures of general cognitive ability and the five-factor model personality constructs (emotional stability, extraversion, openness to experience, agreeableness, conscientiousness). Thus, these assessments provide useful information regarding likely occupational success beyond that provided by measures of broad individual differences, themselves known to be valuable predictors of organizational behavior.

### Item Attributes

As noted, biodata items can differ in a number of ways. F. A. Mael has presented a useful outline of 10 major biodata item attributes.

1. Historical versus hypothetical (i.e., past behaviors versus predicted or anticipated behaviors in “what if” scenarios)
2. External versus internal (i.e., behaviors versus attitudes)
3. Objective versus subjective (i.e., observable-countable events versus self-perceptions)
4. Firsthand versus secondhand (i.e., self-descriptions versus how people would say others describe them)
5. Discrete versus summative (i.e., single events versus averaging over a period of time)
6. Verifiable versus nonverifiable
7. Controllable versus noncontrollable (i.e., circumstances could or could not be influenced by the individual’s own decisions)
8. Equal access versus unequal access (i.e., access to opportunities with respect to the group being tested)
9. Job relevant versus nonjob relevant
10. Noninvasive versus invasive (i.e., matters usually kept private)

### Scoring Biodata Measures

A number of biodata measure scoring methods have been proposed. In situations where linkages between

items and constructs are relatively clear, scoring can be quite straightforward. For example, item content may have been developed to tap a specific set of constructs or categorizations might be supported by subject matter expert item sorting. In these cases, each item might be scored along a single underlying continuum (i.e., more is better), consistent with the approach used with traditional Likert-scale self-report measures of personality.

Alternatively, a criterion-keying approach is typically a more complex scoring method. This approach involves obtaining item responses and relevant criterion scores for a sample of individuals. Mean criterion scores or criterion-related validity coefficients are calculated for each response option, across all items. These values are then used as item response weights for scoring purposes. These are strictly empirical weights that can be adjusted, for example, when there are range restriction effects that can be estimated or when nonlinear patterns are found for what conceptually appear to be relatively continuous response options. Keying items based on empirical relationships can also be carried out using personality or other individual difference measures, rather than a criterion measure. This type of scoring may be particularly useful in situations where respondents are motivated to present themselves in a socially desirable manner (e.g., job applicant contexts). In these situations, it may be relatively easy for test takers to manipulate scores on traditional personality measures, whereas scores on a set of personality-relevant but objective or verifiable biodata items may be less susceptible to this sort of response distortion.

One other approach, referred to as *configural scoring*, involves placing individuals into subgroups based on their profiles of biodata scores. An attempt is made to identify subgroups in an initial sample that are internally consistent but externally distinct. The mean biodata profiles from these subgroups may be linked to relevant organizational criteria and then labeled (e.g., a “goal-oriented leaders” profile). Individuals completing the biodata measure subsequently are assigned to these subgroups based on an index of similarity between their biodata profile and the mean subgroup profile (e.g., squared Euclidean distance or profile correlation). These assignments may operationalize various decisions about individuals such as hiring, placement, training, and development decisions.

Although numerous scoring approaches have proven useful, two general recommendations appear



most appropriate. First, scoring methods should be informed by both rational and empirical considerations. A rational or theory-based approach is often very useful for item development, item revision, and score use and interpretation. Clearly, empirical findings that suggest revisions to the conceptual foundation of the measure should not be ignored; this information may lead to both improved prediction and theoretical understanding. Second, a given approach to item scoring developed on one sample should be cross-validated on an independent sample. Any scoring method with weights derived from one particular sample will capitalize on chance to some degree. Therefore, cross-validation is necessary to ensure that findings from the derivation sample (e.g., strong criterion-related validity, reduced group mean differences) are robust.

### Test-Taker Reactions to Biodata Measures

Given that biodata items ask respondents about personal characteristics and life experiences, the potential for negative test-taker reactions to these instruments exists, particularly when they contain items whose purpose is not transparent. Reviews of test-taker reactions research indicate that, compared with other personnel selection measures, biodata tend to be rated as moderate in terms of favorability. Specifically, these measures generally score around the midpoint of favorability rating scales and are typically rated lower than interviews, resumes, and cognitive ability tests, but higher than integrity tests. However, reactions to biodata measures also vary across studies, likely due to the diversity of these instruments. In general, biodata measures are viewed more favorably when the content is perceived as job relevant and a fair reflection of the individual's life experiences.

*Patrick D. Converse and Frederick L. Oswald*

**See also** Achievement, Aptitude, and Ability Tests (v4); Industrial/Organizational Psychology (v1); Personality Assessment and Careers (v4); Person–Environment Fit (v4); Quantitative Methodologies (v1)

### Further Readings

Dean, M. A., & Russell, C. J. (2005). An examination of biodata theory-based constructs in a field context.

*International Journal of Selection and Assessment*, 13, 139–149.

Mael, F. A. (1991). A conceptual rationale for the domain and attributes of biodata items. *Personnel Psychology*, 44, 763–792.

Mount, M. K., Witt, L. A., & Barrick, M. R. (2000). Incremental validity of empirically keyed biodata scales over GMA and the five factor personality constructs. *Personnel Psychology*, 53, 299–323.

Oswald, F. L., Schmitt, N., Kim, B. H., Ramsay, L. J., & Gillespie, M. A. (2004). Developing a biodata measure and situational judgment inventory as predictors of college student performance. *Journal of Applied Psychology*, 89, 187–207.

Ouellette, J. A., & Wood, W. (1998). Habit and intention in everyday life: The multiple processes by which past behavior predicts future behavior. *Psychological Bulletin*, 124, 54–74.

Reiter-Palmon, R., & Connelly, M. S. (2000). Item selection counts: A comparison of empirical key and rational scale validities in theory-based and non-theory-based item pools. *Journal of Applied Psychology*, 85, 143–151.

Stokes, G. S., & Cooper, L. A. (2004). Biodata. In J. C. Thomas (Ed.), *Comprehensive handbook of psychological assessment: Vol. 4. Industrial and organizational assessment* (pp. 243–268). Hoboken, NJ: Wiley.

## BROWN'S VALUES-BASED CAREER THEORY

Brown's values-based career theory emphasizes the central importance of values in career counseling and occupational choice. *Values* are defined as cognitive structures that are the basis for self-evaluation and one's evaluation of others. Values also have an affective dimension, are the primary basis of goal-directed behavior, and are the stimulus for the development of behavior related to goal attainment. Values have been portrayed as more fundamental traits than interests, and it has been suggested that concerns for values should be the primary consideration in career counseling, without precluding the use of other constructs. The values-based approach is also predicated on the idea that career counseling should in most cases be life-role counseling because of the interaction among life roles and the unlikely outcome that an occupation can satisfy all of an individual's values.

The model assumes three types of values—cultural, work, and life values. Cultural values can be subdivided



into five categories of social relations, time, relationship to nature, activity, and self-control. Work values are those values that clients expect to fulfill as a result of choosing and entering an occupation. Life values are those values that clients expect to have satisfied as a result of the choices they make in their major life roles, such as work, leisure, citizen, and relationships to significant others. Understanding these three types of values provides career counselors with the information needed for lifestyle planning.

Life-career counseling from a values perspective is based on the following assumptions: (1) Highly prioritized work values are the primary basis of career choice. When choosing an occupation to match values is constrained, structuring other life roles in ways that will satisfy highly prioritized life values should be pursued. (2) The most successful decision makers are likely to be those individuals or groups who have a future or past-future time orientation and a doing-activity value. (3) Clients with an individualism social value are required to make a series of estimates about their personal characteristics and the occupations they are considering if they are to be successful. (4) The sources of job satisfaction will vary for people who hold individualism and collateral social values. (5) Job success as determined by the supervisor or employer will be determined by the same factors for people regardless of their social relations value.

Sensitivity and attention must be given to cultural, work, and life values as a counselor works through the following stages of career counseling: client identification, relationship building, goal setting and assessment, problem solving, and termination. Perhaps the most important issue to be addressed during this process is to crystallize and prioritize the client's cultural, work, and life values in the context of life roles. Culturally sensitive interviewing, card sorts, and standardized values clarification surveys are helpful techniques for this process. The Life Values Inventory is an empirically derived values assessment instrument developed from the principles of this model. At the end of the process clients should be aware of their values in the context of life roles; how values influence their motivation, goal setting, self-evaluation and thus satisfaction; and their evaluation of others.

*Duane Brown and Robert Kelly Crace*

**See also** Career/Life (v4); Cultural Values (v3); Life-Role Balance (v4); Multicultural Career Assessment Models (v4); Values Scale (v4); Work-Family Balance (v4); Work Values (v4)

### Further Readings

- Brown, D., Crace, R. K., & Almeida, L. (2006). A culturally sensitive, values-based approach to career counseling. In A. J. Palmo, W. J. Weikel, & D. P. Borsos (Eds.), *Foundations of mental health counseling* (pp. 144–171). Springfield, IL: Charles C Thomas.
- Crace, R. K., & Brown, D. (2002). *Life Values Inventory*. Williamsburg, VA: Applied Psychology Resources. Available from <http://www.lifevaluesinventory.com>

---

## BUREAU OF LABOR STATISTICS

---

The Bureau of Labor Statistics is an agency with the Department of Labor, whose task it is to gather, analyze, and provide information on all aspects of labor, economics, and the workforce in the United States. The bureau was established by President Chester A. Arthur in 1884 as part of the Department of the Interior.

### Information Available From the Bureau of Labor Statistics

The Bureau of Labor Statistics currently provides data and information in the following areas:

- Inflation and consumer spending
- Wages, earnings, benefits, other compensation
- Productivity, both in the United States and internationally
- Occupational safety and health
- Descriptive information about occupations
- Demographic information about those in and out of the workforce
- Information about industries and the costs of doing business

While the bureau collects its own data, it also utilizes data from the census and various state agencies. The data and reports produced by the bureau are currently available in both print and Web formats. Major publications of interest to career counselors include the *Occupational Outlook Handbook*, the *Occupational Outlook Quarterly*, the *Career Guide to Industries*, and the *Monthly Labor Review*. The *Occupational Outlook Handbook*, first published in 1949, provides information on occupations and preparation for them. The *Occupational Outlook Quarterly*, first published in 1957, was designed to provide more frequent



updates to the *Occupational Outlook Handbook* than were possible with the latter's biennial publication schedule. The *Career Guide to Industries* describes this same information from the perspective of the industry in which the occupation is embedded.

Note that the *Dictionary of Occupational Titles* and subsequent occupational definition system, the *Occupational Information Network* (O\*NET), are publications of the Employment and Training Administration within the Department of Labor, not the Bureau of Labor Statistics.

### History of the Bureau of Labor Statistics

Prior to the establishment of the bureau, the only data available at the national level on employment and labor issues was information gathered as part of the decennial census. The bureau was established in response to a growing awareness of the lack of information for policy making in the area of labor and the conditions of employment. In its early years the bureau produced a number of reports, such as an annual report on industrial depressions (beginning in 1886) and a report on retail prices and wages (1891). Another annual report produced beginning in that same period was titled "The Slums of Baltimore, Chicago, New York, and Philadelphia" (1893) that included not only data on employment, but on such topics as crime, literacy, health, and crowding.

In 1913, the Bureau of Labor Statistics joined three other bureaus (Immigration, Naturalization, and Children's) to form the Department of Labor. Although there have been numerous changes in the bureaus that comprise the Department of Labor over the years, the

Bureau of Labor Statistics has remained a constant component of the Department. Currently, the Bureau of Labor Statistics is joined by the following agencies in the Department of Labor: Employment and Unemployment Statistics, Prices and Living Conditions, Compensation and Working Conditions, and Productivity and Technology. Although the aforementioned agencies are not part of the Bureau of Labor Statistics, their titles provide an idea of the topics on which the bureau, as the research arm of the Department of Labor, conducts research. In addition, the Bureau of Labor Statistics studies and evaluates the research methods used to gather and provide their data.

Marie S. Hammond

*See also* Demographics, United States (v3); *Dictionary of Occupational Titles* (v4); Job Loss (v4); Occupational Information (v4); Occupational Information Network (v4)

### Further Readings

- Douty, H. M. (1984). A century of wage statistics: The BLS contribution. *Monthly Labor Review*, 107(11), 16–28.
- Goldberg, J. P., & Moye, W. T. (1985). *The first hundred years of the Bureau of Labor Statistics* (Bulletin 2235). Washington, DC: Bureau of Labor Statistics.
- Pilot, M. J. (1999). Occupational Outlook Handbook: A review of 50 years of change. *Monthly Labor Review*, 122(5), 8–26.
- Weinberg, E. (1984). BLS and the economy: A centennial timetable. *Monthly Labor Review*, 107(11), 29–37.

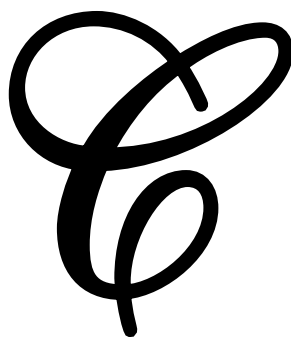
### Web Sites

Bureau of Labor Statistics: <http://www.bls.gov/home.htm>









---

## **CAMPBELL INTEREST AND SKILL SURVEY**

---

The Campbell Interest and Skill Survey (CISS) is a career assessment instrument that analyzes an individual's self-reported interests and skills to assist in effective career planning and decision making. The CISS provides four kinds of scales that help individuals age 15 through adult understand how their interests and skills relate to important areas in the world of work and to specific occupations, particularly those requiring a college or professional degree. The test's primary author, David P. Campbell, incorporated measures of self-assessed skills into the survey to highlight the importance of an individual's self-confidence in skills when making career decisions. The profile reports both interest and skill scores on 7 Orientation Scales, 29 Basic Scales, 60 Occupational Scales, and 2 Special Scales (Academic Focus and Extraversion), providing comparisons between an individual's strength of interest and strength of self-confidence for each scale. The CISS's innovative combination of interests and skills scales provides the user with valuable information that is unavailable from alternative inventories that measure interests alone. The CISS can be used to identify areas of academic study and to clarify occupations that are likely to lead to both satisfaction and success for traditional-aged and adult students, and to support career changers, transitioning employees in outplacement programs, and preretirees in future career and life planning.

### **History of the Survey's Development**

Campbell developed the CISS building on his more than 30 years of experience in interest measurement research. Campbell's experience with interest measurement research began in 1959 when, as a graduate research assistant at the University of Minnesota, he became involved in revisions of the Strong Vocational Interest Blank (SVIB). After many years on the faculty at Minnesota researching and revising the SVIB, and later the Strong-Campbell Interest Inventory (SCII), Campbell was recruited to the Center for Creative Leadership in 1974 where he continued to develop other assessment instruments. Eventually, in 1988, he ended his professional ties with the developers of the SCII, and turned his focus to developing a new, easy to use survey with both interest and skills scales intended to be free of bias in vocabulary, norms, and profile presentation. Building on his long-term experience on the Board of Directors for National Computer Systems (NCS), Campbell chose NCS—now Pearson Assessments—as the publisher of the CISS in 1992.

### **Item Content**

Campbell carefully selected 320 items for the CISS out of an extensive pool of hundreds of items to avoid content that was biased or offensive and on the basis of item response characteristics. The CISS has 200 interest items. A unique feature of the CISS interest items for occupations is that each occupation is defined. For example, the item for architect reads, "An architect, designing new homes and buildings."



The key strength of the CISS is that it also has 120 skill items that measure individuals' beliefs about their abilities to perform a range of activities. The skill items are designed to be measures of self-confidence in abilities rather than direct measures of skills. Research data reported in the manual indicate that individuals' self-rated skills and behavioral observations of their skills are highly correlated.

The CISS uses a 6-point response format that allows for a refined response to the items and also forces respondents to state at least a mild preference in one direction or the other by eliminating a neutral response. Respondents are asked to rate their level of interest for most of the interest items using the response options: *strongly like*, *like*, *slightly like*, *slightly dislike*, *dislike*, and *strongly dislike*. Respondents are also asked to rate their level of skills for the skill items using: *expert*, *good*, *slightly above average*, *slightly below average*, *poor*, and *none*.

## Scale Construction

### The Orientation Scales

The CISS profile report is organized around seven factors referred to as the Orientation Scales. The Orientation Scales are homogenous scales based upon earlier factor studies of interests by Thurstone, Strong, Holland, and Campbell. After numerous analyses designed to accommodate the Basic Scales, Campbell chose a seven-component structure for the Orientations. Campbell's Orientations are similar to Holland's RIASEC (Realistic, Investigative, Artistic, Social, Enterprising, and Conventional) types, but are described using action-oriented words (gerunds) with clearer meanings more connected to workplace activities. The seven orientations are Influencing, Organizing, Helping, Creating, Analyzing, Producing, and Adventuring.

### Basic Scales

The 29 Basic Scales comprise parallel interest and skill scales that measure individuals' attraction to and confidence in a range of life activities. The Basic Scales are homogeneous subscales of the Orientation Scales and were constructed by identifying items that had high intercorrelations with each other, low correlations with items in other clusters, and appeared to belong together, based on their content.

### Occupational Scales

The 60 Occupational Scales were empirically constructed from a general reference sample made up of all respondents from 65 occupational areas by identifying items that statistically differentiated members of each occupational sample of workers who reported they enjoyed their work. Each Occupational Scale consists of a set of items that varies widely in content, and it is not intuitively obvious which item belongs to which Occupational Scale. The Occupational Interest Scales contain positively and negatively weighted items that reflect both the likes and dislikes of an occupational group. For example, a respondent might score higher on a particular Occupational Scale simply by disliking the same items that members of that Occupational sample disliked. The Occupational Skill Scales, however, contain only positively weighted items—the rationale being that it would be unwise for a client to make a career decision based on negative data, such as, “You have the same lack of skills as an attorney; therefore, you should consider law.” The CISS uses combined gender scales to ease interpretation.

### Special Scales

The Academic Focus Scales, intended to measure respondents' interests and confidence in doing well in formal academic endeavors, were constructed by identifying items that were rated high and low by people with high levels of education and by assigning positive and negative weights, respectively. The Extraversion Scales, which measure respondents' interests and confidence in working with people (as opposed to working alone), were constructed through identifying and positively weighting items that correlated with “Extraverted” and negatively weighting items that correlated with “Introverted” on the Campbell Leadership Index.

## Administration

There are several ways to administer the CISS, including the Internet, local scoring software, an optical scan scoring system, and paper and pencil administrations using a mail-in scoring service to Pearson Assessments. It takes anywhere from 25 to 40 minutes to complete the 320 multiple-choice items.



## Report Format

The CISS results are reported in an appealing profile format with both interest and skill scores presented for each of the Orientation, Basic Interest and Skill, Occupational, and Special Scales. The interest and skill scores are presented both numerically and graphically for ease in interpretability, allowing respondents to compare the strength of their interest with strength of their self-reported skill on each scale. The numerical scores are standard scores based on the reference group, whose distribution is bell shaped with a mean of 50 and a standard deviation of 10. The consistency of score reporting makes it easy to identify scores of 60 and above as high scores, and scores of 40 and below as low across all scales. In addition, the patterns of interest and skill combinations for each scale are further clarified with the following helpful descriptors: Pursue, Develop, Explore, and Avoid, which can enlighten further career exploration and choice.

## Interpretation

The CISS can be taken online by any interested individual without assistance from a career counselor. Respondents are provided helpful online tools to aid in interpretation, such as the CISS Career Planner. However, individuals are encouraged to discuss the CISS profile with a skilled career counselor for help with understanding the profile layout, the definitions of the scales, and the meaning of the scores. An interpretation of the CISS profile from a skilled counselor can be particularly valuable for clients needing help with decision making or with connecting their results to future career exploration.

*Lisa J. Heiser and Jeffrey P. Prince*

**See also** Armed Services Vocational Aptitude Battery (v4); Assessment (v4); Card Sorts (v4); Career Counseling (v4); Holland's Theory of Vocational Personalities and Work Environments (v4); Jackson Vocational Interest Inventory (v4); Strong Interest Inventory (v4)

## Further Readings

Boggs, K. R. (1998). Career decisions: The Campbell and Ms. Flood. *Career Development Quarterly*, 46, 311–319.  
Campbell, D. P. (2002). The history and development of the Campbell Interest and Skill Survey. *Journal of Career Assessment*, 10, 150–168.

Campbell, D. P., Hyne, S. A., & Nilsen, D. L. (1992). *Manual for the Campbell Interest and Skill Survey*. Minneapolis, MN: National Computer Systems.  
Prince, J. P., & Heiser, L. J. (2000). Campbell Interest and Skill Survey. In *Essentials of career interest assessment* (pp. 70–127). New York: Wiley.  
Pugh, R. (1998). Review of the Campbell Interest and Skill Inventory. In *Mental measurements yearbook* (pp. 167–170). Lincoln, NE: Buros Institute of Mental Measurements.

## Web Sites

Pearson Assessments. <http://www.pearsonassessments.com>

---

## CARD SORTS

---

Card sorts are nonstandardized and subjective assessments commonly used in career counseling to help clients clarify their skills and career interests. This entry provides descriptions of the history and varieties of vocational card sorts (VCSs), research findings, and the advantages of using card sorts in career counseling.

## Overview

In this type of assessment, clients typically sort between 30 and 40 cards of various themes or ideas into categories as a way to develop personal or career-related priorities and, as they do so, themes tend to emerge. It is preferable for clients to identify patterns within the sorted categories themselves so that the themes are personally relevant to them. Card sorts are sometimes preferable to more standardized assessments because the information gathered therein is done so informally and through client speech. Therefore, clients are actively engaged in the process of self-awareness. Additionally, through this process counselors can see firsthand how clients organize thoughts and ideas, as the success of the exercise is dependent on the client's ability to engage in the process and recognize and explore patterns or themes.

Any set of ideas may be examined through use of a VCS, including career values, occupations or occupational titles, skills, or college majors. Counselors may also create their own collection of items to reflect a particular theme. The exercise of clients sorting and prioritizing the items within the particular category



appears to be critical to the process. In doing so, the client makes decisions about items relative to one another and expresses his or her reasons for doing so. In working with clients, counselors may offer a more structured setting in which, for example, the client generates a list of occupations to explore. Alternately, the card sort exercise may serve as a springboard for discussion, thus providing ample room for dialogue in a less structured setting. In this way, card sorts can be customized to the needs of a particular client.

### Research

Leona Tyler was the first to describe the VCS in the literature and to provide empirical evidence for their utility. In relation to vocational inventories, such as the Strong Interest Inventory (Strong) or Self-Directed Search (SDS), research on the VCS has received exponentially less attention. This is likely due to many reasons, but most importantly it is because testing a client's interests or skills using inventories preceded the development of card sorts and because inventories as a whole are considered more "research friendly." Card sorts most often need to be completed in the presence of a trained counselor, while inventories can be taken away from the counseling setting, scores can be computed electronically, and inventories such as the Strong and SDS have been validated with thousands of individuals across decades of research.

The research that has been completed on the VCS has mostly related card sort outcomes to vocational inventory outcomes. In a recent review of the literature, studies have shown that clients indicate interest in similar occupations whether a VCS or a vocational inventory is used. Thus, according to this limited body of research, card sorts have appeared to be as valid in determining vocational preferences as inventories.

The degree to which card sorts are helpful with various types of counseling clients has also been researched. For example, a number of studies have separated participants based on levels of career indecision and then had them complete a VCS. Clients who are the most undecided have been consistently found to benefit most from the card sort technique.

Finally, a number of individual studies have been completed with VCSs on various topics. For example, one study found using a VCS with career clients to be a good method of evaluating clients' knowledge of the world of work and the status of their career development. Other studies have found that the card sort method works equally as effectively with students in

both high school and college, and that a VCS may work particularly well with students who have a flat Strong profile.

One of the most widely used and researched card sorts today is the Missouri Occupational Card Sort. Developed for use with undecided college students at a large university, clients learn about themselves through the Holland classification system of personalities and environments. Job tasks and responsibilities are also included on the cards to help clients learn more about each occupation as the cards are sorted.

Although research on VCSs is limited, card sorts have been found to be equally as valid as vocational inventories and to be particularly useful for clients at the beginning stages of their career exploration. These findings may serve to influence the use of card sorts in career counseling practice.

### Advantages in Counseling

Card sorts are one of the techniques career counselors use to help clients clarify their skills, values, and occupational interests. Card sorts are believed to be as effective as standardized assessments in predicting career choice; but because they are subjective in nature and do not produce scores or have norms, their effectiveness depends on the counselor's ability to help the client gain insights and ideas from the results. Card sorts have a number of advantages that make them a valuable tool to use either in place of or in addition to standardized assessments, depending on each client's individual needs. Their advantages are summarized here:

- The short phrases used in card sorts can be more easily read by clients with learning disabilities than checklists often used in paper or computerized assessments.
- The card process can be energizing and engaging because it allows clients to be actively involved in choosing their responses.
- Because of their semistructured nature, card sorts can be modified to meet individual client's needs and used at any point during the counseling process, either as a stand-alone approach or to supplement standardized assessments.
- Card sorts allow for interaction and dialogue between the client and counselor, which can aid in establishing rapport and provide counselors with the opportunity to discuss the rationale for a client's choices. Insights about the client's thought processes can be helpful in



interpreting results of standardized assessments. In addition, viewing the process whereby a client chooses responses, such as the speed or number of changes made in sorting the cards, can be just as revealing as the responses themselves.

- The results are not dependant upon comparison to a norm group, and therefore clients can attach their own individual meaning to card items and apply the results to their needs. Knowing how a client interprets card items can be helpful in understanding his or her worldview and the context in which the client is making decisions. This knowledge can be helpful in working with clients of diverse backgrounds and can give counselors insights about confounding problems interfering with the client's ability to make decisions.
- Card sorts are nonthreatening to individuals who might be wary of standardized tests. In addition, because card items can be moved from one pile to another, clients do not need to be concerned about giving a right or wrong answer, as they might be on a standardized test.

### Additional Advantages

Card sorts may provide clients with the necessary structure to take risks and/or engage in the counseling session. Additionally, collaborating on a task like the card sort may contribute to the formation of the therapeutic relationship and the provision of feedback within the session. Relatedly, counselors may gain insight into clients' cognitive organization by observing how the sorting exercise is conducted and may identify occupational stereotypes or clients' misconceptions about themselves. Moreover, the active nature of the card sort exercise helps to keep the focus on the client and her or his perceptions, thereby minimizing the risk of becoming overly dependent on the counselor. Because card sorts are nonstandardized, they do not rely on statistical data or norm groups. They are flexible and can be adapted to clients from varying backgrounds. Finally, because of the active nature of the process, some researchers have theorized that clients engaged in a card sort may increase their decision-making self-efficacy more than clients who take standardized career assessments.

Ryan D. Duffy, Suzanne M. Friedman,  
and Paul Martin

**See also** Armed Services Vocational Aptitude Battery (v4); Assessment (v4); Campbell Interest and Skill Survey (v4); Career Counseling (v4); Holland's Theory of Vocational

Personalities and Work Environments (v4); Jackson Vocational Interest Inventory (v4); Narrative Career Counseling (v4); Strong Interest Inventory (v4); Work Values (v4)

### Further Readings

- Andersen, P., & Vandehey, M. (2006). *Career counseling and development in a global economy*. Boston: Lahaska Press.
- Brott, P. E. (2004). Constructivist assessment in career counseling. *Journal of Career Development*, 30, 189–200.
- Goldman, L. (1992). Qualitative assessment: An approach for counselors. *Journal of Counseling and Development*, 70, 616–621.
- Gysbers, N. C., Heppner, M. J., & Johnston, J. A. (2003). Gathering client information using an occupational card sort: Using occupational titles as stimuli. In *Career counseling: Process, issues, and techniques* (pp. 216–235). Boston: Allyn & Bacon.
- Prince, J. P., & Heiser, L. J. (2000). *Essentials of career interest assessment*. New York: Wiley.
- Slaney, R. B., & MacKinnon-Slaney, F. (2000). Using vocational card sorts in career counseling. In C. E. Watkins, Jr., & V. L. Campbell (Eds.), *Testing and assessment in counseling practice* (2nd ed., pp. 371–428). Mahwah, NJ: Lawrence Erlbaum.
- Tyler, L. E. (1961). Research explorations in the realm of choice. *Journal of Counseling Psychology*, 8, 195–202.

---

## CAREER ADVANCEMENT

---

Career advancement has been for decades a topic of many books found in the self-help, career, and especially the business sections of bookstores. It is not a topic commonly found in career counseling or vocational psychology textbooks or journal articles. There are several assumptions and key concepts and characteristics commonly found in books about career advancement. These include the broad assumption that in general people are ambitious and urgently seek to improve their employment situation. These books typically assume that promotions are very important to many people. In other words, these books employ a stereotype worker profile that may be appropriate for some, but is not for all kinds of workers, occupations, job settings, and careers.

The books mix common sense, social science, and self-promotion—all of which presume that the readers are ambitious, active, even aggressive and that they surely want to improve their career by following the



advice found within. The books include information on how to set career goals, overcome workplace fallacies, become a coach or use a coach, find a mentor, evaluate one's job personality, survive the workplace jungle, get ahead if one is employed in the government, and otherwise cover a wide range of ideas that then concludes with rules to follow or steps to take. Books on career advancement often oversimplify the ideas they present. Perhaps this fact is what makes them maintain their readership.

In fact, these assumptions and stereotypes may fit some individuals who are employed in business or management jobs. However, these assumptions do not fit many other workers, occupations, job settings, and careers. For example, these concepts may not fit well, or even at all, with people in social service, trades, health care, technical, or artistic careers.

These how-to-do-it books are aimed at people who want help with perceived problems, and so the books are full of advice. Some of the sources for some of the advice offered in these books are extracted from social, organizational, business, or vocational psychology research or theory, and some are borrowed from career guidance and career assessment fields.

These books typically claim to have answers that will help readers handle ongoing or immediate needs. An example is the book by Richard Bolles, *What Color Is Your Parachute*, which was first published in 1972. It has been a best seller. It presents a philosophy and many ideas derived from psychology, and it even employs a version of John Holland's theory of occupational choice, but it presents it in a derivative format rather than using the terms found in Holland's work. The author's background was neither psychology nor counseling. His first career was the ministry.

The topics covered in these books are wide. They are written for adult readers seeking information about topics such as how to handle a job interview or write a good resume, how to get the next promotion or make career progress over time, or how to handle difficult people at work or even acquire *The Seven Habits of Highly Effective People* as described by Stephen Covey in his 1989 book. Covey's training and employment background is in business. A business background is common with the authors of these publications. Some of the career advancement authors have been employed in human resources positions, or they have been executive recruiters prior to writing a self-help book.

Diane W. DeWitt

*See also* Adults in Transition (v4); Career Counseling (v4); Career Interventions (v4); Career/Life (v4); Career Planning (v4); Life Transitions (v2); National Career Development Association (v4); Self-Help Groups (v2)

### Further Readings

- Bolles, R. (1972). *What color is your parachute*. Berkeley, CA: Ten Speed Press.
- Covey, S. (1989). *The seven habits of highly effective people*. New York: Simon & Schuster.
- Washington, T. (2004). *Interview power: Selling yourself face to face*. Bellevue, WA: Mt. Vernon Press.

---

## CAREER ATTITUDES AND STRATEGIES INVENTORY

---

The Career Attitudes and Strategies Inventory (CASI) is a 130-item, paper and pencil, self-report assessment by John L. Holland and Gary D. Gottfredson. The CASI is intended to give the employed or unemployed adult client and career counselor information regarding the client's likelihood of job stability or change, potential career obstacles, or areas for further development. The CASI was developed by two highly respected vocational psychology and career counseling researchers, whose works typically address Holland's RIASEC (Realistic, Investigative, Artistic, Social, Enterprising, and Conventional) theory. The authors of the test note that the CASI should be a supplement to rather than a substitution of interest and ability measures. For example, the manual makes frequent mention of the use of the CASI with some of the other instruments developed to operationalize Holland's theory.

Reviewers have warned that the CASI should be used as a screener or to facilitate discussion between a counselor and a client due to some questionable psychometric data. Yet other reviews do not seem to find a problem with the current psychometric properties of the instrument given its intended use. It seems that most agree that the CASI could use more refinement to address some issues such as norms for special groups and better definition of broad subscales. Overall, the CASI is an interesting, attractive, and easy to use instrument that is useful enough for career counselors to justify continued research and refinement.

CASI items are answered on a 4-point Likert-type scale (*false, mostly false, mostly true, and true*) as they



relate to the test taker. Nine aspects of career or work adaptation are assessed by the CASI: (a) job satisfaction, (b) work involvement, (c) skill development, (d) dominant style, (e) career worries, (f) interpersonal abuse, (g) family commitment, (h) risk-taking style, and (i) geographical barriers.

The manual states that a client can self-score, self-profile, and self-interpret the CASI in about 35 minutes. However, past reviewers of this test supported the use of counselor intervention in the interpretation and discussion of life and career implications relevant to the inventory results. The CASI is published and available for purchase through Psychological Assessment Resources.

The CASI was developed through a commonly utilized three-stage process, which ultimately led to the current version of the measure. The normative group comprises 774 men and women ages 17 to 77 years with education from some high school to postgraduate degrees. The majority of the norm group is European American (79%) with the remaining 21% from other self-identified ethnic groups. Reliability of the test is adequate. The manual reports some validity evidence for the instrument, although this evidence is not well reviewed.

Emily E. Bullock

**See also** Assessment (v4); Career Advancement (v4); Career Barriers Inventory (v4); Career Counseling (v4); Career Development Inventory (v4); Career Interventions (v4); Career/Life (v4); Career Planning (v4); Holland, John L. (v4); Holland's Theory of Vocational Personalities and Work Environments (v4); Job Satisfaction and General Well-Being (v4); Life Transitions (v2)

## Further Readings

- Brown, M. B. (1998). Review of the Career Attitudes and Strategies Inventory. In J. C. Impara & B. S. Plake (Eds.), *The thirteenth mental measurements yearbook*. Retrieved June 6, 2007, from <http://www.unl.edu/buros>
- Holland, J. L., & Gottfredson, G. D. (1994). *Career Attitudes and Strategies Inventory: An inventory for understanding adult careers*. Odessa, FL: Psychological Assessment Resources.
- Kinnier, R. T. (1998). Review of the Career Attitudes and Strategies Inventory. In J. C. Impara & B. S. Plake (Eds.), *The thirteenth mental measurements yearbook*. Retrieved June 6, 2007, from <http://www.unl.edu/buros>

## CAREER BARRIERS INVENTORY

Career barriers have been hypothesized to affect the career development process by inhibiting career aspirations and restricting the range of perceived career opportunities. The Career Barriers Inventory (CBI) is a psychometrically sound, multidimensional, self-report instrument that was developed to assess for career-related barriers. The CBI assesses for a broad array of barriers that college students may perceive. Furthermore, significant gender and racial/ethnic group differences in the perceptions of barriers have been found in the Career Barriers Inventory-Revised (CBI-R).

The original form of the CBI was developed by Jane Swanson and David Tokar to examine a broad realm of barriers that may influence career-related activities. The CBI included 102 items developed to address different types of barriers that may transpire across a range of career-related activities, such as career decision making, college-to-work transition, job performance, work-related discrimination, and work-family balance. The CBI consisted of 18 separate scales. Internal consistency estimates in a sample of college students ranged from 0.53 (*Overqualified for Job Market*) to 0.94 (*Sex Discrimination*). Items for each scale were highly correlated with their respective scales and moderately correlated with one another ( $r = 0.11$  to  $0.68$ ), providing evidence for convergent and discriminant validity.

The original CBI was modified in order to reexamine and redefine the scales, reduce the number of items, clarify item content, and delete overlapping items. The shortened version, the CBI-R, is comprised of 70 items on 13 separate scales that cover a wide range of barriers that college students may perceive. Scales are highly correlated between both versions of the CBI, ranging from 0.72 to 1.00. The 13 scales on the CBI-R include (1) *Sex Discrimination*, (2) *Lack of Confidence*, (3) *Multiple Role Conflict*, (4) *Conflict Between Children and Career Demands*, (5) *Racial Discrimination*, (6) *Inadequate Preparation*, (7) *Disapproval by Significant Others*, (8) *Decision-Making Difficulties*, (9) *Dissatisfaction With Career*, (10) *Discouraged From Choose Nontraditional Careers*, (11) *Disability/Health Concerns*, (12) *Job Market Constraints*, and (13) *Difficulties With Networking/Socialization*. Each scale consists of three to eight items. Internal consistency estimates in samples of college students ranged from 0.64 (*Disapproval by*



*Significant Other, Difficulties With Networking/Socialization*) to 0.86 (*Sex Discrimination*). Inter-correlations among the CBI-R scales vary considerably from 0.27 (*Disapproval by Significant Others* and *Disability/Health Concerns*) to 0.80 (*Racial Discrimination* and *Sex Discrimination*). Gender differences were found on the CBI-R with women scoring higher on *Sex Discrimination*, *Lack of Confidence*, *Multiple-Role Conflict*, *Conflict Between Children and Career Demands*, *Inadequate Preparation*, *Decision-Making Difficulties*, and *Dissatisfaction With Career*. Individuals from racial/ethnic minority backgrounds scored significantly higher on *Racial Discrimination* than their Caucasian counterparts.

Neeta Kantamneni

**See also** Assessment (v4); Career Advancement (v4); Career Counseling (v4); Career Counseling in Colleges and Universities (v4); Career Counseling in Schools (v4); Career Exploration (v4); Career Indecision (v4); Career Planning (v4); School-to-Work Transition (v4)

### Further Readings

- Swanson, J. L., Daniels, K. K., & Tokar, D. M. (1996). Assessing perceptions of career-related barriers: The Career Barriers Inventory. *Journal of Career Assessment*, 4, 219–244.
- Swanson, J. L., & Tokar, D. M. (1991). Development and initial validation of the Career Barriers Inventory. *Journal of Vocational Behavior*, 39, 344–361.

---

## CAREER BELIEFS INVENTORY

---

The Career Beliefs Inventory (CBI) is a tool designed to help people identify career beliefs that may be preventing them from taking action to achieve their career goals. Many people hold beliefs that block their career progress. Maybe they believe that there is only one path to a successful career and that they have already missed one essential step on that path. Maybe they believe they must enter a certain occupation to win family approval. Maybe they believe that hard work is unnecessary until they have clear goals. These are just a few examples of beliefs that have caused troubles for other people and might possibly be interfering with their career progress.

This inventory, consisting of 96 questions, helps individuals examine beliefs about themselves and the

world of work. It identifies 25 belief scales that might possibly be creating difficulties. Career specialists use this inventory as a springboard to discuss attitudes and assumptions that need to be examined when making and implementing career choices. The 25 scales are organized under five categories: current career situation, conditions necessary for happiness, factors influencing decisions, willingness to make changes, and willingness to exert effort. The inventory takes about 25 to 30 minutes to complete.

The CBI was developed from over a thousand stories collected from people who could report a belief that they once held, the trouble it caused, and how they corrected their troublesome beliefs. The reported beliefs were grouped into categories, edited for brevity and clarity, and summarized into 122 items that were then administered to over 7,500 participants. A number of factor analyses were computed from these data, and eventually 25 revised scales were defined based on the 96 best items.

The *CBI Applications and Technical Guide* is the revised manual published in 1999. It contains a summary of the reliability and validity data, directions for use, and a table of norms. The norms would be necessary only if clients wondered how common, or uncommon, their beliefs were. The recommended method for using the CBI, however, is to help people identify beliefs that might be causing trouble for them.

It is used as a conversation starter to begin exploring possible dysfunctional beliefs that may be inhibiting clients from taking appropriate action now.

Two scoring versions are available:

1. Self-Scorable: Users can score their own booklet and see their own results immediately. An explanation of each score is included.
2. Computer Scored: A separate prepaid answer sheet is mailed to CPP, Inc. (formerly Consulting Psychologists Press) for scoring and results are mailed back.

Also available is a client workbook titled *Exploring Your Career Beliefs*. It includes techniques for integrating CBI scores with results from the Strong Interest Inventory and the Myers-Briggs Type Indicator (MBTI).

These materials are distributed by CPP, Inc. They are available online at [www.cpp.com](http://www.cpp.com) or by phone at 1-800-624-1765.

John D. Krumboltz



*See also* Career Advancement (v4); Career Barriers Inventory (v4); Career Decision-Making Difficulties Questionnaire (v4); Career Decision Self-Efficacy Scale (v4); Career Indecision (v4); Career Intervention (v4); Career Thoughts Inventory (v4); Krumboltz Happenstance Learning Theory (v4); Social Cognitive Career Theory (v4)

### Further Readings

- Krumboltz, J. D. (1999). *Career Beliefs Inventory: Applications and technical guide*. Palo Alto, CA: CPP.
- Levin, A. S., Krumboltz, J. D., & Krumboltz, B. L. (1995). *Exploring your career beliefs: A workbook for the Career Beliefs Inventory with techniques for integrating your Strong and MBTI results*. Palo Alto, CA: CPP.

---

## CAREER CONSTRUCTION THEORY

---

The global economy of the 21st century with its digitalization and worker migration poses new questions about career, especially the question of how individuals can negotiate a lifetime of job changes without losing their sense of self and social identity. Career construction theory responds to the needs of today's mobile workers who may feel fragmented and confused as they encounter the restructuring of occupations and transformation of the labor force. The theory's response asserts that individuals build their careers by imposing meaning on vocational behavior. From a constructionist viewpoint, career denotes a moving perspective that imposes personal meaning on past memories, present experiences, and future aspirations by patterning them into a life theme. It is the meaning contained in these biographical themes that will equip individuals to adapt to the social changes that are playing out in their work lives. This personal meaning replaces the holding environment once provided by organizations that contained the task of self-integration as it cared for, protected, and interpreted experiences to its employees. Today, it is the life story that holds the individual together and provides a biographical bridge with which to cross from one job to the next job.

Using social constructionism as a metatheory, construction theory views careers from a contextual perspective that sees people as self-organizing, self-regulating, and self-defining. Relying on its social constructionist epistemology, the theory reconceptualizes both vocational personality types and vocational tasks. It interprets personality types as processes that

have possibilities, not realities that predict the future. It views developmental tasks as social expectations. Career construction theory then uses the concept of life themes to weave together its conceptualizations of vocational personality and career adaptability into a comprehensive theory of both vocational behavior and career counseling. Stated succinctly, the theory holds that individuals construct their careers by using life themes to integrate the self-organization of personality and the self-extension of career adaptation into a self-defining whole that animates work, directs occupational choice, and shapes vocational adjustment.

### Vocational Personality

Career construction theory defines vocational personality as the constellation of an individual's career-related abilities, needs, values, and interests. The theory discusses personality using the nomenclature and framework of Holland's RIASEC (Realistic, Investigative, Artistic, Social, Enterprising, and Conventional) types because it offers a widely used language for describing the personological results of an individual's efforts at self-organization of his or her skills, interests, and abilities. While adopting Holland's language to articulate accounts of personalities and occupations, career construction theory reminds counselors and researchers that the traits constituting RIASEC types are completely decontextualized and quite abstract. It is easy to forget that the traits, especially when denoted with nouns rather than verbs, are really just strategies for adapting. They are dynamic processes that present possibilities, and they should not be reified into realist tools for predicting the future.

Career-related abilities, interests, and values are relational phenomena that reflect socially constituted meanings and categories that should not be considered as anything more than similarities. Therefore, career construction theory asserts that vocational personality types and occupational interests are simply resemblances to socially constructed clusters of attitudes and skills. They have no reality or truth value outside themselves because they depend on the social constructions of time, place, and culture that support them. While vocational personality deals with this self-organization, the second component of career construction theory, namely career adaptability, deals with self-regulation and self-extension of personality into the social environment.



## Career Adaptability

Career construction theory conceptualizes development as driven by adaptation to an environment and integration into the community. From this perspective, an occupation is a mechanism of social integration, one that offers a strategy for sustaining oneself in society. Careers are constructed by adaptive strategies that implement an individual's personality in an occupational role. This adaptation brings inner needs and outer opportunities into harmony, with the harmonics of a good fit amplifying in present activity the individual's past preoccupations and future aspirations. Adaptation involves adjusting to occupational changes that include mastering vocational development tasks, dealing with work traumas, and negotiating job transitions. Career construction theory views adaptation to these changes as fostered by five principal types of coping behaviors: orientation, exploration, establishment, management, and disengagement. These constructive activities form a cycle of adaptation that is periodically repeated as the individual navigates new transitions.

Career adaptability denotes an individual's readiness and resources for handling current and anticipated tasks, transitions, and traumas in his or her occupational roles that to some degree large or small alter his or her social integration. The adaptability dimensions of readiness and resources shape self-extension into the social environment because they condition the actual coping behaviors that constitute orientation, exploration, establishment, management, and disengagement. They function as self-regulation strategies that govern how individuals engage the developmental tasks imposed by the communities with whom they co-construct their careers.

In considering the dimensions of psychosocial adaptability, career construction theory highlights a set of specific attitudes, beliefs, and competencies—the ABCs of career construction—that regulate the coping behaviors for implementing vocational self-concepts into occupational roles. The ABCs are grouped into four dimensions of adaptability: concern, control, curiosity, and confidence. According to this scheme, the adaptive individual is conceptualized as (a) becoming concerned about the vocational future, (b) increasing control over that future, (c) displaying curiosity by exploring possible selves and future scenarios, and (d) strengthening the confidence to pursue one's aspirations.

## Life Themes

The self-organization of personality and its adaptive self-extension into the community produces a self-defining story. The essential meaning of career and the dynamics of its construction are revealed in these self-defining stories about the tasks, transitions, and traumas an individual has faced. Unlike the RIASEC types and adaptability dimensions, career stories fully contextualize the self in time, place, and role and express the uniqueness of an individual. Furthermore, the separate career stories told by an individual are unified by integrative themes that make whole the individual's complex and contradictory experiences by inscribing them with a meaningful coherence and long-term continuity. The theme does not summarize past experiences; rather, it inscribes them with a sense of purpose that provides meaningful coherence and long-term continuity.

Stories are accounts that constitute the self. People talk themselves into existence as they describe what they like and what they are like. From this perspective on the self, occupational preferences express self-conceptualizations in vocational terminology. Accordingly, entering an occupation is viewed as an attempt to implement a self-concept and the work itself manifests the self-concept, giving it substance and story. Thus work provides a context for human development and an important location in each individual's life, a place that matters.

In listening for the theme in career stories, counselors can become disoriented by the numerous particulars of a life. To prevent this confusion, career construction theory suggests that career practitioners and researchers concentrate on the motif, or controlling passion, that arranges the separate stories into a coherent whole. Arranging the actions and incidents randomly portrayed in career stories into a plot can be done in many ways. Career construction theory proposes for this purpose using the narrative paradigm to organize biographical thinking. This perspective for understanding a story and illuminating a life highlights the challenge of the client's life, one that he or she cannot ignore or go around. Career construction theory, applying its narrative paradigm, assumes that the archetypal theme of career construction involves using work to turn preoccupation into occupation, thereby resolving the challenge. Simply stated, careers are constructed as individuals, using adaptability coping strategies, turn their personal preoccupations into



public occupations. The researcher or counselor listens to the stories to learn how the individual has used work to turn a personal symptom into a public strength and then even into a social contribution. Using the narrative paradigm as a biographical organizer enables the listener to draw out the silk thread of a life theme from the cocoon of autobiographical stories.

## Counseling for Career Construction

Counseling for career construction begins with an interview that poses a uniform set of questions to a client. The Career Style Interview elicits self-defining stories that enable counselors to identify and appreciate the thematic unity in a client's life. In addition to revealing the life theme that threads through the client's life, data from a Career Style Interview also manifest the client's vocational personality and substantiate adaptive strategies. Responding to the interview questions enables a client to hear his or her own story in community. The counselor helps clients to increase the narratability of their stories and to relate their life themes to the choices that they must now make. In discussing the alternative choices and how each one might advance the client's story, the counselor retells the story in a manner designed to increase the client's career adaptability, consider what is at stake, and identify occupations that can be used to write the next chapter in their story. Reflecting on and retelling their stories encourage clients to understand how they can use work to become more whole and participate fully in a work role that matters to both them and their community.

*Mark L. Savickas*

**See also** Career Counseling (v4); Career Counseling Process (v4); Career Style Interview (v4); Constructivist Career Counseling (v4); Constructivist Theory (v2); Holland's Theory of Vocational Personalities and Work Environments (v4); Meaning, Creation of (v2); Narrative Career Counseling (v4); Personality Assessment and Careers (v4); Super's Theory (v4)

## Further Readings

Holland, J. L. (1997). *Making vocational choices: A theory of vocational personalities and work environments* (3rd ed.). Odessa, FL: Psychological Assessment Resources.

Savickas, M. L. (1989). Career-style assessment and counseling. In T. Sweeney (Ed.), *Adlerian counseling:*

*A practical approach for a new decade* (3rd ed., pp. 289–320). Muncie, IN: Accelerated Development Press.

Savickas, M. L. (2005). The theory and practice of career construction. In S. D. Brown & R.W. Lent (Eds.), *Career development and counseling: Putting theory and research to work* (pp. 42–70). Hoboken, NJ: Wiley.

Super, D. E., Savickas, M. L., & Super, C. M. (1996). The life-span, life-space approach to careers. In D. Brown & L. Brooks (Eds.), *Career choice and development* (3rd ed., pp. 121–178). San Francisco: Jossey-Bass.

---

## CAREER COUNSELING

---

Most entries in this encyclopedia provide detailed treatments of precise topics. This entry illuminates the relations among these topics. It summarizes the development of career counseling, the most widely used career counseling interventions, the typical settings in which career counseling occurs, important differences among clients who seek career counseling services, the focal issues examined in career counseling, and the career counseling process. The entries appearing in this encyclopedia describe these topics in greater detail.

## Development of Career Counseling

The theoretical underpinnings of career counseling were first recorded around 360 B.C. when Plato observed in *The Republic* that different jobs require different types of workers for optimal performance. Today we regard this as obvious; the jobs of elementary school teacher, truck driver, opera singer, and accountant each require a different set of skills and interests.

Frank Parsons formalized this theory of the relation between people and jobs in the late 19th century. He wrote that effective career placement requires knowledge of the special talents of the worker, the requirements of various occupations, and the relations between these sets of knowledge. Over time Parsons's ideas have been codified into the person–environment fit model and trait and factor counseling. The overlapping disciplines of counseling psychology, vocational psychology, and career counseling emerged from this beginning.

Three crises, World Wars I and II and the Great Depression, helped shape career counseling. Prior to



World War I, French scholars Alfred Binet and Theodore Simon developed a test to measure cognitive ability. Their work paved the way for modern intelligence tests. Entry into World War I suddenly confronted the United States with the need to place hundreds of thousands of workers into suitable jobs. Using the Binet-Simon approach as a starting point, the U.S. Army developed a series of tests (e.g., the Army Alpha and Army Beta) to measure cognitive aptitudes. Scores of these tests were used to place military recruits into suitable jobs. This work developed and validated a model of vocational placement that has been a key component of career counseling for over 90 years.

The Great Depression focused attention on the nation's workforce and provided another stimulus to the development of career counseling. Under the leadership of Donald G. Paterson at the University of Minnesota, the Minnesota Employment Stabilization Research Institute (MESRI) undertook a decade of research on the optimal relation of workers to jobs. MESRI research demonstrated that workers perform better and are less likely to quit or be terminated when placed in occupations that match their interests and aptitudes. The MESRI also developed an extensive library of aptitude tests for use in job placement. MESRI research demonstrated unequivocally that skilled career counseling using a trait-and-factor approach produces beneficial results.

The entry of the United States into World War II again created a need to assign millions of workers to jobs in an efficient manner. The career counseling procedures and instruments developed and validated by the MESRI were applied in the most massive application of career counseling in history.

Following the war, the GI Bill enabled veterans to enter colleges and universities in unprecedented numbers. This created a strong need for career counseling services in those institutions. An even larger number of veterans sought civilian jobs. This created a demand for career counseling services for civilians and stimulated the development of the United States Employment Service.

Clinical psychology was a well-established specialty for treating the mentally ill by the end of World War II. Insightful leaders such as University of Minnesota psychologist John G. Darley recognized that normal individuals sometimes need assistance in dealing with problems confronting them in daily life. Clinical psychologists were ill prepared to provide this assistance, but that is the type of assistance career

counseling personnel had been providing. The contemporary specialty of counseling psychology is an outgrowth of the MESRI research, military experience in vocational placement, and Darley's recognition of healthy individuals' needs for developmentally oriented services.

As the United States became more affluent during the 1950s and 1960s, two social movements furthered the development of career counseling. Early 20th-century generations experienced the strife and deprivation of two world wars and the Great Depression, but the baby boom generation experienced a time of relative affluence and tranquility. The earlier generations' survival concerns were replaced by the baby boomers' desire for an occupation that would enhance their quality of life and contribute to a better world. Established workers also began to consider a midlife career change to a more meaningful occupation. Workers who in earlier times would have unquestioningly followed in their parents' footsteps or taken a job that satisfied their basic survival needs now turned to career counseling for assistance in achieving these goals.

At the same time, leaders like Mohandas Gandhi, Martin Luther King, and Betty Friedan were exposing the glaring inconsistency between the public endorsement of equality and the harsh realities of colonialism, racism, and sexism. Minority group members, women, and immigrants whose parents had few choices were now confronted with increased opportunities, and many turned to career counseling for help in making informed decisions.

The last 2 decades have seen a growing concern about the aging American workforce. In earlier decades relatively few workers achieved retirement age, and most who did died shortly after retirement. Today a steadily increasing proportion of the workforce lives for a decade or more after retirement. The importance of maximizing the efficiency of the workforce is steadily increasing as the proportion of the population in the workforce decreases. Industrial nations cannot afford to ignore the potential contributions of any segment of their workforce. Handicapped and disadvantaged individuals, Native Americans, displaced workers needing retraining, people having limited English proficiency, single parents, criminal offenders, and chronically unemployed workers—the contributions of all are critical to the health of the nation's economy. All must receive the assistance they need to make the most of the opportunities available. The need for skillful career counseling is as great as at any time in history.



## Career Counseling Interventions

Modern career counseling is a multifaceted specialty that provides a rich array of services. This section provides a synopsis of frequently used career interventions: individual counseling, group counseling, computer-based interventions, and career education. It is important to understand, however, that basic activities such as assessing interests, values, and aptitudes; providing occupational and college major information; and providing instruction in job search skills are included in each of these types of counseling interventions.

### *Individual Counseling*

Individual career counseling involves a professional counselor working in a one-to-one relationship with a single client. The objectives of individual counseling may focus on helping clients increase their self-knowledge, decision-making skills, or knowledge of occupational opportunities and the world of work. Often this involves the administration and interpretation of psychological tests and the use of reference sources to obtain detailed occupational information. Individual counseling may also involve other activities under the supervision and coordination of a psychologist. For example, clients may use computer guidance systems such as the System of Interactive Guidance Information (SIGI), may participate in workshops on topics such as study skills or time management, and may participate in structured groups that deal with issues such as assertion training, resume development, or job interviews.

Individual counseling is a desired and important component of effective career counseling. Several studies have shown computer-assisted guidance systems to be effective in enhancing career outcomes. However, clients prefer to use them in conjunction with individual career counseling, and their use in combination with individual counseling is more effective than their use alone.

### *Group Counseling*

Group counseling differs from individual counseling in one important respect; group members learn from each other in addition to learning from their interactions with the counselor. This can be particularly valuable to individuals who are early in their career exploration and lack career-related experience and information.

Group career counseling takes a variety of forms. Career development groups include most of the components found in individual career counseling, and they have similar objectives. Group participants typically take tests and participate in a group discussion of their test results. In addition, they may be assigned to complete a computer-based activity, prepare a resume, complete a homework assignment, or interview a potential employer or a person employed in a career of interest. Clients complete these activities outside the group and discuss their experiences during a group meeting.

Structured group interventions are more narrowly focused on a specific issue. The goals of structured groups are limited only by the needs of clients and the imagination of psychologists. For example, structured groups are commonly offered to teach assertiveness skills, resume preparation, time management, study skills, and interviewing skills. Sensitivity groups focus on interpersonal topics such as sexism, racism, and other workplace behaviors.

### *Electronic Media*

Computer-based career counseling modules are delivered via computer or online via the Internet. Computer-based career assessment inventories are now common. Among the most widely used online career interest inventories are the Strong Interest Inventory, the Self-Directed Search, the Kuder Interest Inventory and Career Planning System, the ACT's Interest Inventory (UNIACT), and the Interest Profiler found in the U.S. Department of Labor's Occupational Information Network (O\*NET). The online administration of aptitude tests is increasing and some, such as the Graduate Records Examination (GRE), now require special arrangements for any other than an online administration.

Career information is also widely available via electronic media. Meta-analyses reveal that access to accurate occupational information is among the most important predictors of a positive outcome. The O\*NET contains a comprehensive set of databases that permit on-line searches of occupational information using criteria such as interests, values, and employment growth. ACT and the College Board maintain free sites that permit users to search for a college using criteria such as admissions requirements, tuition costs, and geographic location.

Computer-based guidance systems now offer the full range of career guidance services. DISCOVER and SIGI house instruments for measuring interests,



abilities and values. Also included are databases containing detailed information about occupations (both military and civilian), majors (ranging from short technical training programs to graduate programs), colleges and universities, and financial aid. Individuals can complete a DISCOVER or SIGI assessment tool to learn about themselves; use the programs' databases to relate their scores to their choices of a school, college major, or career field; and then access information about the education, skills, and background required for their selected options.

Psychologists now provide online career counseling services using online chat, videoconferencing, voice over Internet protocol (VOIP or Internet phone), e-mail, and weblogs. These options make career counseling services available to people who might not otherwise have access to counseling (e.g., homebound individuals and those living in areas not serviced by professionals). Some caution is advisable because these approaches to service delivery have not yet been evaluated sufficiently. There is reason for optimism, however, because preliminary evidence suggests that e-mail, chat, and videoconferencing can provide effective career counseling services for some clients.

### **Career Education**

Career education refers to an organized program of instruction designed to increase vocational self-knowledge, provide occupational information, teach effective decision-making skills, and improve the individual's ability to deal with life transitions. Ideally, children will be introduced to career education during their early years and have continued exposure to career education as they progress through the educational system. Critical considerations in the design of career education for children are the learner's developmental stage, knowledge of the types of activities that are appropriate for learners at each developmental stage, and an understanding of the intended outcomes.

Exposure to career education continues to be important after the completion of formal education. The last 3 decades have seen a shift away from the view of employment as a lifelong commitment between worker and employer. Workers are now regarded more as independent contractors who move from job to job across their work life. Career education for mature workers helps them develop and maintain transferable skills that are useful in multiple employment contexts. Mature workers continue their

career education by enrolling in continuing education programs and by maintaining a lifelong commitment to learning.

## **Career Counseling Settings**

Career counseling is widely available in colleges and universities; in the United States many offer career counseling services for faculty and staff members in addition to students. Career counseling services also are available in a variety of alternative settings in contemporary American society. This section describes career counseling in schools, colleges and universities, businesses, nonprofit and professional organizations, and private practice settings.

### **Schools**

Career counseling in schools begins in the elementary school years and continues through high school graduation. The purpose, particularly in the elementary and middle school years, is to inform students about career-related issues and to spark the career development process. Successful activities are consistent with the students' vocational maturity (i.e., their stage in the career development process). Most elementary school students have not yet begun to think realistically about career issues; career education initiates the transition from career fantasies (i.e., being a ballerina or baseball player) to realistic career planning.

Much of the early career-related instruction appears in examples in assigned reading materials (e.g., readers and social studies books). As students progress through the elementary grades, career education activities become more common. Many of these take the form of special assignments or modules introduced by the teacher. Other career education activities include career days and speakers who talk about career-related topics.

The pace of career development varies greatly as adolescents progress through the middle school and high school years. Many can benefit from group activities such as workshops, but others require more specialized attention such as that provided by group counseling or individual counseling. The objectives during the middle school years are to broaden the range of options students consider and to provide the information they need to think realistically about careers.

During high school, students begin to plan for their entry into the workforce or to attend a college or university. Individual counseling, group counseling, and



structured workshops are more common during these years. It is only at this age that most students begin to be able to relate career issues to their personal situation. The goals are to sensitize students to the vocational significance of their personal values, interests, and skills and to provide information about the demands and benefits of alternative career options.

### ***Colleges and Universities***

For most students, the entry into college demarks the beginning of their ability to act upon career choices. Although many have given considerable thought to their career plans, their ability to explore their ideas in a meaningful way has been constrained by their age, dependence on their family, and limited work experience and high school curricular offerings. Thus, many enter higher education with an understanding of the importance of career choice and with feelings of anxiety regarding their relative lack of progress.

Most college students engage in a period of exploration during which they try out various courses, part-time jobs, and volunteer activities to learn more about themselves and their career options. Often they recognize a need for increased personal understanding of their interests, values, and aptitudes. The need for greater self-knowledge may also involve gaining a more mature understanding of their own unique circumstances as a woman, racial minority group member, disabled individual, or gay, lesbian, or bisexual person. Older adults returning to college after an absence from school often face additional issues such as work–family conflicts, stress, and age discrimination.

A wide variety of career services are available in campus settings, including individual and group counseling, structured workshops, internships, student work opportunities, and assistance with job placement. In aggregate, these services strive to achieve the goals of Frank Parsons's model: helping students learn about themselves, the world of work and the relation between the two sets of knowledge.

### ***Organizations***

Among the earliest organizations to provide career counseling services were the corporations that emerged with the industrial revolution. Until recent years the primary focus of these organizations was employee selection and individual career advancement (often referred to as career management).

Corporations began to offer a wider range of services in the late 1980s, and many now offer a program of career counseling services.

Government agencies such as the military, rehabilitation agencies, and correctional facilities also provide career counseling services. Career counseling on military bases tends to emphasize the transition from a military specialty to a civilian occupation. Rehabilitation counseling helps people identify suitable training and employment options so that they can become self-supporting. The focus in correctional and mental health facilities is on helping clients develop work attitudes, behaviors, and marketable skills that will permit them to secure and maintain employment following their discharge.

Many organizations employ staff members (often in their human resources department) to provide career services. Specialists employed as independent contractors may supplement the routine services by providing specialized services such as psychological assessment and work evaluations. Other organizations contract with independent professionals or corporations (e.g., an employee assistance firm) for career counseling services.

### ***Private Practice***

Until recently there was little opportunity for career counselors to work exclusively in private practices. Free career counseling is available to most individuals through schools, colleges and universities, services organizations (e.g., B'nai Brith and Big Brothers and Big Sisters of America) and government agencies (e.g., the United States Employment Service, the Rehabilitation Services Administration, and the military). However, expansion of the range of career services offered by corporations in the late 1980s increased the opportunities for psychologists in private practice to specialize in career counseling. Organizations often find that contracting with private practitioners is cost-effective because career services can be purchased on an as-needed basis.

The career counseling services most frequently provided by private practitioners are those specialized or time-intensive services that are not cost-effective to provide in house. These include individual counseling, psychological assessment, assistance with career decision making and coaching, and career management.

Private practitioners also have organizations as their clients. Their functions in these arrangements often include assistance with staffing decisions



(e.g., evaluating candidates for employment or promotion), the development of succession plans and programs, assisting employees in dual-career and dual-partner relationships with their career transitions and career search, and outplacement. Organizations often seek the assistance of an independent contractor when issues such as sexual harassment, sexism, or racism require attention.

### **Career Counseling Clients**

Psychologists and counselors who provide counseling services recognize and value the uniqueness of each client. They approach their counseling interactions with clients without preconceived notions, but they also recognize that all people are influenced by their cultural and social experiences. This section briefly reviews some of the critical issues that psychologists and counselors consider when providing career counseling services to selected groups of clients.

#### ***Work-Bound Youth***

Work-bound youth have limited life and work experience to draw upon in making life-shaping career decisions. To become successful employees, they must possess basic academic (e.g., reading, writing, and mathematics) and cognitive (e.g., decision-making and problem-solving) and social and personal (e.g., conscientiousness and self-management) skills. Psychologists and counselors counseling work-bound youth formulate an approach for career counseling based on their evaluation of the client's vocational maturity and proficiency in these domains. The choices made by these youngsters are the initial steps in their career, so career counselors help them make decisions that will maintain their future options rather than foreclose future possibilities.

#### ***Adults in Transition***

The cohort of adults making career transitions is varied because any passage that causes a change in status (e.g., marriage, birth of a child, death of a loved one, termination from employment, and decision to retire) can trigger a career transition. Transitions such as school-to-work and a change in job title and responsibilities can be anticipated. This permits the development of a strategic plan that allows some control over the timing, pace, and details of the transition.

Nevertheless, anticipated transitions require some changes in behavior and relationships, and they involve both losses and gains.

Unanticipated transitions catch people by surprise. They can result from events (e.g., downsizing and health issues) or planned events that fail to occur. Unanticipated transitions allow little or no time to develop plans for minimizing negative consequences, and they often cause a sense of personal crisis.

#### ***Clients With Disabilities***

Disabilities can be classified as physical, psychiatric, or cognitive in nature. Physical disabilities limit people's ability to perform the full range of typical motor functions. They can result from congenital conditions, physical injuries, or progressive conditions such as diabetes. The environment is an important factor in determining the effects of a condition. For example, the inability to stand is not a limitation in most situations where keyboarding is performed because most people perform that activity while sitting.

Psychiatric disabilities affect the person's ability to reason and to deal successfully with typical life events. Cognitive disabilities affect the individual's problem-solving and decision-making abilities. Contrary to stereotypes, people's ability to perform many occupations is unaffected by these disabilities.

Psychologists and counselors working with individuals having a disability evaluate both the nature of the disability and the individual's adjustment to the disability. Adjustment takes time, and people also differ in their ability to accept changes in their status. Clients who have not yet made a realistic adjustment to their present status typically require different counseling services than those who have adjusted to their status and are committed to making the best of their life.

An individual's adjustment to a disability may vary over time. Conditions that require careful attention to a medical or physical regimen are susceptible to variations in adjustment. For example, some people with a psychiatric disability may function successfully for a period of time, but then relapse because they discontinue their medication.

Another consideration is whether the disability is stable or progressive. Stable disabilities allow the counselor and client to make career plans based on the client's present status. Progressive conditions require career plans that anticipate the progression of the disability.



Regardless of these differences, however, psychologists and counselors avoid making the disability the focus of their attention. The goal of counseling is to identify vocational options that provide an optimal fit for the client. This determination is made in the context of the Americans with Disability Act (ADA), which requires employers to make reasonable accommodations to enable persons with disabilities to perform jobs successfully. Psychologists and counselors help clients understand their rights under the law, identify the accommodations that will allow them to perform desired occupations successfully, and help them practice constructive ways to communicate this information to employers and prospective employers.

### ***Ethnically and Culturally Diverse Clients***

Differences attributable to cultural and social experiences are universal. For example, collectivist cultures endorse values and behaviors that differ from those preferred by individualist cultures. Important cultural differences exist even among groups many unthinkingly regard as homogeneous: Euro-Americans who trace their ancestry to Scandinavian countries (e.g., Danes, Swedes, and Norwegians), the British Isles (e.g., Irish, English, Scots, and Welsh), and Germanic countries (e.g., Dutch, Germans, and Austrians). Some groups (e.g., Irish and German) have suffered from pervasive discrimination in recent memory, and others are still targets of discrimination (e.g., African Americans and Native Americans). Some groups are still targets of negative stereotypes (e.g., Jewish, Irish, homosexual, and Native American individuals).

Psychologists and counselors avoid stereotyping, but they recognize that members of social, gender, and ethnic groups are likely to have had common experiences and to share similar views of the world. Psychologists and counselors attempt to understand and respect the influence of their client's cultural heritage. The following sections describe factors psychologists consider when providing career counseling to individuals from selected segments of American society.

#### **African Americans**

Understanding the African American culture in the context of White American culture is critical to success in counseling African Americans. Developing an understanding of the differences in the way African

Americans experience American society is necessary to work effectively with them. Variables that are important include the client's racial identity development, social network, role models, family influences, and perception of the barriers that racism and lack of economic resources impose to reaching their career goals.

#### **Asian Americans**

The stereotype that Asian Americans are a model minority is as harmful as the more negative stereotypes attached to other groups. Asian Americans' reticence to disclose personal problems to avoid "loss of face" may account in part for this stereotypic impression. Nevertheless, this stereotype suggests that Asian Americans need less attention than other segments of American society. That view encourages neglect, and it contributes to the fact that relatively little is known about Asian Americans' career development and career behavior.

Asian Americans' career interests, values, and vocational behavior tend to differ from those of the typical Euro-American. For example, parental influence plays a greater role in their career decision making. Asian Americans rely more heavily on collectivist approaches to work-related tasks, a difference that is sometimes interpreted as reflecting insecurity and a lack of leadership qualities. From an Asian American perspective, however, these behaviors reflect their cultural emphasis on collectivist approaches to problem solving.

#### **Latinos**

Latinos form a diverse group of individuals whose ancestry derives from Spanish-speaking countries in Central America, South America, and the Caribbean. As a group, their career aspirations are as high as those of other segments of American society, but their expectations to achieve their aspirations are lower than those of other groups. This lack of confidence is attributable in part to a lack of self-efficacy beliefs and to their perception of barriers to their career goals. These factors cause Latinos to eliminate desirable career options from consideration.

Latinos value family strongly; many place greater importance on being a part of the family unit than on meeting their individual needs. Latinos are likely to make career decisions in consultation with family



members. They give strong consideration to the effects of their choices on their family, and they may sacrifice personal needs to the family's welfare.

Latinos are concentrated in the working class and in working-class neighborhoods. They are underrepresented in many desirable high-paying and high-status occupations. These factors limit the occupations to which they are exposed and influence the quality of the education they receive. Many obtain a less than average education from the public school system and lack the resources to pursue additional education or other career training. In addition, discrimination may pose a barrier to considering some career options.

### **Native Americans**

Success in pursuing educational and career objectives requires Native Americans to balance their commitment to their traditional culture with the need to become comfortable in the dominant Euro-American culture. This challenge is unique to Native Americans, and it calls into question the cultural validity of some mainstream career development constructs such as career maturity.

Native Americans often live in rural locations in impoverished communities. They have the highest unemployment rate and the lowest rate of academic achievement among minority groups in America. Many Native American tribes emphasize a sense of physical place and view their relation to the environment differently than Euro-Americans. Many also emphasize collectivist values, and they regard competition less favorably than Euro-Americans. They value the advancement of the social unit rather than efforts by a single individual to stand out above the rest.

These factors influence Native Americans' approach to career development. For example, they involve family and tribe in their career decision making and in the career development process. Career counseling that considers the culture, context, and constructions of the Native American culture may be more successful than counseling from the perspective of the majority culture. It may be important to include family members and even tribal leaders in the career counseling process.

### **Immigrants**

Although many immigrants share a racial heritage with African Americans, Asian Americans, or Latinos,

they differ in that they are new to the country in which they reside. They may not speak the dominant language, may not have a locally accessible network of friends or relatives, and may not be aware of the resources available to help with their career and related issues. Regardless of their educational level and technical training, administrative barriers such as work permits and licensing requirements may limit the types of positions they can hold. Counselors may need to assist immigrant clients in dealing with the bureaucratic requirements that impose barriers to career development.

People immigrate to a new country for a variety of reasons including better economic prospects, political persecution, and a natural disaster. In some instances, families arrive intact; while in other instances, immigrants arrive alone. Many immigrate legally, but approximately half of the immigrants enter the United States illegally. These factors influence immigrants' willingness and ability to benefit from career counseling.

In addition to discrimination, language skills, and administrative barriers, subtle factors also influence the career development of immigrants. Career counselors may need to deal with personal issues such as loss of power and status, changes in role appropriate behavior, and feelings of impotence from loss of ability to provide for the family. Interpersonal styles that are accepted in the immigrant's native culture may be considered inappropriate in the United States. Immigrants from male dominant cultures may find that their values and role expectations are inconsistent with Euro-American values. Females from these cultures may feel uncomfortable making decisions without the permission of the significant males in their lives. Individuals from collectivist societies may need to include their entire family in the career decision-making process.

### **Gay and Lesbian Clients**

In contrast to other segments of American society, gay men and lesbians must contend with the reality that discrimination against them is legal and institutionalized. Those who are employed often have to contend with discriminatory institutional policies (e.g., limits in healthcare coverage) and a workplace climate that is unwelcoming or hostile. Some segments of society even regard such discrimination as a sign of the moral superiority of the person practicing the discrimination.



Because discrimination against them is legal, many homosexual persons feel threatened and are reluctant to participate openly in psychological research. As a consequence, information about their vocational interests, career aspirations, and other aspects of their career development is not readily available. For example, stereotypes suggest that gay men and lesbians tend to value gender nontraditional occupations, but there is little scientific research to illuminate this possibility. It is not clear whether homosexual individuals possess genuinely nontraditional interests and aspirations, or whether they are attracted to occupations they perceive to be more accepting of homosexual individuals.

Career counselors take care to ensure that their personal values do not interfere with their work with homosexual clients. They refrain from imposing their values on the client and remain sensitive to their clients' needs, values, and aspirations. They are comfortable discussing their client's sexual identity. They help their clients consider how negative stereotypes and covert and overt discrimination may affect their career choices and career development, how open their clients plan to be regarding their sexual identity, and the potential consequences of that decision.

### **Career Counseling Issues**

Psychologists and counselors place no artificial limits on the issues clients can raise in career counseling. Clients often come to career counseling wanting help with a specific issue and intending to talk only about a limited range of topics, but achieving a beneficial outcome often requires the examination of a wide range of issues and topics. For example, unhappiness at work can have negative consequences at home and vice versa. Resolving problems that involve work often require dealing with problems in other aspects of life. Every issue discussed in this volume of the *Encyclopedia of Counseling* is relevant for discussion in career counseling.

### **Career Counseling Process**

Career and personal counseling evolved from the job placement and vocational guidance models that psychologists developed during the first half of the 20th century, and career and personal counselors use many of the same helping skills. Although the external appearance of counselor–client interactions may

differ across these specialties, the underlying elements that account for much of the success of the counseling interaction are the same. Both specialties require proficiency in basic interviewing and psychological assessment skills.

Success in career counseling depends upon the skillful use of active listening skills and the development of a therapeutic counselor–client relationship. This involves establishing an emotional bond between the counselor and client based on mutual respect and trust and reaching an agreement on the goals of therapy and the tasks that will be undertaken to achieve those goals. Development of the therapeutic relationship begins in the first interview and continues throughout the course of counseling.

Success in career counseling also depends upon the skillful use of assessment procedures to assist the client's self-exploration. An individualized interpretation of the test results and knowledgeable assistance in relating the test results to occupational information leads to the identification of a narrowed range of potential occupational alternatives for the client to consider. This enables the client to gather more detailed information about those occupations and ultimately to make informed career decisions.

Throughout the career counseling process psychologists and counselors provide emotional support, help their clients establish goals, and provide assistance in developing problem-solving and decision-making skills when needed. Many career counselors also help their clients develop resumes, interviewing skills, job search skills, and social support and career networks.

### **Conclusion**

Career counseling theory and practice is an effective psychological specialty that has benefited from over 90 years of innovation and experimentation. Meta-analyses of decades of research reveal that career interventions produce measurable benefits. Individual career counseling, structured career counseling groups, career workshops, and career education are all effective interventions that are useful for helping clients explore options and make career decisions. Nevertheless, efforts continue to identify even more effective career counseling interventions that can be used to assist an increasingly diverse clientele.

*Howard E. A. Tinsley*



**See also** Adults in Transition (v4); Career Counseling, African Americans (v4); Career Counseling, Asian Americans (v4); Career Counseling, Gay and Lesbian (v4); Career Counseling, History of (v4); Career Counseling, Immigrants (v4); Career Counseling, Latinos (v4); Career Counseling, Native Americans (v4); Career Counseling in Colleges and Universities (v4); Career Counseling in Organizations (v4); Career Counseling in Schools (v4); Career Counseling Process (v4); Career Education (v4); Career Planning (v4); Computer-Assisted Career Counseling (v4); Decision Making (v4); Discrimination and Oppression (v2); Diversity Issues in Career Development (v4); Group Therapy (v2); Individual Therapy (v2); Life Transitions (v2); Parsons, Frank (v4); Personal and Career Counseling (v4); Person–Environment Fit (v4); Person–Environment Interactions (v2); Persons With Disabilities (v4); Private Practice Career Counseling (v4); Psychoeducation (v2); Rehabilitation Counseling (v2); School-to-Work Transition (v4); Social Discrimination (v4); System of Interactive Guidance Information (v4); Test Interpretation (v2); Trait-Factor Counseling (v4); Work-Bound Youth (v4); Working Alliance (v2); Work Values (v4)

### Further Readings

- Arbona, C. (1996). Career theory and practice in a multicultural context. In M. L. Savickas & W. B. Walsh (Eds.), *Handbook of career counseling theory and practice* (pp. 45–54). Palo Alto, CA: Davies-Black.
- Brown, S. D., & Ryan Krane, N. E. (2000). Four (or five) sessions and a cloud of dust: Old assumptions and new observations about career counseling. In S. D. Brown & R. W. Lent (Eds.), *Handbook of counseling psychology* (3rd ed., pp. 740–766). New York: Wiley.
- Brown, S. D., & McPartland, E. B. (2005). Career interventions: Current status and future directions. In W. B. Walsh & M. L. Savickas (Eds.), *Handbook of vocational psychology* (2nd ed., pp. 195–226). Mahwah, NJ: Lawrence Erlbaum.
- Croteau, J. M., Anderson, M. Z., DiStefano, T., & Kampa-Kokesch, S. (2000). Lesbian, gay, and bisexual vocational psychology: Reviewing foundations and planning construction. In R. M. Perez, K. A. DeBord, & K. J. Bieschke (Eds.), *Handbook of counseling and therapy with lesbians, gays and bisexuals* (pp. 383–408). Washington, DC: American Psychological Association.
- Gerstein, L., & Shullman, S. (1992). Counseling psychology and the workplace: The emergence of organizational counseling psychology. In S. Brown & R. Lent (Eds.), *Handbook of counseling psychology* (2nd ed., pp. 581–625). New York: Wiley.
- Greenhaus, J. H., Callanan, G. A., & Vodshalk, V. M. (2000). *Career management* (3rd ed.). Orlando, FL: Harcourt.
- Gysbers, N. C., Heppner, M. J., & Johnson, J. A. (2003). *Career counseling: Process, issues, and techniques*. Boston: Allyn & Bacon.
- Holland, J. L. (1997). *Making vocational choices: A theory of vocational personalities and work environments* (3rd ed.). Odessa, FL: Psychological Assessment Resources.
- Leong, F. T. (1995). *Career development and vocational behavior of racial and ethnic minorities*. Hillsdale, NJ: Lawrence Erlbaum.
- Pope, M. (2000). A brief history of career counseling in the United States. *Career Development Quarterly*, 48, 194–211.
- Rounds, J. B., Jr., & Tinsley, H. E. A. (1984). Diagnosis and treatment of vocational problems. In S. D. Brown & R. W. Lent (Eds.), *Handbook of counseling psychology* (pp. 137–177). New York: Wiley.
- Subich, L. M. (Ed.). (1993). How personal is career counseling? [Special section]. *The Career Development Quarterly*, 42, 129–191.
- Whiston, S. C., & Oliver, L. W. (2005). Career counseling process and outcome. In W. B. Walsh & M. L. Savickas (Eds.), *Handbook of vocational psychology: Theory, research, and practice* (3rd ed., pp. 155–193). Mahwah, NJ: Lawrence Erlbaum.

---

## CAREER COUNSELING, AFRICAN AMERICANS

---

Early in the 21st century there continues to be economic disparities between racial ethnic groups. The latest census indicated that Asian American couples had the highest average annual earnings at about \$57,500 per year, followed by Caucasian Americans at roughly \$49,000, then Hispanics with \$39,241, and finally African Americans at about \$30,000 per year. There are three times as many African American males imprisoned as there are in college. In the state of Tennessee, 80% of the people living in poverty are women and children, and African American women are over represented in those numbers. While African American youths are closing the high school graduation rate between them and White American youths, African Americans still tend to be overrepresented in low-pay/low-skill jobs and underrepresented in high-skill and professional jobs, although African American youths have equivalent career aspirations as those of their White counterparts.



Given these continuing seemingly intractable facts one wonders how a career counselor can make a difference. Certainly many authors have maintained that traditional career counseling theories do not easily fit this population. Although social cognitive career counseling has shown some promise of being broad enough to include African Americans, some scholars maintain that perhaps the entire field of career counseling needs to be refocused for some populations away from career decision making and toward theories of work. A career implies a directional succession of jobs or work that is driven by choice and intentionality. Individuals who are dealing with poverty, the prison system, and other societal barriers are often working at any job that meets their survival and basic human needs versus working toward a career. It could be, however, that even in these situations an appropriate career development theory coupled with an effective assessment method and intervention could be useful.

### **Factors That Influence Career Development**

Theorists have proposed that an individual's career choice is affected by layers of interacting factors that can be depicted as a set of expanding circles. At the core of the circles are biological factors. They suggest that our genes influence our predispositions to certain types of behaviors, emotions, and psychological traits that may tend to lead us to one type of career or job as opposed to another. It could be that as we continue to understand the human genome those predilections will become clearer.

Next are gender factors. In the United States significantly more males than females are found in realistic occupations, and more females are in the social occupations as defined by the Holland Hexagon. Society seems to begin to push boys and girls toward different activities and careers when they are very young.

The theorists next propose that careers are influenced by families and the families' life circumstances. It is not unusual to see families in which several generations are doctors, politicians, or involved in the criminal justice system. An African American male child with a parent in the criminal justice system is over 50% more likely to also be involved with that system. It is very difficult for African Americans born into poverty to rise out of that poverty. If the parents,

however, push education, then the child has a greater chance of entering the middle class. African American parents do have a great deal of influence on a child's interest in education.

Racial and ethnic subgroups are theorized to have an impact on career development and career choices of the groups' members. Although race and ethnicities are often viewed as social constructions, some work suggests that there is a racial identity development phenomenon and that individual behavior and even approaches to career decision making is influenced by that identity development process. Even in integrated settings racial and ethnic groups often divide along racial lines. In her book, *My Freshman Year*, Rebekah Nathan noted that in the dining hall of a large predominantly White university the Black students sat with each other as did the Whites, the Asians, and so on. Even though some authors have stated that today's college students, called Millennials, are more desegregated than ever, it was among this group that Nathan noted her findings. So it is reasonable to assume that the people with whom one spends time are likely to influence one's career development and career decisions.

Finally, the dominant or majority group has an impact on career and job outcomes. Structural factors, perceptions, and barriers can determine whether or not one can rise in the corporate culture or even get in the door. It is in this circle that sexism, racism, or the other isms exist and help determine career choice or lack thereof.

It is important for a career counselor to explore all five of the interacting circles if he or she is to have a meaningful interaction with an African American individual. In order to explore the factors in the circles one needs good assessment instruments. Two practical instruments described next can be used in applied settings.

### **Cultural Assessments**

It is important for the counselor to develop some understanding about African Americans if the counselor is to offer an effective intervention. It is just as important for the client to gain some clarity about his or her career questions. To help the counselor and client, researchers developed the Multicultural Career Counseling Checklist and the Client Career Counseling Checklist.



The Multicultural Career Counseling Checklist encourages counselors to make sure they are familiar with African American culture in context with the majority White American culture. Such understanding includes familiarity with class, family, gender, and structural factors. The counselor is also directed to understand personal racial identity development and the racial identity development of the client.

The Career Counseling Checklist is given to clients prior to any interventions. Clients are asked to think about matters that include abilities, cultural issues, career knowledge and behaviors, self-confidence, secret daydreams, and so on. The counselor can use the information to establish an appropriate intervention, though the counselor may still be unsure where to begin.

### Steps to Multicultural Career Assessment

Researchers recommend that counselors begin with cultural variables, including worldviews, racial identity development, and structural factors such as barriers imposed by class or racism. Sometimes when these barriers are explored, the career questions are answered at that step.

Other times one must move to gender variables including asking African American men and women about how they were socialized in their respective gender roles, work-home salience, and even extended family expectations. The counselor may then need to explore the client's level of confidence in self, ability to do the job, or even ability to overcome social and structural barriers. It is only after all the above areas are explored that moving to traditional assessment instruments like the Strong Interest Inventory or interventions like a career shadowing experience is recommended.

If a counselor will explore the cultural factors that influence career development, prepare him- or herself and the client through a thorough cultural assessment, and follow the steps to multicultural career assessment, then the intervention is likely to be more effective whether one is helping a client prepare for a job or a career.

*Rosie P. Bingham*

*See also* African Americans (v3); Afrocentricity/ Afrocentrism (v3); Assessment (v4); Black Psychology

(v3); Career Barriers Inventory (v4); Career Counseling (v4); Career Counseling Process (v4); Diversity Issues in Career Development (v4); Holland's Theory of Vocational Personalities and Work Environments (v4); Multicultural Career Assessment Models (v4); Multicultural Career Counseling Checklist (v4)

### Further Readings

- Blustein, D. L., (2006). *The psychology of work: A new perspective for career development, counseling and public policy*. Mahwah, NJ: Lawrence Erlbaum.
- Cross, W. E. (1971). Negro-to-Black conversion experience; Toward a psychology of Black liberation. *Black World*, 20, 13–27.
- Fouad, N. A., & Bingham, R. P. (1995). Career counseling with racial and ethnic minorities. In W. B. Walsh & S. H. Osipow (Eds.), *Handbook of vocational psychology: Theory, research and practice* (2nd ed., pp. 331–366). Mahwah, NJ: Lawrence Erlbaum.
- Helms, J. E. (1990). *Black and White racial identity: Theory, research and practice*. Westport, CT: Greenwood Press.
- Holland, J. L. (1985). *Making vocational choices* (2nd ed.). Englewood Cliffs, NJ: Prentice Hall.
- Lent, R. W., Brown, S. D., Sheu, H., Schmidt, J., Brenner, B. R., Gloster, C. D., et al. (2005). Social cognitive predictors of academic interests and goals in engineering: Utility for women and students at historically Black universities. *Journal of Counseling Psychology*, 52(1), 84–92.
- Nathan, R. (2005). *My freshman year: What a professor learned by becoming a student*. Ithaca, NY: Cornell University Press.
- Ward, C. M., & Bingham, R. P. (2001). Career assessment for African Americans. In W. B. Walsh, R. B. Bingham, M. T. Brown, & C. M. Ward (Eds.), *Career counseling for African Americans* (pp. 27–28). Mahwah, NJ: Lawrence Erlbaum.

---

## CAREER COUNSELING, ASIAN AMERICANS

---

It has been repeatedly observed that the current literature has limited information on the development and career behaviors of Asian Americans. For example, Asian Americans and Pacific Islanders are more likely to request information about career issues and are also more likely than other ethnic groups to use college career information centers. Since Asian Americans are



the fastest-growing minority group, it means that professionals will need culturally sensitive career theories and interventions in order to be culturally effective with Asian Americans. Ultimately, this will translate to culturally informed career assessments, counseling, and interventions for this population. Synthesizing career practice with suitable theories will help professionals meet the needs of Asian Americans within an arena that is considered important to their well-being and functioning.

### **Levels of Analysis**

There are two levels of analysis in the review of career counseling among Asian Americans: (a) an individual level of analysis that involves issues such as career interest, values, choices, and behaviors; and (b) a group and societal level of analysis that consists of the effects of macrolevel processes such as family influences, occupational stereotyping, occupational discrimination, occupational mobility, and occupational segregation. All these factors have certain implications for career counseling with Asian Americans.

#### ***Individual Level of Analysis***

##### **Career Interests**

When counseling Asian Americans regarding career issues, it is important to consider the client's career interests. Over the past 20 years only a handful of studies have highlighted the career interest patterns among Asian Americans. For example, in most studies where Chinese American males were compared to other ethnic males, they demonstrated a greater interest in the occupational fields of physical science, skilled technical trades, and business. These males also showed lower levels of interest in areas associated with social service and welfare, sales or business contact, and verbal-linguistic occupations (social). There are other recent studies that show how Asian Americans display career interests that are consistent with realistic and investigative domains. Another way to examine career interests among Asian Americans is to investigate the courses and majors students choose. Data from the National Science Foundation suggest that Asian Americans are twice as likely as White students to have an interest in a science field, and this interest is usually paralleled by high educational aspirations (e.g., aspirations to obtain a doctorate or medical degree).

##### **Occupational Values**

Career counselors have to attend to the occupational values of Asian Americans, some of which are money, task satisfaction, prestige in career, and service dedication. When compared to European Americans, Asian Americans placed a greater emphasis on the extrinsic and security values on the occupational values scales and less of an emphasis on values such as self-expression, power, and social factors. This emphasis on extrinsic factors such as security, money, and service to others can be traced back to Asian cultural importance on issues such as pragmatism, collective styles in decision making, and the influences of the processes of acculturation and the experiences of immigration.

##### **Career Choices**

It would appear that career choices would be a direct reflection of career interests. However, there are a host of factors that influence career choices among Asian Americans regardless of their career interests. For example, Asian Americans place a high value on parental involvement in their career-related choices, to the point that higher parental involvement can predict more traditional career choices (i.e., science or technology career paths). Studies have shown that Asian American parents are more likely to exert direct influences on their children's career choices and aspirations as a result of fear of their children having to undergo the effects of discrimination. Other influential factors include Asian values of respecting authority and submitting to the wisdom of elderly and family, level of acculturation, family background, and self-efficacy. These factors have yet to be empirically tested, but they suggest that it is imperative to include family in the career counseling process.

##### **Career Behaviors**

Asian Americans display a higher level of dependent type decision-making styles than do Whites, a pattern that could be attributed to the value placed on collectivism. However, during counseling this interdependence cannot be confused with dependence, which can be equated to a lack of independence or low career maturity among Asian Americans. Research has highlighted three main personality traits associated with career behaviors among Asian Americans: locus



of control (less autonomous, more dependent, and more obedient to authority), social anxiety (more emotionally withdrawn, socially isolated, and verbally inhibited), and intolerance of ambiguity (valued practical applications and were more socially conforming).

### ***Group and Societal Level of Analysis***

#### **Family Influences**

A few studies have been conducted confirming the existence of the significant and central role families have in the psychological and social lives of Asian Americans. Family influence, especially parental, has been known to predict career choices in math and science-related fields for Asian Americans. This family influence can also be associated with conflict such as the stress of dealing with high expectations of parents to do well. This possibility suggests that families need to be involved in career counseling efforts with Asian Americans.

#### **Occupational Stereotyping**

Historically, Asian Americans have been victimized by occupational stereotyping as a function of gender and/or race. Usually stereotyping is observed across three domains: (1) probability of success, (2) qualifications of training, and (3) acceptance by others. A study found both positive and negative stereotypes with regard to gender and race groupings. However, the research investigating the specifics and psychological impact of these stereotypes has yet to be empirically studied, especially with regard to internal and external barriers, but these effects still need to be considered in counseling.

#### **Occupational Discrimination**

Asian Americans are known as the model minority group, often associated with success and high aspirations. As a result of this portrayal of being able to overcome injustices and setbacks toward success, Asian Americans are usually not considered to be exposed to stereotypes or discrimination. This usually ends up covering up the occupational constraints, obstacles, and inequalities experienced by Asian Americans. Contrary to popular belief, Asian Americans do experience discrimination (e.g., Asian American males are less likely than Whites to occupy management

positions and are less likely to get equal pay despite having higher competencies), and counselors need to be able to acknowledge those experiences.

#### **Occupational Segregation**

Asian Americans have been subjected to occupational segregation, for they have been observed to be overrepresented in some occupations while underrepresented in others. For instance, Asian Americans demonstrate a pattern of gravitating toward the biological and physical sciences, while avoiding the social sciences and humanities. Asian Americans compared to other ethnic groups have also been segregated into lower paying jobs and denied access to higher paying jobs. This segregation arises from societal and cultural barriers imposed on the occupational aspirations of Asian Americans, suggesting that counseling may involve advocacy efforts.

### **Assessment Instruments and Other Factors**

Assessment of career issues is an important precursor to successful career counseling and intervention. This is an important phase to consider as Asian Americans can be perceived to be less mature than Whites as a result of their different decision-making processes, a difference that in turn can lead to biased hypotheses. This assessment phase needs to consider occupational interests, values, choices, and behaviors on the individual level and processes such as segregation, discrimination, stereotyping, and family influences on the social-group level. Due to the lack of sufficient empirically validated career assessment instruments, care needs to be taken to use these measures with a considerable amount of caution.

When counseling Asian Americans, certain factors need to be highlighted. For example, Asian Americans display large within-group variability and differences. Each ethnic subgroup within the larger Asian group has its own culture and history. Other factors include Asian values such as respect for elders and family, issues of loss of face or maintaining face, effects of processes such as acculturation and immigration, gender role differences, expectations and values, and socioeconomic class differences.

*Frederick T. L. Leong and Arpana Gupta*



*See also* Asian Americans (v3); Assessment (v4); Career Counseling (v4); Career Counseling, Immigrants (v4); Career Counseling Process (v4); Collectivism (v3); Confucianism (v3); Cultural Values (v3); Diversity Issues in Career Development (v4); Filial Piety (v3); Model Minority Myth (v3); Multicultural Career Assessment Models (v4); Multicultural Career Counseling Checklist (v4)

### Further Readings

- Leong, F. T. L. (1985). Career development of Asian Americans. *Journal of College Student Personnel*, 26, 539–546.
- Leong, F. T. L., & Gim-Chung, R. H. (1995). Career assessment and intervention with Asian Americans. In F. T. L. Leong (Ed.), *Career development and vocational behavior of racial and ethnic minorities* (pp. 193–226). Hillsdale, NJ: Lawrence Erlbaum.
- Leong, F. T. L., & Gupta, A. (2007). Career development and vocational behaviors of Asian Americans. In F. T. L. Leong, I. G. Arpana, A. Ebreo, L. Hsin Yang, L. M. Kinoshita, & M. Fu (Eds.), *Handbook of Asian American psychology* (2nd ed., pp. 159–178). Thousand Oaks, CA: Sage.
- National Science Foundation. (2004). *Women, minorities, and persons with disabilities in science and engineering* (NSF04-317). Washington, DC: Author.

---

## CAREER COUNSELING, GAY AND LESBIAN

---

Gay and lesbian persons refers to men and women, respectively, whose primary sexual attraction is toward people of the same sex. Nonetheless, the word *gay* is sometimes used as a collective term to include both gay men and lesbian women. Due to negative stereotypes, societal stigma, oppression, and discrimination related to homosexuality and nonconformity to traditional gender roles, gay and lesbian persons often face internal and external barriers in their career development and adjustment. Professional literature addressing career counseling issues with gay and lesbian persons began to emerge in the 1980s. Some of the most important topics include career choice, work discrimination, and coping strategies. These topics are introduced below, followed by a discussion of career counseling with gay and lesbian clients.

### Career Choice

Stereotypes and the limited research available suggest that compared with heterosexual persons gay men and lesbians tend to aspire to or be employed in occupations that are nontraditional for their gender (e.g., interior designers, nurses, hairdressers for gay men; landscapers, mechanics, bus drivers for lesbians). A study found that gay men had higher social and artistic interests, but lower realistic and investigative interests when compared with heterosexual men. These findings signify gay men's nontraditional career interest patterns. On the other hand, scientific research on lesbians' career interests and choices is still lacking.

It is not certain from literature whether gay and lesbian persons' nontraditional career interests are intrinsic or a result of attraction toward occupations that are more accepting of gay men and lesbians. In any case, gay and lesbian persons may be affected by society's negative reactions to gender nonconformity and its stereotypical association with homosexuality, resulting in barriers in implementing nontraditional career choices.

### Work Discrimination

Work discrimination based on sexual orientation is legal in the United States, from federal employment to private sectors. One theoretical model identifies three dimensions of work discrimination related to homosexuality. The first dimension includes formal and informal discrimination. Formal discrimination refers to institutional policies or decisions that are unfair to gay and lesbian employees (e.g., a lack of nondiscrimination policy or domestic partner benefits; hiring, firing, salary, promotion, and job assignment decisions). Informal discrimination pertains to interpersonal or workplace climate that is unwelcoming or hostile to gay and lesbian workers (e.g., social isolation, prejudice, harassment, and physical assault). The second dimension includes potential and encountered discrimination. The former refers to possible discrimination should a person's same-sex orientation be known or assumed by others. The latter refers to the encountering of discrimination after the person's same-sex orientation is known or assumed. The third dimension includes real (based on reality) and perceived discrimination (based on the person's perception). These three dimensions result in eight different kinds of work discrimination that may have various effects on



the work status, well-being, and coping of gay and lesbian workers.

### **Coping Strategies**

To deal with the aforementioned forms of work discrimination, gay and lesbian workers may use different coping strategies for survival, self-protection, and self-assertion. A number of coping strategies have been identified in literature, two sets of which are discussed below.

#### ***Identity Management***

To cope with potential discrimination, gay and lesbian workers may use strategies to control the disclosure of information about their gay or lesbian identity, a process called identity management. Five strategies were identified in literature: (a) acting (engaging in heterosexual relationships to make believe that one is heterosexual, e.g., bringing a date of a different sex to a company party), (b) passing (fabricating information to make believe that one is heterosexual, e.g., changing a partner's name and pronoun or making up a story about having a heterosexual relationship), (c) covering (censoring information related to one's homosexuality, e.g., telling a coworker about attending a book club when it is a lesbian book club), (d) implicitly out (allowing interface between work and personal lives without explicitly identifying oneself as gay or lesbian so that people can make their own conclusions, e.g., taking a same-sex partner to a company party without identifying that person as a romantic partner), and (e) explicitly out (explicitly identifying oneself as gay or lesbian, e.g., displaying the picture of a same-sex partner at work and telling coworkers about the partner). These five strategies progress from hiding one's sexual identity to being the most open about it. They may be used sequentially depending on the identity development of the person, or they can be used at about the same time depending on the situation and risk assessed. For example, a person may use the covering strategy in one job interview and the explicitly out strategy in another job interview in the following week.

#### ***Discrimination Management***

When encountering work discrimination, gay and lesbian persons may apply various strategies for the

purpose of discrimination management. Researchers identified three categories of discrimination management strategies: (a) nonassertive (e.g., quitting, silence, avoiding discriminatory persons or situations, using self-talk, or overcompensating in order to evade discrimination), (b) social support (from partner, friends, family, coworkers, and counseling professionals), and (c) confrontation (with offender, complaint to supervisor or human resources, taking legal actions, approaching the media, or circumventing company policies). Multiple strategies may be used simultaneously, depending on the person's sexual identity development, personality, resources available, and the specific situation.

### **Career Counseling**

Career counseling with gay and lesbian clients may involve a number of issues. First, counselors may examine how their own values and beliefs regarding homosexuality or gender-role conformity may influence their work with gay and lesbian clients. Supervision, consultation, continuing education, or referrals may be considered. Second, when conducting career assessments with gay and lesbian clients, counselors examine possible assessment bias and attend to the appropriate use and interpretation of assessment tools with these clients. Third, counselors can explore with gay and lesbian clients how their sexual identity may play a role in their career development. Some clients may feel that their sexual orientation is irrelevant to their careers, whereas others may feel that it is important to be able to express their sexual identity in the workplace or to be able to serve or advocate for the gay and lesbian communities through their careers. Clarification of these values will be important for career planning. Fourth, counselors can assist their gay and lesbian clients to examine how negative stereotypes, oppression, and discrimination may affect their career choices and adjustment. A better understanding and more accurate assessments of the various forms of work discrimination as well as gaining competence with various coping strategies will be helpful. Counselors help their clients identify the most appropriate coping strategies based on their sexual identity attitudes and risk assessment for discrimination and enhance clients' mastery of such strategies through exploration of resources, role-play exercises, and reinforcing clients' self-efficacy. Furthermore, effective counselors refrain from



imposing their values on whether, when, and how clients should come out in the workplace. Instead, they are sensitive to clients' needs, values, and cultural backgrounds in helping clients manage their sexual identity and encountered discrimination. Finally, counselors may engage in social advocacy in order to facilitate changes in the systems that perpetuate oppression and discrimination.

*Y. Barry Chung*

**See also** Career Counseling (v4); Career Counseling Process (v4); Coping (v2); Diversity Issues in Career Development (v4); Gay, Lesbian, and Bisexual Therapy (v2); Sexual Orientation (v4)

### Further Readings

- Chung, Y. B. (2001). Work discrimination and coping strategies: Conceptual frameworks for counseling lesbian, gay, and bisexual clients. *The Career Development Quarterly*, 50, 33–44.
- Chung, Y. B. (2003). Ethical and professional issues in career assessment with lesbian, gay, and bisexual persons. *Journal of Career Assessment*, 11, 96–112.
- Croteau, J. M., Anderson, M. Z., DiStefano, T., & Kampa-Kokesch, S. (2000). Lesbian, gay, and bisexual vocational psychology: Reviewing foundations and planning construction. In R. M. Perez, K. A. DeBord, & K. J. Bieschke (Eds.), *Handbook of counseling and therapy with lesbians, gays and bisexuals* (pp. 383–408). Washington, DC: American Psychological Association.
- Griffin, P. (1992). From hiding out to coming out: Empowering lesbian and gay educators. In K. M. Harbeck (Ed.), *Coming out of the classroom closet* (pp. 167–196). Binghamton, NY: Harrington Park.
- Hetherington, C. (1991). Life planning and career counseling with gay and lesbian students. In N. J. Evans & V. A. Wall (Eds.), *Beyond tolerance: Gays, lesbians and bisexuals on campus* (pp. 131–146). Alexandria, VA: American College Personnel Association.
- Levine, M. P., & Leonard, R. (1984). Discrimination against lesbians in the work force. *Signs: Journal of Women in Culture and Society*, 9, 700–710.

United States in the latter 19th century out of societal upheaval, transition, and change. This new profession was described by historians as a progressive social reform movement aimed at eradicating poverty and substandard living conditions that had been created by the rapid industrialization and consequent migration of people to major urban centers at the turn of the 20th century.

The social upheaval in the United States that gave birth to career counseling was characterized by a host of economic issues: the loss of jobs in the agricultural sector, increasing demands for workers in heavy industry, the loss of permanent jobs on the family farm to new emerging technologies such as tractors, the increasing urbanization of the United States, and the concomitant calls for services to meet this internal migration pattern—all this in order to retool for the new industrial economy. Returning veterans from World War I and those displaced by their return also heightened the need for career counseling.

### First Stage: Job Placement Services (1890–1919)

The focus of the first stage in the history of career counseling was job placement. Frank Parsons, the founder of career counseling, began as a social worker heavily influenced by the work of Jane Addams in Chicago. In Boston, Parsons established a settlement house program for young people either already employed or currently unemployed who had been displaced during this period of rapid change. The placement of these young people into new jobs was one of the initial and most important purposes of this new agency.

Parsons's career counseling model was grounded in simple logic and common sense and relied on the observing and interviewing skills of the counselor. Parsons stated that there are three broad factors in the choice of an occupation: (1) knowledge of self, (2) knowledge of the requirements for success in different occupations, (3) matching these two groups of facts. This largely intuitive and experiential foundation of career counseling formed the basis for Parsons's establishing the Vocation Bureau at Civic Service House in Boston in 1908, the first institutionalization of career counseling in the United States.

During this first stage, an important factor in the establishment of career counseling was the increasing involvement of psychological testing with career counseling. Psychological tests became an important

---

## CAREER COUNSELING, HISTORY OF

---

Career counseling, or vocational guidance as it was originally known, has a long history within the counseling professions. Career counseling was born in the



and necessary part of the first functional stage in career counseling, that is, self-assessment. Testing gave career counseling respectability in U.S. society. Without a scientific procedure to justify this first stage, it is unlikely that career counseling would have been so popularly accepted. Francis Galton, Wilhelm Wundt, James McKean Cattell, and Alfred Binet made important contributions to the newly emerging field of psychological testing and through extension to career counseling.

Another important factor in the establishment of career counseling was the early support for vocational guidance that came from the Progressive social reform movement. Child labor laws were the reason for this collaboration as this crusade to prohibit the exploitation of children grew. Although some states beginning with Pennsylvania had established minimum age laws in the latter half of the 19th century, the first decade of the 20th century continued to see over half of a million children from 10 to 13 years of age employed. Effective federal legislation did not come about until the passage of the 1938 Fair Labor Standards Act. Parsons was a prominent leader in the struggle to eliminate child labor.

Furthermore, laws supportive of vocational guidance were beginning to receive much social support. For example, the landmark Smith-Hughes Act of 1917 established secondary school vocational education training. This legislation was strengthened in succeeding years by the George-Reed Act (1929), George-Ellzey Act (1934), and the George-Deen Act (1936)—all supporting vocational education as an important part of the public schools. Furthermore, in 1913 the U.S. Department of Labor (DOL) was founded, and the Bureau of Labor Statistics (BLS), which had been part of the Department of the Interior, was moved into the DOL.

Also out of this transition came the founding in 1913 of the National Vocational Guidance Association (NVGA; now the National Career Development Association [NCDA]) in Grand Rapids, Michigan, at the Third National Conference on Vocational Guidance. The founders of NVGA included Frank Leavitt (first president), Jesse B. Davis (second president), Meyer Bloomfield (third president and Parsons's successor at the Boston Vocation Bureau and teacher of the first course in vocational guidance in 1911 at Harvard University), and John M. Brewer (fifth NVGA president and author of the definitive history of career guidance in the United States, 1942).

## **Second Stage: Educational Guidance in the Schools (1920–1939)**

Educational counseling, the second stage in the development of career counseling, emerged from the work of humanitarian, progressive social reformers in the schools. Such reformers included Jesse B. Davis, who served as a counselor on educational and career problems at Central High School in Detroit in 1898 and Eli Weaver, who was a New York City school system principal in 1906. Promoting career development in the schools, however, was slow work. For example, as late as the 1930s there were no vocational guidance programs in at least half of the schools in cities in the United States with populations of 10,000 or more. Elementary and secondary education, however, received an influx of students both as a result of increased needs for literacy to cope with increasing demands of industrialization and the increase in numbers of school-aged children as a direct result of the boom in pregnancies following the end of World War I.

Organized labor's strength was growing fast in the wake of the economic depression, and President Franklin Roosevelt's New Deal was a response both to the growing power of unions as well as to loss of jobs. The Civilian Conservation Corps (CCC) was established in 1933 to provide training and employment opportunity for unemployed youth, and the educational services of the CCC were supervised by the U.S. Department of Education.

Then, in 1935, the Works Progress Administration was established through federal legislation as an employment source for the millions of people out of work. Finally, the B'nai B'rith Vocational Service Bureau was opened in 1938 in Washington, D.C., and local Jewish Vocational Services were established in 25 major U.S. cities. The first edition of the *Dictionary of Occupational Titles* (the official government occupational classification) was published in 1939.

## **Third Stage: Colleges and Universities and the Training of Counselors (1940–1959)**

The third stage was characterized by the focus of societal resources on colleges and the training of professional counselors as response to a new social transition engendered by two major events that set the tone for all subsequent worldwide actions: World War II and the USSR's (Union of Soviet Socialist



Republics—now the Commonwealth of Independent States, including Azerbaijan, Armenia, Belarus, Georgia, Kazakhstan, Kyrgyzstan, Moldova, Russia, Tajikistan, Turkmenistan, Uzbekistan, and Ukraine) successful launching of rockets that orbited Earth and even landed on the moon.

First, World War II focused the energy and attention of all nations of the world on this contest between nationalistic fascism (Germany, Japan, Italy) and capitalism–communism, which were allied at this time (United States, USSR, Great Britain, France). President Harry S. Truman's Fair Deal program was a response to the problems encountered by returning armed services veterans. The lack of jobs and the subsequent displacement of current workers by these returning veterans were important societal problems that the Truman program attempted to address.

Second, the USSR successfully launched the first space probe (*Sputnik I*, 1957), followed by *Lunik II* (1959) landing on the moon. These two events more than any other humbled American capitalism for a time. The United States had considered itself far superior technologically to any other country on Earth; however, when the USSR was so successful in their space program, this impelled federal legislators to begin to address the problems in science and math education all across the United States. The passage of the National Defense Education Act (NDEA, 1957) was a direct response to this. The Counseling and Guidance Training Institutes were established under NDEA to provide training for counselors who were to identify and encourage science and math majors for college education. This was a boom period for the training of counselors and almost 14,000 counselors received training in these NDEA Institutes.

Two social conditions characterized the post–World War II period that led to the rise of the professional practice of career counseling: (1) the personal and career problems of veterans, especially those who were disabled during the war; (2) the influx of new types of students to higher education (generally older, nontraditional) as a result of the GI Bill of Rights.

As a direct result of the growth of vocational guidance and the realization that there was strength in joining together with other professional organizations, the NVGA became one of the founding divisions of the American Personnel and Guidance Association (later to become the American Association for Counseling and Development, and now the American Counseling Association) in 1951.

### **Fourth Stage: Meaningful Work and Organizational Career Development (1960–1979)**

The 1960s were a time of idealism and hope. John F. Kennedy's election as U.S. president (1960), Lyndon Johnson's Great Society (1965), the beginning of the great modern-day civil rights movements, the Vietnam War, and the economic highs of this stage all came together to focus a generation of young people on the potential, myths, and illusions of American society, providing for them a new vision of personal, social, and cultural relations.

Many young people wanted jobs that were meaningful and that would allow them to change the world for the better. Young Americans were questioning the character of available jobs and the overly conforming and depersonalizing conditions under which most individuals worked. The United States at that time was regarded as a rich, sophisticated, yet humane nation dedicated to providing all of its citizens with a broad spectrum of services and opportunities for achieving the good life. And young people wanted the United States to live up to its ideals.

The type of federal legislation enacted into law during this period is also illustrative of the expectations of Americans during this fourth stage. At the beginning of the 1960s, the unemployment rate was 8.1%, the highest since the 1930s. President Kennedy entered office in 1961 and as one of his first acts appointed a panel of consultants on vocational education who issued their report through the U.S. Department of Health, Education, and Welfare in 1962, which stated that school counselors need to also have exceptional understanding of the world of work and its complexities. Their recommendations were written into legislation in the Vocational Education Act of 1963 and updated through its amendments in 1968 and 1976.

This report was soon followed by more federal legislation similarly crafted. Not since the founding of the United States in 1776 had there been such a plethora of social programs enacted into law in such a short time, including the Area Redevelopment Act (1961), Manpower Development and Training Act (1962), Economic Opportunity Act (1964; this act created Job Corps, Neighborhood Youth Corps, Volunteers in Service to America, Youth Opportunity Centers, and Head Start), Social Security Act (1967; this act included Work Incentive Program for welfare clients).



Finally, the National Occupational Information Coordinating Committee (NOICC) and the State Occupational Information Coordinating Committees were established by the Vocational Education Act Amendments of 1976. These supra- and intragovernmental coordinating agencies were designated to coordinate the delivery of labor market and other career information among four federal agencies—the Employment and Training Agency, National Center for Education Statistics, BLS, and the Education Commission—and among similar state entities. Led by Juliet Lester, this forced yet historic alliance among such federal agencies to make career information available for coordinated public use was to have far-reaching consequences in the next 20 years, for it would supply the information needs for both the career counselors who required such data for their livelihood and the general public who required such data for career decision making.

As a direct result of the legislation enacted during this fourth stage, career counseling in organizational settings came to the forefront of the career counseling movement. Growth in career counseling in governmental agencies, nonprofit community agencies, and business and industry were the hallmarks of this stage. Such governmental agencies as Lawrence Livermore National Laboratories and Office of Management and Budget had large career development centers with substantial staffs. Such companies as Glaxo Pharmaceuticals, Pacific Bell, and IBM also developed internal career services centers.

### **Fifth Stage: Independent Practice Career Counseling and Outplacement Counseling (1980–1989)**

The late 1970s, however, were characterized by a declining economic system rather than by the growth and prosperity of the early 1960s. This began the fifth stage transition in the 1980s—from an industrial age to an information and technology age. This new transition spawned another host of problems, such as loss of jobs in the industrial sectors of our economy, increasing demands from employers for technological skills, loss of permanent jobs to contract labor, loss of job security, and marginalization of organized labor—all in order to retool for the information and technology economy.

In 1987, the Hudson Institute commissioned and published a report titled *Workforce 2000*, which laid

the foundation for the career development policies of both presidents George H. W. Bush's (1988–1991) and Bill Clinton's (1992–2000) federal administrations. This report was particularly noteworthy in the history of career counseling because of its demographic assumptions about the composition of the new American workforce, that new entrants into that workforce will be predominantly ethnic and racial minorities.

During this stage, the emergence of the private practice career counselor was the direct result of the beginnings of national acceptance of career counseling as an important service to provide to a citizenry in occupational transition as well as to the proliferation of mental health private practices. This practitioner whose livelihood depended on continuous marketing of short-term career counseling provided the vitality for the expansion and growth of the professional practice of career counseling during this period as well as for the credentialing of such practitioners.

NVGA had always taken the lead in establishing standards for the profession: (1) standards for the practice of vocational guidance, (2) standards for occupational materials, (3) standards for the training of counselors, and (4) standards for vocational counseling agencies. As a result of the emergence of the private practice career counselor and the heavy pressure from within the profession, NVGA initiated a specific credential for career counseling professionals. The National Certified Career Counselor credential included substantial academic and experiential requirements along with an examination (National Career Counselor Examination). As a precursor to that credential, NVGA promulgated Vocational/Career Counseling Competencies in 1982, which were developed as a list of competencies necessary for counselors to perform the task of career–vocational guidance and counseling. These competencies were preceded by the AVA–NVGA Position Paper on Career Development (1973), the APGA Position Paper on Career Guidance (1975), the ACES Position Paper on Counselor Preparation for Career Development (1976), the AIR Report on Competencies Needed for Planning, Supporting, Implementing, Operating, and Evaluating Career Guidance Programs (1979), and the APGA Career Education Project (1980). NVGA then established the National Council for Credentialing Career Counselors in 1983; and using the above competencies, this independent credentialing body developed the National Career Counselor Examination that was



first administered at the 1984 AACD Convention in Houston, Texas. Also, in 1984, a letter of intent to affiliate was filed with the new National Board for Certified Counselors (NBCC). The National Certified Career Counselor credential became the first specialty certification area for NBCC.

Concurrent with the emergence of the private practice of career counseling, outplacement counseling also had its beginning. *Outplacement* is a term used when a company is having economic difficulties and begins to downsize or fire currently employed workers to decrease staffing costs and increase profit margins. Outplacement counselors are then brought in to help those workers find new employment—placement outside of their company. Outplacement led to the founding of such firms as Bernard Haldane; Drake, Beam, and Morin; Lee Hecht Harrison; and Right Associates, who competed for these lucrative outplacement contracts side by side with career counselors in independent practice.

The rise in the use of technology in business and industry in the United States led to the passage of two very important federal laws during this stage: Omnibus Trade and Competitiveness Act (1988) and Carl D. Perkins Vocational Education Act (1984). The Omnibus Trade Act included provisions to assist persons to enter into or advance in high technology occupations or to meet the technological needs of other industries or businesses as well as preemployment skills training, school-to-work transition programs, and school–business partnerships.

The Carl D. Perkins Vocational Education Act became law in 1984. This replaced the Vocational Education Act of 1963, which had been amended in 1968 and 1976, and extended federal authorization for vocational education programs through 1989. It was notable for strengthening programs for underserved populations, listed as “disadvantaged individuals, handicapped individuals, adults requiring training/retraining, Indians, limited English-proficient students, participants in programs to eliminate sex bias in vocational education, native Hawaiians, single parents/homemakers, criminal offenders, and unemployed or workers threatened by unemployment.” The Perkins Act has been amended continuously by the federal government, but even today continues to be the vehicle for career guidance authorization in the schools.

During this fifth stage, NVGA was in transition as well, and the change of name in 1984 to the NCDA completed a process begun by Donald Super in the

1950s. Super’s developmental theory led to a redefinition of vocational guidance as a more life-span, now termed career, developmental orientation. The acceptance and use of this new concept, career development, by practitioners and theoreticians alike was the necessary precursor to the organizational name change.

### **Sixth Stage: New Directions (1990–Present)**

At the end of the 1980s and beginning of the 1990s, career counseling had found itself being extended in a variety of new directions: upward (outplacement, senior executives, with attorneys), downward (poor people, resume writers for homeless), outward (schools and agencies through federal legislation), and inward (multicultural and other specialties).

The upward extension was into the populations of business executives who had rarely used these services before, but now through economic imperatives (they were losing their jobs and had nowhere else to turn) they found themselves looking for work at times in their lives when they should have been planning for a financially successful retirement from the companies that they had spent their entire lives building.

The downward extension was into the poor and homeless socioeconomic classes who were being required to go to work because of new governmental policies like the Greater Avenues to Independence, the Job Training Partnership Act, Welfare to Work (1997), and Workforce Initiative Act (1998). The Welfare to Work Act (1997) was the harshest of these laws as it set a 5-year limit on any person in the United States receiving economic support through a federally administered economic support program called Temporary Assistance for Needy Families, which replaced the federal program called Aid to Families with Dependent Children. The idea was to get those who have experienced or have characteristics associated with long-term welfare dependence into unsubsidized jobs, to get them in jobs first (called a work first service strategy), and then to train them postemployment. The role of career counseling and development professionals was to assist in this process where they could, a process that varied from state to state and from local agency to local agency.

The outward extension was brought about through renewed interest and support for career development through the policies of the federal government. Not since the 1960s had so many important laws affecting



American citizens' career development been passed. Beginning with President George H. W. Bush and carrying over to President Bill Clinton, there was a resurgence in interest in the lifelong career development of the American populace, as shown in such federal legislation as the School-to-Work Opportunities Act (1994), One-Stop Career Centers Act (1994), and Americans with Disabilities Act (1990), along with the reauthorization of the Carl D. Perkins Vocational and Applied Technology Education Act Amendments of 1998 (formerly titled the Carl D. Perkins Vocational Education Act), the Higher Education Act, and the Elementary and Secondary Education Act.

The role of organized career counseling and development professionals and federal agencies working together through the NCDA, American Vocational Association (AVA; now Association for Career and Technical Education), NOICC and State OICCs, and American School Counselor Association was pivotal to the final legislation authorizing the School-to-Work Opportunities Act. This legislation began a revolution in the process of schooling in the United States by refocusing the nation's educational resources on the very real, difficult, but underattended transition that all students must make from schooling to jobs. Finally, an inward development was that specialties within the field of career counseling began to be developed by career counseling private practitioners. Such specialties included multicultural populations (African Americans, Asian Americans, gays and lesbians, people with disabilities), attorneys, senior executives, and spousal and international relocation to name but a few. Such increasing specialization is the result of the maturing of a profession.

The changing demographics of the American workforce also came to the forefront during this period. Ken Hoyt addressed NCDA in 1988 and reviewed the progress that women and ethnic and racial minorities in the United States have made during the past 20 years. Hoyt, who worked for the U.S. Department of Education and wrote their definition of work, was president of both the American Counseling Association and NCDA. These changing demographics have led to a greater emphasis in career counseling on multicultural counseling skills.

Another aspect of the sixth stage is an increasing technological sophistication that has led to instant communication by telephone, facsimile transmission, and the Internet to anywhere in the world. Personal communication devices such as pagers and cellular-digital

telephones have made it possible to contact people wherever they are. Extensions of these changes for the career counselor was the provision of career services over the Internet and by telephone as well as the opening up of career counseling markets in other countries.

With the dissolution of the former Soviet Union, opening of economic doors in China, and the steady 7% annual economic growth in Southeast Asia, career counselors from the United States have also expanded their practices internationally. This expansion has included substantial energy and economic investment in taking career counseling to other countries. Career counselors from the United States are doing substantial contract work in Singapore, Russia, China, Hong Kong, Malaysia, Australia, Estonia, and Poland, to name but a few. This is only the beginning of this trend as these technological advances drive the worldwide dissemination of information and innovations in the delivery of career counseling services.

*Mark Pope*

**See also** Assessment (v4); Career Counseling (v4); Career Counseling in Organizations (v4); Career Counseling in Schools (v4); Career Counseling Process (v4); *Career Development Quarterly* (v4); Counseling Psychology, History of (v1); Cross-Cultural Training (v3); Personal and Career Counseling (v4); Private Practice Career Counseling (v4)

### Further Readings

- Brewer, J. M. (1942). *History of vocational guidance*. New York: Harper & Brothers.
- Johnston, W. B., & Packer, A. E. (1987). *Workforce 2000: Work and workers for the twenty-first century*. Indianapolis, IN: Hudson Institute.
- National Center on Education and the Economy. (1990). *America's choice: High skills or low wages*. Rochester, NY: Author.
- Norris, W. (1954). Highlights in the history of the National Vocational Guidance Association. *Personnel and Guidance Journal*, 33(4), 205–208.
- Pope, M. (2000). A brief history of career counseling in the United States. *Career Development Quarterly*, 48, 194–211.
- W. T. Grant Foundation Commission on Work, Family, and Citizenship. (Ed.). (1988). *The forgotten half: Pathways to success for America's youth and young families* (Final Report). Washington, DC: Author.



---

## CAREER COUNSELING, IMMIGRANTS

---

For counselors working with immigrants, it is essential to first understand how and why people immigrate to the United States, and what challenges they face once they are here. The Center for Immigration Studies estimates that as of March 2005 there were 32.5 million immigrants in the United States, accounting for about 12% of the population. Furthermore, 7.9 million immigrants arrived here between 2000 and 2005, making this the highest 5-year period for immigration in U.S. history. The majority of current immigration to the United States is from Mexico, though growing numbers of immigrants come from other Latin American countries, as well as from Asia, Canada, and Eastern Europe. The primary reason for immigration to the United States is a perceived opportunity for economic growth beyond what is available in the individual's country of origin. Others come to the United States as refugees as a result of political turmoil or natural disasters in their home countries. In some cases, only one family member will move initially, planning to send money home and to relocate the rest of the family once she or he becomes established.

Processes for immigration vary. Some individuals obtain temporary visas for educational or work purposes and then apply for permanent resident status. For individuals working in high technology fields, employers may assist in this process. Permanent residents hold what are called *green cards*. Others may apply immediately for permanent resident status based on family members in the United States or for humanitarian reasons (refugees, individuals in need of medical treatment, or those seeking political asylum). Since 9/11, this process has become much more difficult, however. Because of substantial backlogs in the processing of immigration paperwork, temporary visas may expire before an application for permanent residency is approved. Then, an individual or family is faced with the difficult choice of giving up an established life or remaining in the country illegally. For families with children who were born here, and thus are U.S. citizens, this decision can be wrenching.

In many cases, the process of legal immigration appears so overwhelming that desperate individuals or families, particularly from very poor countries, attempt to immigrate to the United States without any legal status. This is a dangerous process involving covert border crossings, falsified documents, and exploitation by

individuals who assist in the process but may threaten to expose an immigrant's illegal status if exorbitant demands for payment or services are not met. In the case of female immigrants, these demands may include forced sex. Of those immigrants who arrived between 2000 and 2005, about half either came here illegally or lost their legal status when their visas expired.

### Challenges for Career Counselors

Counselors may encounter immigrants in a variety of settings, including schools, community agencies, and mental health clinics. Immigrant children—including children of illegal or undocumented immigrants—may receive career counseling in a more traditional secondary-school setting. Adults may seek career counselors as part of a job search or as a result of personal counseling that raises career concerns. Counselors who are doing outreach in poorer communities may also work with undocumented immigrants and may be called on to help with the process of obtaining legal status.

As with all career counseling, part of the process is providing information. With immigrants, this is likely to include basic employment concepts in the United States, including taxes and Social Security, pay periods, and benefits. The U.S. Citizenship and Immigration Services Web site ([www.uscis.gov/graphics/index.htm](http://www.uscis.gov/graphics/index.htm)) provides helpful information to guide new immigrants and their counselors through this process. However, there are significant barriers to employment of immigrants. While federal law prohibits discrimination because of immigration status, discrimination nonetheless remains a significant issue. Limited English skills or a strong accent can pose difficulties for obtaining employment, particularly in jobs requiring a great deal of interaction with English-speaking customers, suppliers, or coworkers. Also, interpersonal styles that may be appropriate in the immigrant's country of origin may be considered inappropriate here—and these may be misconstrued as arrogant or aggressive. In such cases, a counselor may be able to assist by role-playing with the client in a mock interview. Even if the above issues are addressed, however, professional credentials from foreign countries are often not recognized in this country. Thus, immigrants who held professional positions in their countries of origin may face significant underemployment, which contributes to increased financial stress as well as to feelings of loss.



In planning a career intervention, approaches to general multicultural counseling are equally important in career counseling. For example, counselors should consider the client's worldview and value orientation, including the degree to which the client's home culture is individualistic or collectivistic. It may be important for those from collectivistic cultures (Asian or Latino/a, for example) to consider the needs and desires of the family rather than solely one's own personal needs and interests in determining a career goal.

Gender issues may be significant in immigrant couples, particularly when the culture in the country of origin was more male dominant. Because of increased opportunities for women in the United States and because women may be more willing to take lower-status positions, the female partner is likely to find employment first. Thus, traditional gender roles may become reversed as the wife provides the primary financial support for the family. If the couple has children, they may also acculturate faster than will their father, increasing strain in the family because of behavior that their father may perceive as disrespectful of his authority. In this case, career counseling for a male immigrant may require also addressing his loss of status, power, and ability to provide for his family—all of which contribute to diminished self-efficacy, family conflict, and potential depression.

The stress of adjusting to a new culture can compound the stresses of unemployment or underemployment, particularly when this culture must be negotiated in an unfamiliar language. Loss of social support networks and extended family contact may contribute to a sense of isolation. Furthermore, traumatic experiences prior to or during immigration can affect clients' overall functioning—which clearly can affect their occupational functioning.

For career counselors working in more traditional high school or college settings, it is likely that counseling will be more related to career choice than immediate employment. Recent research has established the cross-cultural validity of Holland's RIASEC (Realistic, Investigative, Artistic, Social, Enterprising, and Conventional) model of career personality and work environment, and the 1994 and 2004 revisions of the Strong Interest Inventory have also increased its cross-cultural validity. Because children often become quickly acculturated, this work may be closer to traditional career counseling. However, it is important consider the role the family

and their culture may play in these students' educational and career choices.

## Ethical Issues

In doing any type of counseling, the American Counseling Association Code of Ethics mandates that counselors consider the cultural backgrounds of their clients in their assessment, diagnosis, and treatment. Furthermore, counselors and agencies must provide translators if necessary. Note that to avoid conflict in family roles and to demonstrate respect for parents, it is not appropriate for minor children to be used as translators.

Other ethical issues may become more complicated by immigration status, particularly with undocumented immigrants. Particularly after 9/11, immigrants face legal restrictions of the types of employment available to them. While children who were born in the United States are full citizens, those who came as infants with their parents may still lack the necessary documentation and may face legal challenges to higher education and employment following high school. Thus, counselors should assist and advise clients in obtaining necessary credentials as appropriate, but they should avoid encouraging a client to pursue a career path that may not be legally available.

Finally, when counselors become aware of career barriers related to employment discrimination, it may be appropriate to take an advocacy role to assist the client in obtaining legal support. Before doing this, counselors are ethically obliged to consult with their clients to obtain consent to this role.

*Pamela F. Foley, Mary E. Kelly,  
and Enmanuel Mercedes*

*See also* Barriers to Cross-Cultural Counseling (v3); Career Counseling, Asian Americans (v4); Career Counseling, Latinos (v4); Cross-Cultural Training (v3); Diversity Issues in Career Development (v4); International Approaches (v4); Multicultural Career Assessment Models (v4); Multicultural Career Counseling Checklist (v4); Multicultural Counseling (v3); Multicultural Counseling Competence (v3); Social Discrimination (v4)

## Further Readings

American Counseling Association. (2005). *Code of ethics and standards of practice*. Washington, DC: Author.



Retrieved June 30, 2006, from <http://www.counseling.org/Counselors/>

- Camarota, S. A. (2005). Immigrants at mid-decade: A snapshot of America's foreign-born population in 2005. *Backgrounder*. Washington, DC: Center for Immigration Studies. Retrieved June 23, 2006, from <http://www.cis.org/articles/2005/back1405.pdf>
- Cheatham, H. E. (1991). Cultural changes and career changes: The case of Mr. Ebo. *Career Development Quarterly*, 40(1), 31–35.
- Espin, O. M. (1987). Psychological impact of migration on Latinas: Implications for psychotherapeutic practice. *Psychology of Women Quarterly*, 11, 489–503.
- Halstead, R. W. (1991). Career counseling and culture: The case of Ebo. *Career Development Quarterly*, 40(1), 24–30.
- Leong, F. T., & Hartung, P. J. (2000). Adapting to the changing multicultural context of career. In A. Collin & R. A. Young (Eds.), *The future of career* (pp. 212–227). New York: Cambridge University Press.
- Perez-Foster, R. (2001). When immigration is trauma: Guidelines for the individual and family clinician. *American Journal of Orthopsychiatry*, 71, 153–170.

### Web Sites

- U.S. Citizenship and Immigration Services:  
<http://www.uscis.gov/graphics/index.htm>

---

## CAREER COUNSELING, LATINOS

---

Latinos are a diverse group of individuals with ancestry in Spanish-speaking countries in Central and South America as well in the Caribbean. Currently Latinos are the largest ethnic minority group in the United States; government projections estimate that in 2050 almost 25% of the total U.S. population will be Latinos.

Career counseling with Latinos requires counselors to move from traditional frameworks of career counseling, for there are unique issues that arise from Latinos' experiences that may influence career development. When providing career counseling services to Latinos, counselors must embrace a broader perspective that takes into account personal and social contexts.

Knowledge is a key component to culturally competent practice, and understanding issues that are central to Latinos' career development process can

facilitate effective career counseling. Historical (discriminatory policies), sociological (immigration factors, networks, socioeconomic status), sociocultural (acculturation, ethnic identity), and psychological (self-efficacy) factors may interact to influence the differential social, educational, and occupational experiences of Latinos. Competent career counselors should be informed about the roles these factors play in shaping the career opportunities and decisions of Latinos, while incorporating this information with appropriate theoretical frameworks to develop a plan for effective career counseling.

### Latino Issues in Career Development

Many factors are important to the career development of Latinos; this entry highlights a few salient factors that may either influence or impede Latinos' career development, focusing particularly on the role of culture.

### Career-Related Self-Beliefs

Among the self-beliefs that are important to evaluate in career counseling with Latinos are aspirations, expectations, and self-efficacy or confidence in their abilities. Research indicates that Latinos have high career aspirations, but are less likely to believe that they will achieve these goals. Some have conjectured that the discrepancy between aspirations and expectations may be attributed to the presence of real or perceived career barriers. In addition, a limited exposure to a wide range of activities may restrict their development of career-related self-efficacy beliefs, likely to influence interests and goals in particular career fields. A lack of confidence in abilities can hinder career achievements, for some may aspire to specific career fields but not pursue them due to low self-efficacy beliefs for related activities. Conversely, some Latinos may not even consider certain careers (particularly high-status, high-paying careers in which other Latinos may be underrepresented) simply because they have had limited exposure to learning activities that can give rise to their self-efficacy beliefs in specific career activities.

Career counselors have the opportunity to intervene with Latinos to optimize their career potential. Professionals should assess Latinos' aspirations and goals, as well as explore career expectations to ensure that lowered expectations for success are not inhibiting potential. It is also important to provide access to



information about the world of work, to increase clients' self-awareness of interests, values, and skills, and to help clients identify opportunities for increasing their confidence in their abilities to succeed in the world of work.

### **Family**

Family is a core value for Latinos and thus influences every aspect of their life, including careers. For Latinos, being part of the family unit may be far more important than individual needs (i.e., seeking careers that match personal interests); thus their career decisions may take into consideration how their choices may affect their family. Latinos may also make major life decisions, such as career choices, in consultation with family members and may sacrifice personal needs for the family's welfare. It is important not to judge this Latino cultural value as negative or deviant, but to simply be aware and recognize the role of the family in career decisions. Furthermore, the support of the family for career endeavors and decisions is invaluable and provides encouragement in the face of adversity. Numerous recommendations emphasize the need to incorporate the family, including supporting Latino clients' discussions about careers and career-related decisions and possibly inviting family to counseling sessions.

### **Mentors**

Mentors can be a facilitative factor for Latinos' career development by helping Latinos confront and navigate career-related barriers and by countering negative career-related messages that Latinos receive. Mentors may also be able to provide support and access to information, resources, and networks. Mentors may be able to aid in exploring career options, aid in making progress in career decision making, and affirm career self-efficacy beliefs. Mentors or role models of the same cultural background may be especially important in implicitly conveying the message that, like them, they too can succeed.

### **Environment**

Environment-related factors that influence the career development and opportunities of Latinos include social class and experiences of discrimination and prejudice. In particular, social class influences

career development in myriad ways—from the exposure to career options to the quality of education one receives. Whereas Latinos with more financial privileges are likely to have more flexibility and access to pursue career options, Latinos are highly concentrated in the working class and may not have the financial resources to pursue a wide range of options. In addition, discrimination and prejudice are real factors that influence Latinos' career development, acting as barriers related to race-ethnicity that eliminate the career possibilities.

### **Culture**

The importance of culture cannot be ignored in career counseling Latinos. Culture influences how individuals view themselves and the world around them and also influences how career is constructed and given meaning. Specifically, the influence of self-beliefs, family, mentors, and the environmental context is greatly shaped by acculturation, generation status, cultural values, and racial/ethnic identity. Thus, the individual and additive effects of these variables may vary from one Latino to another; that is, not all Latinos are affected by the same forces or have the same experiences.

## **Career Counseling Theories and Models for Latinos**

In comparison to the past, more research is being conducted on career counseling with diverse populations, but relatively few studies have been conducted with Latino samples. As a result, limited empirical information is available to use for creating new theories to describe Latinos' career development and to develop frameworks for effective career counseling. Consequently, few career theories and models have been developed specifically for Latinos; career counselors often utilize and adapt theories that have been developed to explain the career development of women, persons of color, or individuals in general. When utilizing these theories that were originally designed for the general population and that do not include sociohistorical-contextual considerations or those that have been primarily validated on non-Latino samples, it is important to take into account culturally relevant variables and to understand how culture influences other person-level career factors in conceptualizing and strategizing a plan for career counseling with Latinos.



### ***Latino-Specific Theories***

Rivera and colleagues created a developmental career model for Mexican American women. Central components to this model are values (e.g., family harmony), social issues (e.g., discrimination), and culture (e.g., family) as they relate to the career choice process. Implications for career counseling practice includes structuring interview questions according to the three foundational components to better understand the internal cognitions that may direct Latino clients' decisions. Gomez and colleagues developed another Latino-specific model that depicts the career path as a nonlinear process that is influenced by a series of four interactive concentric life spheres consisting of the self; culture, family, and personal background; context; and sociopolitical conditions. Each sphere consists of various dimensions that help to shape the individual's career development. Thus, a Latina's career development is conceptualized as an interaction of the person's identity, values and life goals, her cultural and gender role socialization, family's aspirations for her, the opportunities, barriers, and resources within her immediate environment, and the historical context in which her life is taking shape.

### ***Multicultural Theories***

Gloria and Rodriguez developed the psychosociocultural model that focuses on individual, environmental-social, and cultural factors simultaneously in counseling Latinos. Specifically, they argue that it is the contextual interaction between these factors that provides more accurate perspectives of Latinos. Using this framework in career counseling would provide culturally relevant career information to Latinos in the world of work. Furthermore, Blustein's psychology of working provides a framework for career counseling with Latinos. In this framework, work perspectives and experiences may vary depending on the individual, while dimensions of race-ethnicity and social class are also included. Implications for career counseling include discussing perceptions and meaning of work, barriers to work, and discrimination at work with Latino clients.

### ***General Theories***

Major theories have been tested, and in some cases altered, for use with Latinos. For example, social cognitive career theory, typology theories, and developmental

theories have demonstrated support for use with Latinos ranging in age from adolescents to adults. Research continues to be conducted to expand and refine the use of these theories and other career models for use with Latinos.

### **Career Assessment With Latinos**

Important contributions to career assessment with Latinos have identified psychometric concerns that career counselors should be aware of when utilizing traditional career assessment instruments, such as language equivalence, conceptual equivalence, and normative reference data.

### **Counseling Considerations**

The multicultural guidelines offer guidance for providing culturally competent career counseling practice. In terms of working with Latinos, career counselors need to recognize personal attitudes and beliefs that may negatively influence their assessment of and work with Latinos. If left unexamined or unchallenged, even well-intentioned attitudes can impede the career counseling process. In addition, career counselors need to understand the Latino client within the cultural context in which her or his life has taken shape. In particular, career counselors must be aware of and sensitive to a family's history of living in the United States and past and current experiences in educational and work systems. Finally, career counselors must utilize intervention strategies that are culturally appropriate and sensitive. Utilizing theories, models, and tools that are sensitive or adaptable for understanding Latinos' career development is important. In summary, assessing personal attitudes, understanding the life experiences of their Latino clients and the factors that combine to shape their career paths, and implementing culturally sensitive intervention practices will ensure the effective delivery of career counseling services with Latinos.

*Lisa Y. Flores, Rocio Rosales,  
and Shiloh E. Jordan*

*See also* Acculturation (v3); Career Counseling (v4); Career Counseling, Immigrants (v4); Career Counseling Process (v4); Cross-Cultural Training (v3); Cultural Values (v3); Culture (v3); Diversity Issues in Career Development (v4); Ethnicity (v3); Familismo (v3); Latinos (v3);



Multicultural Career Assessment Models (v4);  
 Multicultural Career Counseling Checklist (v4);  
 Multicultural Counseling (v3); Multicultural Counseling  
 Competence (v3); Worldview (v3)

### Further Readings

- Arbona, C. (1990). Career counseling research and Latinos: A review of the literature. *The Counseling Psychologist, 18*, 300–323.
- Arbona, C. (1996). Career theory and practice in a multicultural context. In M. L. Savickas & W. B. Walsh (Eds.), *Handbook of career counseling theory and practice* (pp. 45–54). Palo Alto, CA: Davies-Black.
- Flores, L. Y., Byars, A., & Torres, D. M. (2002). Expanding career options and optimizing abilities: The case of Laura. *Career Development Quarterly, 50*, 311–316.
- Flores, L. Y., Navarro, R. L., & Ojeda, L. (2006). Career counseling with Latinas. In W. B. Walsh & M. J. Heppner (Eds.), *Handbook of career counseling for women* (2nd ed., pp. 271–313). Mahwah, NJ: Lawrence Erlbaum.
- Fouad, N. A. (1994). Career assessment with Latinos/Hispanics. *Journal of Career Assessment, 2*, 226–239.
- Fouad, N. A. (1995). Career behavior of Hispanics: Assessment and career intervention. In F. T. L. Leong (Ed.), *Career development and vocational behavior of racial and ethnic minorities* (pp. 165–192). Hillsdale, NJ: Lawrence Erlbaum.
- Gloria, A. M., & Rodriguez, E. R. (2000). Counseling Latino university students: Psychosociocultural issues for consideration. *Journal of Counseling and Development, 78*, 145–154.
- Gomez, M. J., Fassinger, R. E., Prosser, J., Cooke, K., Mejia, B., & Luna, J. (2001). Voces abriendo caminos (Voices forging paths): A qualitative study of the career development of notable Latinas. *Journal of Counseling Psychology, 48*, 286–300.
- Leong, F. T. (1995). *Career development and vocational behavior of racial and ethnic minorities*. Hillsdale, NJ: Lawrence Erlbaum.
- McWhirter, E. H. (1997). Perceived barriers to education and career: Ethnic and gender differences. *Journal of Vocational Behavior, 50*, 124–140.

---

## CAREER COUNSELING, NATIVE AMERICANS

---

The need for effective career counseling and related research among Native Americans is striking. Census data show that Native Americans have the highest

unemployment rates of any minority group with the exception of African American males. Unemployment approaches 50%, and the number of children living below the poverty level exceeds 50% on many reservations. Likewise, American Indians have the lowest rates of persistence in postsecondary education. Despite evidence of academic ability, postsecondary dropout rates are higher for American Indians than for any other minority. American Indians are also underrepresented in graduate programs. Other researchers have found that American Indian students have a lower rate of academic achievement than students in other minority groups. Despite these obvious challenges, relatively little research has focused on Native Americans' career development.

Scholarly writing on career-related issues among Native Americans can be roughly divided into two historic foci. Early research focused primarily on understanding Native Americans' career development vis-à-vis existing theories and used instruments that assumed universal constructs. These efforts could be labeled *modern perspectives on Native Americans' career development*. More recently, career research and practice have used more contextual and culture-driven perspectives. These efforts can be grouped as *postmodern perspectives on Native Americans' career development*. Both of these paradigms have generated findings that have important implications for career counseling with Native Americans.

### Modern Perspectives on Native Americans' Career Development

Early researchers (pre-1990) focused on similarities and differences between the mainstream population's and Native Americans' career development. Some researchers worked to demonstrate the universality of career development constructs by showing similarity between assessment results from mainstream populations and Native American populations. A common assumption in these studies was that the construct being researched (e.g., occupational values, career maturity) and the assessment used to assess the construct (e.g., Kuder, E., Self-Directed Search, Career Maturity Inventory) were valid and appropriate for the Native American participants. Such assumptions were characteristic of the positivistic perspective taken by many researchers and practitioners over much of the last century. Interestingly, the discussion of these studies often included questions about the viability of the constructs and instruments of the dominant culture.



Some researchers took traditional career assessment instruments and proposed the possibility that diverging worldviews of minority groups, including Native Americans, could challenge the validity of their use. Such questions gave rise to the postmodern perspectives that became more common in both research and practice around the turn of the century.

### **Example**

Dennis West conducted a study that related the career maturity of Native American college students to their academic performance. West also compared these correlations to those of non-Native American students on the same variables. The study found that Native American students scored lower on assessments of career maturity and that career maturity ratings were related to academic performance for all students. However, West was confused by the fact that Native American students' career maturity ratings did not seem to increase with age and academic standing as they did with non-Native Americans. He concluded that constructs such as career maturity, at least as they were defined by current research and assessment instruments, may not be appropriate for Native American populations.

## **Postmodern Perspectives on Native Americans' Career Development**

The past 2 decades have seen a marked shift in assumptions about career development among many researchers and practitioners. Frustrated with the positivistic and universalistic assumptions of the modernist paradigm, many have turned to more postmodern perspectives. These alternative perspectives have focused more on the culture, context, and constructions relevant to Native Americans' career development. Rather than take constructs from the existing understanding of career development in the dominant culture and apply them to Native American cultures, these postmodern efforts have worked to understand Native Americans' career experiences from a culturally situated perspective.

### **Examples**

Cindy Juntunen and colleagues conducted a study of American Indian women's perspectives of their career journeys. Responding to questions about the relevance of career constructs based in the dominant

culture, this qualitative study explored the idea of career from the perspective of the participants. The study found that participants had culturally situated definitions of career and that various supportive factors and obstacles impact Native Americans' ability to live in two worlds—the dominant White culture and Native American culture. Biculturality was seen as an inevitable part of a career development, as most workplaces are based in European American values and culture. The use of a qualitative method that reflected the researchers' postmodern leanings led to culturally relevant, context-bound findings. This research also led to recommendations for models and programs of career development that are similarly culturally relevant.

Rod M. McCormick and Norman E. Amundson made a progressive attempt to develop a culturally relevant model of career development for First Nations People (aboriginal peoples in Canada). Their model reflects a postmodern perspective in its attempt to account for cultural values common among First Nations People as well as career development factors common across many cultures.

The growing body of postmodern perspectives on Native Americans' career development includes some culture-specific implications for career counseling and career education. These implications, in addition to some of the implications of modernist perspectives, are outlined below.

## **Implications**

Although many have questioned the validity of mainstream career assessments for Native Americans, evidence suggests that traditional ways of conceptualizing and measuring interests (e.g., Holland's RIASEC—Realistic, Investigative, Artistic, Social, Enterprising, and Conventional—model) are viable with Native American groups. This research suggests that while Native American groups may have idiosyncratic response patterns related to cultural identity, rural locations, or tribal affiliation—the general construct of interests with varying degrees of interrelatedness among them, seems to have utility with Native Americans. This, in turn, suggests that counselors might use Holland code-based assessments with some degree of confidence in both their validity and utility.

Another general implication, supported by both modern and postmodern research, is the importance of considering social connections in career counseling. Native Americans often include tribe, community, or



family in the process of career decision making and career development. This collectivist perspective may also color one's values. For example, a Native American client from a reservation may put a high value on homeland—both the importance of living in a certain physical place and the importance of contributing to one's home community through one's work. Some suggest that career counselors include parents, family members, or tribal leaders in the career counseling process.

Like many people of color, Native Americans often experience the challenge of becoming bicultural as part of their career development. This challenge involves maintaining a commitment and investment in one's traditional culture and at the same time becoming fluent in the dominant culture in order to enhance one's career development. Regardless of one's linguistic background, the process of becoming bicultural can be likened to the cognitive and emotional difficulty involved in learning a new language.

### An Important Caveat

While it is important for counselors to consider how cultural factors might affect Native Americans' career development, it is also important to avoid thinking of Native Americans as a homogenous group. There are more than 500 different tribes in the United States, with more than 250 languages. Canada has 50 First Nations along with other aboriginal groups. Obviously, there is considerable diversity within the broader Native American culture. Career counselors, while considering general aspects of Native American culture, should also attend to specific cultural identity factors such as tribe, community, and language.

Despite these inherent challenges, the recent pluralization of research methods and the breadth of implications they can provide seem to provide a foundation for increasingly more productive research and effective career intervention with Native Americans.

*Aaron P. Jackson, Christopher E. Peck,  
and Jeffrey L. Elder*

*See also* Alaska Natives (v3); American Indians (v3); Career Counseling (v4); Career Counseling in Schools (v4); Career Counseling Process (v4); Career Maturity (v4); Holland's Theory of Vocational Personalities and Work Environments (v4); Multicultural Career Assessment Models (v4); Multicultural Career Counseling Checklist (v4); Multicultural Counseling (v3); Spirituality and Career Development (v4)

### Further Readings

- Herring, R. D. (1990). Attacking career myths among American Indian college students. *School Counselor*, 38, 13–18.
- Hoffman, L. L., Jackson, A. P., & Smith, S. A. (2005). Career barriers among Native American students living on reservations. *Journal of Career Development*, 32(1), 31–45.
- Jackson, A. P., Smith, S. A., & Hill, C. L. (2003). Academic persistence among Native American college students. *Journal of College Student Development*, 44(4), 548–565.
- Juntunen, C. L., Barraclough, D. J., Broneck, C. L., Seibel, G. A., Winrow, S. A., & Morin, P. M. (2001). American Indian perspectives on the career journey. *Journal of Counseling Psychology*, 48(3), 274–285.
- Martin, W. E., Jr. (1991). Career development and American Indians living on reservations: Cross-cultural factors to consider. *Career Development Quarterly*, 39, 273–283.
- McCormick, R. M., & Amundson, N. E. (1997). A career-life planning model for First Nations People. *Journal of Employment Counseling*, 34(4), 171–179.
- Turner, S. L., Trotter, M. J., Lapan, R. T., Czajka, K. A., Yang, P., & Brissett, A. E. (2006). Vocational skills and outcomes among Native American adolescents: A test of the integrative contextual model of career development. *Career Development Quarterly*, 54, 216–226.
- West, D. K. (1988). Comparisons of career maturity and its relationship with academic performance. *Journal of American Indian Education*, 27(3), 1–7.

---

## CAREER COUNSELING IN COLLEGES AND UNIVERSITIES

---

The process of acquiring knowledge is the essence of higher education. Career decision making is a tangible expression of this process, and since almost half of all college students change majors and even more change career goals while in college, career services for higher education students are crucial to the mission of the institution.

### Characteristics of Higher Education Students as Related to Career Decision Making

Developmental theory is the foundation on which career services at colleges and universities are based. Developmental theorists describe students' cognitive maturation as progressing from dualism, where



students view career choice as an irreversible, once in their lifetime decision, to relativism, where students realize that choices are complex and have multiple aspects. Similarly, students' growth can be conceptualized as moving from low commitment to and exploration of options, to having a successfully resolved and integrated ego identity. Career theorists link in to these psychological models by characterizing career development as people progressing through a series of life stages with attending coping behaviors and tasks. Most college and university students find themselves in the exploration stage, a time in which they sort out career choices. Others describe a process of differentiation, where people through life experiences become increasingly aware of their unique types of interests, skills, and values.

In addition to students' broad-spectrum developmental issues described above, university students may have specific concerns related to disability, gender, age, or cultural differences. Through society's prejudicial attitudes and because of their limited life experiences, students with disabilities may make inadequate career choices because they may lack occupational information and/or have an incompletely defined self-concept. Women's career development, research shows, involves attention to personal issues including low self-esteem and self-efficacy, low expectancies for success, math avoidance, and family-career conflict. In addition, gender bias in education and occupations and a lack of role models play a role. People of color may not have the endless opportunities implied by the term *career choice*. Overt and covert racism and a negative self-image may limit their number and kind of career decision-making choices. Finally, adults returning to college to seek retraining or more advanced training may experience stress related to transitions and unmet expectations.

### Types of Services Offered

Career services at colleges and universities tap into students' differential levels of maturation and special needs by providing career decision-making support ranging from individual and group counseling for self-exploration and exploration of the world of work to resume writing and learning job interviewing skills. The services are guided by theory and typically consist of three focal points: knowledge of self, knowledge of the world of work, and ways to match these personal traits with job characteristics. For those in the early stages of development or for those who have

special needs, the model's first focal point may be of most relevance.

To learn more about oneself, individual career counseling is available, an option that may help students examine how the environment and their reactions to its expectations have created their belief systems and notions about career decision making. This kind of career counseling, which most typically happens at university counseling centers, encourages students to examine the role work plays in their life, to problem solve, and to develop a clear picture of their values, skills, interests, and goals. Furthermore, students' interests, values, and skills can be explored using formal and informal assessment devices such as interest inventories, values checklists, card sorts, and computerized career guidance systems. Individual counseling as well as interpretation of assessment profiles likely shape students' academic pursuits, which in turn help students further test and refine their career decision making.

Many of these activities can take place not only during individual counseling, but also as part of group counseling, projects in classes, seminars, workshops, or career clubs provided by the campus counseling center or career center. Class or group assignments address personal interests, skills, and values as well as the content of academic majors and careers. Counselors help integrate the results of such exploration into students' future life-work relationships by problem-solving and decision-making practices.

For those who need less direction, counseling and career centers provide self-directed career planning activities, including computer-guided self-assessments. Through their sophisticated interactive nature, these programs help individuals assess abilities, interests, and values and match these with occupational and educational information.

For those who have decided or tentatively decided on a major, the second element of the paradigm, knowledge of the world of work, becomes the center of attention in career counseling, students are given the opportunity to participate in career events or discipline-related panels and fairs organized by campus career centers, where they can connect with alumni or employers to get information on particular jobs. They engage in informational interviewing to learn about work in a particular field and to start networking. They utilize library and Internet resources for information and may participate in internship and externship programs where they observe and work with professionals. Such activities help students gain



experience, build career-related skills, build mentoring and networking relationships, and further test their commitment to a career choice. Especially students with unique needs because of limited work experience or exposure to the world of work benefit from intern- and externships since they are key to testing and perhaps revising assumptions and self-image. Through these activities, knowledge of self becomes interwoven with the world of work, which represents the third focal point of the aforementioned paradigm.

Finally, career services most typically utilized by students who are ready to graduate involve using resource rooms in the career center, which provide information on careers and job options. Students can explore alumni and parents' career databases as well as job listings in different fields. Web links provide information on job market conditions, future trends, and earning potential in different types of work. Graduating seniors receive help with job search strategies including researching potential employers, writing a resume and cover letter and then learning how to publish them online, and learning how to interview for a job and how to apply for a job online.

### Professionals Providing Career Services

Career services are provided in different offices by a range of professionals on campus. Career decision-making concerns representing identity development or cognitive and environmental obstacles require a broad based kind of counseling often provided by counselors who work in campus counseling centers. These counselors are trained to address immediate and life-threatening crises, but also difficulties with disabilities, relationships, depression, substance abuse, and identity processes, some or all of which could be related to career decision making.

Campus career centers typically provide job placement services, consisting of appraising and dispensing credentials and organizing job fairs, panels, and interviews, but they also offer self-assessment, diagnostic tests and aids, programs and resources on choice of major and career, and counseling in career exploration and decision making.

Cooperative education and internship programs include myriad experiences consisting of out-of-class, during-the-school-year, summer work, for-credit, not-for-credit, salaried, and volunteer activities. They may be housed in academic departments, in career centers or placement offices, or in a specifically designated office.

Advice on the selection of appropriate course work, helping students recognize the complexity of professional schools' admission processes, writing letters of recommendation, and helping students gain information on admission into professional schools is offered by administrators, faculty advisors, and mentors in academic departments such as prelaw, dentistry, or medicine.

Minority student services offices were created to recruit those that historically had been unable to attend college, and they provide services to help people of color in the areas of residential, academic, financial, and personal concerns. As it became clear that career horizons of women and people of color needed to be expanded, career advising and programming have been added to minority service functions.

Finally, academic departments and colleges, alumni offices, the office of financial aid, student employment, adult and women's resource centers, and campus libraries are involved in career services.

Career services at colleges and universities are important to traditional and nontraditional students; to their parents, faculty members, and administrators; and to the campus as a whole since they help directly and indirectly advance higher education's mission of teaching, research, and public service.

Margaretha S. Lucas

**See also** Career Counseling (v4); Career Counseling in Schools (v4); Career Counseling Process (v4); Career Education (v4); Career Exploration (v4); Career Planning (v4); Career Services Model (v4); College Student Experiences Questionnaire (v4); Decision Making (v4); Multicultural Career Counseling Checklist (v4); School Counseling (v1); University Counseling Centers (v1)

### Further Readings

- Holland, J. L. (1997). *Making vocational choices: A theory of vocational personalities and work environments* (3rd ed.). Odessa, FL: Psychological Assessment Resources.
- Krumboltz, J. D. (1996). A learning theory of career counseling. In M. L. Savickas & W. B. Walsh (Eds.), *Handbook of career counseling theory and practice* (pp. 55–80). Palo Alto, CA: Consulting Psychologist Press.
- Super, D. E. (1990). A life-span, life-space approach to career development. In D. Brown, L. Brooks, & Associates (Eds.), *Career choice and development: Applying contemporary theories to practice* (2nd ed., pp. 197–261). San Francisco: Jossey-Bass.



---

## CAREER COUNSELING IN ORGANIZATIONS

---

Career counseling in today's work organizations reflects career development's dynamic history in North American business and industry during the 20th century. A 21st-century perspective on this counseling specialty encompasses the practitioners, the places, and the procedures of career counseling in organizations.

### 20th-Century Foundation

#### *Industrial Era*

The dawn of 20th-century North America witnessed a continued decline in the agricultural-based economy as the Industrial Revolution advanced. The burgeoning economy, with its need for selection and assignment of personnel to an ever-expanding array of jobs, promulgated the first vocational programs. With the influx of immigrants and veterans into the labor force following World War I and World War II, corporate giants such as Ford Motor Company, R. H. Macy and Company, and Western Electric's Hawthorne Plant initiated industrial-based programs with a mental health emphasis. Psychiatrists, personnel or industrial psychologists, as well as social workers commonly staffed the vocational programs of this era.

#### *Information-Service Era*

Toward the middle of the 20th century, the industrial era peaked as an information-based and then a service-based economy emerged by the final quarter-century. Unprecedented geopolitical, socioeconomic, and biotechnical advances culminated in the restructuring of the North American corporate landscape (e.g., divestitures, mergers-acquisitions, downsizing, and outsourcing jobs offshore).

The postindustrial economy brought with it an increased focus on workers' mental health. Corresponding to growth in individual psychology, there was added appreciation for the role of individual career choice in contrast to employer selection of individuals. Consequently, to the litany of career service providers, were added occupational psychiatrists, vocational-career psychologists, and employment-career counselors.

### *Organizational Settings*

The career specialties were not the exclusive domain of business and industry. A number of governmental entities shared the mission of counseling for career development, or *career management*—the preferred term of reference outside of the educational arena. These included military bases, with an emphasis on the translation of military to civilian occupations, as well as rehabilitation settings, which focused on the employment needs of persons with physical and/or mental disabilities. Correctional facilities and the U.S. Employment Service carried the charge of facilitation of skill acquisition, as well as securing continuous employment.

Beyond corporate and governmental agencies, there were civic or public settings where career counseling occurred. Prevalent among these were mental health and/or substance abuse centers. These settings targeted mediation of the effects of psychological and substance abuse issues on employability.

### Contemporary Perspective

#### *Professional Identity*

Providers of career counseling in organizations are divisible into two general categories: professional counselors and nonprofessional counselors. Professional counselors, those possessing counseling and/or counseling-related graduate degrees, licenses, and certifications, most often have as their primary professional identity, counselor or psychologist. As such, their main professional affiliations are the American Counseling Association (ACA) and the American Psychological Association (APA). Career, as a professional specialty, may be indicated by membership in ACA and APA divisions promoting careerism:

National Career Development Association and National Employment Counseling Association, both divisions within the ACA, and the Society for Vocational Psychologists, Division 17 (Counseling Psychology) of the APA

Career practitioners who deliver counseling and/or counseling-related activities but who are not professional counselors/psychologists may carry the following titles: career development facilitator, career adviser-specialist, career management consultant (outplacement), employment-workforce development specialist, job-search trainer, job developer, and career



coach. Those paraprofessional counselors frequently hold membership in the following professional affiliations: Association of Career Professionals International, Society of Human Resources Managers, American Society of Trainers and Developers, Career Planning and Adult Development Network.

## Role and Function

### *Organizational Perspective*

Career practitioners provide counseling services via internal and external relationships with organizations. Career professionals who are employees are often a part of the human resource function. Practitioners external to organizations, by contrast, provide services on a contingency or contractual basis. Both internal and external career professionals perform a variety of roles: from the organizational to the individual level. At the system or organizational level, career professionals target the organizational structure by programmatic design, implementation, and staffing and evaluation of career services.

In general, the role and function of career practitioners varies by the organization's location on the business life cycle. For example, an employing organization at the start-up phase requires a wide range of highly skilled workers, those who will immediately drive production and create a market presence. Then, as the organization moves to the establishment phase, there is a corresponding need for consistency of production or service delivery, to demonstrate the organization's earned place among its competitors.

As the organization reaches the advancement phase of the business life cycle, the need shifts toward more innovation and distinctive products or services—that which differentiates the organization from its competitors and defines its market niche. As each phase requires unique general characteristics from its workers, so change the role and function of the career practitioner in helping identify and develop the workforce.

## Career Counseling Interventions

The counseling methods used to effect career enrichment, advancement, and transition vary across the historical eras. During the industrial era's vocational guidance movement, intervention strategies-of-choice were individual interviewing, history taking, and test

administration and interpretation. These methodologies were particularly driven by an explosion in psychometric testing and individual counseling techniques advanced by the then leading theories of counseling (e.g., behavioral, developmental, and existential).

The information-service era added computer-assisted career guidance systems as a convenient intervention for the administration of assessment tools and the delivery of occupational, educational, and company information. A second strategy of this era was the accelerated use of group guidance (e.g., information, general direction) and counseling (e.g., self-knowledge and self-change) as cost-effective interventions for the greatest number of workers in an organization. In addition, this period saw assessment centers and corporate universities, with their emphasis on self-assessment, self-guided learning, and skill training, reach a zenith.

## Future Prospects

Historically, the ebb and flow of societal change directly influenced the nature of work in organizations. Consequently, as the workplace evolves, there is a need for ongoing application of emerging counseling strategies and techniques to the confluence of organizational and individual needs. The contemporary workplace suggests the following as the individual and organizational issues for career counseling's future:

- the influence of work-life issues on career decision making and adjustment;
- the public health movement will embrace career fitness (e.g., career adaptability, career resilience);
- the positive and negative impact of corporations without walls on workers' well-being;
- redefinition of career—individual adopts multiple work roles/styles (e.g., free agent, contingency worker, employee, and entrepreneur) across the life span;
- the application of cybercounseling techniques to the stages of career development (i.e., entry and establishment, maintenance, and advancement and the transition and disengagement);
- movement beyond focus on recruitment and retention to psychological engagement as the litmus test of stellar performers;



- transformation of organizational cultures to one that is values-driven and developmental (e.g., emotionally, spiritually, and culturally); and
- increased demand for retirement counseling that integrated the role of leisurite with meaningful work during late-adulthood (age 65 and older).

Whatever the structure of work organizations in the future, whether physical or virtual, career counseling is positioned as an intervention-of-choice for individuals and groups of individuals confronted by the challenge for effective entrance into, adjustment within, and separation from work organizations.

*Michael E. Hall*

*See also* Adult Development (v1); Adults in Transition (v4); Career Advancement (v4); Career Counseling (v4); Career Counseling, History of (v4); Career Exploration (v4); Career Resource Centers (v4); Retirement (v4); Theory of Work Adjustment (v4); Work–Family Balance (v4); Work Values (v4)

### Further Readings

- Figler, H., & Bolles, R. N. (1999). *The career counselor's handbook*. Berkeley, CA: Ten Speed Press.
- Gerstein, L., & Shullman, S. (1992). Counseling psychology and the workplace: The emergence of organizational counseling psychology. In S. Brown & R. Lent (Eds.), *Handbook of counseling psychology* (2nd ed., pp. 581–625). New York: Wiley.
- Greenhaus, J. H., Callanan, G. A., & Godshalk, V. M. (2000). *Career management* (3rd ed.). Fort Worth, TX: Dryden Press.
- Grutter, J., & Lund, S. L. (2000). *Making it in today's organization using the Strong and the MBTI*. Palo Alto, CA: Consulting Psychologists Press.
- Hall, D. T. (2002). *Careers in and out of organizations*. Thousand Oaks, CA: Sage.
- Knowdell, R. L. (1996). *Building a career development program: Nine steps for effective implementation*. Palo Alto, CA: Davies-Black.
- Liptak, J. T. (2001). *Treatment planning in career counseling*. Belmont, CA: Wadsworth.
- Niles, S. G., & Bowlsbey, J. H. (2005). Career development interventions in community settings. In *Career development interventions in the 21st century* (2nd ed., pp. 376–389). Upper Saddle River, NJ: Prentice Hall.
- Sandhu, D. S. (Ed.). (2002). *Counseling employees: A multifaceted approach*. Alexandria, VA: American Counseling Association.

## CAREER COUNSELING IN SCHOOLS

Career counseling in schools exists at the intersection of the career education program and the provision of personal counseling. It potentially draws from and contributes to both individual pupils' career development and individual counseling. Career counseling has been a core activity of the school counseling movement from the time of Frank Parsons, and although its nature has changed in response to theoretical and societal developments, it remains a central part of the work of the counselor. This aspect of the counselor's work enables contributions to be made to young people's future planning and may provide evidence of a more visible role that school counselors can play.

### Defining Characteristics

Career counseling in schools needs to be differentiated from the broader category of school-based career interventions due to its more personalized nature characterized by career-focused face-to-face interaction and focused on occupational selection and decision making in relation to the individual's view of self in relation to life and future work roles. In contrast to other forms of counseling, the use of some form of assessment may contribute to the discussion and planning process. While career education promotes career development through its focus on knowledge and skills, career counseling enables the individual to refine the process through consultation and discussion. In the literature, there has been an extensive debate about interaction between personal counseling and career counseling with many authors acknowledging not only their complementarity, but also the distinctive sets of specialized skills needed by counselors in both aspects of the work.

### Impact of Developmental Stages

Career education begins (whether explicitly a part of the curriculum or not) in elementary school, but career counseling is more likely at particular phases of secondary school. Career choices are among the most important decisions any young person has to make. Young people today have greater awareness of the world of work as they experience the impact of parents'



occupations, with more mothers working, and may see friends and older siblings struggling to find employment or experiencing work as stressful. They also develop ideas about the working world through television viewing. In adolescence, the learner is developing a sense of personal identity and refining ideas about the self.

Career counselors are likely to see youth at various stages of the career development process with varying levels of readiness for planning and decision making being evident through the course of adolescence, and differences across a cohort will be evident at key decision points. Some studies have shown that as young people approach school-leaving, it may be the parents rather than the individual who show more concern or express anxieties about the future.

In adolescence, individuals are located within the exploration stage (as first identified by Donald Super), and young people will have developed different levels of competencies in the different tasks required to progress in this stage (self- and occupational awareness, crystallization, and specification). James Marcia expanded on Erik Erikson's work related to adolescent identity development and identified four identity statuses: foreclosure (where the young person tends to conform to expectations), diffusion (where the young person has not yet committed to a direction), moratorium (where active exploration of alternatives is occurring), and achievement (good progress has been made toward a sense of identity). It is very important for career counselors to be sensitive to these variables because they have a substantial impact on the young person's readiness for engagement in the process and because different individuals will have different needs at any point. Some measures of career maturity or readiness for career decision making have been developed; for example, the Career Decision Scale (developed by Super and his colleagues) and the Career Maturity Inventory (see Crites, John O.).

Through the provision of career education, young people should be exploring four aspects of the career choice process:

- self-awareness of capacities, interests, and skills and social–personal development;
- knowledge of the diversity of careers and developing the skills of accessing information of relevance;
- building awareness of the opportunities open to them; and
- decision-making skills.

The role of career counseling is to personalize this process for the individual, especially at key decision-making points, such as when selecting subjects and courses of study and especially as the person approaches school-leaving and the related transition period.

## Information and Its Application

Since the time of Parsons, the occupational world has grown tremendously both in size and complexity. This growth has made the skills of accessing and understanding career information an essential aspect of career counseling. The complexity of accessing up-to-date career information is challenging because there is only one constant—that of ongoing change. It is therefore necessary for providers of career information to use systems that are capable of being expanded and are sufficiently flexible to provide adequate assistance to support the counseling process.

## Contextual Considerations

The rapidly changing world of work at the beginning of the 21st century poses great challenges for school-based career counselors. Accelerating technological change, the influence of globalization, and the impact of economic events have resulted in people needing to adapt to changes in the world of work in unprecedented ways. Careers are evolving, moving away from job stability and security in the hierarchies of government and big corporations of the industrial era toward the following:

- labor-intensive, low-tech, and competitive informal groupings where people are expected to multitask and where there is little security;
- flatter hierarchies, teamwork, and contract work characterized by job mobility;
- entrepreneurial careers not dependent on structures, but dependent on individual skills, adaptability, and the willingness to take risks; and
- the use of agencies to provide services and the employment of part-time and piecework workers requiring greater individual flexibility.

The new career realities are therefore unpredictable, uncertainty, and insecurity with the likelihood that individuals will move away from initial choices. The skills of adaptation, lifelong learning,



compromise, and adjustment will all be required; potentially increasing levels of stress for many may be sources of marginalization and exclusion for those who are ill prepared. This change requires the counselor to be sensitive to both contextual and personal variables and risks when jointly exploring possibilities with young people.

### **Counselor Knowledge, Roles, and Competencies**

The school counselor will require knowledge and competencies in generic counseling skills-process and specific career-related aspects, which may be more directed and information driven. It is important to make links to other forms of individual counseling in order to assess where the two might intersect and inform the other, as well as seeking links to the counselor's preferred theoretical orientation to promote active listening and problem solving within the chosen framework. Alternatives to individual face-to-face counseling may also need to be sought, for example, e-mail communication, and there is great potential for small group counseling sessions to optimize available time. Further considerations relate to parental engagement and involvement (in contrast to some other aspects of personal counseling). There is great value in utilizing forms of career assessment to promote self-understanding and assess progress in terms of career development, but it is important that the chosen instruments are as free of gender and cultural bias as possible.

The roles of the counselor may therefore expand on those of traditional counseling, including information provision, group assessment (to then feed into individual understandings), consultation (e.g., in career education program development and related to pupils' developmental processes), and facilitation of linkages, in particular those related to school-to-work schemes. It is also important for the counselor to be sensitive to issues related to disability (of various kinds) and diversity (such as race and minority group).

The National Career Development Association (NCDA) of the United States has developed a list of competencies in 11 designated areas: career development theory, individual and group counseling skills, individual/group assessment, information/resources, program management and implementation, consultation, diverse populations, supervision, ethical/legal issues, research/evaluation, and technology. To explore

these areas, descriptions of these competencies may be accessed from the NCDA Web site.

### **Theoretical Developments**

Traditionally, trait-factor approaches, material related to John Holland's theory and Super's models, have formed the basis of career counseling. These approaches have been complimented by psychological inventories that have aided the process of information gathering and counseling. Career information processing has gained ground in the past decade and has acknowledged the importance of thinking and decision-making skills as well as higher-order metacognitive contributions to career development and adaptation. Each of the aforementioned theories and approaches to counseling emphasizes the individual as a processor of information and has been critiqued for making assumptions about the self (as something relatively fixed and self-contained) and the relationship between the individual and the environment that may not be appropriate in non-Western contexts.

Alternative ways of approaching career counseling include constructivist and hermeneutic approaches and the use of a developmental-contextual framework (such as that developed by Fred Vondracek and colleagues). Such approaches are focused on gaining a shared understanding of the perspective of the young person and the many influences (social, cultural, educational, historical, and political) to which he or she has been exposed. Reality is viewed as a collective construction through language and social discourse, leading to the individual incorporating many perspectives. These are subject to negotiation and reinvention over time as the person takes on different roles and responsibilities, depending on changes in the situation. These approaches employ more qualitative data gathering techniques; an example is *My System of Career Influences* developed by Mary McMahon and associates.

Middle-class counselors need to be particularly sensitive to the limitations on choices and challenges experienced by learners from disadvantaged backgrounds. It is important to constantly consider the need to be inclusive in order to reach out to minority groups and to be more responsive to learners' contexts.

Time constraints often affect school counselors' capacities to offer comprehensive career counseling. While it is ideal to be able to spend a number of



sessions with one individual, to cover the complexities of the personal and situational variables in a developmental way, this may be limited to briefer interactions and sessions. It is thus necessary to work in close collaboration with broader career education programs in order to optimize available time. The competent counselor has an important role to play in the school's efforts to promote the career development of youth and to prepare young people for the challenges they face.

*Jacqueline E. Akhurst*

*See also* Armed Services Vocational Aptitude Battery (v4); Campbell Interest and Skill Survey (v4); Career Counseling (v4); Career Counseling in Colleges and Universities (v4); Career Education (v4); Career Exploration (v4); School Counseling (v1); School Psychology (v1); School-to-Work Transition (v4); Work-Bound Youth (v4)

### Further Readings

- Brott, P. E. (2001). The storied approach: A postmodern perspective for career counseling. *Career Development Quarterly*, 49, 304–313.
- Brown, D. (2006). *Career information, career counseling, and career development* (9th ed.). Boston: Allyn & Bacon.
- Gibson, R. L., & Mitchell, M. H. (2005). *Introduction to career counseling for the 21st century*. Upper Saddle River, NJ: Prentice Hall.
- Kidd, J. M. (2006). *Understanding career counseling: Theory, research and practice*. London: Sage.
- Sharf, R. S. (2006). *Applying career development theory to counseling*. Belmont, CA: Thomson.

### Web Sites

National Career Development Association: <http://ncda.org/>

---

## CAREER COUNSELING PROCESS

---

Career counseling has been defined as an ongoing, face-to-face interaction between counselor and client with career- or work-related issues as the primary focus. The goal of career counseling is typically to assist individuals in developing self-understanding, articulating direction in their careers, and achieving their potential and discovering their purpose in daily activities.

There are indications that many people at some point during their lives would like assistance with career planning or with making decisions related to vocational or occupational issues. Although there are some uncertainties related to what specific process factors should be included in career counseling, there are still indications that most clients benefit from participating in career counseling. It should be noted that there are many similarities between the process of career counseling and personal counseling, but counselors need specific training for career counseling. More knowledge is needed, however, on the underlying processes and mechanisms that lead to effective change in career counseling. Specifically, there is a need for additional research related to which career interventions work with whom and under what conditions.

Multiple studies have found that individuals benefit from career counseling, and this entry will discuss the research related to the process of the career counseling that assists clients with work issues. More specifically, career counseling process relates to the overt and covert thoughts, feelings, and behaviors of both clients and counselors while engaged in career counseling. This discussion of the career counseling process will address the following: (a) whether career counseling process is different and distinct from personal counseling, (b) process factors that positively affect outcome, (c) process factors that negatively affect outcome, and (d) process factors worthy of additional investigation.

### Process in Career Counseling Versus Personal Counseling

There has been a long and extensive debate about the distinctions between career counseling and personal counseling or psychotherapy. Some scholars have argued that there is research support for the integration of career and personal counseling because there are similarities among clients, associated with research related to similarities of clients; common elements or counseling techniques; and similar outcomes for many clients. Both career and personal counseling clients share common problems, and they are not different in terms of level of adjustment or amount of emotional discomfort. In career and personal counseling, counselors use many of the same helping skills. A study conducted in England found that clients, counselors, and expert witnesses all agreed that the career guidance interviews were more effective if the counselor helped the client feel comfortable in



discussing personal information. Interestingly, both career and personal counseling have been found to decrease clients' harmful psychological symptoms and to increase their abilities to solve problems. Although the process of career counseling is similar to personal counseling, practitioners also need to know about career or vocational theories and specific interventions strategies.

### **Process Factors That Produce Positive Outcomes**

In comparison to psychotherapy research, there is limited process research in career counseling and therefore significantly less is known about the relationship between the process of the counseling and what contributes to positive results. However, researchers have identified five critical ingredients that should be included in any type of career counseling. The five critical ingredients are written exercises, individualized interpretations, occupational information, modeling, and attention to building support. Each of these critical ingredients contributes to positive outcomes for clients, and research suggests that clients benefit from the addition of each critical ingredient to the career counseling process.

Other researchers have found outcome in career counseling to be positively influenced when the counselor encourages clients to engage in self-exploration and provides emotional support. Other process factors found to be helpful in career counseling were helping clients clarify assets and values, providing feedback from tests, and incorporating occupational information.

### **Process Factors That Negatively Influence Outcome**

In addition to factors that positively influence career counseling process, there is knowledge related to factors that have little effect or that negatively influence outcome. It is important that career counseling involve a counselor, as there is substantial research that indicates that counselor-free interventions (e.g., Internet assessments) are not effective. In addition, there are indications that individuals do not consider the following to be helpful: (a) tests that do not produce new leads, (b) exercises that do not yield sufficient career direction, (c) unskilled counselors (e.g., inattentive, mechanical test interpretation), and (d) insufficient assistance in finding adequate career information. Counselors need to be trained on how to conduct

career counseling in order not to use ineffective activities. Ineffective career counseling activities, such as ones that are poorly selected or are implemented in a haphazard manner, are not helpful to individuals who need help with their career planning.

### **Process Factors Worthy of Additional Investigation**

Although there is an expanding body of research that can guide counseling psychologists about the most effective processes in career counseling, there are still areas where additional research is needed to provide more detailed clinical guidance to practitioners. One of the areas of substantial research in personal counseling or psychotherapy concerns the importance of the working alliance. The alliance is often conceptualized as (a) counselor and client agreement on the goals of therapy, (b) counselor and client agreement on the tasks to achieve the goals, and (c) the quality of the emotional bond between counselor and client. Experts in the field of career counseling frequently indicate that they work on establishing a therapeutic relationship when describing their approaches to career counseling; however, some researchers have not found a significant relationship between the working alliance and the positive outcome.

There are also some questions about the most effective number of sessions in career counseling, which is often referred to as the *dose effect*. Some researchers have found that longer career counseling tends to produce better results for clients. Other researchers have found that the most effective career counseling occurs in four or five sessions.

Another area in which counselors need to conduct more research is related to what types of career counseling work best for which types of clients. Even though there has been research that documents the vocational obstacles and barriers often faced by minority clients, there has been very little exploration of whether differing types of career interventions are more productive with clients from different racial and ethnic backgrounds. There are some models that have been developed to provide career counseling specifically for clients from diverse ethnic and racial backgrounds, but there has yet to be sufficient investigations of whether these models improve career outcomes for these clients.

Another area of fertile research related to the process of career counseling concerns effective methods for conducting and interpreting career assessments.



This is surprising given the significant role assessments have traditionally played in career counseling. In addition, many of the research studies related to the process of career counseling have been with college students, and additional studies are needed with older adults who are experiencing a variety of career transitions. For most people, work has a daily impact on their quality of life; therefore, it seems important to identify career counseling process factors that can assist individuals in finding work that is both satisfying and rewarding.

Susan C. Whiston and Ilene M. Buck

*See also* Career Counseling (v4); Career Indecision (v4); Computer-Assisted Career Counseling (v4); Constructivist Career Counseling (v4); Multicultural Career Counseling Checklist (v4); Narrative Career Counseling (v4); Occupational Information (v4); Performance Modeling (v4); Personal and Career Counseling (v4); Relationships With Clients (v2); Working Alliance (v2)

### Further Readings

Brown, S. D., & Ryan Krane, N. E. (2000). Four (or five) sessions and a cloud of dust: Old assumptions and new observations about career counseling. In S. D. Brown & R. W. Lent (Eds.), *Handbook of counseling psychology* (3rd ed., pp. 740–766). New York: Wiley.

Gysbers, N. C., Heppner, M. J., & Johnson, J. A. (2003). *Career counseling: Process, issues, and techniques*. Boston: Allyn & Bacon.

Whiston, S. C., & Oliver, L. W. (2005). Career counseling process and outcome. In W. B. Walsh & M. L. Savickas (Eds.), *Handbook of vocational psychology: Theory, research, and practice* (3rd ed., pp. 155–193). Mahwah, NJ: Lawrence Erlbaum.

Whiston, S. C., Sexton, T. L., & Lasoff, D. L. (1998). Career intervention outcome: A replication and extension. *Journal of Counseling Psychology*, 45, 150–165.

---

## CAREER DECISION-MAKING DIFFICULTIES QUESTIONNAIRE

---

Dealing with career indecision has long been a focus of theory and research, and helping clients to overcome their difficulties in making decisions is among the core roles of career counseling. The Career

Decision-Making Difficulties Questionnaire (CDDQ) is based on the taxonomy of career decision-making difficulties proposed by Gati, Krausz, and Osipow and was developed to validate the proposed taxonomy and to be a means for locating the focuses of individuals' career decision-making difficulties, a step that is among the first in providing individuals with the help they need.

### The Taxonomy of Career Decision-Making Difficulties

This taxonomy provides a decision-theory-based systematic framework for characterizing an individual's career decision-making difficulties. It comprises three major categories of difficulties, which are further divided into 10 specific difficulty categories. Lack of Readiness includes three categories that precede the actual engagement in making a specific career decision: *lack of motivation* to engage in the career decision-making process, *general indecisiveness* concerning all types of decisions, and *dysfunctional beliefs* about career decision making. The other two major categories focus on difficulties that may arise during the engagement in the process. Lack of Information includes *lack of knowledge about the steps involved in the process* of making a career decision, *lack of information about the self*, *lack of information about the various occupations*, and *lack of information about the ways of obtaining additional information*. Inconsistent Information includes three categories of difficulties in using the information: *unreliable information*, *internal conflict* within the individual (such as contradictory preferences), and *external conflicts*, involving disagreements with significant others.

### The Revised CDDQ

The revised version of the CDDQ consists of 34 items (with a 9-point response scale), including 2 validity items and 2 to 5 items per scale. The individual's difficulties are summarized in a 10-scale score profile corresponding to the 10 difficulty categories, each representing the mean of the responses to the items included in it. The empirical structure of the 10 categories was found similar to the theoretical one. The reported test-retest reliabilities range from .67 to .80, the median Cronbach-alpha internal-consistency



coefficients of the 10 scale scores range from .68 to .84, and that of the total CDDQ from .87 to .96. After the credibility of the responses to the questionnaire and the differentiation of the 10 scale scores are ascertained, the core of the interpretation involves locating the focuses of the individual's difficulties on the basis of the relative salience of the scale scores; reservations are added when needed. The CDDQ allows a multidimensional assessment of the individuals' difficulties. Further information on the CDDQ, including its Internet version with validated interpretation and an abridged professional manual with the studies that tested or used it, can be found at [www.cddq.org](http://www.cddq.org).

### Research Findings

The construct and concurrent validity of the CDDQ was supported by analyses of both the paper and pencil and the Internet versions of the questionnaire with various cross-cultural samples. Specifically, its pattern of correlations with various other measures, including the Career Decision-Making Self-Efficacy Scale, the Career Decision Scale, the Vocational Decision-Style Indicator, and the Career Thoughts Inventory, were as expected. A large difference in the total CDDQ score was found between decided and undecided individuals. Finally, the focuses of clients' career decision-making difficulties as located by the CDDQ were found compatible with the conclusions of career counselors. The CDDQ was found useful in face-to-face counseling for the initial assessment of individuals' career decision-making difficulties and as a measure of the effectiveness of individual and group career-counseling interventions.

*Itamar Gati*

**See also** Career Decision Scale (v4); Career Decision Self-Efficacy Scale (v4); Career Indecision (v4); Career Thoughts Inventory (v4); Decision Making (v4); Osipow, Samuel H. (v4); Prescreening, In-Depth Exploration, and Choice Model (v4); Tiedeman's Decision-Making Theory (v4)

### Further Readings

Amir, T., & Gati, I. (2006). Facets of career decision-making difficulties. *British Journal of Guidance & Counselling*, 34(4), 483–503.

- Gati, I., Krausz, M., & Osipow, S. H. (1996). A taxonomy of difficulties in career decision making. *Journal of Counseling Psychology*, 43, 510–526.
- Kleiman, T., & Gati, I. (2004). Challenges of Internet-based assessment: Measuring career decision-making difficulties. *Measurement and Evaluation in Counseling and Development*, 37, 41–55.
- Osipow, S. H., & Gati, I. (1998). Construct and concurrent validity of the Career Decision-Making Difficulties Questionnaire. *Journal of Career Assessment*, 6, 345–363.

---

## CAREER DECISION SCALE

---

The Career Decision Scale (CDS) grew out of S. H. Osipow, C. Carney, J. Winer, B. Yanico, and M. Koschier's counseling experience with undergraduate students who sought help in dealing with their inability to decide on an educational or career goal. Specifically, it was thought that identifying a limited number of problems connected with that indecision would lend itself to the development of specific counseling interventions designed for helping resolve career indecision.

Based on clinical experience, a limited number of statements were devised, each designed to allow the client the opportunity to indicate the degree to which each statement describes his or her situation. Ultimately, 16 indecision type statements were devised along with 2 statements of a decided type for a total of 18 items. The respondent is required to indicate on a 4-point scale the degree to which each statement accurately described his or her situation. From these responses, a total undecided score can be calculated by summing the one to four responses for each of the 16 undecided items as well as a total certainty score by adding the two decided items. Thus, scoring is simple, and a total indecision score can be generated for each respondent.

A variety of reliability and validity studies have been conducted on the instrument. These include studies of the correlation of the CDS with other instruments purporting to measure career indecision. The studies also assessed the ability of the instrument to differentiate between self-proclaimed decided and undecided students as well as students of different levels of career maturity. In all, the results of these studies generally support the validity of the CDS.



Studies of the effects treatment for indecision were also made in a variety of settings, again generally indicating that the instrument is responsive to interventions for career indecision. Test–retest reliability measures have generally shown high correlations between undecided scores over short time periods, but not so high that interventions would be unable to change an individual's status.

Finally, a number of investigators have studied the factor structure of the measure. Here, the results are mixed with some studies finding four factors, others fewer, and the interpretation of each factor being slightly different. The factors have been described as a lack of structure and confidence in dealing with vocational decision making, an external barrier to a preferred choice, an approach–approach problem where two options appear to be equally attractive, and finally a personal conflict of some type interfering with implementing a choice.

The interpretation of scores is based on a set of norms—norms for high school males and females, college student males and females, adults seeking continuing education, and adult women returning to college—and on comparisons between males and females at the high school and college levels. Comparisons by age are also available.

In summary, the CDS can be useful in counseling by identifying problem areas. It can also be useful in measuring the outcomes of various group and individual interventions to deal with career indecision and has the virtue of well-established norms, reliability, and validity.

*Samuel H. Osipow*

**See also** Career Barriers Inventory (v4); Career Decision-Making Difficulties Questionnaire (v4); Career Decision Self-Efficacy Scale (v4); Career Indecision (v4); Career Thoughts Inventory (v4); Decision Making (v4); Osipow, Samuel H. (v4); Prescreening, In-Depth Exploration, and Choice Model (v4); Tiedeman's Decision-Making Theory (v4)

## Further Readings

- Osipow, S. H. (1987). *The manual for the Career Decision Scale*. Odessa, FL: Psychological Assessment Resources.
- Osipow, S. H., Carney, C. G., Winer, J. L., Yanico, B., & Koschier, M. (1976). *The Career Decision Scale* (3rd ed.). Odessa, FL: Psychological Assessment Resources.

---

## CAREER DECISION SELF-EFFICACY SCALE

---

The Career Decision Self-Efficacy Scale (CDSE) was developed by Karen Taylor and Nancy Betz in order to apply Albert Bandura's theory of self-efficacy expectations to the domain of career decision making. Career decision self-efficacy was originally defined by Taylor and Betz as the individual's belief that he or she can successfully complete tasks necessary in making career decisions. In order to define these tasks, the theory of career maturity of John O. Crites was used. Crites's theory defined career maturity as the individual's degree of possession of five career choice competencies and five career choice attitudes. The five career choice competencies and sample items are (1) accurate self-appraisal ("Accurately assess your abilities"), (2) occupational information ("Find out the employment trends for an occupation over the next 10 years"), (3) goal selection ("Select one occupation from a list of occupations you are considering"), (4) planning ("Make a plan of your goals for the next 5 years"), and (5) problem solving ("Change occupations if you are not satisfied with the one you entered"). In the original CDSE, each scale consisted of 10 tasks in which the individual indicated his or her degree of confidence in his or her ability to complete the task; the response continuum ranged from 0 (*not at all confident*) to 9 (*very confident*).

In 1996 a 25-item short form was developed from the best items of the original 50-item form. The short form has been found to have levels of reliability and validity comparable to or superior to those of the long form. In addition, research by Betz, Marie Hammond, and Karen Multon indicated that a five-level response continuum provided measurement as reliable and valid as that provided with the 10-level response continuum, so it is recommended that most users use the short form with the five-level response continuum.

Based on extensive research evidence, it can be said with considerable certainty that career decision making self-efficacy is related to other indices of adaptive career decision making. For example, there is ample evidence that career decision self-efficacy is inversely related to career indecision and fear of career commitment and that it is positively related to high versus low vocational identity, to more adaptive career beliefs, and to career exploratory behavior. It



has been found that career decision making self-efficacy was related to academic persistence versus dropout in underprepared college students and that it surpassed all other variables as a predictor of academic and social integration of college students.

### Use in Evaluating Career Development Interventions

Research suggests that career decision self-efficacy is strongly related to both perceived and actual difficulties in making and implementing career decision. There has now been considerable research using self-efficacy theory as the basis for the design and/or evaluation of interventions to increase career decision self-efficacy. Many studies have used the CDSE as the dependent variable in evaluating career interventions such as the use of DISCOVER, a computer-assisted career guidance program, and other career counseling workshops and career exploration courses in college student populations. Results consistently indicate that the CDSE scores of students who receive a viable intervention tend to increase, whereas CDSE scores of students who do not receive an appropriate intervention remain relatively stable over time.

Nancy E. Betz

**See also** Bandura, Albert (v2); Career Decision-Making Difficulties Questionnaire (v4); Career Decision Scale (v4); Career Indecision (v4); Career Interventions (v4); Career Maturity (v4); Career Thoughts Inventory (v4); Decision Making (v4); (v4); Prescreening, In-Depth Exploration, and Choice Model (v4); Self-Efficacy/Perceived Competence (v2); Social Cognitive Career Theory (v4)

### Further Readings

- Bandura, A. (1997). *Self-efficacy: The exercise of control*. New York: W. H. Freeman.
- Betz, N. E. (1992). Counseling uses of career self-efficacy theory. *Career Development Quarterly*, 41, 22–26.
- Betz, N. E., Hammond, M., & Multon, K. (2005). Reliability and validity of five level response continua for the Career Decision Self-Efficacy scale. *Journal of Career Assessment*, 13, 131–149.
- Betz, N. E., Klein, K., & Taylor, K. (1996). Evaluation of a short form of the Career Decision Self-Efficacy Scale. *Journal of Career Assessment*, 4, 47–57.

Betz, N., & Taylor, K. (1994). *Manual for the Career Decision Self-Efficacy Scale*. Columbus: Ohio State University Department of Psychology.

Taylor, K. M., & Betz, N. E. (1983). Applications of self-efficacy theory to the understanding and treatment of career indecision. *Journal of Vocational Behavior*, 22, 63–81.

---

## CAREER DEVELOPMENT INVENTORY

---

The Career Development Inventory (CDI) is a 120-item standardized measure of career development attitudes and knowledge first published in 1979. This measure operationally defines career maturity based on Donald Super's theory of career development. In general, the CDI assesses level of readiness for making realistic educational and career-related decisions. There are two forms of the CDI, one for middle school and high school students and another for college students.

Having its roots in the Career Pattern Study, the CDI emerged as the culmination of years investigating central dimensions related to Super's model of vocational maturity. The five basic scales of the CDI are described as follows:

1. Career Planning (CP; 20 items) assesses future orientation and the extent to which one has thoughtfully engaged in educational and career planning activities.
2. Career Exploration (CE; 20 items) measures clients' willingness to use various educational and career resources (e.g., books, counselors) and the efficacy of those utilized.
3. Decision Making (DM; 20 items) measures understanding of the process of effective career decision making based on respondents' solutions to hypothetical career decisions.
4. World-of-Work Information (WW; 20 items) assesses general knowledge of occupations and understanding of how to attain and succeed in certain fields.
5. Knowledge of Preferred Occupation (PO; 40 items) first involves selecting one of 20 occupational groups (e.g., writing and law) to designate one's work interests. Next, the respondent's degree of knowledge regarding typical duties and personal characteristics of workers involved in that particular occupational group is examined.



Consistent with Super's theory, the CDI includes two broad factors—each comprising two cognitive (DM and WW) and two attitudinal components (CP and CE)—in addition to the PO, a separate content domain suitable only after 10th grade. Composite scores are also provided by combining CP and CE to form the Career Development Attitudes (CDA) scale, DM and WW to form the Career Development Knowledge and Skills (CDK) scale, and CDA plus CDK for a Career Orientation Total.

The CDI has multiple uses including career research, practice, education, and program evaluation. Numerous publications provide insights into interpreting results. Beyond the assessment of interests, abilities, personality, and work values, the CDI provides supplementary information on the process of coping with complex tasks associated with choosing a career.

A substantial amount of research has been conducted on the CDI. The content and theoretical relationships between its scales have proven sound. Scores on attitudinal components increase throughout high school. Interestingly, the cognitive scales of the CDI have shown positive relationships to grade point average and measures of intelligence. These associations are slight, but consistently emerge across studies. Although the CP, CE, and WW scales demonstrate sufficient reliability estimates, lower values for DM and PO warrant caution. In addition to these concerns, factor analyses suggest that users emphasize the broader composite scales. Moreover, ongoing needs for investigating its predictive validity persist.

The CDI is an exemplar applied career assessment based on career development theory. Continued efforts to update the measure are necessary to solidify its legacy for informing our understanding of career development.

Patrick J. Rottinghaus

*See also* Career Counseling in Colleges and Universities (v4); Career Counseling in Schools (v4); Career Decision Scale (v4); Career Education (v4); Career Exploration (v4); Career Maturity (v4); Career Occupational Preference System (v4); Career Planning (v4); Super's Theory (v4)

## Further Readings

Savickas, M. L., & Hartung, P. J. (1996). The Career Development Inventory in review: Psychometric and research findings. *Journal of Career Assessment*, 4, 171–188.

Sundre, D. L. (2002). Review of the Career Development Inventory. In J. T. Kapes & E. A. Whitfield (Eds.), *A counselor's guide to career assessment instruments* (4th ed., pp. 323–330). Alexandria, VA: National Career Development Association.

Thompson, A. S., & Lindeman, R. H. (1981). *Career Development Inventory: User's manual*. Palo Alto, CA: Consulting Psychologists Press.

---

## CAREER DEVELOPMENT QUARTERLY

---

*Career Development Quarterly (CDQ)* is the premier English-language journal in career counseling and development and is the official journal of the National Career Development Association (NCDA). It was first published in 1911.

*CDQ* publishes articles on career counseling, individual and organizational career development, work and leisure, career education, career coaching, and career management. Each article includes implications for practice as *CDQ* is especially focused on fostering career development through the design and use of career interventions. The methodologies that are used in *CDQ* articles include, but are not limited to, literature reviews that make research accessible to practitioners, case studies, history and public policy analyses, qualitative research, and quantitative research that is of specific relevance to the practice of career development.

*CDQ* is consistently rated highly among all of the applied psychology journals based on the *Social Sciences Citation Index* issued each year, published by the Institute of Scientific Information, and reported in its publication, *Journal Citation Reports*. It tracks the number of times original scientific articles are cited in other journals as a reflection of the impact each article (and collectively, each journal) has on the body of scientific literature during that year. Thus, the more times an article is cited from a journal the more stature it and the journal have as a meaningful contributor to the scientific literature. That impact rating, reflecting the level of academic excellence of the journal, is then used to rank all the journals in the applied psychology field that includes *CDQ*.

Since 1988, *CDQ* has published a comprehensive annual review of the professional literature in career counseling and development titled "Practice and Research in Career Counseling and Development." These reviews are developed and written by accomplished professionals who synthesize the professional literature



for that year around the theme, What can the practitioner learn from this year's literature? These annual reviews are the most requested online articles of all the articles published in *CDQ*.

The *CDQ* Editorial Board comprises senior career counseling and development professionals who are selected to a 2-year term with a maximum of three consecutive terms. The *CDQ* editor recommends individuals for appointment with the election by the NCDA Board of Directors. Reviewers are expected to complete at least one review per month. The *Publication Manual of the American Psychological Association* (current edition) serves as the style manual for *CDQ*.

*CDQ* has evolved from its original 1911 format and has had name changes that were appropriate to its evolution. *CDQ* was published as the *Vocational Guidance Newsletter* (1911–1914, Frederick J. Allen, editor), *Vocational Guidance Bulletin* (1915–1918), *The National Vocational Guidance Association Bulletin* (1921–1924), *The Vocational Guidance Magazine, Organ of the National Vocational Guidance Association* (1924–1933), *Occupations: The Vocational Guidance Magazine* (the official origin of the NVGA; 1933–1944), *Occupations: The Vocational Guidance Journal* (1944–1952), *The Vocational Guidance Quarterly* (1952–1986), and the *Career Development Quarterly* (1986–present).

Recently, technology has had an effect upon how *CDQ* is published and accessed by readers. *CDQ* continues to be published in a print format, but in 2000, *CDQ* articles were first allowed to be accessed online, although full-text articles were only available one year after publication. In 2005, that restriction was removed and all articles were available for immediate electronic access upon publication. Also in 2005, *CDQ* moved to a completely electronic manuscript submission and review process.

Further information on *CDQ* including information for authors is available at the NCDA's Web site.

Mark Pope

*See also* Assessment (v4); Career Counseling (v4); Career Counseling Process (v4); Career Interventions (v4); *Journal of Career Assessment* (v4); *Journal of Career Development* (v4); *Journal of Vocational Behavior* (v4); National Career Development Association (v4)

## Web Sites

National Career Development Association: <http://www.ncda.org>

## CAREER EDUCATION

The use of the term *career education* varies across both time and context. In its broadest sense the term refers to educational activities in formal and tertiary education contexts, which aim to foster and enhance learners' knowledge, skills, attitudes, and values related to occupations and the concept of career development over the life span. In the United States, the term has tended to be superseded by curricular school-to-work programs, whereas in the United Kingdom, the term *career support* is often used for career-related activities facilitated by educators. In countries with outcomes-based approaches to education, career education may be incorporated into life skills-based syllabi rather than viewed as a separate strand in the curriculum. Where learner centeredness underpins educational practice, developmentally and contextually sensitive approaches to career education may be promoted.

Programs may be provided by mainstream educators or led by institutionally based careers advisors, or they may be provided by external agencies contracted for the task (depending on the resources available). Where educators have little specialized training in career theory or practice, consultants may be required to design programs and train practitioners. In some contexts, career education practice may be viewed as ancillary to mainstream education, but agencies providing it may be overstretched and subject to financial constraints. An increasing number of theorists have called for holistically planned programs that are integrated into the curriculum.

Key considerations in the provision of career education, including school-to-work programs, are explicit planning, a focus on the learner's life stage, the concept of work to be employed, an approach that is sensitive and responsive to the local context, and the development of transferable skills that support lifelong learning. These considerations are rooted in both developmental and situational perspectives and focus on the many competences and attitudes that support decision making and transitions into and between work roles. Although in the second half of the 20th century career education may have been predominantly didactic in nature, recent shifts have emphasized learners' constructions and narrative accounts of their experiences.

The rapidly changing world of work at the beginning of the 21st century poses challenges for providers of career education. Accelerating technological



change and the influence of global economic forces have resulted in people needing to respond to changes in the world of work in unprecedented ways. The stability and predictability of industrial era career paths no longer exist, and people are expected to be much more adaptable and flexible. New forms of careers need to be considered, including the increasing independence from organizational structures.

The foundations of career knowledge and the skills of planning and decision making should be laid in schools. Educators need to have a greater awareness of their role in preparing learners for the working world. Thus, classroom activities that make links with work, workplace visits, and different types of work experience are being integrated into the mainstream. There are also increasing calls for career education to be provided to adults in the context of lifelong learning and continuing education.

Career education is particularly relevant in the exploration stage of an individual's career development. This occurs initially in adolescence, but may continue during the process of engagement in the world of work as a young adult. It may also occur when voluntarily changing jobs or career direction or when the individual is forced into exploration owing to retrenchment or the need for retraining.

Four major aspects of careers education have been identified:

1. developing self-awareness through understanding individual attributes, interests, dispositions, ideals, and values that impact on career aspirations;
2. fostering knowledge about opportunities available to learners through information gathering on the spectrum of potential occupations, about the impacts of different types of work on lifestyle, and about ways to access information;
3. building explicit awareness of styles of and skills related to decision making; and
4. coping skills for life-span transitions (e.g., school to work, work to unemployment, into continued education, changes in the workplace, reentry into the job market).

Curricular aspects of career education include a body of knowledge that needs to be accessed, skills that can be practiced, and a philosophy and values that warrant attention and discussion. Career education should also be integrated into adult education and

extended to the work of labor and trade union organizations, as well as to the fields of training and personnel development.

Career education is concerned with preparing the person for the choices and transitions that life presents. One of the major challenges faced by providers of career education relates to the readiness for and motivation of learners. Concepts such as career maturity and career decision making have relevance, and it is important for the provider to investigate the degree of fit between envisaged activities and the individuals for whom these are designed. Career education must be planned to enable learners to develop skills to cope with the information overload, uncertainty, confusion, and challenges to the individual's sense of identity that may characterize experiences of postindustrial life.

*Jacqueline E. Akhurst*

**See also** Career Counseling in Colleges and Universities (v4); Career Counseling in Schools (v4); Career Counseling Process (v4); Career Exploration (v4); Career Interventions (v4); Career Maturity (v4); Occupational Information (v4); School-to-Work Transition (v4)

### Further Readings

- Gibson, R. L., & Mitchell, M. H. (2007). *Introduction to counseling and guidance* (7th ed.). Upper Saddle River, NJ: Prentice Hall.
- Irving, B. A., & Beatriz, M. (2005). *Critical reflections on career education and guidance: Promoting social justice within a global economy*. London: Routledge.
- Law, B. (1996). Careers education in a curriculum. In A. G. Watts, B. Law, J. Killeen, J. M. Kidd, & R. Hawthorne (Eds.), *Rethinking careers education and guidance: Theory, policy and practice* (pp. 210–232). London: Routledge.
- McWhirter, E. H., Rasheed, S., & Crothers, M. (2000). The effects of high school career education on social-cognitive variables. *Journal of Counseling Psychology*, 47(3), 330–341.

---

## CAREER EXPLORATION

---

Exploration has been a focus of vocational development research since the inception of the field. The concept was originally invoked to explain the process by which a person examines opportunities and



constraints in the labor market in order to choose a job or career. The conceptual definition has been significantly expanded to become an ongoing complex developmental process that is a central mechanism propelling the transition from school to work and career pathways.

### **Brief History of the Exploration Concept**

Donald Super cast the career exploration concept into life-span terms and identified adolescence as the period when a person begins to employ a dynamic form of exploration that involves aspects of the vocational self (e.g., emerging awareness of career interests, values, and related abilities) that guide a person's exploration of the world of work and aspects of the outer world (e.g., feedback on school and work performance) that guide self-exploration. Central to the issue of children's vocational development, Super and others suggested that most preadolescent children were preoccupied with career fantasies because they were incapable of career exploration that involves the integration of psychological, physical, and social structures into an understanding of how a person fits within the working world.

In an effort to expand a life-span theory of career development focused on adolescents and adulthood, Super employed the curiosity and exploratory behavior research on humans and animals to arrive at a developmental model with childhood curiosity being identified as the fundamental antecedent characteristic driving early career exploration. While the construct of curiosity has not received much attention in the career literature, career exploration has become a bedrock construct explored within several popular content domains including work values, self-concept, occupational learning, vocational aspirations, interests, and identity.

### **A Conceptual and Propositional Model of Career Exploration**

Career exploration involves the dynamic interplay between self-exploration and exploration of the world of work that yields a relatively stable sense of the occupational self-identity and with it a suitable and satisfying occupational choice. Jean Pierre Jordaan, working with Super during the 1960s and 1970s, defined *vocational exploration* as conscious and unconscious activities conducted with an aim toward learning

about the self and the work context and how the two fit together. John Holland supported the position that occupational exploration is a fundamental aspect of career development and asserted that the development of occupational interests through exploration is a critical aspect of the process of moving from an undifferentiated sense of the world of work and toward an occupational choice. Hanoch Flum and David Blustein later extended the exploration construct to include exploratory competence, which presumably develops from the act of exploration over time and involves the belief that a person can effectively explore his or her environment (i.e., seek and gain information and insight that will be beneficial).

As career researchers and theorists employed the career exploration construct, they grew convinced that it was a critically important aspect of vocational development, but they also became relatively disconnected from the broader literature on human exploration. Super referred to this literature (e.g., D. E. Berlyne's work), but did not discuss it at length in later reviews of the exploration literature. Moreover, this broader exploration literature enjoyed a major resurgence during the 1980s that went relatively unreported in the career literature

### **The Broader Literature on Exploration**

The definition of *exploration* in the human exploration literature is similar to the established definition in the career literature, but the definitions differ in terms of when children develop a capacity for exploration. Hans-Georg Voss and Heidi Keller defined exploration as the coordination of perception, behavior, and elements of the self such as interests and values that are motivated by a desire or need to acquire new knowledge. Distinct from the career literature, they contended that such exploration occurs in concert with play behavior during infancy and late childhood. This definition suggests that children may engage in career exploration involving the coordination of personal values, goals, and interests and vocationally related or relevant experiences and information.

The human exploration literature further distinguished between two interrelated types of exploration. Children presumably employ combinations of *diversive* and *specific* exploration to learn about their environment. *Diversive* exploratory behavior is presumably driven by stimulation and excitement and much less



affected by psychological structures of the self or social forces. The definition of specific exploration is consistent with the definition of human exploration discussed above and is motivated by learning more about a situation or object in reference to the self. A child presumably enters a novel situation in a diverse exploration mode, scanning the situation to assess the lay of the land. Situations may afford more or less opportunity for a child to employ diverse exploration, and a child may be more or less motivated to do so. During a period of diverse exploration, specific features of the situation are defined as being more or less enticing, exciting, threatening, or inviting. Having identified or been confronted with the most salient features of the situation, the child may employ a specific exploration behavioral pattern to elicit more information and/or an affective response from those features that are most salient to the child, and this behavior will influence and be influenced by elements of the self such as interests, values, and goals.

### Integrating the Broader Literature on Exploration With Career Exploration

The vocational exploration of children may be described as diverse in nature. Young children explore the world of work attempting to comprehend its elements in more or less enticing, exciting, or threatening terms. As children begin to develop vocationally related interests and values through sequences of diverse career exploration, particular aspects of the world of work (i.e., occupations) may become the target of specific exploration, which is commonly known as career exploration. This shift from diverse to specific career exploration is supported by research suggesting that children shift from glamorous career aspirations (e.g., movie star and astronaut) to more realistic aspirations during the later grade and middle school years.

The integration of the human and career exploration literatures suggests that the developmental course of career exploration is to begin the process of career exploration employing diverse exploration until attention coalesces around a broad class of exciting or glamorous occupations and a sense of self emerges. This period of diverse exploration eventually gives way to a period of specific exploration spanning the adolescent and young adult years. Career theorists have generally assumed that the shift from diverse to specific career exploration occurs during adolescence, but a growing body of research in the career literature suggests that this transition may begin

during the middle to late childhood period. Future research efforts could be committed to developing measures of diverse and specific career exploration and ascertaining the typical and atypical timing of the exploration transition during the childhood and adolescent periods.

### Conclusion

Career theory characterizes early to middle childhood as the period when children physically and psychologically explore the outer world and organize this information into increasingly complex categories and associations. The late childhood and early adolescent period has been theoretically distinguished from the earlier periods within the career literature by the use of a dynamic form of exploration that involves a transaction between aspects of a person's inner and outer world in the pursuit of career goals of varying degrees of specificity. The broader literature on human exploration suggests that exploration as a complex interplay between the inner and outer world occurs during the childhood period, and this may have significant implications for future career research. Regardless of the timing of the process, the developmental course of diverse and specific career exploration is predicted to yield a set of career pathways that are consistent with a child's emerging interests, needs, aspirations, and values on the one hand and his or her environmental opportunities and social pressures (e.g., parental wishes and expectations) on the other. Career exploration is, therefore, a critical aspect of child and adolescent career exploration, and parents, counselors, and educators should aim to promote this process in adolescents and at least consider efforts to do so during the grade school years.

*Erik J. Porfeli*

**See also** Career Counseling in Colleges and Universities (v4); Career Counseling in Schools (v4); Career Counseling Process (v4); Career Education (v4); Career Planning (v4); School Counseling (v1); School-to-Work Transition (v4); Social Cognitive Career Theory (v4); Super's Theory (v4)

### Further Readings

- Berlyne, D. E. (1960). *Conflict, arousal, and curiosity*. New York: McGraw-Hill.
- Flum, H., & Blustein, D. L. (2000). Reinvigorating the study of vocational exploration: A framework for research. *Journal of Vocational Behavior*, 56(3), 380–404.



- Hartung, P., Porfeli, E. J., & Vondracek, F. W. (2005). Child vocational development: A review and reconsideration. *Journal of Vocational Behavior*, 66(3), 385–419.
- Jordaan, J. P. (1963). Exploratory behavior: The formation of self and occupational concepts. In D. E. Super (Ed.), *Career development: Self-concept theory: Essays in vocational development* (pp. 42–78). Princeton, NJ: College Entrance Examination Board.
- Keller, H., Schneider, K., & Henderson, B. (Eds.). (1994). *Curiosity and exploration*. Berlin, Germany: Springer-Verlag.
- Super, D. E. (1957). *The psychology of careers: An introduction to vocational development*. New York: Harper & Row.
- Voss, H. G., & Keller, H. (1983). *Curiosity and exploration*. New York: Academic Press.
- Watson, M., & McMahon, M. (2005). Children's career development: A research review from a learning perspective. *Journal of Vocational Behavior*, 67(2), 119–132.

---

## CAREER FACTORS INVENTORY

---

Career indecision has been an important area of concern in vocational psychology for the last 50 years. An extensive body of research has examined the nature of career indecision, the factors (sometimes labeled barriers) that contribute to career indecision, the consequences of career indecision, and the effectiveness of interventions for career indecision. Most of this research has focused on college students. This work has led to and been enhanced by the development of instruments that measure aspects of career indecision.

The Career Factors Inventory (CFI) is a 21-item instrument developed by Judy M. Chartrand, Steven B. Robbins, and Weston H. Morrill to measure four factors that contribute to career indecision. The CFI yields scores on two cognitive factors (i.e., Need for Career Information and Need for Self-Knowledge) and two emotional factors (i.e., Career Choice Anxiety and Generalized Indecisiveness). The first three scales assess the respondent's present status (i.e., state) on factors that are theoretically amenable to change. The Generalized Indecisiveness scale assesses the respondent's status on a trait that theoretically is more resistant to change. These scores are grouped into two categories labeled informational needs and decision needs. The authors recommend the inventory for use in helping clients determine their readiness to engage in the career decision-making process. Career-related

problems outside of this narrow focus are not addressed by the CFI.

### Description

Respondents rate the CFI items using a 5-point scale. Ten of the items use a Likert scale with response alternatives anchored by 1 (*strongly disagree*) and 5 (*strongly agree*). These items begin with the stem, "Before choosing or entering a particular career area, I need to." Each item concludes with a statement identifying a specific task (e.g., "Talk to people in one or more various occupations" and "Attempt to answer, 'Who am I?'" ). High scores on these items indicate greater levels of career indecision.

The remaining 11 items use the semantic differential format. These items consist of a phrase followed by polar opposite adjectives that anchor the rating scale as illustrated in the following example:

When I think about actually deciding for sure what I want my career to be, I feel:

Cold      1      2      3      4      5      Hot

The other two phrases used in the CFI are, "For me, decision making seems," and "While making most decisions, I am." These phrases are followed by six, three, and two polar adjectives, respectively.

The number of items composing each CFI scale and the range of possible scores on the scales are Need for Career Information and Career Choice Anxiety (6 items each; range = 6–30), Generalized Indecisiveness (5 items; range = 5–25), and Need for Self-Knowledge (4 items; range = 4–20).

### Administration

The CFI was designed to be self-administering, self-scoring and self-interpreting; professional supervision of the administration and scoring should be unnecessary. Despite this, the authors advise psychologists to help examinees understand the purpose of the inventory and the four constructs it measures. Competent practice requires that psychologists make sure clients understand their purpose in completing a psychometric instrument. However, explaining the meaning of the scales prior to completing the instrument may influence the results.

The CFI directions are simple, and the inventory has an eighth-grade reading level. It can be administered



to an individual or a group, and it is appropriate for persons ages 13 and older. The CFI is not timed, but most examinees should be able to complete it in 5–10 minutes.

## Interpretation

The Need for Career Information scale measures clients' needs to acquire occupational information and gain experience prior to making a career commitment. The Need for Self-knowledge scale measures clients' needs for increased self-understanding. The Career Choice Anxiety scale measures clients' anxiety about the career decision-making process. The General Indecisiveness scale measures clients' perceived inability to make decisions even though the conditions necessary for decision making have been satisfied. The authors claim that discussion of these scores in counseling can help clients understand the barriers that are hindering their career decision making and lead to the identification of effective ways to overcome these barriers.

The CFI assumes a normal distribution of scores and provides arbitrary statistical cutoffs for interpreting scores on these scales. The authors do not provide a theoretical or empirical justification for this approach nor any empirical evidence documenting the validity of interpretations based on these cutoffs. These cutoffs are based on norms composed of convenience samples of college students enrolled in psychology classes at two universities. Consequently, interpretation of CFI results for clients other than university students is not warranted, and interpretation of university students' results is speculative because of the inadequate norms.

The authors recommend plotting the four scale scores and joining them to obtain a profile, but they do not provide a rationale or empirical justification for this procedure. The order of the scales on the profile is arbitrary, so the shape of the profile lacks rational or empirical meaning. However, the authors do provide case studies that counseling psychologists can consult for guidance.

The wording of the 10 CFI Likert items poses another problem in interpreting the CFI. These items begin, "Before choosing or entering a particular career area, I need to." The authors interpret these items as measuring the respondent's perceived deficit. An equally viable interpretation is that these items assess the respondent's belief that these statements describe a reasonable, commonsense approach to career decision making. Consider the item, "Before

choosing or entering a particular career area, I need to use my free time or school courses to help determine what type of career I might enjoy and do well in." Clients who have already done this might answer, *strongly agree*, to indicate their belief that the statement describes a reasonable approach to career decision making. Consequently, it is likely that some responses to the CFI indicate a perceived need, while others indicate an evaluation of the action described. This item wording may muddy the interpretation of CFI scores and reduce the validity of the instrument.

## Reliability

Test–retest reliability indicates the stability of a test score across a specific time period (2 weeks in the case of the CFI). The test–retest reliabilities of the CFI range from .76 (Need for Self-Knowledge) to .94 (Generalized Indecision). Scores on the CFI scales that measure states are less stable than desirable, given the short time period. Scores on the trait scale are more stable, as is expected. These values indicate that recent CFI results can be interpreted with caution.

Internal consistency reliability indicates the extent to which the items on a scale provide consistent information. Values lower than .75 indicate that the scale items are somewhat inconsistent. Values above .90 suggest that the scale measures a narrow construct that is unlikely to have practical utility or that the scale uses more items than is necessary to achieve adequate precision.

Internal consistency reliability coefficients for the CFI have been reported for samples of middle school and high school students, community college students, 4-year college and university students, adults, and female offenders. The internal consistency reliabilities have ranged from .73 to .91 for the four subscales and from .73 to .92 for the total inventory. The Need for Career Information scale has the lowest reliability, and some internal consistency reliability coefficients reported for that scale have fallen below the acceptable range. The reliability coefficients reported for the other scales have all been in the acceptable range. The General Indecisiveness scale has the highest reliability.

## Validity

### Factorial Validity

Several studies have investigated the factor structure of the CFI, using both principal components



analysis and confirmatory factor analysis. While the results generally support the four-factor structure of the CFI, high correlations have been observed between the Need for Career Information and Need for Self-Knowledge scales ( $r = .80$ ) and the Career Choice Anxiety and Generalized Indecisiveness scales ( $r = .69$ ). This pattern supports the authors' claim that the CFI measures cognitive and emotional factors. Greater measurement efficiency could be obtained by combining the CFI items into two scales, but some information would be lost. The relative advantages of a four-scale and two-scale interpretation of the CFI are not known.

### **Convergent and Discriminant Validity**

Convergent validity is indicated when scores on a scale correlate highly with other measures of the same construct. Discriminant validity refers to the principle that scores on a scale should not correlate appreciably with measures of different constructs. Evidence indicating the CFI's convergent and discriminant validity is provided by correlations with measures of career crystallization, career decidedness, career development, career indecision, career specialization, goal instability, self-esteem, trait anxiety, and vocational identity. However, most of the expected correlations are in the low .30s, several are below .30, and some are even in the opposite direction from that which is expected. Overall, the evidence provides weak to modest support for the convergent and discriminant validity of the CFI.

### **Criterion-Related Validity**

There is virtually no evidence documenting the criterion-related validity of the CFI. One noteworthy attempt compared CFI scores prior to and following a counseling intervention. The change in scores was consistent with the interpretation that the intervention was effective, but two design flaws weaken the credibility of this interpretation. No evidence was presented to document the effectiveness of the intervention, and no tests of statistical significance were reported. Therefore, it is possible that the observed changes were not significant.

### **Evaluation**

The CFI is a simple 21-item instrument that can be used to assess a client's readiness to engage in the

career decision-making process. It assesses four of the many factors that are known to affect career decision making. Career-related problems outside of this narrow focus are not addressed by the CFI.

The stability of scores on the CFI is less than desirable, and its scales possess borderline to modest internal consistency. The factorial validity of the CFI has been supported by several studies, but the pattern of overlapping scales suggests that it primarily measures cognitive and emotional barriers to career decision making. The convergent and discriminant validity of the CFI are weak to moderate, and it lacks meaningful criterion-related validity.

The ambiguous wording of the CFI Likert items creates interpretive problems and it may, in part, account for the weak validity. The lack of adequate norms and the use of arbitrary statistical cutoffs for interpreting scores further exacerbate the interpretive problems. Interpretation of CFI results for anyone other than a university student is not warranted, and interpretation of university students' results is speculative at best.

Finally, the accuracy of self-scoring instruments is always a concern. Mistakes sometimes happen when clients score their own test results. Steps to minimize these mistakes and to document their frequency are essential. The rationale for self-scoring is not obvious given that the CFI has such a narrow range of application.

Howard E. A. Tinsley

**See also** Assessment (v4); Career Barriers Inventory (v4); Career Decision Scale (v4); Career Exploration (v4); Career Indecision (v4); Decision Making (v4); My Vocational Situation Scale (v4); Psychometric Properties (v2); Test Interpretation (v2)

### **Further Readings**

- Chartrand, J. M., & Nutter, K. J. (1996). The Career Factors Inventory: Theory and applications. *Journal of Career Assessment, 4*, 205–218.
- Chartrand, J. M., Robbins, S. B., Morrill, W. H., & Boggs, K. (1990). Development and validation of the Career Factors Inventory. *Journal of Counseling Psychology, 37*, 491–501.
- Chartrand, J. M., Rose, M. L., Elliott, T. R., Marmarosh, C., & Caldwell, S. (1993). Peeling back the onion: Personality, problem solving, and career decision-making style correlates of career indecision. *Journal of Career Assessment, 1*, 66–82.



- Lewis, D. M., & Savickas, M. L. (1995). Validity of the Career Factors Inventory. *Journal of Career Assessment*, 3(1), 44–56.
- Simon, M. A., & Tovar, E. (2004). Confirmatory factor analysis of the Career Factors Inventory on a community college sample. *Journal of Career Assessment*, 12, 255–269.

---

## CAREER INDECISION

---

Career indecision is the inability to specify an educational or occupational choice and can include focal problems, such as lack of information, or a combination of problems, such as choice anxiety and trait indecision. Career indecision is experienced by high school and college populations not only in the United States, but also in countries such as Belgium, Canada, Portugal, Israel, and Taiwan. Career indecision is a relatively common experience for adolescents and young adults in industrialized countries who are making the transition from formal secondary schooling to higher education or full-time employment. Counselors have an array of assessment tools at their disposal to distinguish between the two major presenting problems: developmental indecision and chronic indecisiveness. Distinct treatment approaches should be implemented for these two forms of indecision.

### The Domain of Career Decision Problems

There are five basic career decision problems.

#### ***Lack of Information and Need for Information***

Lack of information has long been considered to be the primary source of indecision. Information deficit accounts for the largest amount of variance in career indecision measures. Individuals can lack information about personal (“What are my strongest interests?”) and career characteristics (“What do software engineers do?”) or about how to engage in the decision-making process. The modal career counseling intervention is designed to increase self- and career-related knowledge and decision-making skills. Recent findings indicate that students may acknowledge a lack of information without feeling a need to gather more information. Clients who do not express a need

for information are unlikely to value interest–personality assessment or career exploration activities.

#### ***Identity Diffusion***

Identity is a core concept in vocational psychology theory and research. Identity diffusion is reflected in the inability to crystallize one’s career-relevant characteristics or to see a way to implement personal preferences in a career; career indecision may reflect delays or problems in identity development. Researchers have found moderate to strong linear relationships between identity diffusion and career indecision. Undecided students may benefit from interventions that enable them to explore and crystallize their identities prior to extensive involvement in information-gathering activities. Although identity diffusion is highly correlated with perceived lack of information, information gathering may exacerbate confusion for clients with identity diffusion. Both lack of information and identity diffusion can be seen as predecision problems occurring prior to formal decision making.

#### ***Trait Indecision***

Trait indecision reflects chronic and pervasive difficulty in making decisions. Trait indecision interferes with decision making in several domains: relationships, politics, leisure and recreation, spirituality, and career. Trait indecision can interfere with the ability to process and act on information attained through career assessment and counseling. Counselors often recognize trait indecision when they have completed a full course of career assessment and counseling and find that their client (a) has not identified an academic or career goal even when the objective data support one or more viable choices, (b) does not feel ready to terminate counseling, and (c) expresses doubt about her or his decision-making abilities and/or the counselor’s abilities. Trait indecision does not yield to rational analysis or counselor encouragement or support.

#### ***Choice Anxiety***

Choice anxiety is the affective dimension of career indecision. Specifically, it is negative affect experienced in relation to the career choice process and outcome. Choice anxiety can interfere with the client’s ability to gather relevant information, identify salient choice aspects, compare aspects of various choices



under consideration, and determine appropriate choices. Both trait indecision and choice anxiety inhibit the career decision process.

### ***Disagreement With Others***

The final career decision problem relates to disagreement with or disapproval of one's career choices by valued others such as a parent or spouse. This is a decision implementation problem rather than a decision problem because those who anticipate disagreement with others already have successfully formed a career goal. Disagreement with others also is weakly correlated with overall indices of career indecision.

## **Indecision Types**

Conceptualization of career indecision has advanced from a simple dichotomous classification of decided-undecided to multiple-type classification based on cluster analyses of career and personality variables. There is now consensus that there are two distinct career indecision types with differential counseling interventions appropriate for each. Those with developmental indecision have a focal need to acquire career information and initiate career planning. They experience little career choice anxiety, are goal directed, and have ego identity maturity appropriate to their chronological age. Clients with developmental indecision need brief, information-based career counseling.

The second type is chronic indecisiveness, which is associated with need for career information, high levels of negative affect including career choice anxiety, pessimistic views regarding future careers, low decision-making confidence and self-esteem, and poorly developed ego and vocational identity. This type exhibits the identity diffusion, trait indecision, and choice anxiety problems identified in the previous section. As the label indicates, this form of indecision persists over time. For example, it has been demonstrated that career indecision did not decline over a 3-year period for a sample of chronically indecisive French Canadian college students. These individuals require far more from career counseling than to acquire self and career knowledge.

## **Career Indecision Assessment**

Counselors have several tools at their disposal to assess indecision. The Career Decision Scale (CDS)

has been used widely as a global indecision measure. The CDS is unique in being the best available measure of the identity problems that can impede career exploration and decision making. The CDS is somewhat limited in that it does not reflect the full range of career decision problems and there is relatively little information available to assist the counselor in interpreting results. The Career Factors Inventory (CFI) is a brief instrument that reflects the negative cognitive and affective experiences inhibiting decision making. Although CFI does not measure identity diffusion, it provides the broadest coverage of the domain of career decision problems. The CFI is easy to administer and provides good interpretive information for the counselor. The Career Decision-Making Difficulties Questionnaire (CDDQ) is an excellent measure of lack of information and disagreement with others. Because it is not a commercial instrument, relatively little information is available to guide the counselor in interpreting the CDDQ. However, the CDDQ has been translated into several languages, and researchers are actively developing cross-cultural norms for this measure. Finally, the Career Thoughts Inventory (CTI) provides measures of trait indecision, choice anxiety, and disagreement with others. It does not reflect the information deficit or identity diffusion dimensions of indecision. The CTI has an excellent companion workbook that counselors and clients can use to refute negative cognitions associated with trait indecision and anxiety and develop more adaptive thoughts.

## **Career Indecision Interventions**

There are a number of good options for meeting the information needs of students and clients with developmental indecision. First, providing information about personal interests, abilities, and values has been the traditional focus of career counselors. Second, a wealth of career information is available on Internet sources such as the Occupational Informational Network (O\*NET) and America's Career InfoNet. Third, computerized career guidance programs such as DISCOVER are available as stand-alone media or as adjuncts to counseling. Finally, the innovative Making Better Career Decisions system uses a sequential elimination search process to guide users through the career evaluation and decision-making process.

There are three essential elements to intervention for the chronically indecisive. First, counselors must address the pessimistic and negative thoughts associated with trait indecision. It is important to instill hope



that the client can negotiate the challenging decision-making process and that a suitable academic or career goal can be identified. The CTI companion workbook is an excellent resource for developing more adaptive career thoughts. Second, counselors have to stabilize the negative affect associated with chronic indecision. Anxiety can interfere with the process of personal and career exploration and undermine the evaluation of alternatives. Counselors can employ a variety of anxiety management techniques to stabilize mood and clear a working space for career counseling. The third and most challenging goal is working with clients to form a more cohesive identity. Hamachek's articulation of counseling goals based on Erikson's psychosocial framework is a rich resource for counseling to promote ego identity development. Counselors can work with clients to (a) develop autonomy, which increases decision-making self-efficacy; (b) increase initiative by encouraging clients to experiment with novel work, leisure, and relationship roles; and (c) further develop industry. Clients will more readily incorporate personal and career information after developing a more clearly articulated ego identity.

*Kevin R. Kelly*

**See also** Career Counseling (v4); Career Counseling in Colleges and Universities (v4); Career Counseling in Schools (v4); Career Decision-Making Difficulties Questionnaire (v4); Career Decision Scale (v4); Career Decision Self-Efficacy Scale (v4); Career Factors Inventory (v4); Career Planning (v4); Career Thoughts Inventory (v4); Decision Making (v4); DISCOVER (v4); Occupational Information (v4); Occupational Information Network (v4); Prescreening, In-Depth Exploration, and Choice Model (v4); Tiedeman's Decision-Making Theory (v4)

### Further Readings

- Gati, I., & Asher, I. (2001). The PIC model for career decision making: Prescreening, in-depth exploration, and choice. In F. T. L. Leong & A. Barak (Eds.), *Contemporary models in vocational psychology* (pp. 7–54). Mahwah, NJ: Lawrence Erlbaum.
- Holland, J. L., & Holland, J. E. (1977). Vocational indecision: More evidence and speculation. *Journal of Counseling Psychology, 24*, 404–414.
- Kelly, K. R., & Lee, W. C. (2002). Mapping the domain of career decision problems. *Journal of Vocational Behavior, 61*, 302–326.
- Wanberg, C. R., & Muchinsky, P. M. (1992). A typology of career decision status: Validity extension of the vocational decision status model. *Journal of Counseling Psychology, 39*, 71–80.

### Web Sites

America's Career InfoNet: <http://www.acinet.org/>  
 DISCOVER: <http://www.act.org/discover>  
 Making Better Career Decisions: <http://mbcd.intocareers.org/>  
 O\*NET: <http://online.onetcenter.org>

---

## CAREER INTERVENTIONS

---

Career interventions are activities designed to explore and enhance a person's career development by helping the person make, implement, and benefit from a variety of career decisions. As such, career interventions take several forms. The most common include career counseling, assessment interpretation, group counseling, group assessment interpretation, career workshops, career classes, computer-assisted career guidance systems, and counselor-free interventions.

Career interventions took root at the turn of the 20th century with the vocational guidance movement. Started by Frank Parsons with the establishment of the first Vocation Bureau in Boston, the vocational guidance movement was focused on helping alleviate experiences of poverty and marginalization by providing the knowledge necessary to gain meaningful employment. Parsons theorized that these goals could be accomplished by helping people (a) understand their career interests and personalities, (b) obtain occupational information, and (c) integrate personal and occupational knowledge in a process of "true reasoning" to arrive at a meaningful career decision.

Over time, counselors, psychologists, and theorists have expanded and built upon Parsons's work. The present field of vocational psychology contains career interventions designed to help people not only make career decisions but also find jobs and experience satisfaction in their workplaces.

### Types

#### **Career Counseling**

Career counseling refers to an ongoing set of activities and conversations between a counselor and a client designed to help the client (a) decide which career to pursue, (b) complete a job search, or (c) build a sense of satisfaction and achievement at work. Thus, career counselors work with a wide variety of clients facing different career challenges. The specific form career counseling takes varies depending on the goals established by counselor and client.



Counseling for career choice is focused on helping people decide which career to pursue. Often, clients seeking this type of counseling are either beginning a career or considering a career change. These clients may be undecided for a variety of reasons, including a lack of information, too many or too few attractive options, conflict with others concerning these options, or a general difficulty making decisions. Throughout the course of counseling, clients are encouraged to gain a better understanding of how their personalities, interests, values, and skills might be more congruent with certain types of occupations than with others. Career counselors often ask clients to complete inventories or to discuss their personal backgrounds to help them gain self-understanding. Career counselors then assist clients in gathering information about various occupations. A final step is to analyze this information, generate a set of possible careers, and decide which career to pursue.

Counseling for job finding is focused on helping people implement their career decisions by finding jobs. Clients seeking this type of counseling are often either entering the workforce or looking for new jobs. Over the course of counseling, these clients are encouraged to put effort and intensity into a thorough job search. Job search effort and intensity can be influenced by factors such as personality, self-efficacy, social support, and perceived barriers. Clients who commit a great deal of effort and intensity to the job search tend to meet with success. Career counselors help clients conduct thorough job searches by encouraging effort and assisting with a comprehensive array of resources, including information on job search components such as effective resumes, interviewing skills, and networking.

Counseling for career satisfaction is focused on helping people gain a sense of enjoyment and accomplishment in their jobs. Often, clients who seek this type of counseling are employed, yet dissatisfied with their jobs. Dissatisfied workers are also likely to express difficulty performing job-related tasks, feelings of burnout, and stress. Career counselors help clients explore their feelings of dissatisfaction and consider their options. Some clients might choose to search for new jobs. Others might prefer to redesign their current jobs by developing coping strategies, seeking support, taking on new responsibilities, or building skills to improve performance.

Counseling for career choice, job finding, and job satisfaction are very different activities that share several common characteristics. Career counseling can last from a single session to well over 12 sessions, but

research suggests that 4 to 5 sessions may be optimal for many clients experiencing difficulties in making career choices. Research also suggests that these sessions tend to be most effective when the following components are included: (1) clients record their thoughts, ideas, and goals in a journal; (2) counselors provide individualized feedback and attention; (3) counselors and clients gather information concerning different occupations; (4) clients identify models who are engaged in their careers; and (5) counselors help clients build support networks. In addition, career counselors provide support, challenge career myths, and help clients select and pursue meaningful careers. In a multicultural society, it is increasingly important that career counselors appreciate cultural and contextual factors that may facilitate or limit career options. In order to better counsel an increasingly diverse clientele, career counselors need to increase their understanding of issues such as workplace discrimination, cultural values, racial identity, acculturation, and familial obligations.

### ***Assessment Interpretation***

Assessment interpretation is the process of reviewing, explaining, and discussing the results of an inventory designed to clarify (a) individual variables such as interests, abilities, and vocational needs; (b) process variables such as career maturity; or (c) cognitive variables such as self-efficacy. A clearer understanding of these variables can help individuals gain a sense of self-knowledge, clarify goals, and identify fitting occupations. To this end, assessment interpretation typically occurs in the context of career counseling, although assessment inventories can also be taken and interpreted on computers.

Assessment of individual variables is focused on helping clients develop a clearer understanding of their abilities, skills, interests, values, and personalities. These individual variables are usually measured by having clients complete inventories, tests, or card sorts. One commonly used inventory is the Strong Interest Inventory. This inventory provides a personalized profile of client interests. It also provides a profile indicating how similar a client's interests are to people working in and satisfied with a variety of different occupations. Together counselors and clients discuss these profiles with special attention to how profile themes apply personally and professionally to the client's life. While inventories are commonly used to measure interests and personality variables, card sorts are sometimes used to assess values. In this



process, clients rank order their work values by sorting cards into piles. Once the cards have been sorted, counselors and clients discuss the meaning of each value to the client. In addition to inventories and card sorts, clients might be asked to self-rate their abilities or complete ability tests such as the General Aptitude Test Battery. Tests and self-ratings such as these help clients clarify which abilities they possess.

Assessment of process variables is focused on understanding how people make career decisions. Process variables, such as career decision making, career maturity, and career adjustment, are commonly measured using questionnaires. Together counselors and clients review the results of the questionnaires and discuss the client's career development process in depth.

Assessment of cognitive variables is focused on uncovering cognitions that might help or hinder the career development process. Commonly assessed cognitive variables include dysfunctional career beliefs (e.g., "There is one perfect job for me") and career self-efficacy. Once they are known, dysfunctional career beliefs can be corrected and career self-efficacy can be enhanced.

Although assessment interpretation can provide objective and illuminating information, care must be taken to integrate the information provided by standardized assessments with other information on the client's experiences, preferences, supports, and barriers.

### **Group Career Counseling**

Group career counseling represents a popular option for clients seeking help for many types of career-related issues. More specifically, group career counseling is a multisession group experience in which participants may focus on both the pragmatic aspects of career-related issues (e.g., deciding upon a career) and the members' emotional reactions to such issues (e.g., feelings of anxiety or interpersonal concerns). Group career counseling allows participants some of the same therapeutic benefits of individual career counseling, but also provides opportunities for discussion, support, and validation among members.

Career counseling groups are often hosted by community counseling centers, university counseling and career centers, and professional career counseling clinics. These groups may range in size from approximately 8 to 12 members, although they may field smaller or larger numbers depending upon factors such as the purpose of the group or resources available.

Career counseling groups are typically led by a trained professional psychologist, social worker, or counselor. These groups typically meet once or twice per week and may terminate after a set number of sessions or continue indefinitely, allowing members to come and go as their needs are met.

Further, career counseling groups vary in terms of the structure provided. Some may be quite structured with a set agenda for each meeting (e.g., receiving interest inventory feedback, learning about the career decision process, discussing sources of support for career plans, preparing resumes). Others are much less structured and emphasize the processing of group members' emotional reactions (e.g., dealing effectively with career-related anxiety).

### **Group Assessment Interpretation**

Group assessment interpretation is a focused form of group career counseling in which the primary purpose is the administration and interpretation of the results of one or more career-related assessments. For example, a group may convene to interpret a specific assessment, such as the Strong Interest Inventory, or may review a broader battery of inventories and tests measuring aptitudes, values, and personality traits.

These groups share some similarities with both individual assessment interpretation and group career counseling. However, they differ from individual assessment in that the participants do not necessarily receive individualized interpretation or consultation within the group setting, and they differ from group career counseling in that the goals of the group are relatively focused on interpreting the results of formalized assessments. Furthermore, group assessment interpretation is typically confined to one or two sessions, while group career counseling often extends for multiple, regularly scheduled sessions.

A group assessment interpretation session should be led by a professional who meets the minimum qualification requirements for the administration and interpretation of the assessments being used. Beyond these requirements, the leader should also maintain a good understanding of each assessment's psychometric properties as well as an awareness of the prospective areas about which group members typically inquire.

A group assessment interpretation session will often begin with a discussion of the purpose of the assessment, including how assessment results should be incorporated into a broader program of career guidance. The group members may or may not actually



complete the assessment(s) within the group setting. Upon inventory completion and scoring, the group moderator will initiate a detailed interpretation of the assessment results, including scoring procedures, normative information, and possible implications of specific results.

Although group assessment interpretation is not an appropriate environment for discussing the myriad individual concerns that may arise from inventory results and general career issues, group members receiving inventory results can often experience strong emotional reactions. These individuals are often referred to individual counseling as appropriate.

### ***Career Workshops***

Career workshops are a structured set of activities in a group setting that allow participants the opportunity to develop particular skills or complete a specific task, typically within one or two sessions. Career workshops are often difficult to distinguish from structured career groups. Career groups emphasize enhancing group member communication on a variety of topics. Career workshops, however, focus on providing information concerning a single topic. Typical career workshops might, for example, assist members in deciding upon a college major, developing interviewing skills, creating or enhancing a resume, or learning how to begin professionally networking.

Similar to group career counseling, career workshops are typically hosted by university career centers, community counseling centers, and professional career counseling clinics. Professional organizations may also offer their members career workshops, often as part of a broader program, such as an annual conference. A workshop may last less than an hour, extend through several multihour sessions, or even span multiple days. Although a licensed professional may host a career workshop, a trained staff member or an individual familiar with the workshop's topic may just as often deliver them. For example, a corporate human resources representative may present a workshop on effective interviewing skills or a practicing professional may speak about emerging opportunities in his or her career field.

### ***Career Classes***

Located primarily within college settings, career classes offer participants the opportunity to gain information about the world of work as well as explore their

own interests, aptitudes, and values. Goals of particular classes may vary, but often include learning about theories and career-related information sources, exploring relevant academic majors, gaining self-knowledge, and learning job search skills and strategies.

Career classes may or may not bear credits toward degree attainment and may be taught by faculty in an academic department (e.g., psychology) or by counselors from the school's career center. Participants typically come from the hosting institution's student body, but alumni and nonaffiliated individuals may also enroll.

Like more traditional academic courses, career classes often have a syllabus, required readings, and graded assignments. In addition, they typically extend over the duration of the school's regular academic period (e.g., a semester or quarter) and meet once or twice per week. A typical class session may include a lecture component with topics such as major career development theories or job-search strategies and a process component wherein students discuss the lecture or their ongoing career activities. In this way, career classes incorporate elements that appear in both career counseling groups and career workshops and may also include assessment administration and interpretation. However, these classes do not typically include the therapeutic components featured in individual or group career counseling.

### ***Computer-Assisted Career Guidance Systems***

Computer-assisted career guidance systems (CACGS) are computer programs designed to simulate the career counseling process by providing career assessments, occupational and educational information, and tools for making decisions, planning, and beginning a career path. CACGS are often used as tools for individual exploration that supplement and build upon career counseling.

Some commonly used CACGS include CHOICES, DISCOVER, and SIGI PLUS. Each of these systems has specific versions targeted for youth, college students, and adults. Each version offers interest, ability, and value assessment tools. Based on assessment results, these systems generate occupational alternatives. System users can also access specific information on occupations generated as well as on other occupations of interest.

System users are also presented with the educational requirements of each occupation they explore.



CHOICES, DISCOVER, and SIGI PLUS contain detailed data on technical, undergraduate, and graduate educational institutions, including majors offered and availability of financial assistance. Once system users have explored occupational and educational information, DISCOVER and SIGI PLUS present information on making career decisions. All three systems offer information on career planning, including how to write a resume and build a professional network.

While CAGS are user-friendly sources of career and educational information, their use is somewhat limited. Access to CACGS requires both computer access and affiliation with an institution that subscribes to a specific system. Not all schools, colleges, vocational bureaus, and universities can afford to subscribe to a CACGS, and not every client has the necessary Internet access. For clients who are able to use CACGS, these computer systems remain comprehensive, up-to-date sources of valuable information and self-knowledge.

### ***Counselor-Free Interventions***

Counselor-free interventions are activities in which individuals use resources other than a career counselor to obtain and evaluate information related to career development. People participate in counselor-free interventions on a daily basis. They might talk with others about their interests, work personalities, values, skills, preferred occupations, and career aspirations. Such conversations can occur as informal interactions, structured informational interviews, job shadowing, or professional networking.

In addition to talking with others, people might seek out published career information. Many libraries and bookstores contain printed guides to career development. There are also several Internet databases of occupational information. Examples include Web sites maintained by the United States Department of Labor that provide detailed descriptions of occupations, requirements, salaries, career paths, and related jobs. Computer-assisted guidance systems can also be used in a completely self-directed way, and various tools have been developed by professionals to aid people in self-directed career exploration activities (e.g., the Self-Directed Search).

Nonetheless, counselor-free interventions tend to be informal, self-directed, and completed without the assistance of a professional counselor or psychologist. Although such individual career development works

for many people, its main disadvantage is that people might not be aware of the broad array of career resources and tools available to them. As a result, they may base career decisions on quickly gathered or incomplete information. For this reason, the effectiveness of counselor-free interventions has been called into question.

### **Effectiveness**

A great deal of research has accumulated on the effectiveness of various career interventions. Commonly measured outcomes include the certainty of the client's occupational choice, the amount of information gathered, the number of new options generated, the success of obtaining employment, the overall satisfaction with career outcomes, and the counseling process itself.

One means of assessing the effectiveness of an intervention is to calculate its effect size, which is an estimate of the strength of an intervention's effect. For example, if 50 individuals received career counseling and 50 others did not and more of the former group actually found jobs, the numerical difference between the two groups could be considered an estimate of the effect size of the intervention. Although there are several statistical methods used to estimate effect size, one common method is to calculate Cohen's *d*, which is defined as the difference, in standard deviation units, between the means of intervention group and control group outcomes. When  $d = .5$ , for example, the intervention group improved half of a standard deviation more than the control group.

Furthermore, researchers have been able to aggregate the results of multiple studies using a procedure known as meta-analysis. Rather than evaluating an intervention's effect size based on a single study, researchers calculate a combined effect size from the data of many studies, thus producing a more compelling result. Although meta-analytically derived effect sizes can vary substantially, most studies have concluded that career interventions do exert a measurable effect on career outcomes. For example, a study by Susan Whiston, Briana Brechesisen, and Joy Stephens cited three separate meta-analyses that found a large range of career intervention effect sizes between 0.34 and 0.82. These meta-analytically derived outcomes can vary based on many factors, including the type of intervention (e.g., structured or unstructured group), the outcome investigated, or the statistical procedures used.



Despite the variance in effect sizes, two general conclusions can be drawn about career interventions. First, counselor-directed interventions appear to produce demonstrably better outcomes than self-directed interventions. The typical range of effect sizes for counselor-free or self-directed interventions are  $d$ 's from .10 to .11, while those associated with counselor-led interventions range from .34 to .82. Thus, career interventions are, without a doubt, effective means of helping clients explore options, make decisions, and find work.

Second, despite these findings, not all interventions involving counselors may be equally effective. Individual career counseling, individual assessment interpretation, career classes, structured groups, and workshops appear to be more effective on average than unstructured group career counseling, group assessment interpretation, and self-directed CACGS, although the effectiveness of computer guidance systems seems to improve substantially with counselor involvement.

A growing body of research concerning elements of effective interventions has shown that career interventions are most effective when they are (a) directed at older adolescents and adults, (b) between four and five sessions in length, and (c) include the critical components of journaling, goal setting, individualized feedback, information gathering, modeling, and support building. Thus, despite variability in the statistical procedures used, the outcome variables evaluated, and the actual effect sizes themselves, research consistently demonstrates the effectiveness of counselor-directed career interventions. The exception is unstructured groups, which consistently demonstrate meager effects on the types of outcomes that are the focus of most career interventions.

### Future Implications

It appears that most types of career interventions for choice making and job finding difficulties are demonstrably (but sometimes modestly) effective. Thus, people seeking help with self-understanding, job-related information, developing more or fewer occupational possibilities, career decision making, resume development, interviewing skills, and job search strategies can be assured of receiving at least some help with these important vocational difficulties via individual and structured group counseling, workshops, classes, and counselor-assisted, computer-directed guidance systems.

There is, however, much that still needs to be learned to ensure maximum benefit for the widest variety of help seekers. There is virtually no research, for example, that has tested the effectiveness of any form of career intervention for people seeking help for job dissatisfaction. There also appear to be few studies examining the effectiveness of current career interventions for people who have pervasive problems in decision making and problem solving. Whether current career interventions are effective with these people is unknown at this time.

Perhaps most important, there has been growing recognition in recent years that career interventions need to attend more fully to the role that clients' culture, gender, race, ethnicity, sexual orientation, and nationality have on the types of choices they make (and are able to make) and their ability to find satisfying work. There is evidence, for example, that the work choices of many Asian Americans are substantially more influenced by their families than their own personal interests, especially for those who are less acculturated into mainstream U.S. society. There is also clear evidence that people in lower social classes, people of color, and women experience more barriers to occupational choice, attainment, and success than do people of higher social classes: Whites and men. Thus, more data are needed on the effectiveness of career interventions with different groups in order to provide maximally effective career service to the widest array of clientele. Particularly needed is research that would allow counselors to target their interventions to the most pressing, career-limiting issues that the poor and marginalized bring with them to counseling and to factors that would most facilitate these clients' abilities to find more satisfying work. Finally, more research is needed on the cross-national effectiveness of career interventions. The interventions that were described in this entry were developed from a largely Westernized, individualistic worldview. More research is needed on career interventions and their effectiveness in cultures and countries in which collectivism is the dominant cultural value. A pressing question for future research is whether the types of interventions described in this entry can be adapted for these cultures, or whether wholly new culturally specific interventions are needed.

*Kristen Lamp, Kyle Telander,  
and Steven D. Brown*



*See also* Assessment (v4); Career Counseling (v4); Career Counseling, History of (v4); Career Counseling Process (v4); Computer-Assisted Career Counseling (v4); DISCOVER (v4); Self-Directed Search (v4); System of Interactive Guidance Information (v4)

### Further Readings

- Brown, S. D., & McPartland, E. B. (2005). Career interventions: Current status and future directions. In W. B. Walsh & M. L. Savickas (Eds.), *Handbook of vocational psychology* (2nd ed., pp. 195–226). Mahwah, NJ: Lawrence Erlbaum.
- Brown, S., & Ryan Krane, N. (2000). Four (or five) sessions and a cloud of dust: Old assumptions and new observations about career counseling. In S. D. Brown & R. W. Lent (Eds.), *Handbook of counseling psychology* (3rd ed., pp. 740–766). New York: Wiley.
- Hackett, G., & Watkins, C. E. (1995). Research in career assessment: Abilities, interests, decision making, and career development. In W. B. Walsh & S. H. Osipow (Eds.), *Handbook of vocational psychology: Theory, research, and practice* (2nd ed., pp. 181–216). Mahwah, NJ: Lawrence Erlbaum.
- Holland, J. L., & Powell, A. B. (1996). *SDS career explorer*. Odessa, FL: Psychological Assessment Resources.
- Sampson, J., Reardon, R., Humphreys, J., & Peterson, G. (1990). A differential feature-cost analysis of nine computer-assisted career guidance systems. *Journal of Career Development*, 17(2), 81–111.
- Spokane, A., Fouad, N., & Swanson, J. (2003). Culture-centered career intervention. *Journal of Vocational Behavior*, 62, 453–458.
- Whiston, S., Brecheisen, B., & Stephens, J. (2003). Does treatment modality affect career counseling effectiveness? *Journal of Vocational Behavior*, 62, 390–410.
- Whiston, S., Sexton, T., & Lasoff, D. (1998). Career-intervention outcome: A replication and extension of Oliver and Spokane (1988). *Journal of Counseling Psychology*, 45(2), 150–165.

---

## CAREER/LIFE

---

The traditional view of career, what one does on the job at work and the sequence of work-related positions throughout a person's work history, has given rise to a holistic paradigm called career/life that includes the time and energy put into multiple roles simultaneously played throughout one's life. Each

role has the potential of positive or negative consequences for the other roles being played. This career/life paradigm provides numerous outlets for meaning making and self-expression, and it identifies one major outlet, specifically the work role, for money making and sustenance.

### Emergence

Career/life first emerged in the 1970s as theorists and practitioners sought a new model and language (career/life or life/career) to more effectively describe and deal with the realities of individuals struggling with problems associated with balancing work and other life roles such as homemaking, marriage, parenting, and attending school to either enter or advance within the labor market. Many of these persons were midcareer changers, some of whom were women labeled as displaced homemakers and enrolled in women in transition programs. The new term, career/life, coined by E. A. Colozzi in 1977 and reported by E. A. Colozzi and F. P. Haehnlen in their work in Hawaii and the Pacific Basin Rim region, was initially utilized for older adults in transition and later expanded to younger students in college and school-aged youth. Perhaps the most articulate and visually appealing representation of this model is D. E. Super's life/career rainbow that depicts the nine major roles played by people throughout the life-space and life-span continuum of their lives. His conception of the term life/career and subsequent writings have introduced many graduate students to this new paradigm as they are taught how to effectively assist their clients with making decisions about work and life roles.

### Intertwined Career and Personal Issues

Paramount in the early development of this paradigm was recognition that people's lives were complex and woven together with rich stories across life roles that provided important threads of relevance, informed decision making, and were all part of a continuous life journey that involved constant change and multiple transitions. Career and personal issues were now seen as intertwined, as they always have been. Work situations and relationships affect nonwork roles, and all of the nonwork roles directly affect the work role, including productivity and job satisfaction.

A divorce or unexpected death of a spouse can trigger a major transition for a woman who has primarily



been a homemaker and finds herself trying to support her three children as a single parent while taking classes at a community college to prepare for employment. Suddenly the old rules are no longer relevant, and dramatic changes may have occurred across several life roles requiring adjustment, coping skills, and a discovering of a whole set of new rules for survival during her continuing life journey.

### **Vocational Guidance Roots**

This paradigm shift has challenged the vocational psychology and the career development professions to better understand vocational behavior and to develop effective interventions that are relevant to this context of career/life. A brief review of the history of vocational psychology and vocational guidance will help one understand the emergence of career/life during the past 30 years.

In a comprehensive account of the antecedents that formed vocational psychology's foundation, origin, and emergence, M. L. Savickas and D. B. Baker describe vocational psychology as a specialty within applied psychology that advances the scientific research and knowledge about vocational behavior resulting in the development and improvement of career interventions. Its prehistory is rooted in the early stages of vocational guidance that is linked to the emergence of large commercial cities in which the factory system shifted the American economy from agriculture to manufacturing accompanied by industrialization, urbanization, and immigration during the 1800s.

Research by Savickas and Baker describes how the change in population distribution gave rise to many problems related to unemployment, alcoholism, delinquency, and crime, all of which prompted the establishment of the first Boston branch of the Young Men's Christian Association (YMCA) in 1851 to improve the spiritual condition and mental culture of young men. This effort eventually evolved into a combination of counseling and placement activities in conjunction with vocational training programs for youth at a time when educators became interested in individual differences and in addressing industry's need for more effective ways of matching people to new occupations.

The vocational guidance movement and the establishment of the profession, with the formation of the National Vocational Guidance Association in 1913 that

has evolved into the National Career Development Association, is almost 100 years young. It was born in 1909 with Frank Parsons in New England, specifically Boston, Massachusetts. Parsons, a Boston University law professor and leading civic reformer who championed the needs of Boston's poor population, is viewed as the founder of vocational guidance because his three-step paradigm of increasing self-knowledge, providing occupational information, and matching self to job (person to environment or P-E) using true reasoning is a conceptual model on which the field still rests, according to Savickas and Baker.

### **Person-Environment Matching Across Roles**

The career/life model successfully incorporates the Parson's P-E matching process for work-related decisions throughout the 7 to 10 job changes in several unrelated career areas most persons will experience in their work history. Additionally, it facilitates similar P-E matches across multiple life roles as individuals make choices about education, spousing, parenting, volunteer, and leisure activities, all of which affect each other and have the possibility of providing a sense of meaning and purpose.

The career/life model brings relevance to the learner role for students when they understand how the learner role and worker roles are closely connected. This can increase motivation and therefore increase student involvement and retention. Adults can use this paradigm to better understand the normal stressors involved in trying to balance parenting, work, and spousing activities to keep their relationships vibrant and healthy. Workers who are considering retirement now have an effective perspective for remaining active and healthy both emotionally and physically as they sort out leisure and volunteer activities that still provide appropriate and fulfilling P-E matches in nonwork roles. Even young students in K-6 settings can use this model to better understand the importance of developing good work habits in their "jobs" at school—their learner role—as a way of preparing themselves for the next grade level and subsequent school-to-school or school-to-work transitions. A major benefit of career/life, perhaps the most important, is the opportunity for people to realize the multiple ways it is possible to experience meaning and purpose through activating combinations of several career/life roles, one of which can be work.



## Future Challenges and Directions

The career/life paradigm is a response to societal changes resulting from further involvement with the information age. These include family structural changes where both spouses are often working while raising a family and acting as caregivers to aging parents, high divorces rates resulting in more single parents, increased stress related to work and nonwork roles, major technological advances often accompanied by new jobs and different ways of working, globalization, and the desire among many people to search for more meaning and purpose in their work and more balance in their lives as documented by E. A. Colozzi and L. C. Colozzi.

Some, such as D. L. Bluestein, have suggested that the career development field today has neglected the poor and focused mostly on those who are active participants in our educational systems and labor markets. This statement is probably very true, and more needs to be done with this population including the development of public policies that effectively deal with the career development needs of the poor.

Exciting challenges for the field of vocational psychology include initiating important research to advance knowledge about these issues, measuring career interventions, and informing public policy. Equally exciting challenges for the career development profession include promoting excellent career development interventions to effectively serve students in K–12 and postsecondary settings, workers seeking job changes, the unemployed (including the homeless, special needs populations, and other disenfranchised groups), workers planning retirement, and persons dealing with career/life conflicts across multiple life roles.

Perhaps the most important and exciting challenge is to strengthen the dialogue between the vocational psychology and career development professions so excellent research can inform and promote excellent career development practices that effectively facilitate the career/life decisions all people make.

*Edward Anthony Colozzi*

*See also* Adult Development (v1); Adults in Transition (v4); Career Counseling in Schools (v4); Career Counseling Process (v4); Career Exploration (v4); Career Interventions (v4); Life-Role Balance (v4); Life Transitions (v2); Person–Environment Interactions (v2);

Super's Theory (v4); Vocational Identity (v4); Work–Family Balance (v4); Work Stress (v4)

## Further Readings

- Bluestein, D. L. (2006). *The psychology of working: A new perspective for career development, counseling, and public policy*. Mahwah, NJ: Lawrence Erlbaum.
- Colozzi, E. A. (1979). Career/life exploration and planning [Course syllabus available from Leeward Community College library archive. 96–045 Ala Ike—Pearl City, HI 96782].
- Colozzi, E. A., & Colozzi, L. C. (2000). College students' callings and careers: An integrated values-oriented perspective. In D. A. Luzzo (Ed.), *Career counseling of college students: An empirical guide to strategies that work* (pp. 63–91). Washington, DC: American Psychological Association.
- Colozzi, E. A., & Haehnlen, F. P. (1981). The impact of a computerized career information system on a community college in an island state. *International Journal for the Advancement of Counseling*, 5, 273–282.
- Savickas, M. L., & Baker, D. B. (2005). The history of vocational psychology: Antecedents, origins, and early development. In W. B. Walsh & M. L. Savickas (Eds.), *Handbook of vocational psychology* (3rd ed.). Mahwah, NJ: Lawrence Erlbaum.
- Super, D. E. (1980). A life-span, life-space approach to career development. *Journal of Vocational Behavior*, 13, 282–298.

---

## CAREER MASTERY INVENTORY

---

The Career Mastery Inventory (CMAS) evolved from the Career Adjustment and Development Inventory (CADI), a measure that was developed by John Crites as a means of assessing important facets related to career adjustment and development in early adulthood. Accordingly, six developmental tasks associated with the establishment stage of career development were identified. The establishment stage is typically defined as being between the point of occupational entry and midcareer. The CMAS consists of two parts. The first part assesses mastery of the developmental tasks. The second part assesses the ability to cope with problems in the work place.

The first part of the CMAS consists of 90 items that make up the subscales that reflect the six tasks:



(1) Organizational Adaptability involves the process of becoming socialized to the expectancies of the work environment, (2) Position Performance refers to learning the duties and tasks associated with a job, (3) Work Habits and Attitudes involves being dependable and receptive to supervisory feedback and having a positive attitude, (4) Co-Worker Relationships involves being cordial with others and dealing with interpersonal conflicts as they occur on the job, (5) Advancement involves promotion within the organization, and (6) Career Choice and Plans involves establishing goals and identifying a career path to follow. These scales are ordered along the sequence in which they would be encountered developmentally. Thus, the CMAS provides a series of developmental tasks that gauges an individual's level of adaptability during the establishment stage. Theoretically, mastery of these six tasks results in success at work and job satisfaction. A total score provides an overall index of career adjustment.

The second part of the CMAS consists of 20 open-ended items that assess how well a person can cope with problem situations on the job. These items reflect thwarting or barrier conditions that occur in the work place. Scores on this part of the CMAS reflect how well a person managed each situation. Responses to these items are scored on three levels of adjustment: *integrative*, *adjustive*, or *nonadjustive*. An integrative response indicates that the person was able to remove the barrier condition and reduce tension and anxiety. An adjustive response indicates that the person was able to reduce tension and anxiety, but was unable to remove the barrier condition. A nonadjustive response indicates that neither the barrier condition was removed nor tension and anxiety reduced.

The CMAS can be either hand or machine scored. Raw scores are plotted on a profile and matched against the corresponding standard score. Further information regarding scores can be found in the *CMAS User's Guide*, which also includes case study illustrations. CMAS scores can be used to benchmark how well individuals are progressing in their career development when compared to their peers in an organization, thereby providing a means of identifying those who may require intervention in their career development.

Brian Taber

*See also* Assessment (v4); Career Advancement (v4); Career Barriers Inventory (v4); Crites, John O. (v4)

## Further Readings

Crites, J. O. (1996). Assessment and counseling for career mastery. In M. L. Savickas & W. B. Walsh (Eds.), *Handbook of career counseling theory and practice* (pp. 237–250). Palo Alto, CA: Davies-Black.

---

## CAREER MATURITY

---

Career maturity is defined as the degree to which individuals are prepared to make good educational or vocational decisions. It is usually seen as dependent on their knowledge of themselves and of the world of work, their ability to make decisions, and a positive attitude toward making career decisions. It is developmental in nature, following an individual's growing maturity in all life areas. Frank Parsons, generally considered to be the father of career development, saw career maturity as encompassing a clear understanding about oneself, knowledge of the requirements of different occupations, and true reasoning on the relationships among these. The term *career maturity* was first promulgated by Donald E. Super, and many authors have used it subsequently in developing career counseling assessment instruments and career counseling processes and procedures.

Counselors and others who run career programs in schools and other institutions that are developmental in nature often consider career maturity to be an objective of these programs. This is in contrast to programs that see a career decision as the desired outcome of intervention.

Career maturity may encompass the ability to make good career decisions or the state of having made these decisions. The term *good* is used as a shortcut for the variety of elements that enter into career decision making. These elements include areas of self knowledge, such as knowing one's values, understanding one's interests, being aware of one's temperament, and thinking about one's lifestyle preferences. The term includes knowing about one's strengths and weaknesses, abilities and liabilities, skills, aptitudes, learning style, and motivation. The elements of good also include knowledge of the world of work, such as knowing about the requirements of various occupations—training or formal education, apprenticeship, on the job training, and so forth. It includes knowledge of the opportunity structure, for example, is the field growing



or declining? How many potential openings are there in an individual's desired geographical location? It includes understanding how to find out occupational information. And of course it basically means knowing what the work entails.

A positive attitude toward making a career decision is implicit in the concept, and that attitude includes individuals' confidence in their knowledge and skills in the arenas outlined above including confidence in their ability to make good decisions. This often derives from having had successful previous experience in decision making.

Recently, there have been questions about the appropriateness of the concept in a world where individuals must frequently reassess their career plans and objectives. Some, including notably Super himself, have stated that career flexibility or adaptability may be more fitting descriptors for individuals who are capable of being self-directed in their career decision making.

Jane Goodman

**See also** Career Decision-Making Difficulties Questionnaire (v4); Career Education (v4); Career Indecision (v4); Career Maturity Inventory (v4); Decision Making (v4); Super, Donald Edwin (v4); Super's Theory (v4); Tiedeman's Decision-Making Theory (v4)

### Further Readings

- Herr, E. L., Cramer, S. H., & Niles, S. G. (2004). *Career guidance and counseling through the lifespan* (6th ed.). Boston: Pearson.
- Parsons, F. (1989). *Choosing a vocation*. Garrett Park, MD: Garrett Park Press. (Original work published 1909)
- Super, D. E. (1957). *The psychology of careers: An introduction to vocational development*. New York: Harper.

---

## CAREER MATURITY INVENTORY

---

The Career Maturity Inventory (CMI) is a 50-item standardized measure designed to assess the process of how adolescents and adults approach career development tasks. John Crites developed this measure in the 1960s as the Vocational Development Inventory to assess the readiness attitudes of students in making appropriate vocational plans. It became the CMI in 1973 and was

enhanced to include career planning competencies, including knowledge of self and the world of work. The CMI was revised in 1978 and most recently in 1995. Potential uses of the CMI include researching career development, needs assessment, career counseling, and program evaluation. Counselors may supplement interpretations by using an additional guide, the *Career Developer*, to explain correct answers.

Crites's conceptualization of career maturity is based on Donald Super's theory of career development, which emphasizes general factors related to realistic career choice content and process. Based on longitudinal analyses, items were selected to differentiate adolescents across a developmental continuum toward higher levels of career maturity. Higher CMI scores identify individuals with mature career decision-making approaches resulting in readiness to make informed career plans.

Consistent with Crites's model of career maturity, the original CMI assessed five competencies (self-appraisal, occupational information, goal selection, planning, and problem solving) and five attitudes (decisiveness, involvement, independence, orientation, and compromise). The 1995 CMI collapsed these into broader dimensions measuring competence, attitudes, and career maturity total because the previous more specific scales yielded low reliabilities that were not readily incorporated into counseling practice. Clients respond to statements drawn equally from each of the original scales to address each construct. The original CMI used a true or false item format, whereas the current version uses an agree or disagree format. A sample Attitudes item, "I seldom think about the job I want to enter," reflects one's involvement in the process. The competencies section comprises 25 statements in which respondents appraise the appropriateness of content reflected in brief narratives.

Over 3 decades of research, including 2,000-plus investigations, have shown that CMI scores increase throughout adolescence and as the result of interventions. However, the individualistic nature of career maturity has raised questions regarding cross-cultural validity and counseling utility. For example, Asian Americans who typically represent a collectivistic orientation tend to score lower on the CMI because of their more interdependent decisional style. Although extensively researched, ongoing attention to examining psychometric qualities of the revised CMI is warranted.



Recently, the concept of career maturity has been expanded and termed career adaptability to encompass adult career concerns. In their 1995 revision, Crites and Mark Savickas sought to strengthen its practical relevance, to update standardization samples, and to minimize cultural bias in item content. Several items were modified or deleted to increase applicability with postsecondary clients. In addition, they shortened administration time, increased content relevance to adults, collapsed the subscales into broader dimensions, produced a companion guide to enhance counseling applications, and improved scoring options. Although some research has been conducted on the revised CMI, concern about the internal consistency of scales persists. Nonetheless, the rich empirical and theoretical foundations of the CMI warrant continued use in counseling and research.

*Patrick J. Rottinghaus*

**See also** Career Decision-Making Difficulties Questionnaire (v4); Career Development Inventory (v4); Career Education (v4); Career Indecision (v4); Career Maturity (v4); Decision Making (v4); Super, Donald Edwin (v4); Super's Theory (v4); Tiedeman's Decision-Making Theory (v4)

### Further Readings

- Busacca, L. A., & Taber, B. J. (2002). The Career Maturity Inventory—Revised: A preliminary psychometric investigation. *Journal of Career Assessment*, 10, 441–455.
- Crites, J. O., & Savickas, M. L. (1996). Revision of the Career Maturity Inventory. *Journal of Career Assessment*, 4, 131–138.
- McDivitt, J. (2002). Review of the Career Maturity Inventory. In J. T. Kapes & E. A. Whitfield (Eds.), *A counselor's guide to career assessment instruments* (4th ed., pp. 336–342). Alexandria, VA: National Career Development Association.
- Savickas, M. L. (2000). Assessing career decision making. In C. E. Watkins, Jr., & V. L. Campbell (Eds.), *Testing and assessment in counseling practice* (2nd ed., pp. 429–477). Mahwah, NJ: Lawrence Erlbaum.

### Web Sites

Vocopher: <http://www.vocopher.com>

## CAREER OCCUPATIONAL PREFERENCE SYSTEM

The Career Occupational Preference System (COPSystem) is a coordinated career guidance program consisting of three assessment instruments all keyed to eight major career clusters. The three assessment components are the COPSystem Interest Inventory (COPS), the Career Ability Placement Survey (CAPS), and the Career Orientation Placement and Evaluation Survey (COPES) and their accompanying interpretive materials. Interpretation of the three assessments is organized around an easy to use group of eight occupational clusters representing all possible jobs in the world of work. The COPSystem measures interests, abilities, and values in terms of these eight major career clusters: science, technology, outdoor, business, clerical, communication, arts, and services with five of the eight cluster results representing both professional and skilled-level occupations for a total of 14 clusters. The COPSystem assessments are designed to assist individuals in the career exploration and decision-making process.

The COPS consists of 168 job activity items, and examinees respond to these items according to their degree of like or dislike for each item based on a 4-point scale from *like very much* to *dislike very much*. The norms are based on samples of high school and college students throughout the United States and are updated every 2 to 5 years. The COPS is a valid and reliable instrument. Alpha reliability coefficients range from .86 to .92, and validity has been established through a long-term study demonstrating that 64% of students were in a job or college major that matched one of their three highest interest areas from 1 to 7 years after taking the COPS.

The CAPS consists of a battery of eight 5-minute ability tests that provide a comparatively brief and cost-effective measure of ability for career development. The eight ability tests in the CAPS are Mechanical Reasoning, Spatial Relations, Verbal Reasoning, Numerical Ability, Language Usage, Word Knowledge, Perceptual Speed and Accuracy, and Manual Speed and Dexterity. The CAPS scores are reported based on three norm groups; grade levels 8–9, 10–12, and college. Examinees receive scores for abilities as compared to each of the 14 career clusters reported on the COPS, demonstrating areas of



strength and weakness in terms of ability. The CAPS test–retest reliability coefficients range from .70 to .95 and predictive validity studies show that ability scores are significantly related to subsequent career choice.

The COPEs is a measure of personal values that reflect major dimensions representing vocational motivation based on the following scales: Investigative Versus Accepting, Practical Versus Carefree, Independence Versus Conformity, Leadership Versus Supportive, Orderliness Versus Flexibility, Recognition Versus Privacy, Aesthetic Versus Realistic, and Social Versus Reserved. Each dimension is measured by two-choice, paired comparison items, and scores are reported for each values scale as well as related to the COPSys system career clusters. The reliabilities range from .70 to .83, and a preliminary follow-up study found an 89% hit rate for work values matched to subsequent career or college major choice.

The benefit of the COPSys assessment program is that the three most key components of choosing a career are combined on a single profile allowing the examinee to consider a complete profile and make an informed decision on how to move forward in the career exploration process.

*Lisa Knapp-Lee*

*See also* Assessment (v4); Career Education (v4); Career Exploration (v4); Career Planning (v4); Decision Making (v4); Occupational Information (v4); Roe's Theory of Personality Development and Career Choice (v4); Work Values (v4)

### Further Readings

Knapp, R., Knapp, L., & Knapp-Lee, L. (1985). Occupational interest measurement and subsequent career decisions: A predictive follow-up of the COPSys Interest Inventory. *Journal of Counseling Psychology*, 32, 348–354.

---

## CAREER PLANNING

---

Career planning refers to the process of making educational and career choices based on knowledge of self and of the environment. The purpose of career planning is to encourage individuals to explore and

gather information about various educational and career opportunities thus enabling them to develop realistic career goals. Career planning is an ongoing activity that should be implemented as early as the middle school years and extend into adulthood. The career planning process can be divided into four stages. These stages include (1) self-assessment, (2) knowledge of academic-career options, (3) in-depth evaluation and goal setting, and (4) career plan implementation.

Self-assessment refers to an individual's ability to gather information about his or her interests, skills and abilities, values, and personality type. Examples of questions to consider at this stage include the following: What types of work and school-related courses and activities do I enjoy? What can I do well? What types of skills have I gained through various curricular and cocurricular experiences? What values do I consider important in my preferred career? Many of these questions can be answered through career assessments such as the Kuder Career Planning System, Strong Interest Inventory, or Self-Directed Search.

Knowledge of academic-career options refers to an individual's ability to gather information about the world of work. Knowledge of specific jobs, occupations, and organizations; work conditions; required education; job outlook; and chances for advancement are important factors in choosing the right career. Individuals can explore possible careers using a number of different resources such as the Occupational Information Network (O\*NET), *Occupational Outlook Handbook*, or computer-assisted guidance systems. Other activities could also include spending time with adults who are engaged in occupations related to one's interests, job shadowing, volunteer work, and discussing one's educational plans with parents, teachers, and guidance counselors.

In-depth evaluation and goal setting refers to an understanding of how to make decisions based on the information one has gathered in the first two stages of career planning; an awareness of the factors that may impact one's ability to implement one's decisions; and the setting of short-, medium-, and long-term goals. During this stage, individuals may want to consider questions such as, Do my interest, skills, and values match those of the occupation I've selected? What schools offer the training that will be needed to pursue my career of interest? How long will it take me to



complete the education required of my career of interest? Are there other occupations that I should consider as alternatives?

Finally, the last stage of the career planning process is career plan implementation, which involves making an initial choice and taking steps toward reaching career goals. The primary focus of this stage is on job and educational preparation. Individuals at this stage should make deliberate efforts to (1) apply to various education and training programs, (2) gather information on specific companies, (3) develop a job search strategy, (4) develop résumés and cover letters, and (5) prepare for job interviews.

Levon T. Esters

*See also* Career Advancement (v4); Career Decision-Making Difficulties Questionnaire (v4); Career Development Inventory (v4); Career Education (v4); Career Exploration (v4); Career Planning Survey (v4); Occupational Information Network (v4); Self-Directed Search (v4); Strong Interest Inventory (v4)

### Further Readings

- Bardick, A. D., Bernes, K. B., Magnusson, K. C., & Witko, K. D. (2006). Junior high school students' career plans for the future. *Journal of Career Development, 32*(3), 250–271.
- Bowlsbey, J., Dikel, M. R., & Sampson, J. P. (2002). *The Internet: A tool for career planning* (2nd ed.). Tulsa, OK: National Career Development Association.
- Niles, S. G., & Harris-Bowlsbey, J. (2002). *Career development interventions in the 21st century*. Upper Saddle River, NJ: Prentice Hall.

---

## CAREER PLANNING SURVEY

---

The Career Planning Survey is a paper-based career assessment system designed to help students in Grades 8 through 10 identify and explore personally relevant occupations and high school courses. The assessment elements consist of an interest inventory, an inventory of ability self-estimates, and two optional academic ability tests. In addition, students can complete checklists assessing their work-relevant experiences and the characteristics they want in a job.

Counselor materials encourage the use of the Career Planning Survey in group settings to teach students how to gather and consider self and occupational information essential to the exploration of educational and occupational options.

The Career Planning Survey is published by ACT. It is one of several ACT programs (such as PLAN, EXPLORE, and DISCOVER) that use the ACT World-of-Work Map to graphically show students how their assessment results relate to occupations and how occupations relate to each other. The Career Planning Survey was introduced in 1997.

### Features

#### Assessments

The revised Unisex Edition of the ACT Interest Inventory (UNIACT) assesses preferences for work-related activities. The 90 items emphasize activities that are familiar to people either through participation or observation. Scales are organized according to the six types of basic interests described in John Holland's theory of careers.

The Inventory of Work-Relevant Abilities (IWRA) obtains informed self-estimates for 15 abilities shown by research to differentiate occupational groups. Example abilities are mechanical, sales, leadership, and scientific. Scales are organized according to the six types of basic interests described in John Holland's theory of careers. As described in the *Career Planning Survey Technical Manual*, IWRA has been empirically shown to improve the career exploration validity of tested abilities.

Two optional academic ability tests assess level of development in reading skills and numerical skills. Results are nationally normed by grade level.

#### Score Report and Student Materials

The unique Career Planning Survey score report is the only paper-based score report that visually links both interest and ability results to occupational options. Both UNIACT and IWRA scores are converted to directional information on the research-based World-of-Work Map, permitting students to visually compare their interests to their abilities and to see career options in line with each.

A booklet accompanying the score report guides students to information on more than 500 occupations.



These materials use a step-by-step approach designed to broaden career horizons while simultaneously providing focus for career exploration. As described in the *Career Planning Survey Counselor's Manual*, panels of high school students and counselors reviewed assessment and student materials for age appropriateness.

### **Japanese Edition**

The Career Planning Survey—Japanese Edition was introduced in Japan in 1998. There are currently two versions: a paper-based version and an Internet version. It is used by college students to explore personally relevant occupations, and by adults in career transition. These products are jointly owned by ACT and Nippon Manpower Co., Ltd.

Kyle B. Swaney

*See also* Assessment (v4); Career Counseling in Schools (v4); Career Education (v4); Career Exploration (v4); Career Planning (v4); DISCOVER (v4); Holland's Theory of Vocational Personalities and Work Environments (v4); Unisex Edition of the ACT Interest Inventory (v4)

### **Further Readings**

ACT. (2001). *Career Planning Survey counselor's manual*. Iowa City, IA: Author.

ACT. (2001). *Career Planning Survey technical manual*. Iowa City, IA: Author.

---

## **CAREER RESOURCE CENTERS**

---

A career resource center (CRC) refers to a physical facility and to the location of materials, resources, and personnel delivering career services to individuals and groups. A CRC is typically located in the career center, counseling center, human resources office, library, or training and development unit of an organization. In contrast, a career center is an administrative unit of an organization—for example, school, business, or agency—that employs staff who deliver a variety of career programs and services. Comprehensive career centers provide career counseling and assessments, experiential career opportunities such as internships and cooperative education, educational and career

information, job hunting assistance, and employment information. They may also provide services to employers seeking to fill their hiring needs. Less comprehensive career centers may provide only some of these services. A career center would almost always include a CRC.

When the vocational guidance movement in the United States emerged in the early 1900s, the development of CRCs was one of its most tangible and lasting accomplishments. The roots of the movement sprang from the social reform and humanitarian activities in urban areas in the Midwestern and Eastern United States. CRCs were often located in settlement houses, which provided a variety of social services including vocational guidance to immigrants and others. Career counseling developed in the context of these CRCs. A distinguishing CRC feature was and remains the provision of resources and information about occupations, jobs, training, financial aid, employability, and career planning. This entry briefly reviews some of the characteristics of the first CRCs that have carried forward to the present time and describes the characteristics of modern CRCs.

### **The Development of Career Resource Centers**

Frank Parsons, generally regarded as the father of vocational guidance, at the turn of the last century created one of the first CRCs. His Vocation Bureau was located in the Civic Service House, a Boston settlement house that provided a variety of social and civic services to citizens and Italian immigrants. Parsons created this early CRC with a private grant provided by a wealthy Boston matron, and he formulated a technique for providing career counseling in this context. His book, *Choosing a Vocation*, was published posthumously in 1909 and included details about the resources, materials, and staffing of the Vocation Bureau.

With the passage of time, CRCs moved from community settings such as settlement houses mostly into colleges, universities, and high schools and less often into business organizations, governmental, and social service agencies. The Vocation Bureau, for example, found a new home at Harvard University. In educational settings, CRCs were typically housed in either a counseling center or a career planning and placement center. More recently, CRCs are most likely to



be located in a career center and provide the resources used by staff and clients to solve career problems and make career decisions.

The resources in a CRC can include inventories and tests, card sorts, books, descriptions of occupations or educational and training institutions, CDs and DVDs, pamphlets, clippings, Web pages, instructional modules, multimedia resources, training materials, magazines, take-away materials (free handouts), and procedures for locating information or preparing for a job campaign, for example, resume writing and interviewing. Career counseling is another resource that might be available in a CRC, and professional counselors or paraprofessionals, sometimes called career development facilitators, could provide it. The intended outcome of using career resources, including career counseling, is client or customer learning and a change in career-related behavior.

Career resources can be grouped into three broad categories: (1) assessment instruments, (2) information sources, and (3) instruction. Assessment resources include instruments that enable persons to examine their self-knowledge, typically interests, values, skills, and abilities, in order to create information for career problem solving and decision making. These instruments may be used in a self-help format or with the assistance of a professional counselor.

Information resources describe the characteristics of occupations, education, training, and employment that individuals use to refine their career options. Occupational information describes the nature of work, the nature of employment, and the requirements for employment in occupations (e.g., accountant) and categories of occupations. Occupational information is also used to identify and learn about job targets in employment decision making. Educational information describes the nature of education or training, the nature of the institution or training provider, and admission to individual institutions or categories of institutions (e.g., community colleges). Employment information describes sectors, industries, employers, and positions in the job market.

Instructional resources are used to help persons clarify self-knowledge, knowledge of their options, and knowledge of the decision-making process. In this context, career counseling could be considered as a form of instruction. Instruction is related to career assessment and career information described previously, although several differences exist. For example,

instruction or counseling integrates several sources of information in a meaningful sequence designed to achieve a specific learning outcome, for example, a booklet on how to make a career decision. In comparison with assessment and information, instruction or counseling is a less commonly available type of career resource.

## **Career Resource Center Operations**

### ***Staffing and Operations***

Successful operations in a CRC require special management and administrative staff. A hierarchy of professionals, paraprofessionals, and support staff work together to maintain the library and resources and to provide effective career service to users. A media specialist or librarian should be available to manage the materials, and information technology professionals are needed to monitor computer software. A manager, often a professional counselor, should oversee CRC operations and provide supervision to the counselors and other staff.

The manager or consultant knowledgeable about all aspects of both career development and organizational structure, perhaps aided by an advisory committee, designs and implements the CRC program. After conducting a needs assessment, the manager proceeds to create a mission statement, design a program plan, coordinate existing programs, and ultimately run a pilot study prior to implementation.

### ***Budget***

A CRC budget varies according to the size, location, and complexity of the center, as well as the needs of the users. It typically includes funds for salaries, tests and inventories, furniture, equipment, technological support, books and materials, printing, subscriptions, staff training, and office materials.

### ***Location and Facilities***

As noted earlier, a CRC can be located in various settings, ideally in a high traffic area with easy user access. It is important that the site and facilities have interior open space with windows and have walls for displaying posters and signs directing users to resources. Facilities should include an ample amount



of shelf space and file cabinets to store the materials, as well as counseling offices, meeting rooms, study tables and chairs, display racks, bulletin boards, and a copier. With the advent of the Internet, CRCs have increased user access to materials and resources via the Web resulting in virtual CRCs.

### **Materials Acquisition, Management, Collection, Cataloging, and Evaluation**

Typically, the counseling staff and the media librarian or specialist are responsible for selecting, managing, and collecting materials for the CRC. It is crucial for these staff members to consider the population utilizing the materials most often, as well as the funds available to maintain, update, and acquire new resources. Both the staff (counselors and professionals) and the community should be able to locate and use the resources with little or no assistance if necessary. Scores of vendors—for example, professional associations, commercial publishers, government agencies, news organizations—offer materials for a CRC, materials that include many free and low-cost products. Some professional associations, such as the National Career Development Association (NCDA), have established guidelines for evaluating career information and resources.

### **Marketing and Public Relations**

A CRC requires continuous marketing of programs and resources. In a college or university setting, for example, incoming students can be targeted as well as those in other transitions, for example, those about to graduate. A Web site and electronic mailing lists are used in marketing along with varied print media. Conducting workshops at various locations and writing articles for community publications can disseminate news of CRC programs. These marketing techniques should explain the CRC's mission and objectives as well as how users will be treated when they seek services.

*Robert C. Reardon and Sara E. Cummings*

**See also** Assessment (v4); Career Counseling (v4); Career Counseling Process (v4); Career Education (v4); Career Exploration (v4); Career Interventions (v4); Career Services Model (v4); Decision Making (v4); Help-Seeking Behavior (v3); National Career Development Association (v4); Occupational Information (v4); University Counseling Centers (v1)

### **Further Readings**

- Brown, D. (2007). *Career information, career counseling, and career development* (9th ed.). Boston: Allyn & Bacon.
- Epstein, S., & Kinsley, K. (2004). The career resource library: Development and management issues. In J. Sampson, R. Reardon, G. Peterson, & J. Lenz (Eds.), *Career counseling and services: A cognitive information processing approach* (pp. 249–266). Belmont, CA: Thomson.
- Parsons, F. (1909). *Choosing a vocation*. Tulsa, OK: National Career Development Association.
- Sampson, J. P., Jr., Reardon, R. C., Peterson, G. W., & Lenz, J. L. (Eds.). (2004). *Career counseling and services: A cognitive information processing approach*. Belmont, CA: Thomson.
- Vernick, S., Garis, J., & Reardon, R. (2000). Integrating service, teaching, and research in a comprehensive university career center. *Career Planning & Adult Development Journal*, 16, 7–24.

---

## **CAREER SERVICES MODEL**

---

A difficult task facing career counselors concerns applying abstract career theories to concrete problems presented by clients. Over the years, counselor educators have voiced concern about their trainees' ability to accurately assess client problems and make sound clinical decisions. In practice, novice career counselors also become perplexed by the multitude of career methods and materials available to them. Conceptualizing a client's career problem requires a map to guide the selection of appropriate career services, and vocational scholars have proposed diagnostic classifications of career problems. A recent theory-based classification by Savickas was designed as a matrix to strengthen the connection between theory and practice as well as to ease the transaction between researchers and counselors. This model, summarized here, elaborates upon the Savickas model for career services and offers a practical schema useful for counselors who provide career counseling services. This taxonomic model has two conceptual domains, interpersonal and intrapersonal, that each encompasses three developmental levels. These domains and levels constitute six career service areas: career guidance, career placement, career education, career counseling, career life-development, and career adjustment.



Career problem assessment begins by locating a career problem in one of two conceptual domains for further exploration. Within the interpersonal domain, there is active negotiation with the environment or a high degree of contact with other persons. The implicit problem in career guidance involves making a career choice. The counselor often explores whether the client wishes to begin a new job or change an existing position. The objective is to assist clients in learning how to explore matches between their clarified self-concept and jobs. The implicit problem in career placement involves starting a career. The counselor is concerned with how clients attain their chosen positions. The objective is to assist a client after he or she has made an occupational choice: preparing and refining self-presentation behavior. The implicit problem in career education involves developing one's career. The counselor focuses on the individual's dispositions and problem-solving abilities.

The intrapersonal domain is growth seeking and discomfort reducing. It involves contact with one's feelings, emotions, and cognitions. The implicit problem in career counseling involves one's self-conception. The counselor explores the client's self-concept, approach to meaning making, and cognitive structure. The objective is to prepare a client to articulate and develop his or her vocational self-concepts and public identities and to develop career decision-making skills. The implicit problem in career development involves managing and coping with work. The counselor explores how the client has been and is adapting to multiple life roles in the context of work. A primary objective is to prepare a client to anticipate, become aware of, and cope with concerns arising within the stages of the career life span. The implicit problem in career adjustment involves adaptation to a career. The counselor explores how the client is adapting to thwarting conditions. The objective is to help a client adjust to unanticipated and unique events within his or her work position by developing coping skills and resilience.

Assessment begins with a focus on how a client experiences his or her career problems and aids in determining the experiential level of the presenting problems. Level A problems involve choosing an occupation (i.e., career guidance and career counseling). Level B problems involve preparing to enter a chosen occupation (i.e., career placement and career development), and Level C problems involve coping with a career (i.e., career education and career adjustment).

Career guidance shows clients how to gather information about themselves and the world of work.

Career counseling helps a client with intrapersonal barriers to career choice closure. Career placement helps a client develop and plan ways to attain a new position. Career/life development applies theories and measures to assist clients in coping with, preparing for, and managing concerns primarily related to balancing work with other life-role activities. Career education engages students and clients in discussion about their competencies such as planning and decision making, and fosters self-management attitudes such as future orientation and autonomy. Career adjustment explores client's work personality and work competencies.

Although not presented here, this model locates the major theories and common measures applied as they relate to the six service areas. As this framework aids in the understanding of a client's presenting career problem, it also serves to guide intervention planning, provides a perspective to guide further inquiry, and intends to stimulate necessary research efforts to investigate its effectiveness for counselors.

Louis A. Busacca

*See also* Assessment (v4); Career Counseling (v4); Career Counseling Process (v4); Career Education (v4); Career/Life (v4); Career Planning (v4); Life-Role Balance (v4); Person-Environment Fit (v4)

### Further Readings

- Busacca, L. A. (2002). Career problem assessment: A conceptual schema for counselor training. *Journal of Career Development*, 29, 129-146.
- Nelson, M. L., & Neufeldt, S. A. (1998). A pedagogy of counseling: A critical examination. *Counselor Education and Supervision*, 38, 70-88.
- Rounds, J. B., Jr., & Tinsley, H. E. A. (1984). Diagnosis and treatment of vocational problems. In S. D. Brown & R. W. Lent (Eds.), *Handbook of counseling psychology* (pp. 137-177). New York: Wiley.
- Savickas, M. L. (1996). A framework for linking career theory and practice. In M. L. Savickas & W. B. Walsh (Eds.), *Handbook of career counseling theory and practice* (pp. 191-208). Palo Alto, CA: Davies-Black.

---

## CAREER STYLE INTERVIEW

---

The career style interview (CSI) consists of six questions and is the primary means of assessment for those



interested in applying the theory of career construction as developed by Mark L. Savickas. This theory helps individuals to find meaning in the nonlinear careers of today and is an expansion and clarification of Donald Super's life-span life-space approach to careers. An individual's career style is often an unspoken means of viewing and interacting with the world and especially with the world of work. The CSI, therefore, is a qualitative interview that serves to draw out the narratives that are active and present in a person's life while also providing objective feedback to foster clarification and delineation of one's themes. The measure often provides the crucial link needed for individuals to recognize their active life themes, tie them to their vocational behavior, and make their vocational decisions more effectively.

The counselor and the client collaborate through the CSI to identify, interpret, and construct what the person prefers, how the person copes, and why the person pursues what he or she does through work. In the terms of vocational psychology, the CSI provides a means of determining and then linking an individual's vocational personality, career adaptability, and life theme into an organized whole. This understanding allows the individual to see the unity of his or her motivations and the consistencies of the individual's past, present, and future career paths. The CSI is ultimately a tool designed to empower individuals through clarifying how their work can make personal meaning and matter to others.

## History

The CSI was initially developed by Savickas in 1989 as a measure to clarify life stories' relation to career choices and decisions. The instrument draws from several historical models of assessment including Adlerian and constructivist approaches. The model, however, values and uses narrative or self-stories to tie the career components together for the individual. Narrative story in this context is not an attempt to determine the future from the past, but is the process of actively making meaning and providing direction for the present and future. The assessment process reveals and then unifies the subjective and objective influences upon individuals' career trajectories and concerns, facilitating a link between their life motivations and passions and their career motivations and choices. Although the CSI was initially used with individuals uncertain of career choices, its ability to

bring to light a broad spectrum of career concepts has encouraged its use with a variety of career counseling issues.

## Process

The CSI measure is a qualitative interview that consists of six basic questions related to family, interests, role-models, and recollections. The questions examine the goal for career counseling, past and present nonfamily role models, reading and television preferences, hobbies, favorite sayings, preferred school subjects, and several early recollections. Responses to these questions are written down by the counselor in the client's own words. Upon completion of the questions, the interviewer then uses the written notes to highlight the client's consistent themes. Consistent themes are identified through repeated verbs, words, phrases, and concepts expressed during the interview. The notes serve as a concrete reference point for the counselor and client to begin reflection and discussion about the content of the interview. The CSI process is a collaborative event where the counselor and client validate, construct, and refine the themes noted as a result of the questioning process.

## Personality

The process of validation often begins with reflection upon the vocational personality or the interest preferences of the client. Vocational personality relates to what an individual prefers to do and where his or her personal preferences may fit with the world of work. A typical framework used to conceptualize the individual's responses is according to John Holland a differential theory of vocational personality. Counselors often rely upon formal structured assessments to measure these preferences, but the CSI questions can provide the individual's primary Holland codes in an indirect manner. Using the Holland RIASEC (Realistic, Investigative, Artistic, Social, Enterprising, and Conventional) model as a framework, the counselor can often identify the two or three primary codes of the client from his or her narrative stories. The codes are often clearly expressed in the client's responses to the questions about school subjects, hobbies, and role models. The counselor usually overviews the Holland framework with the client and then discusses how the various preferences have been suggested in the responses to the CSI. This



information is processed with the client in an open discussion focused on delineating the primary codes and what the preferences may mean for the person.

Identifying individuals' Holland coding is not pursued simply to restrict their choices, but to provide new possibilities and more direction for future career pursuits and decisions. The coding can be used for a number of career purposes including validation of current or future career direction or highlighting the inconsistency of past or present work fields or positions. In addition, the CSI uses the Holland code to construct a success formula with the individual after the end of the interview. The client's code is used to develop a basic success formula statement using motivational phrases selected from a success formula grid and refined with the client. Phrases are suggested and a statement is constructed that provides a measuring stick that identifies what it takes for the individual to feel successful. This can then be used in making modifications to the individual's current position or in making decisions about work that would foster self-actualization. How the individual makes those decisions, however, is related to his or her career adaptability.

### ***Career Adaptability***

The career adaptability of the person is revealed through his or her narrative and clarified through further discussion with the counselor. An individual's CSI narratives will often indicate how the person interacts with or adapts to career developmental tasks, transitions, and setbacks. Career adaptability is conceptualized as consisting of four dimensions regarding career that include concern, control, curiosity, and confidence. Adaptive individuals are developing their attitudes, beliefs, and competencies in these four areas. Through the interview, the counselor often notes a lack of development in one or more of these dimensions and will discuss this with the person. The goal of the discussion is to develop a plan of action that will foster growth in the underdeveloped areas and increase the individual's career adaptability overall.

The CSI also seeks to identify the individual's early role models by asking directly and indirectly about them. Early role models are important to explore because they are conceptualized as solutions to the problems or challenges individuals faced in their early life. The role models often serve as a prototype for how one should make life and career decisions successfully. The CSI also views career as an

extension or an attempt of the individual to enact a self-concept, and role models relate to this purpose. Similarities and differences between the individual and the role models are explored, and this helps clarify some to the reasons for their selection. In addition, further discussion with the counselor about the role models frequently sheds light onto why a person pursues certain things through work. Early recollections also help to answer this question.

The end of the CSI includes several questions to illicit deeper projective stories related to earliest recollections or memories. The counselor using this technique is not assessing for factual truths, but is actually looking for repeated themes that permeate the individual's life and are expressed through his or her recollections stories. The stories that the individual selects and shares frequently provide the solution to the current career problem or demonstrate the strength needed to successfully navigate it. These stories can reflect fear, abandonment, or uncertainty, but they can also include joy, celebration, and support. The counselor notes the description and clarifies the emotions in the recollection, clarifying any relationship to the client's present career context. In addition to recounting the three recollections, the person is asked to title each with an active headline. These stories and their headlines are then used in conjunction with the rest of the client's narrative to identify deeper themes that permeate the individual's life.

### ***Life Theme***

The life theme concisely organizes the behavior of an individual and demonstrates the consistency of the person across time. It highlights a client's motivations and beliefs while also answering the why question behind his or her enactments both vocationally and avocationally. Life themes can often include a metanarrative of turning past pain into others' gain or turning a life preoccupation into an occupation. The themes frequently include motivations that need to be expressed or included in vocational decisions and commitments. When reviewing the overall data produced by the CSI, the counselor looking for the life theme is not necessarily focusing on the facts, but on the glue that seems to hold all of the facts together. The life theme underlies all of what has been shared by the individual and should pull all of the ideas together in a complete picture that clarifies the ruling passion of the individual's



life. It frequently communicates what is at stake in the person's life or what gives purpose and meaning to his or her work. The life theme discussion is a process of illumination that can take time and is often simplified by a thorough review of the notes where the counselor focuses upon repeated verbs, words, phrases, and themes. The condensed content then becomes the basis of the discussion to construct and validate the life theme of the individual. The CSI and the resultant narrative interpretation seek to clarify and refine the theme that permeates the individual's life with meaning and produces a life that matters to others as well.

Mark C. Rehfuss

**See also** Assessment (v4); Career Construction Theory (v4); Constructivist Career Counseling (v4); Constructivist Theory (v2); Empowerment (v3); Holland's Theory of Vocational Personalities and Work Environments (v4); Narrative Career Counseling (v4); Narrative Therapy (v2); Qualitative Methodologies (v1); Super's Theory (v4)

### Further Readings

- Busacca, L. (2007). Career construction theory: A practitioner's primer. *The Career Planning and Adult Development Journal*, 23(1), 57–67.
- Holland, J. (1997). *Making vocational choices: A theory of vocational personalities and work environments* (3rd ed.). Odessa, FL: Psychological Assessment Resources.
- Rehfuss, M. (2007). The case of Frank: Application of the theory of career construction. *The Career Planning and Adult Development Journal*, 23(1), 68–76.
- Savickas, M. L. (1989). Career style assessment and counseling. In T. Sweeney (Ed.), *Adlerian counseling: A practical approach* (3rd ed., pp. 289–320). Muncie, IN: Accelerated Development Press.
- Savickas, M. L. (1995). Constructivist counseling for career indecision. *Career Development Quarterly*, 43(4), 363–373.
- Savickas, M. L. (1998). Career style assessment and counseling. In T. Sweeney (Ed.), *Adlerian counseling: A practitioner's approach* (4th ed., pp. 329–360). Philadelphia, PA: Accelerated Development Press.
- Savickas, M. L. (2005). The theory and practice of career construction. In S. D. Brown & R. W. Lent (Eds.), *Career development and counseling: Putting theory and research to work* (pp. 42–70). Hoboken, NJ: Wiley.

---

## CAREER THOUGHTS INVENTORY

---

The Career Thoughts Inventory (CTI) is a theory-based assessment and intervention resource intended to improve thinking in career problem solving and decision making. The CTI measures dysfunctional career thoughts that may inhibit the ability to effectively engage in career decision making. The 48-item inventory is self-administered and objectively scored. The assessment is designed to be used by 11th- and 12th-grade high school students, college students, and adults who are choosing an occupation, choosing a major or field of study, seeking employment, or making an employment change.

The CTI is based on cognitive information processing theory, which states that effective career decision making requires effective processing of information in the four domains of self-knowledge, occupational knowledge, decision-making skills, and executive processing. The CTI draws on concepts from cognitive therapy specifying that dysfunctional cognitions have a negative impact on behavior and emotions. The CTI can be used to identify negative career thoughts that impede the effective processing of information necessary for career problem solving and decision making. The *CTI Workbook*, which accompanies the CTI, comprises cognitive restructuring activities similar to those used in cognitive therapy for depression and anxiety.

Items on the CTI are scored on a Likert scale with responses ranging from *strongly agree* to *strongly disagree*. The total CTI score reflects the extent to which individuals engage in thinking that may inhibit effective career problem solving and decision making. Higher scores are indicative of the presence of dysfunctional thoughts that may impede the processing of information necessary to confidently make an informed career choice. Lower scores reflect few dysfunctional career thoughts that negatively impact the career decision-making process and suggest overall readiness to engage in career decision making. Information on the standardization, potential for bias, readability, reliability, validity, and utility of the CTI is presented in the professional manual.

Three construct scales underlie the CTI: Decision Making Confusion, Commitment Anxiety, and External Conflict. Construct scale scores of the CTI enable practitioners to identify specific blocks that impede the processing of information. Mental health concerns such as depression and/or anxiety may also exist when



high scores are reflected in Decision Making Confusion and Commitment Anxiety. Similarly, high scores on the External Conflict scale may suggest family issues that would be beneficial to address. Individual items on the CTI may also be used as a stimulus for the client to verbalize internal and external barriers to decision making.

The CTI can be quickly administered and scored, easily interpreted, and readily integrated into a variety of counseling modalities. As such, it provides a cost-effective measure for use in career services in a variety of settings. The CTI has multiple uses and can be used as a screening tool, for needs assessment, and as a learning resource. The use of a limited number of scales on the CTI simplifies interpretation and enhances its usefulness in practice. When used in combination with the *CTI Workbook*, practitioners have access to interpretive information about the scales and materials for test interpretation. All of these contribute to easier integration into existing programs and services.

*Denise E. Saunders and James P. Sampson, Jr.*

*See also* Assessment (v4); Career Barriers Inventory (v4); Career Counseling in Colleges and Universities (v4); Career Counseling in Schools (v4); Career Exploration (v4); Career Factors Inventory (v4); Career Indecision (v4); Cognitive Information Processing Model (v4); Decision Making (v4); Personal and Career Counseling (v4)

### Further Readings

- Sampson, J. P., Jr., Peterson, G. W., Lenz, J. G., Reardon, R. C., & Saunders, D. E. (1996). *Career Thoughts Inventory*. Odessa, FL: Psychological Assessment Resources.
- Sampson, J. P., Jr., Peterson, G. W., Lenz, J. G., Reardon, R. C., & Saunders, D. E. (1996). *Career Thoughts Inventory workbook*. Odessa, FL: Psychological Assessment Resources.
- Sampson, J. P., Jr., Peterson, G. W., Lenz, J. G., Reardon, R. C., & Saunders, D. E. (1996). *Career Thoughts Inventory: Professional manual*. Odessa, FL: Psychological Assessment Resources.
- Sampson, J. P., Jr., Peterson, G. W., Lenz, J. G., Reardon, R. C., & Saunders, D. E. (1998). The design and use of a measure of dysfunctional career thoughts among adults, college students, and high school students: The Career Thoughts Inventory. *Journal of Career Assessment*, 6, 115–134.
- Sampson, J. P., Jr., Peterson, G. W., Reardon, R. C., & Lenz, J. G. (2004). *Career counseling and services: A cognitive information processing approach*. Pacific Grove, CA: Brooks/Cole.

## CAREER TRANSITIONS INVENTORY

The Career Transitions Inventory (CTI) is a 40-item Likert format measure designed to assess an individual's internal process variables that may serve as strengths or barriers when making a career transition. For purposes of this instrument, the term *career transition* was defined as a situation in which any of the following kinds of career changes were being considered: (a) task change—a shift from one set of tasks to another set of tasks within the same job and same location (e.g., a software designer changes into software sales), (b) position change—a shift in jobs, with the same employer or a different employer (e.g., a secretary moving to a different department within the same company), or (c) occupational change—a transition from one set of duties to a different set that might include a new work setting (e.g., a farmer becomes a factory worker).

The fact that increasing numbers of individuals are making career transitions was a primary reason for creating the scale. Increased technology, labor force participation rates, and global change all contribute to the growing number of career transitions. Although the field of career development had numerous scales available to measure interests, skills, ability, and values, there was a dearth of scales to measure the barriers and supports adults have when making a career transition. The inventory was created to aid in the transition process by helping adults recognize the skills they bring to a transition as well as possible internal barriers that may serve as obstacles to the career transition process. All of the factors measured by the CTI are considered states, rather than traits, and thus are malleable to intervention.

The CTI was created and validated through factor analyses and a series of investigations examining the inventory's reliability and validity. Five distinct factors were found through factor analytic studies. These factors were Career Motivation (Readiness), Self-efficacy (Confidence), Perceived Support (Support), Internal-External (Control), and Self Versus Relational Focus (Decision Independence). These factors were found to have good internal consistency ranging from .66 for perceived support to .87 for readiness. Total scale alpha coefficients for the CTI are .85. Test-retest coefficients for the total CTI over a 3-week period was .84. The CTI has been found to correlate positively and significantly with age, marital status, length of time in the transition process, and five global



ratings of coping (i.e., perceived level of stress in the career transition process). In addition, enduring personality traits such as those measured by the NEO Personality Inventory have been found to predict career resources as measured by the CTI. For example, Openness to Experience from the NEO has been found to predict all five factors on the CTI, indicating that a willingness to try new things is an important variable in predicting how one negotiates the career transition process. The CTI has been translated into French, Italian, Mandarin, Japanese, and Korean. Additional psychometric work has been conducted in some countries to determine if the factor structure is the same.

Mary J. Heppner

**See also** Adult Development (v1); Adults in Transition (v4); Assessment (v4); Career Barriers Inventory (v4); Career Counseling in Colleges and Universities (v4); Career Counseling in Organizations (v4); Career Development Inventory (v4); Career Factors Inventory (v4); Career Planning (v4); School-to-Work Transition (v4)

### Further Readings

- Fernandez, A., Fouquereau, E., & Heppner, M. J. (in press). The Career Transitions Inventory: A psychometric evaluation of a French version (CTI-F). *The Journal of Career Assessment*.
- Gysbers, N. C., Heppner, M. J., & Johnston, J. A. (2003). *Career counseling: Process, issues, and techniques* (2nd ed.). Boston: Allyn & Bacon.
- Heppner, M. J., Fuller, B., & Multon, K. D. (1998). Adults in involuntary career transition: An analysis of the relationship between the psychological and career domains. *Journal of Career Assessment*, 6, 135–145.
- Heppner, M. J., Multon, K. D., & Johnston, J. A. (1994). Assessing psychological resources during career change: Development of the Career Transitions Inventory. *Journal of Vocational Behavior*, 44, 55–74.

---

## COGNITIVE INFORMATION PROCESSING MODEL

---

There is an adage, “Give people a fish and they eat for a day, but teach them to fish and they eat for a lifetime.” This wise maxim succinctly captures the

ultimate aim of the cognitive information processing (CIP) approach to career counseling—that is, enabling individuals to become skillful career problem solvers and decision makers. Through the CIP approach, individuals learn not only how to solve the immediate career problem and make an appropriate decision, but also how to generalize this experience to future career problems.

In the 1970s, a line of inquiry emerged from the cognitive sciences that offered a new way of thinking about problem solving and decision making. This paradigm, known as CIP, was initially formulated in the works of Earl Hunt, Allen Newell and Herbert Simon, and Roy Lackman, Janet Lackman, and Earl Butterfield. When applied to career choices, this paradigm, herein referred to as the CIP model, provides a way to describe the fundamental memory structures and thought processes involved in solving career problems and making career decisions. With the CIP model, career counselors can assist clients in becoming better career problem solvers and decision makers.

The CIP model is described in four sections. The first presents key concepts that form its foundation, the second discusses assessing client needs from a CIP perspective, the third describes interventions consistent with this theoretical frame, and the fourth concerns the application of the model in career counseling practice.

### Definitions and Concepts

The following are key definitions in the CIP model to facilitate the understanding and utility of the approach.

*Career problem:* A gap between an existing state of career indecision and a more desirable state of decidedness. The gap creates a state of cognitive dissonance that becomes the primary motivational force driving the problem-solving process. The presence of a gap results in tension or discomfort that individuals seek to eliminate through problem solving and decision making.

*Problem space:* All cognitive and affective components contained in working memory as individuals approach a career problem-solving task. In clients’ lives, the problem space entails the career problem at hand, in addition to all the issues associated with it such as marital and family relationships, financial exigencies, and the emotional states embedded in them.



*Career problem solving:* A complex set of thought processes involved in acknowledging a gap, analyzing its causes, formulating and clarifying alternative courses of actions, and selecting one alternative to reduce the gap. A career problem is solved when a career choice is made from among the alternatives.

*Career decision making:* A process that not only encompasses career choice, but also entails a commitment to and the carrying out of the actions necessary to implement the choice.

*Career development:* The implementation of a series of career decisions that comprise an integrated career path throughout the life span.

### **The Pyramid of Information Processing and the CASVE Cycle**

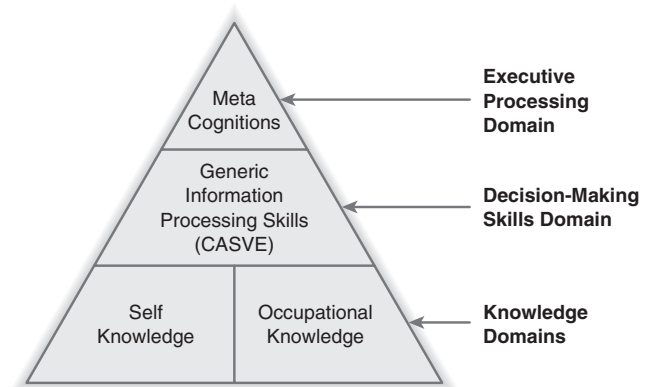
Two fundamental structures comprise the CIP model: the Pyramid of Information Processing and the CASVE Cycle.

#### **The Pyramid of Information Processing**

In order for individuals to become independent and responsible career problem solvers and decision makers, certain information processing capabilities must undergo continual development throughout the life span. These capabilities may be envisioned as forming a pyramid of information processing domains with three hierarchically arranged domains (see Figure 1). The knowledge domain lies at the base, the decision-making skills domain comprises the mid level, while the executive processing domain is at the apex.

*The Knowledge Bases.* Two knowledge domains, self- and occupational knowledge, lie at the base of the pyramid. Self-knowledge includes knowledge about one's interests, abilities, skills, and values based on an ongoing construction of one's life's experiences. Occupational knowledge consists of one's own unique structural representation of the world of work and an understanding of individual occupations in terms of their duties and responsibilities, as well as education and training requirements to attain them.

*The CASVE Cycle.* The midlevel of the Pyramid of Information Processing, referred to as the decision-making



**Figure 1** Pyramid of information processing domains in career decision making

Source: Sampson, J. P., Jr., Peterson, G. W., Lenz, J. G., & Reardon, R. C. (1992). A cognitive approach to career services: Translating theory into practice. *Career Development Quarterly*, 41, 67–72. Used with permission.

skills domain, involves generic information processing skills that combine occupational knowledge and self-knowledge to solve a career problem and to make a decision. A 5-phase recursive information transformation process (see Figure 2), the CASVE Cycle (pronounced “ca-sah-veh”), is used as an overarching heuristic to structure the career counseling process.

1. Communication (C). An individual engages the career problem-solving process by receiving and encoding information that signals that a problem exists. One then queries oneself and the environment to formulate the gap (or discontinuity) that is the problem. This phase also entails getting in touch with all components of the problem space including thoughts, feelings, and related life circumstances.
2. Analysis (A). The causes of the problem are identified and the relationships among problem components are placed in a conceptual framework or mental model.
3. Synthesis (S). Possible courses of action to eliminate the gap are formulated through the creation of possibilities (synthesis elaboration) and then narrowed (synthesis crystallization) to a manageable set of viable alternatives.
4. Valuing (V). Each course of action or alternative is evaluated and prioritized according to its likelihood of success in removing the gap and its probable



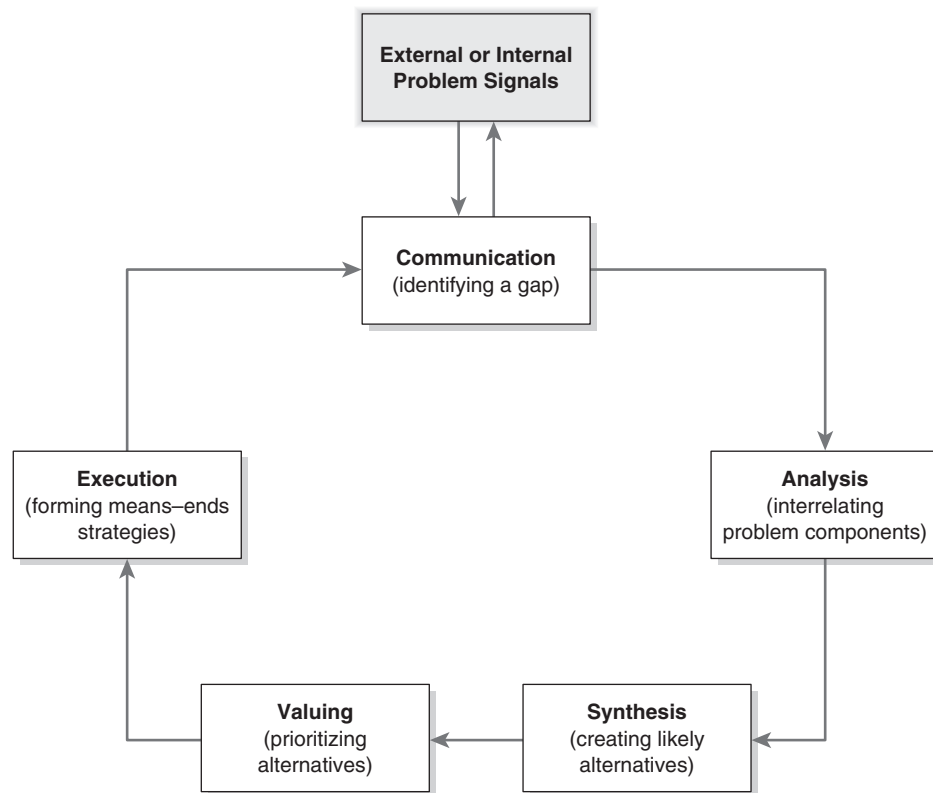
impact on one's self, significant others, cultural group, and society. Through this process a first choice emerges that has the highest prospect of removing the gap. The career problem is now solved.

5. Execution (E). An action plan is formulated to implement the choice, which becomes a goal for the client. A series of milestones are laid out that will lead step-by-step to the attainment of the goal. Thus, a career decision is made when individuals move deliberately toward a goal, such as enrolling in an educational program or taking a job in a chosen occupational field.

Upon executing the plan, there is a return to the Communication phase of the cycle to evaluate whether the decision successfully removed the gap. If so, the individual moves on to solve succeeding problems that arise from the implementation of the

solution. If not, one recycles through the CASVE Cycle with new information about the problem, one's self, and occupations acquired from the initial pass through the CASVE Cycle. Hence, self-knowledge and occupational memory structures evolve with each pass through the cycle.

*The Apex.* The apex of the pyramid, the executive processing domain, contains metacognitive components that guide and regulate the lower-order cognitive functions. This domain can be referred to as thinking about thinking, which entails the ability to view one's self as a career problem solver from a detached perspective. The domain involves metacognitive components that (a) control the selection and sequencing of cognitive strategies to achieve a goal, and (b) monitor the execution of a given problem-solving strategy to determine if a goal has been reached.



**Figure 2** The five stages of the CASVE (Communication, Analysis, Synthesis, Valuing, Execution) Cycle of information processing skills used in career decision making

Source: Sampson, J. P., Jr., Peterson, G. W., Lenz, J. G., & Reardon, R. C. (1992). A cognitive approach to career services: Translating theory into practice. *Career Development Quarterly*, 41, 67–72. Used with permission.



## Assessment of Client Learning Needs

Assessment from the CIP model perspective concerns what clients need to learn to enhance their career problem-solving and decision-making skills so as to effectively address the career problem at hand. The pyramid and the CASVE Cycle serve as heuristics for identifying client learning needs and formulating interventions to remove the gap.

### ***Assessing Readiness for Career Problem Solving and Decision Making***

Not all clients are prepared to immediately engage in the career problem-solving process—they may require intensive personal assistance from a career counselor to manage factors in the problem space that impede learning before they are able to progress through the cycle. Assessing client readiness may be accomplished through integrating information gathered via an intake interview and some type of objective assessment, for example, the Career Thoughts Inventory (CTI). The CTI is a 48-item, self-report measure that assesses the level of client's dysfunctional thinking through three construct scales, Decision-Making Confusion (DMC), External Conflict (EC), and Commitment Anxiety (CA). Scale scores, along with responses to individual items, enable a career counselor, together with the client, to identify discrepancies in the pyramid or blocks in the CASVE Cycle that impede career problem solving and decision making. On the basis of the readiness assessment, clients may be assigned to one of three levels of career service: (1) self-help, (2) brief staff-assisted, and (3) individual case-managed career counseling.

### ***Assessing Career Problem-Solving Skills***

The assessment of problem-solving and decision-making skills entails identifying specific domains in the pyramid that require further development to enable a client to solve the career problem at hand and to make a decision.

*Self-Knowledge.* Assessing self-knowledge is often a confirmatory process in which interest inventories, such as the Self-Directed Search, allow clients to clarify and reaffirm their interests. Computer-assisted career guidance (CACG) systems, card sorts (values, interests, skills), and autobiographical sketches may also be useful.

*Occupational Knowledge.* Occupational knowledge may be assessed through vocational card sorts or by using a card sort as a cognitive mapping task. Through a think-aloud procedure, clients reveal their knowledge about occupations as they sort the cards into like, dislike, or maybe piles. In a cognitive mapping task, clients reveal a schema of the work world by sorting 36 occupational cards into piles of related occupations and then identifying the pile “Most like me.”

*Decision-Making Skills.* The CTI may be used to identify specific CASVE Cycle phases in which clients experience blocks in the career problem-solving process brought about by dysfunctional career thoughts. The DMC scale reveals dysfunction in the communication, analysis, and synthesis phases that entail deriving career alternatives; the EC phase addresses the valuing phase in which clients weigh the importance of their views in relation to views of significant others; and the CA scale alludes to reaching closure in identifying a first choice, as well as the transition from arriving at a career problem solution in the valuing phase to a commitment to action in the execution phase.

*Executive Processing.* Dysfunctional thoughts in this domain may also be assessed through responses to individual items on the Executive Processing content scale of the CTI. In addition, during the client interview a career counselor may listen carefully for instances of negative self-talk, ineffective cognitive strategies, and lack of thought or behavioral control in staying focused on the problem-solving task at hand.

The outcome of the assessment process is the development of an individualized learning plan (ILP) consisting of counseling goals to address the identified deficiencies and blocks that impede problem solving and decision making.

## **Interventions to Help Clients Acquire Career Problem-Solving and Decision-Making Skills**

The pyramid and CASVE Cycle are instrumental in developing interventions that facilitate the acquisition of required self-knowledge, occupational knowledge, and career problem-solving and decision-making skills identified in the assessment process.



### ***Acquiring Self-Knowledge***

The acquisition or clarification of self-knowledge may be accomplished through the use of interest inventories, values inventories, and ability and skills assessments that typically affirm and clarify the elements of the self-knowledge domain. Autobiographies may also be helpful in describing and organizing life experiences that bear on the career problem at hand.

### ***Acquiring Occupational Knowledge***

In career counseling, clients engage in the processes of schema specialization in which they are able to make finer discriminations among occupations, as well as schema generalization in which they form more extensive networks of connections among extant occupational knowledge structures. When career counseling takes place within comprehensive career centers, the acquisition of occupational knowledge may be facilitated through the use of a variety of media, including occupational briefs, vocational biographies, reference books, special topics books, videos, interactive media, and Internet Web sites. Reality testing through job shadowing or interviews with job incumbents allows clients to experience occupations even more directly.

### ***Acquiring Career Problem-Solving and Decision-Making Skills***

The concept of the Pyramid of Information Processing Domains is presented directly to clients in a handout called "What's Involved in Career Choice." The concepts of communication, analysis, synthesis, valuing, and execution and the cyclical relationship among these concepts are learned via a handout depicting the CASVE Cycle, which uses simple statements to describe each phase. Then, through subsequent review of ILP activities and feedback from a counselor, clients begin to accommodate and assimilate the CIP model into their own decision-making style. At the termination of counseling, the counselor reviews the decision-making process undertaken and demonstrates how the CIP model can be used in future career problem situations.

### ***Acquiring Metacognitive Skills in the Executive Processing Domain***

When dysfunctional or negative thoughts are identified in the assessment process, clients learn how to

change their dysfunctional or negative career thoughts using the ICAA algorithm (Identify, Challenge, Alter, and Act). *The CTI Workbook* takes clients step-by-step through a cognitive restructuring process. Clients also learn how to self-monitor their progress through the CASVE Cycle.

## **Implementing the CIP Model in Career Counseling**

### ***The Seven-Step Sequence***

A seven-step career service delivery sequence is used as a heuristic for implementing the CIP model in career counseling.

1. *Initial interview:* The career counselor gathers qualitative self-report information about the nature of a client's presenting career problem.
2. *Preliminary readiness assessment:* An individual's readiness for career counseling is assessed through administering the CTI. The findings are reviewed and discussed with the client.
3. *Define the problem and analyze the causes:* The counselor and the client come to a mutual understanding or common mental model of the career problem and related issues. The specific causes of the problem lie in the deficiencies within the respective domains of the pyramid or blocks that impede progress through the CASVE Cycle.
4. *Formulate goals:* The counselor and client together formulate a set of attainable goals, stated in behavioral terms, to remove the gap.
5. *Develop an ILP:* For each goal, the counselor and client develop learning activities to attain the goal, resources used in the activities, estimated time to carry out the activities, and the priority for each activity.
6. *Execute ILP:* Clients carry out the ILP while the counselor monitors the attainment of the respective goals and assists the client when required.
7. *Summative review and generalization:* The client and counselor review the process used to solve the problem and make the decision at hand and evaluate its effectiveness. They also explore how the CIP model might be applied to future career problems or even to life problems in general.



### **Implications for Best Practices in Career Service Delivery**

The CIP model advances the state-of-the-science in career counseling by providing a theory base for introducing a value-added dimension, that is, using the problem at hand as a means for furthering the acquisition of career problem-solving and decision-making skills. Moreover, focusing specifically on what clients are required to learn to improve their career problem-solving skills, counselors can look beyond the traditional one-on-one counseling relationship and creatively develop facilitative learning environments. Finally, assessing readiness for career problem solving enables counselors to match career service delivery resources to the depth and scope of the presenting problem, thereby fostering greater efficiency in the administration of career services.

The CIP model serves as a heuristic to enable individuals to systematically think through a career problem. By applying the model to solve a presenting problem, clients become better career problem solvers and decision makers, which in turn, can lead to satisfying, meaningful, and productive careers.

Gary W. Peterson, James P. Sampson, Jr.,  
Robert C. Reardon, and Janet G. Lenz

*See also* Career Education (v4); Career Services Model (v4); Career Thoughts Inventory (v4); Computer-Assisted Career Counseling (v4); Decision Making (v4); Empowerment (v3); Occupational Information (v4); Self-Directed Search (v4); Tiedeman's Decision-Making Theory (v4)

### **Further Readings**

- Hunt, E.B. (1971). What kind of computer is man? *Cognitive Psychology*, 2, 57–98.
- Lackman, R., Lackman, J. L., & Butterfield, E. C. (1979). *Cognitive psychology and information processing*. Hillsdale, NJ: Lawrence Erlbaum.
- Newell, A., & Simon, H. A. (1972). *Human problem solving*. Englewood Cliffs, NJ: Prentice-Hall.
- Peterson, G. W. (1998). Using the vocational card sort as an assessment of occupational knowledge. *Journal of Career Assessment*, 6, 49–67.
- Peterson, G. W., & Leasure, K. K. (2004, July). *Problem mapping: The nexus of career and mental health counseling*. Paper presented at the annual convention of the National Career Development Association, San Francisco, CA.

- Peterson, G. W., Sampson, J. P., Jr., Lenz, J. G., & Reardon, R. C. (2002). A cognitive information processing approach to career problem solving and decision making. In D. Brown (Ed.), *Career choice and development* (4th ed., pp. 312–369). San Francisco: Jossey-Bass.
- Peterson, G. W., Sampson, J. P., Jr., & Reardon, R. C. (1991). *Career development and services: A cognitive approach*. Pacific Grove, CA: Brooks/Cole.
- Sampson, J. P., Jr., Peterson, G. W., Lenz, J. G., Reardon, R. C., & Saunders, D. E. (1996). *The Career Thoughts Inventory (CTI)*. Odessa, FL: Psychological Assessment Resources.
- Sampson, J.P., Jr., Peterson, G. W., Lenz, J. G., Reardon, R. C., & Saunders, D. E. (1996). *Improving your career thoughts: A workbook for the Career Thoughts Inventory*. Odessa, FL: Psychological Assessment Resources.
- Sampson, J. P., Jr., Peterson, G. W., Reardon, R. C., & Lenz, J. G. (2000). Using readiness assessment to improve career services: A cognitive information processing approach. *The Career Development Quarterly*, 49, 146–174.
- Sampson, J. P., Jr., Reardon, R. C., Peterson, G. W., & Lenz, J. G. (2004). *Career counseling and services: A cognitive information processing approach*. Belmont, CA: Thomson.

---

## **COLLEGE STUDENT EXPERIENCES QUESTIONNAIRE**

---

The College Student Experiences Questionnaire (CSEQ) is a versatile tool that assesses the quality of effort college students expend in using resources and opportunities provided by an institution for their learning and development. Quality of effort is a key dimension for understanding student satisfaction and persistence and for understanding the effects of attending college. The more students engage in educationally purposeful activities, especially those recognized as good practice in education, the more they benefit in meaningful ways in their learning and development.

The CSEQ asks students to report the frequency with which they participate in common college activities, their perceptions of the college environment, and their estimates of individual gains related to areas of their personal and social development. The college activities questions explore such topics as how often students make contributions in classes, how often they receive prompt faculty feedback, and how often they interact in meaningful ways with peers in different



contexts. The college environment questions ask students about their perceptions of the psychological climate for learning that exists on the campus. For example, do they view their campus as supportive of their academic efforts? The estimate of gains items ask students to reflect on their entire college experience and to estimate how much progress they feel they have made in areas of personal and practical development common to the college experience. The gains items represent holistic development, assessing such wide-ranging outcomes as acquiring relevant career information, writing clearly and effectively, understanding self and others, and gaining the ability to think analytically and critically.

Institutions use CSEQ data to determine program effectiveness, measure learning outcomes, assess academic year initiatives, and expand efforts of academic affairs and student affairs divisions, among others. With more than 150 items, the CSEQ provides institutions with valuable information about student experiences. Furthermore, student respondents may also benefit from the reflection and self-evaluation exercise associated with completing the survey. Many students say filling out the questionnaire prompts them to recall the range of activities in which they participated during the year and the progress they made toward important goals.

In addition to the CSEQ instrument, the CSEQ Research Program offers the College Student Expectations Questionnaire (CSXQ), which assesses new student goals and motivations. New students arrive with expectations about how and with whom they will spend their time in college. These expectations provide clues about how they will interact with peers and faculty members, which are behaviors that directly affect achievement and satisfaction with college. When paired together, the CSEQ and CSXQ instruments allow institutions to assess the degree to which student and institutional expectations are met.

*George Kuh*

*See also* Assessment (v4); Career Counseling in Colleges and Universities (v4); Environmental Assessment Technique (v4); National Survey of Student Engagement (v4); Process and Outcome Research (v4)

### Further Readings

Chickering, A. W., & Gamson, Z. F. (1987). Seven principles for good practice in undergraduate education. *AAHE Bulletin*, 39(7), 3–7.

Gonyea, R. M., Kish, K. A., Kuh, G. D., Muthia, R. N., & Thomas, A. D. (2003). *College Student Experiences Questionnaire: Norms for the fourth edition*. Bloomington: Indiana University Center for Postsecondary Research.

Kuh, G. D., Kinzie, J. K., Schuh, J. H., Whitt, E. J., & Associates. (2005). *Student success in college: Creating conditions that matter*. San Francisco: Jossey-Bass.

Pace, C. R. (1984). *Measuring the quality of college student experiences*. Los Angeles: University of California Center for the Study of Evaluation.

Pascarella, E. T., & Terenzini, P. T. (2005). *How college affects students: A third decade of research*. San Francisco: Jossey-Bass.

---

## COMPETENCIES

---

*See* STANDARDS AND COMPETENCIES

---

## COMPUTER-ASSISTED CAREER COUNSELING

---

Computer-assisted career counseling is the use of computers in educational and career guidance. When faced with the prospect of having to make an important educational or career decision, many individuals look for career or educational information and professional guidance. Individuals making educational decisions might access college brochures and catalogs or might request application and financial aid materials. Alternatively, individuals considering a possible career path might access information about the tasks involved in a job or might research the employment outlook for a particular occupation. Furthermore, some individuals seek the guidance of trained career counselors and psychologists as they grapple with making their decision. More and more, individuals are turning to their computers and the Internet for both information and guidance. A recent report, for example, suggests that almost half of all U.S. Internet users have turned to the Web when making important educational and career decisions.

The use of computers in educational and career guidance has a long history. In the 1960s the U.S. Department of Labor funded a project to develop a computer program that could provide users with up-to-date data on employment and educational



opportunities. Early computer-assisted career guidance (CACG) programs were available in the 1970s and included automated career assessments; searchable databases of colleges, majors, and occupations; and guidance-related information to promote action planning and decision making. The widespread proliferation and availability of Internet technologies has radically changed the landscape of computer-assisted career counseling. Today, computer-assisted career counseling takes four primary forms: computerized career assessment, electronic sources of career and educational information, comprehensive CACG systems, and online career counseling.

### Computerized Career Assessment

In an effort to help clients understand their educational and career interests, skills, and values, career counselors and psychologists will often administer one or more career assessment inventories. Results from these inventories can be used to help clients identify career paths, confirm existing choices, or narrow the number of career alternatives considered. Several benefits can be realized when administering career assessment via computer. Traditional paper and pencil inventories require that all items be administered in a fixed order. Computers can administer items dynamically based on individuals' responses (referred to as computer adaptive testing or CAT). Computers can also be programmed to provide a reliable interpretation of an individual's inventory results. When linked with other computer career assessment results, clients can be provided with interpretations and recommendations based on the integrated findings from multiple inventories. Finally, assessment interpretations themselves may be dynamic and interactive, requiring input from users or linking results and interpretations to sources of educational and occupational information.

Today, most computerized career assessment inventories are delivered via the Internet. Professionals and consumers should exercise caution when selecting online career inventories as many Internet-delivered inventories are of questionable origin. Inventories distributed by reputable testing companies or independently developed inventories that are supported by published research are preferred. Professionals should review the psychometric properties of any instrument prior to using it in practice. Three of the most widely administered online career interest inventories are the Strong Interest Inventory, the Self-Directed Search, and the Kuder Interest Inventory and Career Planning

System. Other widely administered interest inventories include the UNIACT and the Occupational Information Network (O\*NET) Interest Profiler, which are embedded with comprehensive computer guidance systems. In addition to interest inventories, work values and skill confidence inventories can also be found online.

### Online Source of Education and Career Information

The use of computers to provide education and career information was first realized by the Department of Labor in the 1960s. Today, universities, private business, government agencies, and private citizens are free to publish information on the Internet. When compared to traditional printing methods, the Internet offers several benefits. Information can be updated on a regular basis and published almost immediately. Electronically delivered material can be quickly indexed and cross-referenced and text-based materials can be easily searched by end users. When the information is maintained in a relational database, it can be searched using preprogrammed compound searches. For example, a user can request a listing of all occupations that have starting salaries averaging greater than \$50,000, require a bachelor's degree or less, provide opportunities to supervise others, and are projected to be in high demand in coming years.

Several excellent college search sites are currently available free of charge. Both ACT, Inc., and the College Board provide an interface that permits searching for colleges by geographic location, admissions selectivity, tuition costs, and a host of other criteria. Resulting lists are linked directly to the college's homepage.

The most comprehensive source of free occupational information is the U.S. Department of Labor's O\*NET. The O\*NET is a comprehensive system of products, databases, and services designed to organize, describe, distribute, and collect information on occupations and the workforce. The O\*NET database is in the public domain and can thus be freely downloaded and distributed. The O\*NET online permits searching of the O\*NET database using several criteria (e.g., interests, values, job family, employment growth). Several CACG systems make use of the O\*NET database in delivering occupational information to their subscribers. The Department of Labor continues to maintain the *Occupational Outlook Handbook*, which served for many years as the primary governmental source of occupational information.



While the Internet has revolutionized the way education and career information is distributed, it has also caused some concern among career counseling professionals. Of particular concern is the overall quality and accuracy of career and educational information provided on the Web. Several professional organizations have established guidelines and standards for providing online career information. For example, the National Career Development Association has established guidelines that can be used by practitioners who wish to use the Internet to provide career information and planning services. Similarly, the Association of Computer-Based Systems for Career Information has established a set of standards to help guide career guidance program developers in building the highest quality career information services. Counselors and career professionals are urged to familiarize themselves with guidelines for evaluating the accuracy and currency of Internet delivered career and educational information.

The availability of accurate educational and career information may be more important than was previously thought. Results from a recent meta-analysis suggest that some elements of career counseling are more important than others. These authors suggest that providing clients with opportunities to access information about the world of work might be among the most potent predictors of positive outcomes among clients who are making initial career decisions.

### **Computer-Assisted Career Guidance Systems**

CACG system is a term used to describe a computer application that combines career assessment, career information, and career guidance into one integrated system. CACG systems have been available since the 1970s and have evolved to take advantage of new computer technologies (e.g., personal computer, Internet). A growing number of CACG systems are available and most today are sold as subscription services delivered through the Internet.

CACG systems are unique in that they combine the advantages of providing online assessment; searchable databases of schools, college majors, and occupations; and other guidance and exploration experiences with the additional advantages that come from combining these features into one integrated system. In these systems, users typically receive their career interest assessment results in a format that permits

immediate exploration of career alternatives. In the DISCOVER program, for example, individuals' interests are compared to the characteristics of occupational environments and users are provided with possible career areas to explore (ordered from highest to lowest) based on their interests. Selecting a career area provides the individual with a list of occupations within that group and users can subsequently research occupational titles to learn about job tasks, educational requirements, employment outlook, or salary. Similar crosswalks are often created between values and skills assessments and occupational characteristics. Furthermore, CACG systems often provide information related to college majors and postsecondary schools in relational databases. These elements may also be searched using standard compound search routines.

CACG systems offer several other advantages. Because CACG systems are so costly to produce and distribute, they are generally produced by established for-profit and not-for-profit companies. As such, one can assume a level of quality assurance and professional review that may not be present with some stand-alone Web sites. Many CACG systems also permit some level of site customization. For example, site administrators may customize log-in banners, create unique surveys that appear within the program, or construct site specific data elements (e.g., high school coursework planner that shows site specific course names and numbers). Several CACG systems are currently in widespread use including DISCOVER, SIGI PLUS, and Choices.

There is a growing body of research suggesting that CACG systems are effective at promoting career development and decision making. Several recent meta-analyses show that CACG is effective, though effect sizes appear to be larger when computer-assisted guidance is combined with counselor-assisted guidance. Counselors or psychologists wishing to use CACG systems in their practice are urged to consider ways in which CACG systems can supplement their one-on-one or group-based career interventions.

### **Online Career Counseling**

The computer and the Internet are expanding the ways in which clients and counselors are engaging in career counseling. The expansion of career counseling to the Internet is not surprising; counselors have a history of incorporating technology and distance communication



(e.g., telephone) into their practice. New modes of service delivery include e-mail, online chat, videoconferencing, voice over IP (Internet phone), and Weblogs. While there are endless possibilities for the provision of career counseling services through distance communication technologies, many risks and challenges accompany these new delivery platforms.

Online career counseling is particularly exciting as it may create the opportunity for geographically isolated or homebound individuals (due to mental illness or physical disability) to access services that would otherwise not be available. Individuals who traditionally have not sought counseling, those who are more comfortable with the anonymity provided by the Internet, and those underserved or underrepresented populations may also be more likely to seek services. Online career counseling also presents substantial challenges and potential risks. There are a number of untested legal issues that arise in online career counseling, including practicing across state lines and the coverage of malpractice insurance. It is also possible that not all career concerns are appropriate for online counseling, and most graduate training programs are not preparing counselors to provide online services. Finally, access to technology, particularly high-speed Internet, will limit the ability of many to access career counseling services.

One important distinction in online career counseling is the difference between asynchronous and synchronous communication. E-mail and blogs represent asynchronous communications, where two individuals are not required to be present or online at the same time to communicate. Exchanges through e-mail or blogs allow individuals to compose, edit, review, and respond to messages at their convenience and to create great flexibility in the speed, timing, and frequency of response. Another potential benefit of this communication modality is that clients may derive therapeutic benefit through the act of writing itself. Challenges include maintaining the client's confidentiality, the loss of nonverbal cues, and counselors clearly articulating the timing and frequency of their responses to clients.

Synchronous communication is characterized by real time interaction between client and counselor and includes online chat, videoconferencing, and voice over IP. Online chat is accomplished through messaging systems or Web pages and allows clients and counselors to communicate in real time through typing. Online chat allows the counselor to experience the

timing of responses as well as immediately respond to clients' content. Ethical concerns with this mode of interaction include the possibility of losing tone and emphases of verbal communication, misunderstandings due to not recognizing cultural differences, the security and storage of transcripts of sessions, and potential technology failure. Videoconferencing, which most closely approximates traditional face-to-face counseling, builds upon many of the above benefits and increases the likelihood that verbal and vocal cues will be conveyed during interaction. Access to a broadband Internet connection, expensive video equipment, as well as lighting difficulties and restricted field of vision are all limitations to career counseling through online videoconferencing. Finally, voice over IP is essentially the equivalent of telephone counseling, but may be done at much lower cost and allows participants to simultaneously view content such as assessment results or blog postings on the Internet.

The preliminary research examining the effectiveness and equivalency of online counseling is positive and suggests that e-mail, chat, and videoconferencing are appropriate modalities of career counseling services for some clients. For example, research has compared counseling offered through videoconferencing, speakerphone, or traditional face-to-face counseling and found equivalent and positive outcomes for clients in all three conditions. Findings such as this are encouraging first steps, while much more research remains to clearly identify the problems, clients, career interventions, and communication modalities that are appropriate for online career counseling.

### Considerations for Counseling Professionals

Technological advances during the past 25 years have shaped the work of vocational psychologists and career counselors. Online counseling, Internet assessment, and comprehensive CACG programs are now common aspects of many professionals practice. Professionals are encouraged to embrace these and emerging technologies in their practice but to do so in a way that ensures that technology is applied in helpful and responsible ways.

*Paul A. Gore and Wade C. Leuwerke*

*See also* Career Counseling (v4); Career Counseling Process (v4); Career Exploration (v4); DISCOVER (v4);



E-Counseling (v1); Kuder Career Search (v4); Occupational Information Network (v4); Strong Interest Inventory (v4); System of Interactive Guidance Information (v4); Unisex Edition of the ACT Interest Inventory (v4)

### Further Readings

- Brown, S. D., & Ryan Krane, N. E. (2000). Four (or five) sessions and a cloud of dust: Old assumptions and new observations about career counseling. In S. D. Brown & R. W. Lent (Eds.), *Handbook of counseling psychology* (3rd ed., pp. 740–766). New York: Wiley.
- Gore, P. A., Jr., & Hitch, J. L. (2005). Occupational classification and sources of occupational information. In S. D. Brown & R. W. Lent (Eds.), *Career development and counseling: Putting theory and research to work* (pp. 382–413). Hoboken, NJ: Wiley.
- Horrigan, J., & Rainie, L. (2006). *The Internet's growing role in life's major moments*. Retrieved January 5, 2007, from [http://www.pewinternet.org/pdfs/PIP\\_Major%20Moments\\_2006.pdf](http://www.pewinternet.org/pdfs/PIP_Major%20Moments_2006.pdf)
- U.S. Department of Labor, Bureau of Labor Statistics. (2006). *Occupational outlook handbook*. Washington, DC: Author. Available from <http://www.bls.gov/oco/>

### Web Sites

ACT, Inc.: <http://www.actstudent.org>  
 Choices: <http://www.choices.org>  
 College Board: <http://www.collegeboard.com>  
 DISCOVER program: <http://www.act.org/discover/>  
 Kuder Interest Inventory and Career Planning System: <http://www.kuder.com>  
 O\*NET OnLine: <http://online.onetcenter.org>  
 Pearson Assessments: <http://www.pearsonassessments.com/tests/ciss.htm>  
 Self-Directed Search: <http://www.self-directed-search.com>  
 SIGI PLUS: <http://www.valparint.com/sigi.htm>  
 Strong Interest Inventory: <http://www.cpp.com>

---

## CONSTRUCTIVIST CAREER COUNSELING

---

The theory of constructivism has roots in philosophy, science, psychology, sociology, and anthropology. The core of the theory involves the idea that reality is relative rather than absolute and that people actively create reality by the way in which they experience and

interpret events. As an example, take the idea of stealing another person's money. While some may say that stealing is always wrong and is never justified, others may say that certain circumstances may make stealing understandable. The story of Robin Hood certainly appeals to that notion that what is right and what is wrong is a matter of perspective.

Like other theory-based practices, career counseling has evolved to account for this idea that reality is relative and is created through experience and interpretation of that experience. Although models of practice developing from this new perspective are varied, the theoretical underpinnings share common characteristics that separate them from more traditional mainstays in vocational psychology. Traditional vocational counseling theory developed in an age of modernist ideals and emphasized objectivity, neutrality, reductionism, quantification, and measurement. Models and interventions based on these theoretical underpinnings focused on the person, represented by a set of stable, measurable traits and the world of work, represented by definable characteristics of established occupations and stable career paths.

### Paradigm Shift for Career Theory

Constructivist career theory represents a paradigm shift from these modernist principles toward postmodern ideology. Postmodernists believe that multiple realities exist simultaneously rather than the presumption of one measurable truth. Reality and truth are matters of individual perception and are constructed by individuals as a way of organizing complex information about themselves and the world. Human behavior, then, can be understood only in the context in which it occurs. People use personal constructs or theories they have created about life to organize and account for their experiences and associate meaning through decisions and actions. Individuals use these constructs to evaluate themselves and others, make judgments about the world, and predict the future. As active agents in their lives, people refine their constructs over time based on their life experiences and their reactions to and processing of those experiences.

### Implications for Career Counseling

This core conceptual change has strong implications for the theory and practice of career counseling. Operating under the new assumption that individuals



actively participate in the creation of their own reality, career is viewed as an individual construct. The meaning people attach to career is reflective of their social, psychological, historical, and cultural relationships and experiences. Traditional vocational psychology with its emphasis on stable personal traits and measurable characteristics of occupations becomes less relevant within the context of changing realities.

Specifically, constructivist career counseling requires a paradigm shift from examining behavioral traits to looking at action, meaning, and life themes. In addition, it requires a shift from assessment of causation to more reflective processing. It also encourages counselors and clients to see the self as progressively constructed or a work in progress rather than predetermined. Instead of quantifying traits, career counseling involves exploration of how clients construct meaning from present actions and past experiences. As a construct itself, career accounts for connectedness between actions, accommodates roles and relationships in a variety of settings, reflects purposeful efforts toward planning and goal setting, as well as reflecting internal states such as emotion, arousal, passion, and personality. An individual's construct of career is an overarching framework for understanding and organizing complex patterns of intentional actions over the lifespan. The career development process therefore involves individuals intentionally engaged in acquiring meaning within the constructs of their lives. Life and career transitions, whether purposeful or in reaction to unexpected change, stimulate changes in personal constructs.

R. Vance Peavy was among the first to outline, articulate, and advocate the shift to constructivist career counseling. In a time when clients' lives and careers are increasingly ambiguous and uncertain, Peavy suggested that self-construction and life planning replace simple focus on career choice. He emphasized that clients should move away from the idea that there is one right answer, but rather that some answers are better than others. As individuals create realities through the interpretations they make and the actions they take, they must take responsibility for their own thinking and actions.

Peavy also focused a great deal of time and attention on the relational nature of career construction. People use language to make meaning out of their daily lives, especially in interactions with others and with aspects of the surrounding world. The counseling process is one of collaboration with the counselor bringing expertise on the career development process

and the client bringing self-expertise. The goal then becomes pattern recognition and mindfulness toward the creation of new constructs, receptivity to new information, and awareness of multiple perspectives.

## The Practice of Career Counseling

The process of constructing possible realities involves action. As individuals define themselves and their environments they are actively participating in the creation of new realities and personal stories. The use of language and dialogue (internal or with others) is critical to the creation of meaning and knowledge. In career counseling, individuals' career constructs, stories, and personal mythology are explored and a new reality is created through dialogue between counselor and client. This process invites nonlinear conversations wherein new stories are written, existing stories are revised, and possible selves are explored. Unlike some traditional models that compared individuals to a set of norm-referenced traits, constructivist career counseling respects sociopolitical and cultural contexts in which clients live. This makes constructivist counseling especially useful with diverse client populations and a vast array of individual differences.

A number of models have emerged within this theoretical perspective including narrative career counseling, action theory, the self-construction model, and relational theory. Within these models, new vocational interventions designed to complement the counseling experience are being developed. Although diverse in nature, design, and intended outcome, these interventions generally encourage reflection on activity through storytelling, assessment of themes, journaling, concept mapping, assessment of strengths and accomplishments, and metaphor. With the focus on dialogue and relational empowerment, constructivist career counseling is also being used increasingly in group settings. In addition, more traditional interventions are being reviewed, revised, and reinterpreted for understanding within a constructivist point of view.

*Lisa E. Severy*

*See also* Action Theory (v4); Career Counseling (v4); Career Counseling Process (v4); Career Construction Theory (v4); Constructivist Theory (v2); Diversity Issues in Career Development (v4); Multicultural Career Assessment Models (v4); Multicultural Career Counseling Checklist (v4); Narrative Career Counseling (v4); Narrative Therapy (v2); Qualitative Methodologies (v1)



### Further Readings

- Bujold, C. (2004). Constructing career through narrative. *Journal of Vocational Behavior*, 64(3), 470–484.
- Clark, M. A., Severy, L. E., & Sawyer, S. A. (2004). Creating connections: Using a narrative approach in career group counseling with college students from diverse cultural backgrounds. *Journal of College Counseling*, 7(1), 24–31.
- Cochran, L. R. (1997). *Career counseling: A narrative approach*. Thousand Oaks, CA: Sage.
- Collin, A., & Young, R. A. (1992). Constructing career through narrative and context: An interpretive perspective. In R. A. Young & A. Collin (Eds.), *Interpreting career: Hermeneutical studies of lives in context*. Westport, CT: Praeger.
- Hoskins, M. (1995). *Constructivist approaches for career counselors* (Report No. EDO-CG-95-62). U.S. Department of Education, Office of Educational Research and Improvement. (ERIC Document No. ED 401 505)
- Neimeyer, G. J. (1992). Personal constructs in career counseling and development. *Journal of Career Development*, 18(3), 163–173.
- Peavy, R. V. (1992). A constructivist model of training for career counselors. *Journal of Career Development*, 18(3), 215–228.
- Peavy, R. V. (1995). *Constructivist career counseling* (Report No. EDO-CG-95-61). U.S. Department of Education, Office of Educational Research and Improvement. (ERIC Document No. ED 401 504)
- Savickas, M. L. (1993). Career counseling in the postmodern era. *Journal of Cognitive Psychotherapy: An International Quarterly*, 7(3), 205–215.
- Savickas, M. L. (1995). Constructivist counseling for career indecision. *Career Development Quarterly*, 43(4), 363–373.
- Stead, G. B. (2004). Culture and career psychology: A social constructionist perspective. *Journal of Vocational Behavior*, 64(3), 389–406.
- Young, R. A., & Collin, A. (2004). Introduction: Constructivism and social constructionism in the career field. *Journal of Vocational Behavior*, 64(3), 373–388.

---

## CONTRACT WORK

---

Rather than continuing as a salaried employee at a college or agency position, some counselors choose to establish a private career counseling practice and engage in contract or consulting work. Contract work can be very fulfilling, financially rewarding, and provide tremendous freedom to develop and experiment

with numerous interventions while focusing on preferred niches that match one's highest passions. Success ultimately depends on discipline, setting priorities, and having a measured sense of risk, adventure, and entrepreneurship.

### Factors Associated With Choosing Contract Work

A main motivation for many private practitioners that probably influences them to engage in contract work is the opportunity and freedom to concentrate primarily on individual counseling activities with clients and engage in those activities directly related to preferred interests. Counselors choose to be counselors because they enjoy the counseling relationship and believe that this one-on-one interaction can effect change and assist clients with their concerns. Individual counseling does work, and many counselors prefer this one-on-one relationship for good reasons.

Research findings by T. L. Sexton, S. C. Whiston, J. C. Bleuer, and G. R. Walz indicate the primary factors that effect outcome in career counseling are the type of treatment modality and the duration of time spent counseling and cite individual counseling as the most effective treatment modality. Further research by A. R. Spokane describes individual career counseling as the most efficient career intervention in terms of amount of gain per hour of effort. This one-on-one approach is viewed by J. Rayman as a superior career intervention based on a therapeutic alliance that should be available in comprehensive career centers. Ironically, this presents a daunting challenge to those counselors who prefer the infrastructure of a college or agency setting to consider alternative methods to sufficiently meet client demand. Several factors affect career services providers in college and agency settings and deter them from delivering their preferred mode of individual counseling.

### Time Constraints

Time on task is a major concern. The reality is that most career services providers, especially in college settings, are very busy with many noncounseling job responsibilities and unable to sufficiently provide the comprehensive individual career counseling required to meet the needs of their clients. Department meetings, administrative responsibilities such as report writing and budget preparation, orientation and



registration activities, academic advising, classroom presentations, and teaching career exploration courses take time and effort, and can detract from concentrated in-depth individual counseling interventions. Even in those college and agency settings where more time might be available for individual counseling, very small percentages of counselors are able to provide the 9 to 10 sessions normally required for effective career interventions.

### ***Client Demand***

Another factor that deters counselors from providing individual counseling relates to the large client demand evident at most postsecondary institutions and agency settings. Secondary school students' needs for career guidance remain largely unmet, and they bring their unmet needs to the college environment, contributing to the estimated half of all undergraduates in colleges and universities who need some form of career assistance. As calls for accountability increase from multiple stakeholders and more colleges and agencies utilize important needs assessment and outcomes research, the evidence of unmet needs will be further documented resulting in more pressure on staff to produce better results.

### ***Insufficient Staff***

Finally, there are simply not sufficient numbers of counselors to provide comprehensive individual-based services within the infrastructure of most education and agency settings in the United States or in similar settings internationally. These settings are not structurally organized up to provide comprehensive individual career counseling to large numbers of clients. Few counselors are hired, and yet these few counselors are expected to provide appropriate services to meet the career counseling needs of many clients. Thus, counselor-client ratios are very high leaving a limited pool of stressed-out counselors to attempt to accomplish the important work that needs to be done.

Colleges and agencies need to think creatively and wisely as they develop ways to cost-effectively meet the needs of the many clients who frequent their physical structures. Unfortunately, individual counseling, career exploration and planning courses, workshops, the use of computer-assisted career guidance systems (CACGS), and other activities cannot

effectively reach the multitudes. In many college and agency settings, the prevailing treatment modality remains career counseling by appointment, a familiar, comfortable, and proven intervention, yet clients' needs are not sufficiently met. What is needed is the application of systematic career guidance (SCG) with small structured groups that at least begins to cost-effectively deal with this demand. Sadly, the majority of college students will probably experience their college years without spending sufficient time and energy in what E. A. Colozzi describes as committed career exploration activities. Their unmet needs will be carried forth into their first time employment experiences from which they will eventually change jobs 7 to 10 times in two or three unrelated careers during their work history.

### **A Catalyst for Inspiring Contract Work**

These factors will result in a great need for private practice counselors to assist with the growing demand for career/life counseling in an ever-changing global economy. This situation presents a very positive employment opportunity for school, college, and agency counselors who might be considering establishing a private practice because they prefer not to deal with the many other activities that often are an integral part of the job responsibilities at most educational and agency settings. Thus, the stage is set for those career services providers who choose to shift from being salaried employees to being consultants who provide contract work and earn income directly from one or several sources including individual paying clients and corporate or agency clients.

Choosing to become an entrepreneur is an exciting venture that requires a business vision, planning, marketing, constant evaluation, support from others such as family, friends or mentors, and a sense of adventure, even calculated risk. Research indicates entrepreneurs establish an average of 500,000 new businesses monthly in the United States with small businesses (independent businesses having fewer than 500 employees) representing 99.7% of all employer firms. Small businesses are the largest growing segment of the U.S. economy, responsible for more than two thirds of new jobs, and the majority of small businesses are entrepreneurs without employees as reported by S. Gelardin in a new monograph that focuses on starting and growing a new business.



## **Contract Work Opportunities**

There are several creative ways to provide services to potential individual and corporate clients. One involves direct services to clients needing individual counseling and career/life coaching. Another involves providing services to an agency college or corporate client that might include onsite individual counseling and small and large group workshops for employees. Some corporate clients may simply have a need for the development of materials that better serve their target niche of clients and customers, and this type of contract work would preclude directly seeing individual clients and doing group workshops. Distance counseling via telephone or using the Internet with blogs, Podcasting, and video are other ways to meet client needs. New technologies are expanding the many and varied exciting ways to provide career counseling in a global community that presents a thriving economy for the contract career counseling profession.

## **Establishing the Office and Targeting the Market**

The establishment of a private practice where clients come to an office or home office and obtain services directly from a counselor is an obvious choice. Less overhead and other costs result in more income. Penetrating the right market increases income. The focus could be on comprehensive individual career counseling and perhaps small group work. Selecting a niche such as adults 30 to 50 years of age, new entrants to the labor market who have primarily been homemakers, or focusing on young adults are just a few of many possibilities. The key is to start from one's strengths and passions. Concentrate on abilities, talents, and interests to identify a target niche, and then develop a marketing plan to penetrate that selected market. The focused approach of niche marketing needs to be carefully balanced with creating sufficient content or product diversification to ensure income flow if one's niche market experiences an economic hiccup! It is difficult and unwise to establish a private practice immediately following graduate school. One requires experience to be successful, and experience is best gained from working in an educational or agency setting where many clients or customers seek career counseling. If one dreams of doing contract work as a private practitioner, consider any work at an appropriate college or agency setting as

simply a paid internship—a bridge job that progresses one forward and teaches new skill sets.

## **Being a Successful Businessperson and Counselor**

There are numerous rewards associated with establishing oneself as a contract worker and private practitioner, including a great amount of freedom to do the specific types of work and projects that are fulfilling. One key to success is the clarity one has concerning the role division between businessperson and counselor. It is important, even critical as one develops a business plan, to be aware of the many business tasks that are necessary to successfully provide contract work as a private practitioner and consultant.

If the assumption is that to be successful in private practice, one must see oneself equally as a businessperson and a career counselor, a 50/50 even split, not a businessperson first and then a career counselor, the contract work may quickly end due to unrealistic priorities. It is imperative to always see oneself and act as a businessperson first—at least 51%. This requires organizing time and tasks in the context of business goals first and then serving customers—clients with integrity in ways that meet their needs. This approach will allow a reasonable profit so the contract work can continue to support one's business as a private practitioner, doing the counseling and consulting one thoroughly enjoys. The other option is to work for a college or agency setting primarily as a career counselor and not have to deal with the business aspects of running a private practice and doing contract work.

## **Future Directions**

Small businesses have been around from the earliest time a person started to offer a service or provide a product for the community. They are always growing and changing, and will be offering many exciting opportunities for future generations. In the career counseling field many people are discovering opportunities to offer their services for a fee. There are human and written resources that will support this effort including advice, mentoring, and basic tips that facilitate starting and growing a successful business in the career counseling profession. Much of this information is available through the National Career Development Association (NCDA), and their Web site



offers excellent free career information and a variety of resources. Another organization that focuses on school youth is JA Worldwide (Junior Achievement), and their Web site offers very user-friendly resources for youth, parents, and educators, including links to arrange having a JA volunteer visit a school and present several workshops for students on many topics such as entrepreneurship, career exploration, and the global economy.

*Edward Anthony Colozzi*

**See also** Adults in Transition (v4); Career Counseling (v4); Career Counseling in Organizations (v4); Career Counseling in Schools (v4); Career Counseling Process (v4); Career Interventions (v4); National Career Development Association (v4); Private Practice Career Counseling (v4); Standards and Competencies (v4)

### Further Readings

- Colozzi, E. A. (2000). Toward the development of systematic career guidance. In D. Luzzo (Ed.), *Career counseling of college students: An empirical guide to strategies that work*. Washington, DC: American Psychological Association.
- Gelardin, S. (2006). Starting and growing a business in the new economy: Successful career entrepreneurs share stories and strategies. *National Career Development Association Monograph Series*.
- Rayman, J. (1996). Apples and oranges in the career center: Reaction to R. Reardon. *Journal of Counseling & Development*, 74, 286–287.
- Sexton, T. L., Whiston, S. C., Bleuer, J. C., & Walz, G. R. (1997). *Integrating outcome research into counseling practice and training*. Alexandria, VA: American Counseling Association.
- Spokane, A. R. (1991). *Career interventions*. Englewood, NJ: Prentice Hall.

### Web Sites

- JA Worldwide: <http://www.ja.org>
- National Career Development Association: <http://www.ncda.org>

---

## CRITES, JOHN O. (1928–2007)

---

John O. Crites completed the A.B. degree in history from Princeton University in 1950 (magna cum laude) and the Ph.D. degree in Counseling Psychology from

Columbia University in 1957. He made a number of significant professional contributions at the University of Iowa where he started the Counseling Psychology Program in 1958. He was the Head of the Counseling Psychology Program and the Director of the University Counseling Service until he moved to the University of Maryland in 1971 as a Professor of Psychology. In 1981, he was hired as a research professor at Kent State University; in 1985, he became Director of the Counseling Psychology Program at Northwestern University; and he became a Visiting Professor of Psychology at the University of Denver as he moved into retirement.

Over the years Crites was a very productive professional person and a leader in the field of counseling and vocational psychology. He authored or coauthored four textbooks, 15 chapters, seven monographs, and 35 published manuscripts. Two books (*Appraising Vocational Fitness*, revised with Donald Super, and *Vocational Psychology*) were early and very original contributions to integrating theory, data, and practice in the field of vocational psychology and career development. His book *Career Counseling: Models, Methods, and Materials* was one of the first attempts to present theories of career counseling within a data-based perspective. He also served on a number of editorial boards during his long and distinguished career.

Honors and awards include the American Board of Professional Psychology Diplomate in Counseling Psychology, the American Personnel and Guidance Association Research Award in 1966, the Merit Award from the National Vocational Guidance Association in 1973, the Recognition Award from the Association of Measurement and Evaluation and Guidance in 1973, the Eminent Career Award from the National Vocational Guidance Association in 1984, and the Walter F. Storey Award from the American Society for Training and Development in 1985. He was a Fellow of the Division of Counseling Psychology of the American Psychological Association and a Fellow of the American Association for the Advancement of Science. In 1972 he served as the President of the Division of Counseling Psychology of the American Psychological Association.

His most notable contributions were twofold. He wrote the first major text defining the field of Vocational Psychology (1969) that has had a long-term influence on research and training in counseling psychology. His operationalization of and theorizing about the vocational development view of careers set



the stage for much of the work that followed. In particular, the Vocational Development Attitude Scale, the Decision-Making Competency Scales, and the Career Maturity Inventory were the forerunners of many current scales and inventories.

Crites had a distinguished career of original research, scholarship, and application as well as of outstanding service and leadership. He was clearly one of the outstanding contemporary counseling psychologists of our time. His theoretical concepts, insights, and empirical research have had a significant influence on the field of counseling and vocational psychology. Crites passed away in March 2007.

*W. Bruce Walsh*

**See also** Career Counseling (v4); Career Counseling Process (v4); Career Decision-Making Difficulties Questionnaire (v4); Career Development Inventory (v4); Career

Education (v4); Career Indecision (v4); Career Mastery Inventory (v4); Career Maturity (v4); Career Maturity Inventory (v4); Decision Making (v4)

### Further Readings

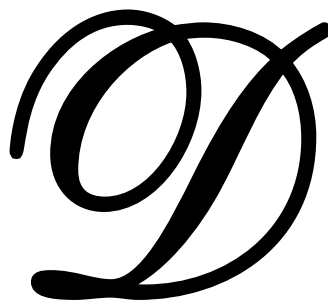
Crites, J. O. (1965). Measurement of vocational maturity in adolescence: Attitude Test of the Vocational Development Inventory. *Psychological Monographs*, 79(2, Whole No. 595).

Crites, J. O. (1969). *Vocational psychology: The study of vocational behavior and its development*. New York: McGraw-Hill.

Crites, J. O. (1973). *Theory and research handbook for the Career Maturity Inventory*. Monterey, CA: CTB/McGraw-Hill.

Crites, J. O. (1981). *Career counseling: Models, methods, and materials*. New York: McGraw-Hill.





---

## **DAWIS, RENÉ VILLANUEVA (1928– )**

---

René Villanueva Dawis continues to be a major contributor to counseling psychology and to the psychology of individual differences. Born in the Philippines in 1928 into the family of a professor of agronomy, Dawis received his B.A. (cum laude) from the University of the Philippines in 1951 and spent 2 years as an instructor in psychology at that same university. He then entered the graduate program in psychology at the University of Minnesota, where he completed his master's degree in 1955 and his Ph.D. in 1956. Dawis returned to the University of the Philippines for a year as an assistant professor, but his graduate adviser—the legendary Donald G. Paterson—recruited him as the research director for a new research project at the University of Minnesota under then Associate Professor Lloyd H. Lofquist and his colleague George W. England.

The goal of the 2-year project, funded by the then U.S. Office of Vocational Rehabilitation (OVR), was to evaluate the effectiveness of the vocational rehabilitation process. The project was so successful that OVR then funded what was to become the Work Adjustment Project with Dawis as its first research director. A major product of that project, which was funded for almost 15 years, was articulation of the theory of work adjustment, which has guided much of Dawis's research in vocational psychology since that time. With Dawis as its research director for 5 years and then coprincipal investigator with his lifetime colleague Lloyd H. Lofquist for the remainder of the project's funded years, the Work Adjustment Project was

the training ground for many Minnesota psychology graduate students who continue with new generations of students to make important contributions to vocational psychology.

The Work Adjustment Project under Dawis's guidance was the source of the Minnesota Importance Questionnaire and the Occupational Reinforcer Patterns, both of which The Work Adjustment Project uses to assist vocational counselors in identifying occupational choices for counselees; the project also uses, among other instruments and materials useful in vocational counseling and counseling research, the world's most popular measure of job satisfaction, the Minnesota Satisfaction Questionnaire. The theory of work adjustment, originally articulated in a 1964 monograph, was revised in 1969 and has been continually expanded and updated since in two books with Lofquist and in numerous journal articles, monographs, and book chapters even after Dawis's retirement from the Psychology Department at the University of Minnesota in 1997.

In his highly productive and continuing career, Dawis has published 63 journal articles, 51 research monographs and technical manuals, six books, and 30 book chapters. His research garnered him awards and recognition from organizations such as the American Personnel and Guidance Association, the American Rehabilitation Association, and the American Psychological Association. In addition, he was the graduate adviser to 78 students who completed Ph.D.s in psychology. Like many University of Minnesota psychology faculty, Dawis was not content to just teach and do research, but he also served as a consultant to over 50 organizations in government, industry, and the



private sector, sharing his expertise for the good of society.

David J. Weiss

*See also* Lofquist, Lloyd Henry (v4); Minnesota Importance Questionnaire (v4); Person–Environment Fit (v4); Theory of Work Adjustment (v4); Trait-Factor Counseling (v4)

### Further Readings

- Dawis, R. V. (1991). Vocational interests, values, and preferences. In M. D. Dunnette & L. M. Hough (Eds.), *Handbook of industrial and organizational psychology*: (2nd ed., Vol. 4, pp. 833–871). Palo Alto, CA: Consulting Psychologists Press.
- Dawis, R. V. (1996). The theory of work adjustment and person–environment correspondence counseling. In D. Brown & L. Brooks (Eds.), *Career choice and development: Applying contemporary theories to practice* (3rd ed., pp. 75–120). San Francisco: Jossey-Bass.
- Dawis, R. V. (2001). Toward a psychology of values. *The Counseling Psychologist*, 29, 458–465.

### Web Sites

Vocational Psychology Research. Work Adjustment Project:  
<http://www.psych.umn.edu/psylabs/vpr>

---

## DECISION MAKING

---

Decision making refers to the process by which an individual comes to choose between two (or more) alternative courses of action. For career decisions, this process might lead to the choice of a major, a more general occupational direction, or a particular job. Decision making might also lead individuals to explore some career directions and not others or to abandon choices previously made. Regardless of the specific context, career decision making reflects the process through which individuals take in, weigh, and make judgments about themselves in relation to the world of work.

Decision making has been studied both as a process and as a source of individual variation. In turn, the process of decision making has been framed in both descriptive and prescriptive ways, and models of individual variation have been advanced that reflect

both individual styles and the context of the decision-making environment. Each of these major perspectives is described here.

### Decision-Making Process

Tracing back to the earliest study of human cognition, theorists have sought to describe how it is that people arrive at a single course of action as well as how decisions should be made optimally.

### *Descriptive Models of Decision Making*

Descriptive models of decision making are those that simply describe or detail the steps involved in the process of making a decision without advocating for how the process should proceed. In one of the first efforts to describe career decision making, David V. Tiedeman provided a comprehensive model that portrayed the process as a sequence of stages leading up to and following the point of choice. Prior to choice is a stage of anticipation in which individuals explore, crystallize alternatives, make a choice, and clarify how the choice will be put into action. Following this is a stage involving implementation in which the individual adjusts after the chosen alternative is enacted. Tiedeman also noted that the process was not necessarily linear and irreversible, arguing that one might recycle through these stages at any point. Such recycling might occur when, for instance, alternatives failed to crystallize (leading one back to exploration) or the selected alternative failed to lead to a satisfactory implementation plan (leading one back to choice making or exploration). Vincent A. Harren further expanded this model to focus specifically on the decision making of college students and to include attention to elements of individual and contextual variability in the decision-making process. His model included four phases of awareness: needing to decide, planning, making a commitment to a particular course of action, and implementation of the chosen alternative.

Other descriptive models of decision making have focused on selected segments of the decision-making process. Seeking to understand what starts the decision-making process, one model suggested that discrepancy between one's beliefs about the world and one's plans for entering it leads to a dissonance that is reduced by initiating a decision-making process. Focusing on how individuals weigh and evaluate assembled information and alternatives, other theorists



offered mathematical models in which alternatives are weighted by combinations of valence, expected outcome, and probability.

### ***Prescriptive Models of Decision Making***

In contrast to the models of decision making that simply detail how a decision is made, there has been considerable effort directed to understanding how decisions should be made. In one of the earliest prescriptive models in the vocational domain, Frank Parsons argued in 1909 that the central task of career decision making was one of assembling information about oneself and about the world of work and using true reasoning to arrive at a match between the two sets of information. This model of a scientific, methodical, rational approach to decision making has been echoed and elaborated in a variety of prescriptive models of decision making.

John D. Krumboltz and his colleagues also offered a prescriptive model to help youth make decisions in a rational, logical manner. Their model both describes the steps in the process and also advocates for a systematic progress through those steps. Known by the acronym DECIDES, this model includes defining the problem, establishing a plan of action, clarifying values, identifying alternatives, discovering probable outcomes, eliminating alternatives systematically, and starting action. This model has similarities to several more generic models of effective problem solving proposed by P. Paul Heppner and others.

Other advocates of the methodical, rational model of the decision-making process focused on classical expected utility approaches. These approaches describe the best decision on which the decider gathers comprehensive information about alternatives, assigns utility or desirability weightings to each alternative, considers the probability of the outcomes of each alternative in a systematic manner, and selects the course of action associated with the highest expected utility.

While many prescriptive models offer a view of the best decision making as undertaken by thoroughly methodical, highly efficient, information processors, others have argued that this does not match well the experiences of most deciders. Itamar Gati, for example, offered a modification of the expected utility approach that better reflected how people manage and process the voluminous information involved in the decision-making process. His sequential elimination

model highlights how deciders can progress through a methodical, sequential process in which they identify the most critical elements of the decision situation, rank alternatives according to those elements, and use the results to narrow down the number of alternatives considered. Accompanying this model is a recommended strategy for helping individuals through the prescreening, exploration, and choice stages of the decision-making process.

Finally, it should be noted that although a variety of models have been offered about what the decision-making process should look like, much remains unknown about the process actually used by high-quality decision makers and about how the limitations of human information processing and judgment can be accurately represented in prescriptions about the decision-making process.

### **Variations in the Decision-Making Process**

In its most basic form, the career decision-making process entails the identification of alternatives, the gathering of information, the weighing of options, and ultimately the choosing and implementing of one course of action. Although this process may appear fairly straightforward, it has been noted that there is considerable individual variation how and how effectively this process unfolds in a given decisional situation. Efforts to understand this variability has led to a number of taxonomies of decision-making strategies or styles.

### ***Decision-Making Styles***

Decision-making styles refer to the characteristic ways in which different people behave in decision-making situations. The earliest efforts to identify these differences proposed trait-like categories of deciders who appeared to be planners, agonizers, delayers, impulsives, intuitives, fatalists, or compliant. From this perspective, it is expected that a decider who showed, for instance, impulsivity in choosing the first available alternative would display that same decisional behavior across all decision-making situations. The most widely used taxonomy in this tradition is that of Harren, who argued that decision making varies in the extent to which the individual assumes personal responsibility (versus assigning responsibility to fate, peers, and authorities) as well as in the extent to which



the decider is logical (versus emotional) in the decision-making process.

His model includes a rational style in which the decider takes individual responsibility; a systematic, logical approach (i.e., an intuitive style) in which the decider also takes individual responsibility, but primarily considers emotional factors often impulsively; and a dependent style in which responsibility is deferred to others and a passive posture is assumed.

Similar categorizations have been advanced that suggest that the noted differences in approaching and behaving in decision making were likely to emerge depending on particular situations. According to this perspective, a decider might be hesitant (procrastinates or postpones decision making) in one situation, while being intuitive (choices based on an inner feeling of rightness or inevitability) or logical (objective appraisal and selection) or compliant (passive; choice basis is expectations of others or self-imposed expectations) in another. Still other taxonomies have suggested that deciders vary in the way in which they gather information (systematically or spontaneously) and process information (internally or externally).

With these noted variations in individual decision making, there has also been a strong endorsement of a decision-making process that includes considerable autonomy and independence and that is approached in a rational, systematic manner. Research has provided some support for this endorsement: the rational decision-making style has been linked with better approaches to problem solving, to greater knowledge about self, to better progress in the overall decision-making process, and to greater progress in implementing selected alternatives. There is also some evidence to suggest that the systematic decider is more likely to have a solid sense of personal identity and less likely to experience career indecision.

Along with the endorsement of the rational style, the prevailing recommendation from the literature discourages use of a dependent or intuitive style. Indeed, the dependent or compliant decision-making strategy has been linked with less favorable or adaptive functioning: individuals with a dependent style have been shown more likely to commit to alternatives without adequate exploration, to show less progress in the decision-making process, to avoid problem solving, and to lack confidence in their problem-solving abilities.

Although the available knowledge indicates that a rational, nondependent decision-making style can be expected to be effective, there is also growing evidence

that such a style is not the only adaptive decision-making strategy. For example, in studies of interventions designed to help deciders, it has been shown that other decision-making strategies can prove helpful.

In a related vein, recent efforts have been made to highlight the possible adaptiveness of styles other than rational. Exploring the research on decision making and human judgment beyond the vocational domain, it has been noted that the rational, autonomous approach to decision making that is advocated may be neither possible nor desirable. From the perspective of information processing, there is considerable evidence that ordinary people and even high-quality decision makers simply do not engage in a comprehensive, dispassionate, systematic, isolated decision-making process. In addition, where emotion or intuition is regarded in the vocational domain as something to be minimized, these qualities can also be viewed as highly relevant sources of information about available alternatives. Furthermore, where reliance on others is seen in the career decision-making literature as a dangerous departure from necessary autonomy, studies of expert judges suggest that making use of the expertise, wisdom, and perspective of others is highly valuable in the decision-making process. Taken together, there is growing evidence that decision-making styles that are different from the traditionally advocated rational style may also have distinct benefits in the decision-making process.

### ***Variations From the Context of Decision Making***

Although early study of variation in decision making focused on qualities of the individual decider, there is also a growing recognition that the context in which decision making occurs is likely to play a major role in how and how effectively an individual proceeds. This recognition has arisen from the growing evidence that cultural and interpersonal factors are as influential as individual differences in shaping behavior. From a cultural perspective, it has been suggested that in contexts where individualistic values prevail, the role and value of others in the decision-making process might be minimal. However, in cultures where collectivist values prevail, the role played by others may be quite pronounced and the value of the role of others emphasized, even within a traditionally rational process. These differences have been observed in studies in which the more confident deciders from



individualistic cultures were those who did not use a dependent style, while the deciders from collectivist cultures were more confident only if they did use a rational style.

From the perspective of the interpersonal context of decision making, other emerging perspectives have focused on the role of others in the decisional situation. These perspectives portray the decider as embedded in a social context that shapes perceptions, defines behavioral options, and influences courses of action. Drawing from knowledge about the powerful relational contexts of human experience, it has been argued that it is too limiting to consider the role of others only from the perspective of dependency or compliance. Rather, a view of an individual's decision-making process experience would be far more complete if it included all of the ways in which the relational context aided, supported, hindered, impinged, and/or ignored the decider's task. Toward this goal, a number of scholars have begun to articulate the variety of ways in which perceptions, alternatives, and experiences in choice making situations are influenced by the decider's relationships. For example, an initial taxonomy has been offered to detail two important dimensions: how deciders use others in decision-making situations in more or less self-directed ways and how others involve themselves in the decision-making process. Efforts such as these are providing increasing confidence that the role of others in decision making may be quite valuable in an individual's decision making.

### Future Directions

Theory and research on career decision making to date has yielded a clear view of the basic steps of the decision-making process and has identified some of the effective ways in which decisions can best be made. Although this knowledge has been advanced based on what may be an unrealistic view of human information processing, newer models are emerging that will capture the best decision-making processes within the capacity of everyday deciders. Similarly, although many extant models of decision-making styles or strategies have placed priority on autonomy and rationality, newer perspectives are incorporating the importance of culture and context, and there is a growing recognition that there may be multiple "good" ways to proceed in decision-making situations.

Susan D. Phillips

**See also** Career Decision Scale (v4); Career Decision Self-Efficacy Scale (v4); Career Exploration (v4); Career Indecision (v4); Cognitive Information Processing Model (v4); Collectivism (v3); Cultural Values (v3); Ethical Decision Making (v1); Krumboltz, John D. (v4); Tiederman's Decision-Making Theory (v4); Vocational Identity (v4)

### Further Readings

- Gati, I. (1986). Making career decisions: A sequential elimination approach. *Journal of Counseling Psychology*, 33, 408–417.
- Gati, I., & Asher, I. (2001). The PIC model for career decision making: Prescreening, in-depth exploration, and choice. In F. T. L. Leong & A. Barak (Eds.), *Contemporary models in vocational psychology* (pp. 7–54). Mahwah, NJ: Lawrence Erlbaum.
- Heppner, P. P., Witty, T. E., & Dixon, W. A. (2004). Problem-solving appraisal and human adjustment: A review of 20 years of research using the Problem Solving Inventory. *The Counseling Psychologist*, 32(3), 344–428.
- Kahneman, D. (2003). A perspective on judgment and choice: Mapping bounded rationality. *American Psychologist*, 58(9), 697–720.
- Phillips, S. D. (1997). Toward an expanded definition of adaptive decision making. *Career Development Quarterly*, 45, 275–287.
- Phillips, S. D., Christopher-Sisk, E., & Gravino, K. L. (2001). Making career decisions in a relational context. *The Counseling Psychologist*, 29(2), 193–213.
- Phillips, S. D., & Pazienza, N. (1988). History and theory of the assessment of career development and decision making. In W. B. Walsh & S. H. Osipow (Eds.), *Career decision making* (pp. 1–32). Hillsdale, NJ: Lawrence Erlbaum.

---

## DICTIONARY OF OCCUPATIONAL TITLES

---

The *Dictionary of Occupational Titles (DOT)* was originally developed in 1939 by the U.S. Employment Service (USES) as a means to organize occupational information into one volume using a standardized format. It was produced to assist with job placement, employment counseling, and labor market estimations; the latest edition was published in 1991. With each revision, the number of jobs included fluctuated as markets and jobs change periodically. The 1991



edition included almost 13,000 general and 20,000 separate jobs. Each job is classified according to a 9-digit number, creating a taxonomy designed to ease use.

The first of the nine digits referred to one of nine occupational categories: professional, technical, and managerial; clerical and sales; service; agricultural, fishing, forestry; processing; machine-trades; benchwork; structural; and miscellaneous. These nine categories were further divided into over 80 occupational divisions, which were further divided into over 500 occupational groups, representing the second and third digits. For example, the professional, technical, and managerial category is divided into types (e.g., architecture and engineering), which are then further divided into additional categories (e.g., civil engineering, marine engineering). The middle three digits relate to ways of doing tasks: ways to deal with data (e.g., synthesizing, compiling) and people (e.g., supervising, serving) and how a person uses things (e.g., precision working, manipulating). These occupational classifications were based on assessments of tasks conducted by people in the particular occupation. The final three digits represent the alphabetical list of titles based on the previous six-digit code numbers and were unique to a specific occupation. Thus, two or more occupations could have the same initial six digits because they are in the same general area, but would differ in the final three.

In order to help job seekers, each of the occupations included a paragraph defining what an individual conducting that work would do. Readers could look up these occupations based on their purposes. For example, someone could review information in a field closely related to what they are already doing, in another industry, or simply by occupational title if he or she is interested in finding more information about a specific occupation. For 70 years the *DOT* has not only been used to match people to jobs, but also for disability decisions, educational program design, vocational rehabilitation, personnel classification, vocational research, counseling, and employee selection procedures.

The *DOT* is not published anymore largely as the result of budget cuts; an ever-increasing need for accurate, timely market information; and a realization that employers began searching for workers with abilities across settings or even across industries. The *DOT* is not used much anymore, except by government agencies to determine disability benefits such as by the Social Security Administration and by

companies working with insurance claims brought by injured workers. A newer computer-based vocational system run by the U.S. Department of Labor called the Occupational Information Network (O\*NET) is currently in use and offers more flexibility and can be updated more frequently. However, the *DOT* filled a need for decades, paving the way for newer systems to assist workers, employers, and market projectors.

Mark M. Leach

*See also* Bureau of Labor Statistics (v4); Occupational Information (v4); Occupational Information Network (v4)

### Further Readings

- Brown, D., & Brooks, L. (1991). *Career counseling techniques*. Boston: Allyn & Bacon.
- Herr, E. L., & Cramer, S. H. (1996). *Career guidance and counseling through the lifespan* (5th ed.). New York: HarperCollins.
- Sharf, R. S. (1992). *Applying career development theory to counseling*. Pacific Grove, CA: Brooks/Cole.

---

## DISABILITY

---

*See* PERSONS WITH DISABILITIES

---

## DISCOVER

---

DISCOVER Career Planning Program from ACT, Inc., is a comprehensive computer-based career guidance system offered on the Internet for Grade 5 through adult. It includes inventories of interest, abilities, and values plus detailed information about occupations (civilian and military), majors, schools, financial aid, and the job search. The results of the career exploration process are organized in an online career portfolio that provides an ongoing record of career choices and a complete resume.

### History

DISCOVER traces its history from 1967 when JoAnn Harris-Bowlsbey, then Director of Guidance at Willowbrook High School, developed a computerized program for career counseling called CVIS



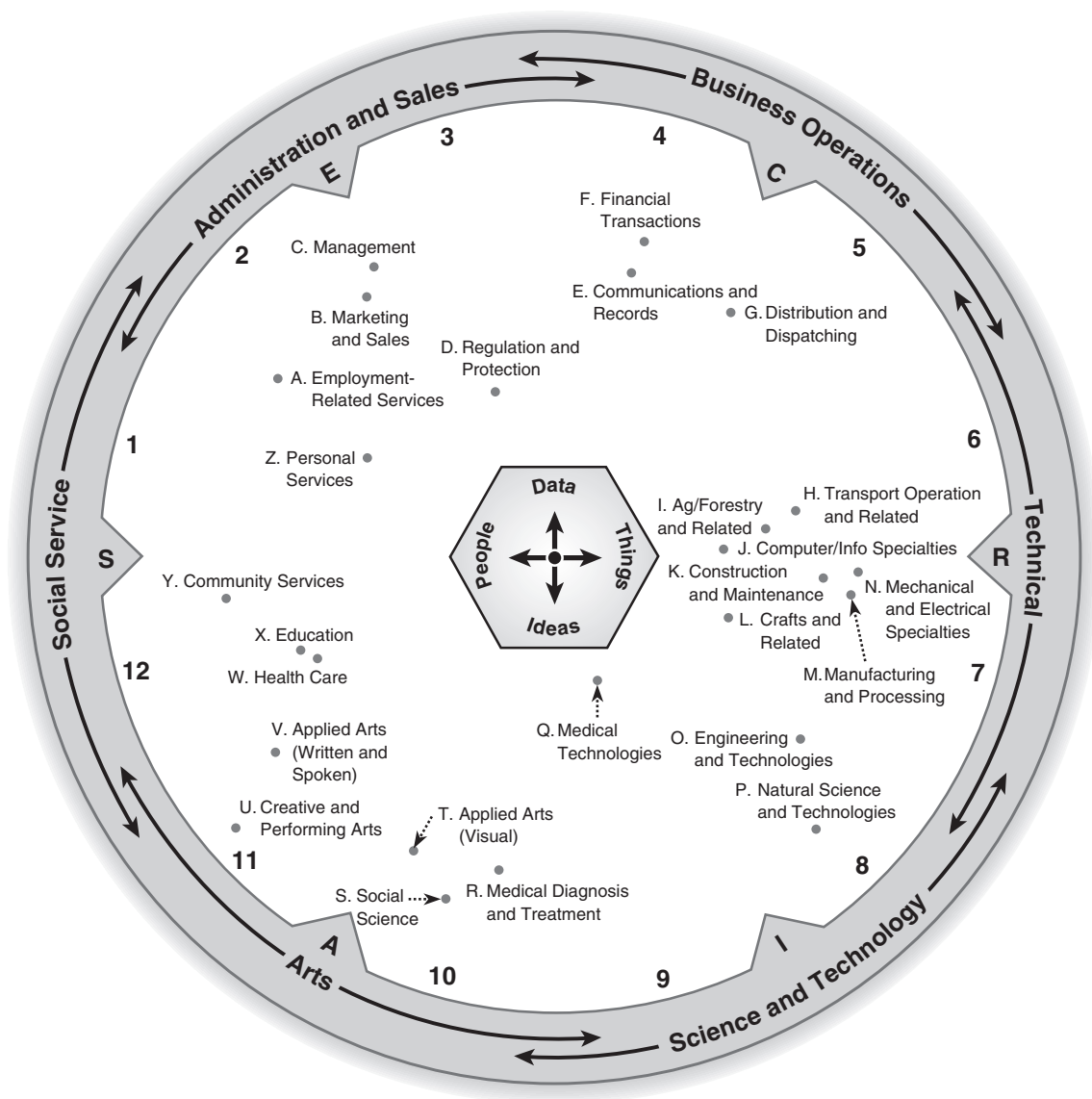
(Computerized Vocational Information System). The next incarnation of her work was called DISCOVER; and in 1982, the DISCOVER Foundation merged with ACT.

With each advance in technology and career development theory, new versions of DISCOVER were developed, and each included different components and features. The core features of DISCOVER remain research-based inventories organized around ACT's World-of-Work Map and quality information about occupations, majors, schools, and other career-related issues. These components are interconnected to

facilitate career exploration for users from middle school throughout the work life.

### Theoretical Model

ACT's World-of-Work Map provides the unifying theme for finding and understanding occupations. Two empirically based dimensions underlie the map: one dimension involves working with data versus ideas, and the other dimension involves working with people versus things. These four basic work tasks (data, ideas, people, and things) serve as the four



**Figure 1** World-of-Work Map

Source: ACT, Inc.



compass points on the map—just like a regular map. Six career clusters, paralleling John L. Holland's six career types, are also represented on the map. Within these clusters, 26 career areas are located on the map. Each career area contains occupations involving similar combinations of basic work tasks. Because both occupations and Holland-type score profiles can be located on these two dimensions, the map provides a simple, yet comprehensive bridge from persons (assessment scores) to occupational options.

### Assessments

People can be located on ACT's World-of-Work Map using a variety of assessments. DISCOVER includes the ACT's Interest Inventory (UNIACT), the Inventory of Work-Relevant Abilities, and the Inventory of Work-Relevant Values. Each inventory has been developed through extensive research, and psychometric information is available at no charge. Inventory results are expressed as career areas on the World-of-Work Map, and users are encouraged to explore and mark their favorites. For many users, the three inventories suggest different career areas. After taking multiple inventories, it is possible to compare the recommendations of these inventories. Occupations that match one's interests may not match one's abilities, and the occupations that are most likely to satisfy one's values may include others that have not matched one's interests or abilities. Counselors can use the comparison of these results to assist clients to understand competing issues related to the career choice process.

DISCOVER also accepts scores from EXPLORE, PLAN, and the ACT. Results of these tests, as well as many tests and inventories from other publishers, are used in DISCOVER to help people find their place on the World-of-Work Map. Combining achievement data with self-assessment provides another valuable opportunity for self-awareness. After completing tests such as these, the use of DISCOVER for career exploration greatly enhances the value of the assessment information.

### Information Components

Over 85% of users take one or more of the inventories in DISCOVER to help them find their place on the World-of-Work Map. DISCOVER encourages

exploration, with about 80% of users investigating descriptions of occupations. The occupational descriptions include detailed information about the occupation, training required, national and state salaries and outlook, and links to Web sites where more information can be found. Occupations are linked to majors and military occupations, both of which have detailed descriptions. Majors link to the schools that offer them, with a comprehensive description provided for each school. The majors and schools span the range from certificates for short training programs to graduate and professional programs of study. Virtually all accredited schools in the United States are included, and the information is updated annually.

Many other topics are also covered, such as financial aid, job search skills, and course planning. Links to information available elsewhere on the Internet allows users to pursue more detailed information on almost any topic. Users can compose a resume suitable for printing. They can also create a course plan. If local schools enter their own course list and graduation requirements, students can use this feature to select the courses they plan to take in high school that relate to their career goals. All of the information accessed in the program is tracked in the career portfolio, which provides a summary of features that have been used, decisions that have been made, and favorites that have been selected. Users are encouraged to keep their portfolio up to date as they change their career goals and educational plans.

### Navigation

All of these components are offered in an easy-to-navigate format. As an Internet-delivered program, DISCOVER may be used anywhere, any time, by both career seekers and family members. While this freedom opens up opportunities for parental involvement and nontraditional counseling settings, it also means that access is often unsupervised and the program must be usable without assistance. DISCOVER offers many types of assistance such as a tour, frequently asked questions, a site map, and detailed instructions on every page. The guidance of career professionals enhances the experience, and users are frequently encouraged to seek professional assistance, but comments from users indicate that most people navigate the program and find the information they are seeking without assistance.



## Professional Support

In addition to features for users, DISCOVER provides extensive support for counselors. Reports are offered to allow staff to assess the usage and value of DISCOVER, as well as review individual career portfolios. Sites that license DISCOVER can also customize the look and contents that their users see. Detailed manuals and guides are provided. Support materials include curriculum guides for middle schools, high schools, and colleges; they provide lesson plans with worksheets or activities to enhance class or group use of the program.

## Target Populations

Differentiation among users from Grade 5 through adult is addressed in two ways. First, some features are suppressed if they are not appropriate for certain age groups, based on the self-reported grade level of the user. None of the inventories in DISCOVER are appropriate for elementary school children, so they are not offered to users in Grade 5 or below. These users are encouraged to explore occupations by using the World-of-Work Map. If they can learn about the six clusters, then drill down through career areas to occupations to find some that interest them, they can begin to assess where they fit on the map. Grade 6 and up are offered age-appropriate versions of the interest inventory. Grade 8 and up are offered age-appropriate versions of the abilities inventory, which asks them to self-estimate their abilities. Although self-estimation accuracy probably improves with age, thinking about these questions can be helpful from middle school through adulthood. The values inventory is available for Grade 9 and up, based on indications that youth become increasingly aware of their values during the high school years.

The second method of differentiation is based on user's choice. Many features are more appropriate for more mature users, such as resume writing and apprenticeship information. But these features are available for use at any age, and the user can decide which topics are relevant. In fact, there is a feature called "Plan My Path" designed to help users decide which features to use.

DISCOVER is used in a wide variety of settings throughout the United States. It is used in schools, colleges, corporations, government agencies, military installations, libraries, prisons, and private counseling

offices. Each year close to a million people use the program.

DISCOVER is a computerized career guidance program that has been used by millions in Grade 5 through adult since its inception in 1967. It includes research-based inventories to guide the career choice process, a unifying theoretical basis, detailed career information, and a career portfolio summarizing each person's choices. It also supports career development professionals by providing usage reports, manuals, and curriculum guides. The Internet version makes all of these features available any time, anywhere.

Marilyn Maze

*See also* Career Counseling in Schools (v4); Career Planning (v4); Career Planning Survey (v4); Computer-Assisted Career Counseling (v4); Holland's Theory of Vocational Personalities and Work Environments (v4); Unisex Edition of the ACT Interest Inventory (v4)

## Further Readings

- ACT. (1995). *Technical manual: Revised Unisex Edition of the ACT Interest Inventory (UNIACT)*. Iowa City, IA: Author.
- ACT. (2000). *Career Planning Survey technical manual*. Iowa City, IA: Author.
- ACT. (2006). *Research support for DISCOVER assessment components*. Iowa City, IA: Author.
- ACT. (2007). *DISCOVER support materials*. Available at <http://www.act.org/discover/support/resource.html>
- Prediger, D. J., & Swaney, K. B. (2004). Work task dimensions underlying the world of work: Research results for diverse occupational databases. *Journal of Career Assessment*, 12, 440-459.

---

## DIVERSITY ISSUES IN CAREER DEVELOPMENT

---

In the early 1970s, the field of vocational psychology began to focus on diverse factors related to career development. Recent trends indicate a sustained increase in the vocational psychology and career development literature pertaining to diversity issues since the early 1990s. These shifts have been fueled in part by the changing demographic patterns in society



and the increasing numbers of women and individuals from diverse racial and ethnic groups comprising the labor force. As the face of the labor force has changed over time, concerns regarding how the field has (a) understood and defined the career development process, (b) conducted vocational research, and (c) trained career counseling professionals for helping a broad range of individuals have been addressed. Today, diversity issues are considered to be crucial in understanding an individual's career development and decision-making process, and diversity issues have become a major focus within the field. As the U.S. population continues to grow increasingly diverse, career counseling professionals will need to be more responsive to the needs of this changing population. When addressing issues of diversity, it is important to note that these discussions should not be limited to race and ethnicity. Career counseling professionals also need to be attuned to the influence of gender, sexual orientation, ability status, socioeconomic status, and other societal and structural factors that influence career development in a variety of ways.

### **Diversity Issues**

As social beings, the environments within which people live and learn have an enormous impact on career development. The opportunities afforded to individuals, the resources at their disposal, and the social framework within which people live all interact and contribute to their sense of self and their awareness and knowledge of various career options. Thus, it is critical that a range of personal and societal factors be taken into consideration in attempting to understand an individual's career development process.

#### ***Individual Factors***

##### **Gender**

From the moment a child is born, a powerful and pervasive socialization process occurs in which girls and boys begin to learn what is expected and socially acceptable behavior based on their gender. This socialization process influences the type of play, leisure, and academic activities children tend to engage in and the development of children's schemas of appropriate gender roles. In addition, this socialization influences how individuals in the child's life will interact with the child and the types of behaviors that are reinforced. Researchers indicate that by the time children are

8 years old, they have developed a sense of what occupations are acceptable and unacceptable for their gender. Thus, children's experiences and gender role schemas have an impact on the types of occupations they consider as adolescents and young adults (e.g., nurse for women, doctor for men).

In the adult years, gender socialization continues to affect the career development of men and women in significant ways. For example, women who are employed outside of the house often struggle with balancing multiple roles and might feel that their roles and responsibilities at work and home are in direct conflict with one another. On the other hand, men may experience immense pressure to achieve at work and to be the main breadwinner for the family. The stress to be successful and to provide for the family to maintain a certain lifestyle may influence the types of career and positions that men consider appropriate. In addition, because a man's personal identity may be highly associated with his work, a man's psychological well-being may be at risk in the event of job loss or underachievement in the work setting. Though changing social norms and work opportunities have lead to an increase in the number of women entering traditionally male-dominated occupations (and to a lesser extent men entering female-dominated occupations), the impact that gender socialization has on career development continues to be a significant source of influence in the career selections and satisfaction of both men and women.

##### **Race and Ethnicity**

Race and ethnicity have been identified as factors that warrant consideration in the career development process. From both a personal and societal perspective, race and ethnicity can influence the types of occupations perceived as acceptable and accessible. For example, from a personal perspective, one's racial and ethnic identity (the extent to which one identifies as a member of a particular racial or ethnic group) can influence the types of occupations individuals consider as possible options. In part, this perception may be influenced by the type of learning experiences and opportunities to which racial and ethnic minority members have been exposed as well as the availability of role models from their racial or ethnic group in various career fields. From a societal perspective, racial and ethnic discrimination and oppression may lead members of racial and ethnic minority groups to eliminate occupations they perceive as inaccessible to



them. Thus, the impact of race and ethnicity on career development of diverse individuals needs to be examined from both a phenomenological as well as a societal point of view.

### **Culture**

Culture, the shared values and belief systems held by members of a particular group, influences how individuals view and interact in the world, and it also affects their behaviors, decision making, and goal identification. An example of a cultural value associated with different racial and ethnic groups is that of collectivism. Collectivism is the tendency for individuals to consider the well-being, wishes, and best interest of the group to which they belong (family or community) when making decisions. For example, a client whose culture values collectivism may consider the wishes of his or her parents or other elders in the family in determining what type of occupation to pursue. In contrast, individualism reflects the tendency to make decisions and choices within the context of what is best for the individual and is highly valued in Euro-American society. Thus, selecting a career based on personal interests and needs may characterize the decision-making process of individuals from individualistic cultures. Career counselors need to be aware of and respectful of the cultural context and cultural values that influence their clients' career development. Additionally, career counselors need to be aware of their own cultural values and beliefs systems and how these may affect the career counseling relationship. Career counselors' awareness of personal values and beliefs will also decrease the chances that they are imposing their values when assisting clients in their career development.

### **Sexual Orientation**

During the past decade, the career development of lesbian, gay, bisexual, and transgendered (LGBT) individuals has begun to receive increasing attention in vocational psychology. Understanding the complex relationship between sexual identity development and career development is critical when working with this population. Sexual identity development can be an extremely stressful experience for LGBT individuals as they may be dealing with gender identity confusion, negative societal stereotypes, and possible conflict with family and peers related to their sexual

identity. This developmental process typically occurs during adolescence, the same period of time during which young people begin to identify career interests and develop goals for their future. Thus, the career development of LGBT individuals may be adversely affected as a consequence of the time, energy, and affective resources that may be focused on their sexual identity development. Once LGBT individuals are ready to make career decisions, their choices may be restricted to occupations considered possible or appropriate options due to their sexual orientation. Additionally, they may eliminate possible occupational options due to real or perceived discrimination anticipated in certain work settings. Thus, sexual orientation and the unique issues that LGBT individuals encounter at work need to be attended to by career counseling professionals.

### **Other Relevant Considerations—Constructs**

Other relevant diversity issues that career counseling professionals need to attend to include, but are not limited to, the presence of physical or learning disabilities and immigration status and language proficiency. For example, individuals with physical or learning disabilities may have limited opportunities to engage in career development-related experiences and to develop effective decision-making skills, which can adversely affect their career development. Career counselors need to assess personal (e.g., self-efficacy), disability-related, and environmental constraints on the career development of individuals with a disability. When working with immigrant populations, particular consideration to the stressors faced by these individuals in a new and different society is critical. Attending to how immigrants are adjusting to their new environment, the stressors they are coping with, language issues, and immediate employment needs are critical as these factors may be affecting the career development process. In order to assist individuals in identifying and working toward realistic and achievable career goals, career counseling professionals must attend to the unique contextual experiences of their clients.

### **Social and Economic Factors**

Many of the traditional career development theories in the field have been criticized for being classist due to the basic tenets on which they are based. For



example, most Western theories of career development assume that individuals exercise volition in selecting careers, that career is central to one's life and identity, that universal definitions of constructs exist, and that opportunities are available to everyone. Ignoring the role of social and economic factors on the career development of individuals in our society can have detrimental consequences for the individuals with whom career counselors work, and disregarding these factors leads to continued class disparities.

### **Socioeconomic Status**

Socioeconomic status is unquestionably one of the diversity-related factors that has been widely understudied in the multicultural career literature, yet its significance in shaping career development cannot be overemphasized. Socioeconomic status has a significant impact on the lifestyles of individuals, the resources available to them, and the types of experiences individuals engage in, all of which influence one's social class. As such, the role of social class in the lives of individuals is especially important to understand because of its reciprocal relationship to work and more specifically the type of work that individuals have access to and to which they aspire. That is, social class can have a strong influence on one's career development, and in turn career plays a large part in determining one's social class.

Wherever one falls along the social class spectrum, there are many ways in which social class background plays an important role in career development. Social class background influences how counselors form attitudes related to success and career aspirations. For example, if a counselor believes that everyone can succeed if only a person works hard enough, the counselor might not address social barriers that might influence the career development of clients who believe that no matter how hard they try, they cannot make it through the system. Believing that talents and hard work are always rewarded or that everyone in society has the same opportunities for economic success places the responsibility of success and failure solely on the individual and ignores the presence of institutional barriers (e.g., discriminatory hiring practices) that can prevent an individual from achieving his or her goals. Social class may also determine whether someone has financial resources to pursue higher education, the social contacts and networks to locate jobs, and access to critical information that can inform career decisions.

### **Education and Academic Preparation**

Socioeconomic status also influences aspects of the environment that can affect the individual's career development. Economic capital (or lack of it) is associated with the quality of housing, neighborhoods, and schools individuals have access to. The quality of teachers, the educational resources available both at school and at home, the types of extracurricular activities offered at the school, and the expectations teachers have for students all contribute to the quality of education a student receives.

During the early years of schooling, a strong, quality educational foundation across the core academic subject areas, but especially math, science, and reading-writing, prepare youth for secondary and postsecondary education. In addition, coursework in the math and science areas has been identified as especially critical for entrée into highly prestigious, high-paying careers. A poor quality education can put youth at risk for not graduating from high school or may limit further educational opportunities down the road. Because education is highly linked to occupational status, it is important that all individuals in society have equal opportunities for receiving a quality education and that supports are available for those wanting to receive advanced levels of education.

### **Real and Perceived Barriers**

Real or perceived barriers related to socioeconomic status that can influence the career decisions and career development of individuals include discrimination; limited exposure to a range of careers; lack of role models from the community employed in a range of careers; lack of financial resources for education or training; lack of support from teachers, peers, or family; and lack of educational preparation. Individually and cumulatively, these environmental barriers can influence the internal beliefs one has regarding his or her ability to achieve his or her goals and can limit the types of careers that individuals believe are realistically attainable.

### **Career Counseling Models**

A number of models and frameworks have been proposed for providing culturally sensitive career counseling with culturally diverse clients, women, LGBT individuals, and individuals with disabilities. Significant components of these models include the attention placed on identifying cultural and contextual factors



that have an impact on individuals' career concerns and include the identification and selection of culturally appropriate interventions. For example, Fouad and Bingham's culturally appropriate career counseling model provides a seven-step process career counselors can follow when working with culturally diverse clients. The seven steps within the model include (1) establishing rapport and a culturally appropriate relationship, (2) identification of career concerns, (3) examination of the impact of cultural variables on the identified concerns, (4) establishing goals consistent with the client's worldview, (5) identifying culturally appropriate interventions, (6) decision making and implementation, and (7) follow-up. Career counselors are encouraged to become familiar with the various models available in order to inform their career counseling work with diverse clients.

### Implications

Race, ethnicity, gender, socioeconomic status, sexual orientation, ability status, and the resources afforded members of diverse groups significantly affect career development. By attending to contextual and societal issues related to diversity within the context of career development, career counseling professionals acquire a more comprehensive understanding of the needs of their clients and are better able to provide effective and culturally competent career counseling services.

The labor force continues to be highly stratified based on race, ethnicity, gender, socioeconomic status, and sexual orientation, and a hierarchy exists that differentiates careers based on status and prestige. As the field has moved toward adopting a social justice perspective, it is apparent that providing career interventions with individuals from diverse backgrounds can be an effective way to begin to address inequalities in our society. It is also important that career counselors advocate for changes in the world of work that are equitable and honor and value all workers, regardless of their backgrounds or positions.

*Lourdes M. Rivera and Lisa Y. Flores*

*See also* Career Counseling, Gay and Lesbian (v4); Career Counseling, Immigrants (v4); Cultural Values (v3); Demographics, United States (v3); Diversity (v3); Ethnicity (v3); Multicultural Career Assessment Models (v4); Multicultural Career Counseling Checklist (v4); Multiculturalism (v3); Organizational Diversity (v3); Persons With Disabilities (v4); Race (v3); Sexual Orientation (v4); Social Class (v4); Social Discrimination (v4); Visible Racial/Ethnic Groups (v3)

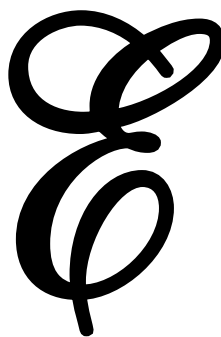
### Further Readings

- Bingham, R. P., & Ward, C. M. (1994). Career counseling with ethnic minority women. In W. B. Walsh & S. Osipow (Eds.), *Career counseling with women* (pp. 165–195). Hillsdale, NJ: Lawrence Erlbaum.
- Fouad, N. A., & Arbona, C. (1994). Careers in a cultural context. *The Career Development Quarterly*, 43, 96–104.
- Fouad, N. A., & Bingham, R. (1995). Career counseling with racial/ethnic minorities. In W. B. Walsh & S. H. Osipow (Eds.), *Handbook of vocational psychology* (2nd ed., pp. 331–366). New York: Lawrence Erlbaum.
- Gottfredson, L. S. (1996). A theory of circumscription and compromise. In D. Brown, L. Brooks, & Associates (Eds.), *Career choice and development* (3rd ed., pp. 179–281). San Francisco: Jossey-Bass.
- Kosciulek, J. F. (2003). An empowerment approach to career counseling with people with disabilities. In N. C. Gysbers, M. J. Heppner, & J. A. Johnston (Eds.), *Career counseling: Process, issues, and techniques* (pp. 139–153). New York: Allen & Bacon.
- Leong, F. T. L., & Hartung, P. J. (1997). Career assessment with culturally-different clients: Proposing an integrative-sequential conceptual framework for cross-cultural career counseling research and practice. *Journal of Career Assessment*, 5, 183–202.
- Pope, M., Barret, B., Szymanski, D. M., Chung, Y. B., Singaraaveu, H., McLean, R., et al. (2004). Culturally appropriate career counseling with gay and lesbian clients. *The Career Development Quarterly*, 53, 158–177.
- Westwood, M. J., & Ishiyama, F. I. (1991). Challenges in counseling immigrant clients: Understanding intercultural barriers to career adjustment. *Journal of Employment Counseling*, 28, 130–141.









---

## EMPLOYEE APTITUDE SURVEY

---

The Employee Aptitude Survey (EAS), used for more than 50 years in selection and career counseling, was developed to yield “maximum validity per minute of testing time” (Ruch, Stang, McKillip, & Dye, 1994, p. 9). Derived from earlier ability tests, it consists of 10 short tests that may be given singly or in any combination. There are alternate forms for nine of the tests. EAS is claimed to be easily administered, hand scored, and interpreted—although, in fact, advanced training or consultation is needed to interpret or use the EAS in selection. The Web site of the company that publishes the EAS ([www.psionline.com](http://www.psionline.com)) contains brief suggestions for use and interpretation of scores and suggests that further technical support is available via phone or e-mail. The tests may be administered in paper and pencil form or online. A technical report suggests that these differing modes of administration yield comparable results. Instructions suggest that group and individual administration are equivalent; data on other ability tests suggest that group administration facilitates performance on highly speeded tests such as the EAS.

The test themselves have not been revised since 1963. The *Examiner's Manual* is newly revised (2005), but the *Technical Manual* (1994) and *Supplemental Norms Report* (1995) are dated. A validation table is available on the Web site, but closer inspection reveals that it is drawn from the 1994 manual, which itself is based largely on older reports. Skippy norm sample detail limits the EAS's value in selection; local validation studies would often be required. Few EAS validity studies have been published in peer-reviewed

journals. A brief example (apparently hypothetical) uses the EAS to increase selection validity and achieve cost savings; the estimates are overly optimistic. Furthermore, the *Supplemental Norms Report* reveals ceiling problems across several tests, making the EAS unsuitable for use in some upper-level occupations.

The norm tables do not constitute validity data since the groups were not selected on some criterion of success. They may serve as rough guides in career counseling, showing clients where they stand relative to various occupational groups. Only the validity coefficients in the *Technical Manual* have been validated for such predictions. They are fewer in number, grouped into eight broad occupational categories. A meta-analysis suggests the EAS has predictive validity across several occupational and educational groups, but differential validity evidence (gender, age, and race) is not included. Only rough predictions about training or occupational success are possible.

Reliability data are limited to alternate form single-session administrations. Although the coefficients are impressive, they overestimate reliability, the tests being homogenous in content and highly speeded. No internal consistency data are presented, although internal consistency ratings would likely be high, given the above. Except for the Manual Speed Accuracy Test, no test-retest (i.e., stability) data are presented.

The EAS has a long record of usefulness in industrial selection and career counseling. Despite these criticisms, the EAS compares favorably with other multifactor ability batteries (e.g., USES General Aptitude Test Battery, Differential Aptitude Test,



Armed Services Vocational Aptitude Battery) when used to test clients seeking information about their abilities. The tests are short, easy to administer and score, and straightforward to complete. Interpretation can be a challenge.

Brian Engdahl

*See also* Achievement, Aptitude, and Ability Tests (v4); Armed Services Vocational Aptitude Battery (v4); Career Counseling in Schools (v4); Computer-Assisted Career Counseling (v4); General Aptitude Test Battery (v4)

### Further Readings

- Ruch, W., & Stang, S. (1995). *Employee Aptitude Survey supplemental norms report*. Los Angeles: Psychological Services.
- Ruch, W., & Stang, S. (2005). *Employee Aptitude Survey examiner's manual* (3rd ed.). Los Angeles: Psychological Services.
- Ruch, W., Stang, S., McKillip, R., & Dye, D. (1994). *Employee Aptitude Survey technical manual* (2nd ed.). Los Angeles: Psychological Services.

---

## ENVIRONMENTAL ASSESSMENT TECHNIQUE

---

The Environmental Assessment Technique (EAT) was developed by John L. Holland and Alexander W. Astin to quickly and easily capture the dominant beliefs, functioning, and goals of the individuals within an organization, using Holland's six environmental models. The EAT consists of eight scales: Institutional Size, Aptitude Level, and six Personal Orientation scales.

### Theoretical Background

The EAT is based upon Holland's theory of vocational personalities and work environments, which suggests that people are both affected by and affect the environments in which they find themselves. His personality types and environmental models represent the bidirectional influence of person and environment. Both personality and environments can be classified using the following categories: Realistic, Investigative, Artistic, Social, Enterprising, and Conventional. Thus, by evaluating the proportion of each type of

people in an environment (the Personal Orientations scales), one can obtain a sense of the character of that environment. Complete descriptions of these categories can be found in Holland's *Making Vocational Choices*.

The EAT has the advantage of using easily available information that is quantitative in nature (thus facilitating comparisons) and heuristic (as the results produce a description of the goals, rewards, motivations, coping styles, and interests most evident and influential in a particular environment). The use of objective data lessens the likelihood of perceptual bias and complements data drawn directly from the population of interest, such as from the Position Classification Inventory.

### Utility

The validity of the EAT is moderate to high with reliabilities in this range over 1 to 5 years and appropriate convergent validity. Although originally developed for use in university environments, the EAT has also been used to evaluate the environment in middle schools, high schools, and the military and of college graduates transitioning to full-time employment. Organizational psychologists have encouraged its use in organizational consulting.

### Scoring and Interpretation

Originally, the scales for the EAT were compiled in the following manner. The Institutional Size scale consists of the square root of the number of students–employees in the institution. The Aptitude Level is taken from the mean score on a nationally normed test (or other measure of cognitive skill, such as found in the Occupational Information Network or the *Dictionary of Holland Occupational Codes*). The Personal Orientation scales are compiled in three steps. The first step is to obtain counts of the number of students in each major or individuals in each occupation. The second step is to aggregate the counts, using the first letter of the code for each major-occupation, according to their fit within Holland's classification of occupations or college majors. The third step entails calculating the percentage of the total majors that fall within each of the six personality–work environments.

The results will produce a Holland Occupational Code for the entire organization. The characteristics of the Personal Orientation scale with the greatest



percentage will have the most influence on the character of the institution as a whole. Interpretation of the resulting code is conducted in conjunction with the definitions from Holland's theory. Holland has developed dictionaries of coding schemes for both occupations and college majors in order to facilitate the use of this technique.

*Marie S. Hammond*

*See also* *Dictionary of Occupational Titles* (v4); Holland, John L. (v4); *Holland's Theory of Vocational Personalities and Work Environment* (v4); *Personality Assessment and Careers* (v4); *Person-Environment Fit* (v4); *Person-Environment Interactions* (v2); *Roe's Theory of Personality Development and Career Choice* (v4); *Self-Directed Search* (v4)

### Further Readings

- Astin, A. W., & Holland, J. L. (1961). The Environmental Assessment Technique: A way to measure college environments. *Journal of Educational Psychology*, 52(6), 308–316.
- Holland, J. L. (1997). *Making vocational choices: A theory of vocational personalities and work environments*. Odessa, FL: Psychological Assessment Resources.
- Schneider, B. (1987). The people make the place. *Personnel Psychology*, 40, 437–453.

---

## EXPRESSED, MANIFEST, TESTED, AND INVENTORIED INTERESTS

---

No universally accepted conceptual definition of *interests* has emerged in vocational psychology. As a result, interests often are defined as what an assessment measures. At the most basic level, operational definitions of interests commonly focus on an individual's constellation or pattern of likes and dislikes for vocational, academic, and leisure activities, as well as for types of occupations, settings, and people. Donald Super organized these operational definitions into four methodological categories: *expressed interests*, *manifest or evidenced interests*, *tested interests*, and *inventoried interests*.

Frank Parsons, an early career specialist, introduced a parsimonious framework in his widely known book *Choosing a Vocation* that provided an impetus

for the measurement of interests. Parsons (1909) argued that individuals seeking to choose a line of work should engage in a rigorous process of self-study during which they consider how their “capacities, interests, resources, and limitations, and their causes” (p. 5) might best fit with the attributes of certain occupations. Parsons intended this process of self-study to occur with the aid of a counselor, and he offered a variety of innovative methods for counselors to assess a client's personal characteristics.

Among these methods, Parsons presented a questionnaire that asked respondents to simply identify and write down their interests as well as the nature of those interests. According to Super's classification system, Parsons's questionnaire elicited expressed interests. In other words, expressed interests are those that an individual is able to articulate via introspection without the assistance of a list of options. For example, in response to the question, “What do you want to do when you grow up?” one could state an occupation (e.g., medical doctor) or an activity (e.g., care for others). Expressed interests are highly subjective in nature and tend not to be limited to certain content areas or levels of specificity. Furthermore, expressed interests reflect how an individual perceives his or her interests rather than provide an objective and complete picture of his or her interests.

A more objective method of assessing interests, also proposed by Parsons, involved asking clients to report how they spend their time, particularly outside of work. For instance, if an individual spends his or her evenings reading novels and writing poetry, then these behaviors may indicate an interest in literature or the humanities. These manifest or evidenced interests have been described as those measured by observing or examining an individual's participation in activities. The most objective form of manifest interests involves direct observations of an individual's behavior over time, whereas the most subjective form involves an individual's self-reported activities.

In addition to reporting how one has previously spent his or her time, Parsons (1909) further suggested that individuals, particularly young individuals with little breadth of experience, should attempt to gather a variety of experiences to bring their “true interests and aptitudes into clear relief” (p. 12). This effort to accumulate a variety of work experiences with the intention of identifying one's interests was later known as *try out* activities. As Parsons and others have suggested, try outs are based on the hypothesis



that experience allows latent interests to emerge into an individual's awareness.

In yet another method of assessment, Parsons suggested that individuals should attempt to compare their memory of the content of certain lectures, plays, or books to that of other individuals such as friends and family. Implicitly, Parsons proposed that an examination of one's memory or knowledge of certain subject matter may indicate personal characteristics such as one's interests in certain subject matter or activities. Interests measured by an individual's knowledge of particular areas have since been classified as *tested interests*. Much of the research on tested interests is based on the notion that one's interests have a positive influence on learning. For example, if an individual has a strong interest in psychology, then he or she is more likely to give more attention to psychological subject matter than other academic subjects and as a result accumulate more knowledge of psychology. That is, interests are thought to influence learning by way of attention. In recent years, researchers have studied domain-specific knowledge, which includes tested interests, as a way to conceptualize knowledge that one accumulates over time as a result of one's constellation of interests, personality characteristics, and abilities.

In the 1920s, checklists and rating scales emerged as methods of measuring interests using surveys. Whereas checklists simply ask respondents to examine a list of activities and indicate those in which they have an interest in participating, rating scales ask respondents to rate the intensity or level of their interest for various activities. Checklists and rating scales evolved into what now are known as *interest inventories*. Interest inventories ask respondents to report their likes and dislikes according to a list of activities, school subjects, and occupations, and then the individual's pattern of likes and dislikes is aggregated into interest scales. Accordingly, *inventoried interests* have been defined as an individual's normative level of interest in a particular content area.

Inventories, and thus operational definitions of interests, became increasingly sophisticated as new methods of measurement were introduced. The four most frequently used methods of scale construction include the empirical method of contrast groups, clustering techniques, rational methods, and sequential methods. The empirical or criterion keying method of scale construction, developed by Edward Kellogg Strong, Jr. in 1927, involves contrasting interests of

certain groups of individuals to determine preferences that predict group membership. In other words, criterion-keyed scales indicate how consistent or similar one's likes and dislikes are to those of a particular group of individuals. Commonly used to measure interests of occupations, items (i.e., survey questions) that predict occupational group membership are aggregated to produce a single score. For example, an occupational scale constructed to measure the interests of psychologists would indicate the level of similarity between an individual's pattern of likes and dislikes and the likes and dislikes of psychologists in general.

Clustering methods of scale construction involve a statistical technique, such as factor analysis, that determines factors or dimensions underlying a group of items. In other words, preferences that can be explained by a certain factor or dimension are aggregated to generate a single scale score. Often, scales determined using a clustering method represent a homogeneous category of activities (e.g., mechanical) and are referred to as basic interest scales.

The rational method of scale development entails simply grouping items in accordance with a theory or rationale; thus, this method of scale construction is not empirical in nature. Proposing that interests can be described by six general types (Realistic, Investigative, Artistic, Social, Enterprising, and Conventional), John Holland's widely known and empirically supported typology is an example of a theoretical model that has served as a basis for the construction of rational interest scales. Interest scales also have been developed using the sequential techniques, which are a combination of construction methods. For instance, the General Occupational Themes of the Strong Interest Inventory (Strong) and the Orientation Scales of the Campbell Interest and Skill Survey (CISS) were developed using Holland's typology to initially select items and then using empirical data and clustering methods to finalize the scales.

The costs and benefits of the different modes of interest measurement tend to determine usage in research and applied settings. Interest inventories are arguably the most common form of interest assessment. Because there is little monetary or temporal cost for measuring expressed interests, career counselors often assess clients' expressed interests as part of an intervention. Due to the high cost of paying observers, interests are rarely, if ever, measured in research or practice via direct observation. More commonly, manifest interests are elicited in practice



through discussion concerning current and past vocational and leisure activities. Interest inventories, which offer objective, comprehensive, quantitative, and convenient measures of interests, are considered to be a comparatively cost-effective method of assessment. The Strong, CISS, Kuder Occupational Interest Survey, and Career Assessment Inventory are commonly used inventories that include general, basic, and occupational interest scales that provide a multifaceted profile of a respondent's interests. The Self-Directed Search also is a commonly used inventory that can be self-administered, self-scored, and self-interpreted. Other interest inventories include the Career Occupational Preference System Interest Inventory, Jackson Vocational Interest Survey, Unisex Edition of the ACT Interest Inventory, and Vocational Interest Inventory.

*Jo-Ida C. Hansen and Shawn T. Bubany*

**See also** Assessment (v4); Campbell Interest and Skill Survey (v4); Career Occupational Preference System (v4); Holland's Theory of Vocational Personalities and Work

Environments (v4); Jackson Vocational Interest Inventory (v4); Quantitative Methodologies (v1); Self-Directed Search (v4); Strong Interest Inventory (v4)

### Further Readings

- Hansen, J. C. (1984). The measurement of vocational interests: Issues and future directions. In S. D. Brown & R. W. Lent (Eds.), *Handbook of counseling psychology* (pp. 99–136). New York: Wiley.
- Holland, J. L. (1997). *Making vocational choices: A theory of vocational personalities and work environments* (3rd ed.). Odessa, FL: Psychological Assessment Resources.
- Parsons, F. (1909). *Choosing a vocation*. Boston: Houghton Mifflin.
- Strong, E. K., Jr. (1943). *Vocational interests of men and women*. Stanford, CA: Stanford University Press.
- Super, D. (1949). *Appraising vocational fitness by means of psychological tests*. New York: Harper.
- Super, D. (1957). *Psychology of careers*. New York: Harper.
- Walsh, W. B., & Betz, N. E. (1995). *Tests and assessment* (3rd ed.). Upper Saddle River, NJ: Prentice Hall.









---

## GENERAL APTITUDE TEST BATTERY

---

The General Aptitude Test Battery (GATB) was developed by the U.S. Employment Service (USES) for use in occupational counseling, primarily by national agencies and in state employment offices. The measure was published in 1947, revised several times, and discontinued in 2002. The battery assessed multiple cognitive, perceptual, and psychomotor abilities as preferred rather than general mental ability when classifying people into jobs. (It is at variance with a competitor battery, the Differential Aptitude Tests, and other similar batteries by virtue of its inclusion of perceptual and psychomotor abilities.) The primary goal of the GATB was to match employee abilities to specific jobs. USES validated the test against some 66 occupational groups in five job families, only a small percentage of those for which it could be used.

GATB Form A was used operationally in 1947 with Form B, which was used for validation research and retesting. These forms were changed over the years. In 1983 Forms C and D were introduced. Spanish-language and nonreading versions were also available during that time period. Some reviewers during the early years of the GATB found the test manual lacking information needed for proper test administration, although the manuals for later forms were improved.

The GATB consisted of 12 separately scored and timed subtests that were used to compute nine aptitude scores. Test administration did not require a professional and took 2.5 hours. The test was appropriate for individuals in Grades 9 through 12 or for those in

the workforce. Subtests included Name Comparison, Computation, Three-Dimensional Space, Vocabulary, Tool Matching, Arithmetic Reasoning, Form Matching, Mark Making, Place (a pegboard test), Turn (another pegboard test), Assemble, and Disassemble. The subtests involve both verbal and quantitative reasoning and both verbal and performance measures. Some subtests were highly speeded and were appropriate for clerical positions. Aptitude scores are computed; most commonly used are cognitive (including general, verbal, and numerical aptitudes), perceptual (including spatial aptitude, form perception, and clerical perception), and psychomotor (including motor coordination, finger dexterity, and manual dexterity) composites. The meaningfulness of the tests comprising the measure was thoroughly considered; it was found that the cognitive subtests demonstrated reasonable construct validity in terms of convergent validity, the perceptual measures were substandard in this regard, and there had been too little research on the psychomotor measures to make an overall judgment. Some criticized the test because the aptitude composites are too highly intercorrelated. That is, some believed that the separate cognitive subtests of the GATB all measured the same thing or qualities that were so highly correlated as to be lacking discriminant validity.

The test was extensively used and researched in both employee counseling and selection, especially in state employment offices. In counseling settings it was probably best used in conjunction with a vocational interest inventory so that abilities and interests could be considered simultaneously. Its use was both widespread and controversial enough that the fairness of its uses was studied and published by the National



Academy of Sciences, as described in Hartigan and Wigdor. The primary issue related to group differences, often a concern for general ability tests. Because Whites scored better on the cognitive subtests than did Blacks by approximately one standard deviation, the National Academy of Science panel called for adjustments to scores depending on group membership, a highly controversial practice, or the use of within-group percentile scoring. Although such a practice is controversial, it eliminates very little of the test's utility for predicting job success, yet it provides a more diverse workforce. Also, concern had been raised over the use of the GATB's requiring relatively high levels of reading and arithmetic calculations with educationally and culturally disadvantaged persons. Furthermore, the original norm groups were limited by being both quite small and entirely male. The job classification system on which the test was based was also quite dated. The group differences coupled with the decline in unskilled and clerical positions probably led to the decision by USES to discontinue publication of the test early in the first decade of this century.

*Kurt F. Geisinger*

*See also* Achievement, Aptitude, and Ability Tests (v4);  
Armed Services Vocational Aptitude Battery (v4); Career

Counseling in Schools (v4); Employee Aptitude Survey (v4); Jackson Vocational Interest Inventory (v4);  
Standards and Competencies (v4)

### Further Readings

- Hartigan, J. A., & Wigdor, A. K. (Eds.). (1989). *Fairness in employment testing: Validity generalization, minority issues, and the General Aptitude Test Battery*. Washington, DC: National Academy of Sciences.
- Jaeger, R. M., Linn, R. L., & Tesh, A. S. (1989). Appendix A: A synthesis of research on some psychometric properties of the GATB. In J. A. Hartigan & A. K. Wigdor (Eds.), *Fairness in employment testing: Validity generalization, minority issues, and the General Aptitude Test Battery* (pp. 303–324). Washington, DC: National Academy of Sciences.
- Keesling, J. W. (1985). [Review of the USES General Aptitude Test Battery]. In J. V. Mitchell, Jr. (Ed.), *The ninth mental measurements yearbook* (pp. 1644–1647). Lincoln, NE: Buros Institute of Mental Measurements.
- Kirnan, J. P., & Geisinger, K. F. (1984). General Aptitude Test Battery. In J. Hogan & R. Hogan (Eds.), *Business and industry testing: Current practices and test reviews* (pp. 140–157). Austin, TX: Pro-Ed.





---

## HALL OCCUPATIONAL ORIENTATION INVENTORY

---

The Hall Occupational Orientation Inventory (HOOI) is an ambitious undertaking designed to aid career and personal exploration through the self-assessment of needs, values, interests, and abilities. Resembling a psychometric one-stop shop, items cover more dimensions at once than other tools used for similar exploratory purposes.

The HOOI was originally published in 1968 in three forms: an intermediate form primarily for students in Grades 3 to 7, a young adult-college form, and an adult basic form. Based on the doctoral dissertation of its developer, Lacy G. Hall, it is now in its fourth edition. There are three forms commercially available: Form II, which is primarily for junior high school students through adults who are not college bound; a Young Adult-College Form; and an Adult Form. All materials, including the 9-page reusable inventory booklet, onetime self-scoring response sheets, self-interpretive folder, manual, and a supplementary reader, *Choosing: Your Way*, can be obtained through Scholastic Testing Service, Inc. This entry will address only the Young Adult-College and Adult Forms.

These two forms contain 175 items that are wedged into 35 scales that are crafted into five scale arrays as follows: (1) nine Needs-Values Scales (Creativity-Independence, Information-Knowledge, Belongingness, Security, Aspiration, Esteem, Self-Actualization, Personal Satisfaction, and Routine-Dependence);

(2) six Career Interest Scales (People-Social-Accommodating, Data-Information, Things-Physical, People-Business-Influencing, Ideas-Scientific, Aesthetic Arts); (3) eight Job Characteristics Scales (Geographic Location, Abilities, Monetary-Compensation, Workplace, Coworkers, Time, Qualifications, and Risk); (4) six Choice Style Scales (Subjective External Authority, Objective External Authority, Subjective Internal Authority, Shaping-Autonomy-Self Empowerment, Interdependent, and Procrastination); and (5) six Ability Scales with the same labels as the Career Interest Scales.

The 35 scale scores are arrived at by summing Likert-type responses to the items on each scale and placing the totals on a self-interpreted profile sheet in the interpretive folder. This allows for the raw scale scores to be converted into one of three groupings: *low*, *average*, or *high*. Descriptive information regarding the scales is available in the interpretive folder.

The items are rationally constructed with three different Likert formats depending on the scale array. Needs-Values, Career Interest, and Job Characteristics scales use a 5-point format ranging from *most desirable* to *very undesirable*. Choice Style uses a somewhat odd 3-point scale with scores of *not like me* at 1, *like me* at 2 and *very much like me* at 3. The Ability scales use a 4-point format ranging from *weak* at 1 to *strong* at 4.

In spite of its potential usefulness, the HOOI has not elicited a strong research following because of the lack of any substantive data attesting to the reliability and validity of user scores. Moreover, normative data are lacking and the hand scoring of the large number



of scales is tedious and potentially error prone; it is not available for online administration and scoring.

The HOOI does have a following among counselors who note that clients find it simple to use and more comprehensive than other standardized career inventories. The instrument's questions force self-examination of a variety of occupational and lifestyle issues. Counselors can think of it as an introductory device that might spearhead in-depth counseling.

*Robert C. Chope*

*See also* Achievement, Aptitude, and Ability Tests (v4); Assessment (v4); Campbell Interest and Skill Survey (v4); Career Counseling in Schools (v4); Expressed, Manifest, Tested, and Inventoried Interests (v4); Holland's Theory of Vocational Personalities and Work Environments (v4); Jackson Vocational Interest Inventory (v4); Self-Directed Search (v4); Strong Interest Inventory (v4); Theory of Work Adjustment (v4)

### Further Readings

Hall, L. G. (2000). *Hall Occupational Orientation Inventory* (4th ed.). Bensenville, IL: Scholastic Testing Service.

### Web Sites

Scholastic Testing Service: <http://www.ststesting.com/toc2.html>

---

## HOLLAND, JOHN L. (1919– )

---

John Holland is primarily identified as a counseling psychologist whose main theoretical and practical contributions have been focused in the field of career choice and adjustment. He has been concerned with the choice and processes involved in selecting, adapting to, and changing occupations. His theory and practical contributions apply most directly to people throughout their working years, but are also relevant to school-age persons who are choosing colleges and selecting major areas of concentration.

### Empirical and Theoretical Research Themes

Holland's most impressive contribution to psychology was the combining of two important theoretical traditions, namely vocational psychology and personality.

In 1959, Holland published his article, "A Theory of Vocational Choice," in which he presented a theory that gave importance to personality as well as to the reinforcement value that specific environmental events could hold for an individual. He was one of the first major theorists to emphasize the critical importance of the interaction between vocational environments and individual differences and personality. He drew upon basic learning theory and modeling theories of personality development to inform others of these issues. In fact, his work anticipated by about 10 years the interest in personality psychology on the interaction between personality and situation in determining behavior.

To operationalize the personality types and model environments, Holland developed a number of inventories that represent a major applied contribution to the field. All of the Holland assessment techniques are practical and useful assessment devices. Initially he developed the Vocational Preference Inventory to define the personality types that he has studied over the years. The self-scoring and self-interpreted Self-Directed Search served to more comprehensively assess the personality types. Self-Directed Search is now the most widely used interest inventory in the world. To assess environments, Holland and Alexander Astin developed the Environmental Assessment Technique, and more recently Gary Gottfredson and Holland constructed the Position Classification Inventory. The theoretical person-environment framework has further been used to restructure the Strong Vocational Interest Blank, now called the Strong Interest Inventory. Related inventories developed to further define the personality types and model occupational environments include the Vocational Identity Scale and My Vocational Situation. More recently, Holland along with Gottfredson has developed the Career Attitudes and Strategies Inventory, another practical inventory to assess clients' internal and external barriers that may limit their career development.

A third major theme and contribution involves the use of his theory of personality types and work environments as a taxonomy for classifying people and jobs. Data from longitudinal studies, job analysis data, and vocational interest data have resulted in an extensive empirical classification of 13,000 occupations in the U.S. economy. All occupations now listed in the *Dictionary of Occupational Titles* (1991) may be classified using the Holland taxonomy. This has been accomplished in the *Dictionary of Holland Occupational*



*Codes* published by Gottfredson, Holland, and Deborah Ogawa in 1982 and revised in 1989 and 1996.

In summary, his theory, constructs, and operational definitions are extroverted, tough, practical, and compact. As Henry Murray noted some years ago, any assessment of the person is incomplete without some assessment of the environment. We cannot take the person out of personality, but at the same time, we cannot ignore the fact that environments, like people, have personalities and influence behavior. Holland's theoretical framework links the person, the environment, and behavior in a data-based framework to help people understand and cope with problems.

### Important Research Findings

At the heart of Holland's research has been the testing of his theory of personality types and work environments. Probably the most profound outcome of this research program is that his theory of personality types and work environments clearly works. For example, an overwhelming amount of evidence clearly indicates that individuals tend to choose, enter, and remain in occupational environments consistent with their interests and personality. He has shown that work satisfaction, and to some extent success in vocational settings, tend to be a function of person–environment fit.

Secondly, instrumentation development has been a very significant research contribution. Over the years, in testing his theory, he has developed the Vocational Preference Inventory, the Self-Directed Search, the Environmental Assessment Technique, the Position Classification Inventory, the Vocational Identity Scale, My Vocational Situation, and the Career Attitudes and Strategies Inventory. These inventories not only have operationalized the concepts of the theory, but also have further served in effectively assessing individuals throughout the world in vocational development and vocational decision making. In sum, Holland's theory, instruments, and research have served to explain vocational constructs in a straightforward way that is meaningful to a variety of people in a number of different environments.

A third important research finding is that his theoretical taxonomy may be used to describe every title in the *Dictionary of Occupational Titles*. This finding is demonstrated in the *Dictionary of Holland Occupational Codes* (1996), which is an extensive empirical classification of 13,000 occupations in the U.S. economy according to job analysis data accumulated by the U.S. Employment Service.

### Significant and Enduring Influences

Holland is one of the most productive researchers in contemporary psychology. His research has had a staggering influence on vocational psychology, personality, and organizational psychology. The enormity of his research findings are best presented in his book *Making Vocational Choices: A Theory of Vocational Personalities and Work Environments* published by Prentice Hall in 1973, revised in 1985, and republished by Psychological Assessment Resources in 1992 and 1997.

One significant and enduring influence of Holland's research is the finding that the choice of an occupation is an expression of personality. His research stream clearly indicates that individuals enter occupational environments because of their interests and personalities and remain in those occupations because of the reinforcements and satisfactions obtained through the interactions in that environment.

A second significant and enduring influence of his work is that the theory and inventories have greatly changed the face of vocational assistance. In other words, the theory and inventories have markedly improved the process of vocational assessment, the classification and interpretation of personal and environmental data, and the conduct of vocational counseling. Psychologists and counselors now have a theoretical framework to organize information about persons, work, and their interaction. The theory and research go a long way in organizing human behavior and occupational environments. This is further demonstrated by the fact that nearly all major interest inventories either use Holland's theoretical framework or are in some way linked to it.

A third significant influence of Holland's work is a function of self-directedness. His self-directed techniques afford individuals the opportunity to make their own choices. This is demonstrated in the self-administering and self-scoring Self-Directed Search assessment technique that has become popular throughout the world. Very few theoretical frameworks facilitate this kind of self-assessment strategy.

### Accolades

Holland has received a number of accolades for his contributions to the field. Within 10 years of his Ph.D. he received a research award from the American Personnel and Guidance Association (now the American Counseling Association). He is a Fellow of



the American Psychological Association for his contributions to both counseling psychology and educational psychology. He has received the E. K. Strong Gold Medal for contributions to interest measurement and the Eminent Career Award from the National Vocational Guidance Association. The esteem with which he is held is also indicated by his election as President of the Division of Counseling Psychology of the American Psychological Association and also by his appointment for one year as a Fellow at Stanford's Center for Advanced Study in the Behavioral Sciences. In 1980, he was honored by an entire symposium dealing with his contributions to psychology that was held at the national meetings of the American Psychological Association. A Festschrift volume was also prepared in his honor. More recently, Psychology Assessment Resources established an Outstanding Achievement Award in honor of Holland. This is titled the John Holland Award for Outstanding Achievement in Career or Personality Research and is awarded through Division 17 (Counseling Psychology) of the American Psychological Association. Finally, in 1995 Holland received the Distinguished Professional Contributions to Knowledge Award from the American Psychological Association. The award recognized his distinguished professional contributions to applied psychology and professional practice.

Holland is clearly world famous among counseling and vocational psychologists. His theory, concepts, inventories, insights, empirical research, and application have significantly changed the field of vocational psychology. Few professional people have been able to bring the innovative theoretical and applied understandings of human behavior to psychology in the way that Holland has. He is without question one of the two or three most important people in the history of the field.

W. Bruce Walsh

**See also** Career Attitudes and Strategies Inventory (v4); Environmental Assessment Technique (v4); Holland's Theory of Vocational Personalities and Work Environments (v4); My Vocational Situation Scale (v4); Person-Environment Fit (v4); Self-Directed Search (v4); Vocational Identity (v4)

### Further Readings

Holland, J. L. (1959). A theory of vocational choice. *Journal of Counseling Psychology*, 6, 35–45.

Holland, J. L. (1996). Exploring careers with a typology. *American Psychologist*, 51, 397–406.

Holland, J. L. (1997). *Making vocational choices: A theory of vocational personalities and work environments*. Odessa, FL: Psychological Assessment Resources.

Walsh, W. B., & Holland, J. L. (1992). A theory of personality types and work environments. In W. B. Walsh, K. H. Craik, & R. H. Price (Eds.), *Person-environment psychology: Models and perspectives* (pp. 35–70). Hillsdale, NJ: Lawrence Erlbaum.

---

## HOLLAND'S THEORY OF VOCATIONAL PERSONALITIES AND WORK ENVIRONMENTS

---

The origin of John L. Holland's theory of vocational personalities can be traced back to his 1966 publication *Psychology of Vocational Choice*, which was followed by four subsequent editions of *Making Vocational Choices*. With each edition, Holland built a more comprehensive theory of career counseling and tackled new issues arising from the complex relationship between human personality and suitable work environments. The theory is formulated around the fundamental observation that people possess different traits, behaviors, and interests that can be organized according to six groupings or types. The six types are called Realistic, Investigative, Artistic, Social, Enterprising, and Conventional (RIASEC), each of which characterizes a type of person who may gravitate to, choose, and enjoy a specific occupation or vocational area. In career counseling circles, it is common to hear a counselor refer to a Social or Investigative type person as a shortcut to describe someone who possesses clear, identifiable traits, personality characteristics, or behaviors. In a similar vein, the theory recognizes that work environments, the settings in which people work, live, and play, can also be organized according to the RIASEC typologies. It is theoretically appropriate to hear a career counselor describe a work function as a Conventional type job or a Realistic type activity. Through the use of the typological system and through the process of matching people who represent specific types with similar typed environments, career counselors try to enhance the likelihood that their clients will make satisfying career choices that lead to career stability and ultimately to career success and achievement.



## The RIASEC Model

### *Types of People*

The six types in the Holland theory describe multiple facets of the typee, which include personal characteristics, preferences, and tendencies. For example, the Realistic type person is considered to be rugged, robust, reserved, practical, and materialistic. People of this type are often inclined toward mechanical, physical, or technical activities where hands-on capabilities are paramount.

Each consecutive type demonstrates a sufficient degree of dissimilarity to the other types:

The Investigative type person is considered to be analytical, intellectual, complex, critical, and cautious. People of this type are often drawn to the sciences, quantitative pursuits, and research and scholarly activities.

The Artistic type is considered to be expressive, imaginative, intuitive, emotional, and nonconforming. People of this type are often drawn to art, writing, theater, and languages.

The Social type is considered to be friendly, warm, understanding, idealistic, and cooperative. People of this type are often drawn to teaching, counseling, social services, and other helping activities.

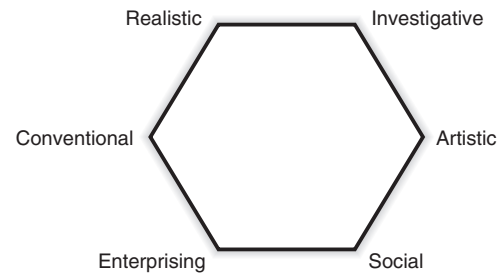
The Enterprising type is considered to be ambitious, energetic, sociable, assertive, and excitement seeking. People of this type are often drawn to politics, business management, leadership, and other entrepreneurial activities.

The Conventional type is considered to be conscientious, methodical, careful, orderly, and thrifty. People of this type are often drawn to accounting, banking, clerical, and computational work.

### *Relationships Between Types*

In addition to the descriptive qualities associated with the types, the RIASEC model also incorporates a spatial component that is depicted via a hexagon (Figure 1).

The distances between the types around the hexagon determine the degree of similarity or dissimilarity between the various types. Adjacent types on the hexagon are most related to one another, and opposite types on the hexagon are least related to one another. The hexagonal model also visually demonstrates a few other key concepts that are central to the Holland



**Figure 1** RIASEC model

theory. These concepts are calculus, consistency, congruence, differentiation, and identity.

### **Calculus**

Calculus provides the spatial foundation for the hexagonal model in that it refers to the degree of relatedness of all the types based on the distances between them on the hexagon. From calculus, one can more clearly understand the following assumptions of the theory as they apply to both people and environments.

### **Consistency**

Consistency refers to the assumption that adjacent pairs of types on the hexagon are most related and accordingly most consistent. For example, career clients whose tests show Social and Artistic as their two highest codes are considered to be more consistent than if they tested Social and Realistic as their two highest codes.

### **Congruence**

Congruence refers to the degree of match between one's type and the type of the work environment that he or she ultimately chooses. For example, persons who measure Artistic as their highest type would be most congruent in an environment that incorporates artistic activities, that allows for artistic expression, and that attracts other artistic people.

### **Differentiation**

Differentiation addresses a person's purity of type or whether that person clearly resembles one or perhaps two types, yet clearly does not resemble the other types. For example, a person is considered highly differentiated if he or she measures high on



Conventional and measures significantly low on all the other types. That same person could also measure highest on Conventional, next highest on Enterprising, significantly lower on all the other types and have both a consistent (due to adjacent codes) and well-differentiated profile

### **Identity**

Identity deals with the clarity of one's whole typological picture. A clear sense of one's career picture that includes an understanding of one's interests, goals, and talents as well as movement toward an accurate career environment is an indication of a firm career identity. Degrees of identity are highly related to the concepts of consistency and differentiation.

### **Types of Environments**

Just as personalities can be measured to determine typology, environments too can take on a typical character of their own. Holland determined that an environment's type was primarily determined by the constellation of personalities that made up the environment. For example, a hospital will present with a much different feel than will an accounting firm primarily because the people drawn to these environments act, relate, and perform work in very different ways. One can understand this dynamic by observing the differences between the hospital environment and the accounting firm environment. Since a hospital is largely staffed by physicians, nurses, and allied health professionals, its work culture is dominated by a unique combination of helpful, analytical, idealistic, intellectual, empathic, and curious people. In essence, it represents a combination of Investigative and Social types. In contrast, an accounting firm is largely comprised of accountants, bookkeepers, and administrative assistants who also define a work culture. This group of people is highly Conventional, so they tend to be careful, orderly, efficient, inflexible, practical, and thorough. Again, the work culture takes on the identity of the people who are in it.

### ***Other Defining Factors for Work Environments***

It is important to note that while work environments are largely defined by the people who are in them, this is not their only defining feature. Certainly,

the tasks required of the environment in order to complete the work have an impact on environmental type. Take for example the hospital with its doctors, nurses, and allied health professionals. The focus of the hospital is to diagnose and treat illnesses and to restore the health of sick people. This mission dictates that its culture is one of caring, responsibility, and curiosity about science and disease.

Work environments are not homogeneous in terms of their type. Some organizations are very large and complex, and therefore different units within the organization take on their own characteristics. Staying with the medical example, most large hospitals comprise separate units such as x-ray, surgery, patient care, business services, and social services. Each of these units attracts people with distinctly different work personalities by nature of the work responsibilities that are required, and in turn the work environment is shaped by the personalities of the people in the environment. It makes intuitive sense that the intense and critical nature of surgery feels very different from the warm, human interactions that occur in the social services area.

Power differentials in the workplace can also influence the culture and ultimately the type of the work environment. If the executives in a work unit exhibit a specific set of behaviors, attitudes, and interests, it stands to reason that they will value these same traits in their employees and both consciously and unconsciously reward these employees. This dynamic creates a workplace where employees to the best of their ability either conform to a type or be viewed as a less valuable. If, for example, the top executive in an organization has a high Realistic in his or her Holland code, then this person will typically value concrete achievements associated with the production of tangible objects, the creation of wealth, and opportunities to gain power and exert control. While it is highly probable that this executive may employ a number of Social employees to tend to necessary human interactions that require tact and diplomacy in an organization, he or she may not fully value the political contributions of these social types.

### **Assessment of Personal Type**

Methods exist for assessing types of people and types of work environments according to Holland coding. In the case of the former, a Holland profile can be determined a couple of ways: (1) utilizing a



well-constructed quantitative measure such as the Self-Directed Search or Vocational Preference Inventory that evaluates a person's interests, competencies, and self-ratings on multiple dimensions and assigns a code or (2) evaluating a person's current or desired career or position and assigning a code based on the work characteristics of the position. The Position Classification Inventory is a formal questionnaire of 84 items designed to assign Holland codes to various positions based on the unique work-related activities and tasks associated with a job.

It is important to note that while the Self-Directed Search is the instrument that is most closely aligned with and derived from Holland's theory, another widely utilized career instrument, the Strong Interest Inventory, also makes use of the Holland typological system. The selection of a method for measuring a person's type can vary depending on the goals of the career client, the training and ability of the career counselor, and the time and resources available to both parties.

### Assessment of Environmental Type

A method has been developed by Holland and Gary D. Gottfredson to measure the type of a work environment. This method is based on capturing the typical profiles of the people in the environment, or the inhabitants of the work environment. By applying codes to the people in an organization according to their occupational roles, training, or education, one can determine the dominant type within the environment. This method, known as the Environmental Assessment Technique, can be applied to any work environment, and it can generate an absolute number of types for an environment or a percentage of types based on the total distribution.

A resource was recently developed by Holland and Gottfredson that categorized all the entries from the *Dictionary of Occupational Titles (DOT)* according to a three-letter Holland code. This *Dictionary of Holland Occupational Codes* utilizes job analysis data to prescribe a corresponding three-letter code to the positions in the *DOT*, allowing for a more complex inventory of organizational type based on a three-letter profile rather than one primary type.

### Matching Person to Environment

The notion of matching people to environments can be broadly conceptualized to include environments

that go well beyond occupational responsibilities and work cultures. Person-environment interactions can apply to the fit between children and parents, students and neighborhoods, students and primary and secondary schools, adults and their social circles, and adults and retirement activities. There is a developmental component to the theory in that the degree of matching, or congruence, between person and environment in any of life's stages can profoundly influence levels of contentment or stress and frustration. In response, new decisions are made that ideally draw upon past experiences to create future situations that are more compatible and congruent. Take for example a student who decides to major in premed because he or she is drawn to being a physician out of a desire to help people, have a status position, and make lots of money. During the first year of college, the student encounters difficult science courses and realizes that he or she is not really congruent with science due to a lack of genuine interest in biology, chemistry, and physics. Consequently, the student modifies his or her choice of major to include potential majors where he or she can help people and make sufficient money, but not in the field of science or medicine. At this point, the student may ultimately choose psychology, human resources, or public administration where new interests and goals can be realized. In a short amount of time a shift has occurred in large part due to the developmental process of maximizing congruence.

### Research Support

Holland's theory of vocational personalities and work environments is a mature theory in that it has been widely researched for a period extending beyond 35 years. Evidence has generally supported the formulation of the Holland types; however, it has been concluded that the hexagon itself is much less symmetrical and exact than the drawings might depict. Nevertheless, the RIASEC ordering does hold true, and it has presented us with a model that is clear, practical, and highly amenable to vocational assessment. Other significant, yet secondary parts of the theory such as differentiation and consistency have received less compelling support since research results have been mixed. The environmental models have received the least attention by researchers, and the categorization of jobs by type remains a complicated process that varies according to the methods by which workers and jobs are measured and analyzed.



## Practical Applications

Perhaps the hallmark of Holland's theory is that it is user friendly. Psychological theories are often complex in both theory and in practice, yet Holland has managed to keep the end user in mind when developing his theory of vocational personalities and work environments. The RIASEC coding allows for a clean and simple method for assigning typologies to people, their current jobs, their career aspirations, their work culture, and a host of environmental factors. From the perspective of the career counselor who sees clients for a limited number of appointments, Holland's theory provides an efficient and effective method for making predictions about satisfaction in many work arenas.

*Dulin W. Clark and Jack R. Rayman*

**See also** Career Attitudes and Strategies Inventory (v4);  
*Dictionary of Occupational Titles* (v4); Environmental

Assessment Technique (v4); Holland, John L. (v4); My Vocational Situation Scale (v4); Personality Assessment (v2); Personality Theories (v2); Person–Environment Fit (v4); Person Matching (v4); Self-Directed Search (v4); Strong Interest Inventory (v4); Vocational Identity (v4)

## Further Readings

- Gottfredson, G. D., & Holland, J. L. (1991). *Position Classification Inventory professional manual*. Odessa, FL: Psychological Assessment Resources.
- Gottfredson, G. D., & Holland, J. L. (1996). *Dictionary of Holland occupational codes*. Odessa, FL: Psychological Assessment Resources.
- Holland, J. L. (1997). *Making vocational choices: A theory of vocational personalities and work environments*. Odessa, FL: Psychological Assessment Resources.
- Holland, J. L., Fritzche, B. A., & Powell, A. B. (1994). *The Self-Directed Search technical manual*. Odessa, FL: Psychological Assessment Resources.





---

## INTERNATIONAL APPROACHES

---

The term *career counseling* can be used in a narrow sense, addressing only a one-on-one or group verbal process and designed to assist counselees to explore, clarify, and understand their personal characteristics, their career concerns, and the behavioral options available. Career counseling can also be used in a wider sense, as a term that summarizes the processes and techniques that may be implemented as part of the career counseling process (e.g., assessment, information about job options, computer-assisted career guidance programs, self-directed exercises, Internet Web sites) to assist counselees to acquire knowledge, attitudes, and skills and to take actions relevant to their career concerns. Often in an international context, the term used as the equivalent of career counseling is *career guidance* or a term used in a native language that embraces elements of career counseling.

### **Career Counseling: A Worldwide Process**

Although career counseling and related interventions have become virtually worldwide in their availability for certain consumers and for selected purposes, there is not one model of career counseling extant across the world. There are many variations in approaches to the processes described as career counseling. Indeed, an increasing number of nations are developing their own indigenous models of career counseling rather than importing a model from another nation.

The nature of career counseling in specific nations is often a function of such factors as whether practitioners of career counseling are trained in a formal, academic setting or in a series of brief workshops; whether career counseling is primarily a function of government policy and legislation and a centralized provision of government or decentralized to many private entrepreneurs who deliver such services; whether there are differentiated career counseling services available to different groups of counselees or whether career counseling is available to any person who wishes such assistance; whether the provision of career counseling is augmented by the availability of online, Internet, computer-mediated career guidance systems or not; and whether the outcomes associated with career counseling are implemented in relation to particular theoretical models, cultural perspectives, or less systematic origins. Some brief examples will illustrate the range of emphases in career counseling among nations.

### **International Approaches: Examples**

Australia—a large nation with scattered populations across great geographic distances and with relatively few career counselors outside of urban areas to meet the demand for career counseling on a face-to-face basis—has provided many self-help resources, using audio, video, and computer technologies; the provision of employment information by telephone help lines and a nationwide telephone information service for career decision making that includes 3- to 5-minute spots on career planning, information, and



adjustment; and a national job network of more than 300 private, community, and government organizations with which the Australian government contracts to provide flexible and tailored assistance to job seekers from job matching to intensive assistance. Increasingly, career development in Australia is linked to lifelong learning and projects the practitioner of the future as a career development facilitator who assists individuals to plan and develop their career. Currently, there are initiatives that focus on the formulation of national quality standards for career practitioners, policy statements that affirm career education in school curriculum, and the development of resources about career activities for parents, school principals, and career advisors.

Canada has made many contributions to theory and practice in career counseling. They include the application of constructivist theory and narrative counseling to career counseling; the concept of active engagement in the creative interaction between career counselors and clients; group employment counseling; peer career counseling and the use of distance education to facilitate career planning; conceptual models of unemployment, its affects, and the role of career counselors in dealing with such problems; blending of counseling theory and the cultural traditions of First Nation peoples; the use of technology to provide career counseling and mental health interventions to widely scattered schools and communities in Newfoundland, Northern Canada, and Labrador; and the development of competencies that career counselors need to acquire in order to practice.

Denmark has made major commitments to the availability of career guidance at all educational levels and through adulthood. Career education begins at Grade 1 and continues until the end of compulsory education and is then available in higher education. Career education is integrated into academic curricula. Career development services are extensive and provided across the life span, primarily by teachers on a part-time basis. For adults, Denmark has instituted one-stop centers, known as counseling houses, in which career counselors offer different types of career counseling and related activities for users including information and counseling for training, educational options, and alternative job opportunities; training and improvement of job search skills; and information on the labor market and different wage, subsidy, and training schemes.

Japan, as a result of the dismantling of its lifelong employment system, the increasing numbers of school

dropouts, and school graduates without full-time employment has recently developed a policy to institute career education programs in schools and in higher education to help students learn to take responsibility for their decision making and their career planning. In addition, earlier than many other nations, Japan has instituted a three-tiered system to identify the level of need for career assistance of clients, on a continuum from largely self-help to intensive assistance in the National Network of Public Employment Security Offices. They also provide a national computer-assisted information system of labor supply and demand that is used as a support process to career counseling.

South Africa's history is unique in its legislated policy of apartheid that segregated citizens by race. When the apartheid regime was defeated and replaced in 1994, it was clear that the social context under which people of all races had lived and negotiated their place in society had to be re-created and that the psychology of despair had to be replaced with a psychology of hope, equality of opportunity, and economic and social equity. Among the large list of economic, educational, and social reforms that were instituted was career guidance. Part of the content of career guidance is assistance to adolescents of the formerly segregated racial groups to come to terms with their identity in a situation of rapid social and economic change.

Many college students who were previously denied access to higher education are now in integrated universities, where they experience anxiety, fears related to academic work, and low self-confidence. They are being provided workshops dealing with career and study skills, career information, job seeking skills, individual and group counseling, testing, the availability of liaison with potential employers, assistance with selection of a major, test-taking skills, time management, decision-making skills, and job search skills.

Public employment services in their career development work with adult job seekers to increasingly use self-directed information and assessment, and life skill training programs including career guidance components, and assessment and counseling.

## Future Outlook

International approaches to career counseling are diverse in their purposes, processes, and content. They reflect national differences in cultural traditions,



in the perceived career concerns of citizens and immigrants, the degree to which career counseling and related services are systematically or randomly implemented, the characteristics and training of those who provide them, and the policies and legislation that support career counseling. Career counseling or an equivalent term is now in place in some form in most nations. In a world of rapid change in the availability of work, its processes, and its content, growth in the development of new theories of career behavior, professionalization and competency standards for career counselors, and the availability of career counseling seems inevitable.

*Edwin L. Herr*

**See also** Career Counseling (v4); Career Counseling Process (v4); Career Development Inventory (v4); Career Education (v4); Career Interventions (v4); Cross-Cultural Training (v3); Cultural Values (v3); International Association for Educational and Vocational Guidance (v4); International Developments, Counseling (v1); International Developments, Counseling Psychology (v1); Multicultural Career Assessment Models (v4); Multicultural Career Counseling Checklist (v4); Multicultural Counseling Competence (v3)

### Further Readings

- Cahill, M., & Martland, S. (1995). Extending the reach: Distance delivery in career counseling. In B. Heibert (Ed.), *Exemplary career development programs and practices: The best from Canada*. Greensboro: School of Education, University of North Carolina, Greensboro. (ERIC Document Reproduction Service No. ED382900)
- Inagami, T. (2004). Changes in the employment system and future labor policies. *Japan Labor Review*, 1(1), 39–51.
- Kosuqi, R. (2005). Introduction. The transition from school to working life issues. *Japan Labor Review*, 2(3), 2–4.
- Nicholas, L. (1996). Patterns of counseling in South African universities. *International Journal for the Advancement of Counseling*, 18, 275–285.
- Patton, W. (2005). Coming of age? Overview of career guidance policy and practice in Australia. *International Journal of Educational and Vocational Guidance*, 5(2), 217–227.
- Plant, P. (2000). Career development in Denmark. In B. Heibert & L. Bezanson (Eds.), *Making waves: Career development and public policy* (pp. 129–148). Ottawa, Canada: Human Resources Development Canada/Canadian Career Development Foundation.

- Van Esbroeck, R., Herr, E. L., & Savickas, M. L. (2005). Introduction to the special issue: International perspectives on educational and vocational guidance [Special issue]. *International Association for Educational and Vocational Guidance*, 5, 85–90.

---

## INTERNATIONAL ASSOCIATION FOR EDUCATIONAL AND VOCATIONAL GUIDANCE

---

The International Association for Educational and Vocational Guidance (IAEVG) is a worldwide educational guidance and counseling professionals association representing individuals as well as national and regional associations concerned with educational and vocational guidance on all continents. It currently has over 20,000 individual and institutional members, including careers practitioners, consultants, and university professors and lecturers. The objectives of the organization are to promote and improve international communication between people and organizations active in educational and vocational guidance; to encourage the continuing professional development of ideas, practice, and research in the field of guidance and counseling; and to collect and disseminate information on the latest educational and vocational guidance practice, study, and research.

### History and Governance

IAEVG was founded in 1951 in Paris. The original objectives of the organization, which are still relevant today, were to provide educational and careers guidance professionals with the opportunity to exchange views and experiences and to benefit from mutual exchanges and experiences and to create an international resource for information on guidance matters.

The IAEVG Board is elected by the membership and includes six executive members: the president, three vice presidents, a treasurer, and a secretary general. Electronic online elections are held every 4 years and are led by the secretary general. Any major policy changes are agreed at the organization's general assembly, which is usually held every 4 years. Day-to-day management and services are handled by the IAEVG's international administrative center in Ottawa, Canada.



### Professional Services

IAEVG provides a number of professional services to its members and other interested parties: (a) a professional community and networking, which include worldwide conferences and networking meetings that are held annually and attended by members and nonmembers from all continents; (b) publications, including a regular newsletter, which is produced in four languages, and the *International Journal for Educational and Vocational Guidance*, both of which are produced several times a year and are free to members; (c) international counselor competencies for vocational guidance practitioners, a new service that enables members to gain international accreditation and certification for their professional work; (d) IAEVG's ethical standards support the quality of guidance delivery and services, as well as providing guidance on appropriate behavior toward clients.

Research is a key area of focus, and IAEVG has completed a number of pieces of work for the United Nations Educational, Scientific, and Cultural Organization, including a study of "Vocational Guidance for Equal Access and Opportunity for Girls and Women

in Technical and Vocational Education" and a joint publication produced with the International Association for Counseling, "New Roles and Challenges for Guidance, and Counseling."

There is ongoing international cooperation between IAEVG on study projects with the Organisation for Economic Co-operation and Development, the European Union, and the International Labour Office.

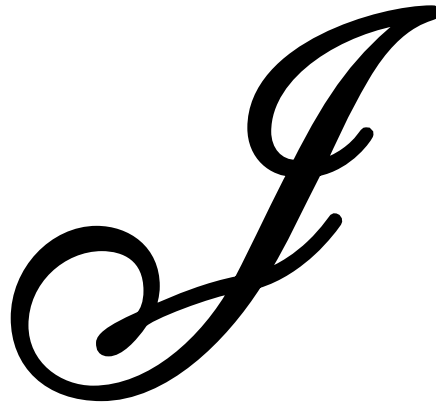
*Linda JC Taylor*

**See also** Career Counseling (v4); Cross-Cultural Psychology (v3); Diversity Issues in Career Development (v4); International Approaches (v4); International Developments, Counseling (v1); International Developments, Counseling Psychology (v1); Multicultural Counseling (v3); Multicultural Counseling Competence (v3); National Career Development Association (v4); Organizational Diversity (v3); Society for Vocational Psychology (v4)

### Web Sites

International Association for Educational and Vocational Guidance: <http://www.iaevg.org>





---

## JACKSON VOCATIONAL INTEREST INVENTORY

---

The Jackson Vocational Interest Inventory (commonly known as the Jackson Vocational Interest Survey or JVIS) is a standardized, normed career interest test that was first published by Douglas Jackson in 1977 after 8 years of research on vocational roles and styles. With the use of factor analytic and related multivariate techniques, Jackson created a unique career assessment tool, published by Sigma Assessment Systems.

The test consists of 289 pairs of statements describing occupational activities. Using an ipsative-choice A–B model, the user will make choices that result in normative scores on 34 work roles and styles scales. The test requires less than an hour to complete. As is stated in the *JVIS Technical Manual*, the internal consistency reliability from the most recent analyses ranged from .54 to .88 with a median of .72 for the Basic Interest Scales and from .70 to .93 with a median of .88 for the General Occupational Themes. Test–retest reliability coefficients based on an interval of 4 to 6 weeks ranged from .69 to .92 with a median of .82 for the Basic Interest Scales.

The resultant profile contains four major components: (1) Basic Interest Scales, (2) General Occupational Themes, (3) Similarity to College Students, and (4) Similarity to Job Groups. The JVIS is the only standardized career assessment tool to include the Similarity to College Students scales, which provide a unique opportunity for the career practitioner to

compare the client's interest in the training and practice of a work sector.

There are four versions of the JVIS Report. The Basic Report is hand-scored and results in only the Basic Interest Scales. The full report, containing all of the four major components, can be generated through mail-in scoring, onsite scoring software, and Web-based scoring.

The Web-based version, first published in 1996, has provided a powerful career-assessment tool. Depending on the printer used, this version generates a 25-page hypertexted profile, which is PIN-protected to the user. The profile contains hotlinks to professional Web sites related to the high-scoring job groups. The last part of this report, titled “Where to Go From Here,” contains Web-based resources and books that assist the user in pursuing further career research.

The JVIS has been effectively used by career practitioners for clients in the full range of career development: adolescents, career transitioners, and retirees. Significant research on the General Occupational Themes by Marc Verhoeve, cybertraining consultant for Sigma Assessment Systems, has resulted in some innovative applications in team management and group counseling. The Web-based JVIS is now used worldwide directly by clients and by career practitioners. Global training is provided by Sigma Assessment Systems utilizing a teletraining model.

*Marc Verhoeve*

*See also* Armed Services Vocational Aptitude Battery (v4); Campbell Interest and Skill Survey (v4); Career Counseling in Colleges and Universities (v4); Career



Counseling in Organizations (v4); Career Counseling in Schools (v4); Career Indecision (v4); Career Planning (v4); Computer-Assisted Career Counseling (v4); DISCOVER (v4); Employee Aptitude Survey (v4); General Aptitude Test Battery (v4); Holland's Theory of Vocational Personalities and Work Environments (v4); Unix Edition of the ACT Interest Inventory (v4)

### Further Readings

Sigma Assessment Systems. (2000). *JVIS manual* (2nd ed.). Port Huron, MI: Author.

Sigma Assessment Systems. (2000). *JVIS professional applications handbook* (2nd ed.). Port Huron, MI: Author.

### Web Sites

JVIS: <http://www.jvis.com/>

Sigma Assessment Systems: <http://www.sigmaassessmentsystems.com/assessments/jvis.asp>

---

## Job Loss

---

Job loss is a stressful life event in which employees involuntarily lose their current job, marking the start of a state called unemployment. Historically, job loss has gained research attention from several academic disciplines including economics, sociology, and psychology. From the psychological perspective, job loss research can be categorized into two major streams. The first research stream concentrates on documenting the detrimental impact of job loss. The second research stream focuses on how unemployed individuals cope with job loss and related institutional efforts that assist in the coping process.

### Detrimental Impact of Job Loss

A large body of research has linked job loss to reduced psychological well-being (e.g., increased depressive symptoms, reduced self-esteem and perception of competence, elevated anxiety and hostility, lowered life satisfaction, increased suicidal attempts, and worsened relationship with family members and friends). Research also shows that individuals who have lost their job may experience a decline in their physical well-being as well (e.g., increased self-report of physical symptoms as well as actual symptoms). In addition, some empirical evidence suggests that

unemployed individuals' well-being is improved shortly after they are reemployed.

M. Jahoda theorized that work serves several manifest and latent sociopsychological functions. An example of manifest function is earning income, while an example of latent function is the social identity endowed by employment. Job loss places these critical functions in significant jeopardy, which in turn leads to reduced well-being. R. H. Price has similarly argued that both economic hardship and eroded identity are two critical mediators of the above job loss–well-being link.

### Coping With Job Loss

According to a recent meta-analysis conducted by F. M. McKee-Ryan, unemployed individuals who possess some key characteristics or factors tend to cope with job loss relatively better than those who do not. These key characteristics include the following: lower career commitment-involvement, more positive self-regard, greater social support, greater financial resources (both objective and perceived), better time structure (able to organize time so as to retain the sense of purpose in life), internal attribution (blaming others for job loss), higher reemployment expectation, and more job search activities. These characteristics were similarly conceptualized by J. C. Latack in her career transition model as factors that enable unemployed individuals to transform job loss into career growth.

It is worth noting that government, unions, and organizations have been increasingly proactive in recent years in helping unemployed individuals (or soon to be unemployed) to better adjust to job loss through combined effort in legislation, government policies, and benefit and training programs. Research suggests that such efforts are modestly effective.

### Future Directions

With continued globalization and shifts of economic focus, job loss will remain an important topic in vocational psychology. Future researchers should implement longitudinal designs more frequently and obtain larger samples. Interdisciplinary research that goes beyond the psychological perspective is greatly needed. Additionally, job loss research in non-Western societies should prove promising in advancing both theory and practice.

*Jinyan Fan*



*See also* Adult Development (v1); Adults in Transition (v4); Career/Life (v4); Career Planning (v4); Coping (v2); Job Satisfaction and General Well-Being (v4); Retirement (v4); Stress (v2); Stress Management (v2); Work Stress (v4)

### Further Readings

- Caplan, R. D., Vinokur, A. D., Price, R. H., & van Ryn, M. (1989). Job seeking, reemployment, and mental health: A randomized field experiment in coping with job loss. *Journal of Applied Psychology, 74*, 759–769.
- Latack, J. C., & Dozier, J. B. (1986). After the ax falls: Job loss as a career transition. *Academy of Management Review, 11*, 375–392.
- Latack, J. C., Kinicki, A. J., & Prussia, G. E. (1995). An integrative process model of coping with job loss. *Academy of Management Review, 20*, 311–342.
- Leana, C. R., & Ivancevich, J. M. (1987). Involuntary job loss: Institutional interventions and a research agenda. *Academy of Management Review, 12*, 301–312.
- McKee-Ryan, F. M., Song, Z., Wanberg, C. R., & Kinicki, A. J. (2005). Psychological and physical well-being during unemployment: A meta-analytic study. *Journal of Applied Psychology, 90*, 53–76.

---

## JOB SATISFACTION AND GENERAL WELL-BEING

---

With the emergence of the field of positive psychology, increasing attention has been paid to factors contributing to general well-being. Job satisfaction has been identified as a major component of general well-being. Meta-analysis has found a correlation of .44 between measures of job satisfaction and general well-being. Given the many life areas impacted by work, it has been argued by some that job satisfaction may contribute more to nonwork related life satisfaction than the obverse. Unfortunately, only limited research has been conducted to explore the specifics of the relationship between job satisfaction and general well-being. However, person–environment fit models, such as the theory of work adjustment (TWA), appear to offer a solid starting point for such inquiries.

### Goal Attainment

Discussions of general well-being often emphasize the importance of goal directedness and goal attainment to well-being. Given the extensive person–environment fit literature demonstrating significant

relationships between job fit and job satisfaction, it has been suggested that these models might provide direction regarding which goals to aim for and provide an aid for understanding the motivation to achieve one's goals. Currently, TWA is the person–environment fit model that is most amenable to making linkages between job satisfaction and general well-being. TWA views work as an interactive and reciprocal process between the individual and the work environment. In simplest terms, individuals may be viewed as fulfilling the labor requirements of the work environment in exchange for the work environment fulfilling a wide range of financial, social, and psychological needs for the individual. The TWA instrumentation developed to operationalize job satisfaction uses 20 dimensions: ability utilization, achievement, activity level, independence, variety, compensation, job security, working conditions, opportunity for advancement, recognition, authority, social status, coworker relations, social relevance, moral values, company policies, supervision (human relations), supervision (technical), creativity, and responsibility. Clearly, these dimensions reflect a mixture of both motivating factors and end goals.

### Hedonic and Eudemonic Perspectives

Most models of well-being may be categorized as either *hedonic* or *eudemonic* in perspective. The hedonic perspective defines well-being in terms of pleasure attainment and pain avoidance. The eudemonic perspective focuses on meaning and self-realization and defines well-being in terms of doing what is worthwhile. Although, the reinforcer dimensions of TWA reflect aspects of both the hedonic and eudemonic models, given the model's overall emphasis on satisfaction of needs, one might conclude that it leans more toward the hedonic perspective. However, structural analysis of the 20 reinforcer dimensions suggests there are six underlying dimensions or values. These values have been labeled *achievement*, *comfort*, *status*, *altruism*, *safety*, and *autonomy*. Achievement reflects making use of one's abilities and feelings of accomplishment. Comfort reflects feeling comfortable and an absence of stress or distress. Status reflects gaining recognition from and/or having authority over others. Altruism reflects helping others and having a sense of doing good deeds for others. Safety reflects an appreciation for structure and order and an absence of unpredictability. Autonomy reflects



being independent and feeling in control. Viewed on this level, TWA appears fairly balanced between eudemonic and hedonic perspectives of well-being.

### Extrinsic and Intrinsic Motivation

Well-being researchers have differentiated between *extrinsic* and *intrinsic motivation*. Intrinsic motivation refers to doing an activity for the inherent satisfaction of the activity itself. In contrast, extrinsic motivation refers to doing an activity to attain some separable reward. This closely parallels the concepts of intrinsic and extrinsic job satisfaction in TWA. In TWA, intrinsic job satisfaction reflects aspects that are inherent to the job itself (e.g., feelings of accomplishment), and extrinsic job satisfaction reflects aspects that are not inherent to the job itself and that are usually under the control of the work environment (e.g., salary). It should be noted that in the well-being literature, it has been argued that individuals who are motivated intrinsically tend to experience greater levels of well-being than individuals who are extrinsically motivated. However, TWA makes no differential predictions; job satisfaction arises from the degree of correspondence between worker needs and job reinforcers regardless of whether the most salient of these dimensions are categorized as being related to extrinsic or intrinsic job satisfaction.

### The Social Ecological Approach

Rudolph Moos's social ecological approach (also referred to as the life domains model) proposes that individuals may be conceptualized as existing within a constellation of overlapping environments, or *life domains*. Some of these domains are self, marriage, family, friends, work, and health. Moos developed 10 Social Climate Scales to characterize the most salient dimensions found across a range of domains. Although specifics vary from domain to domain, Moos found that the broad categories of relationship, personal development and system maintenance, and system change are cross-cutting. This finding is considered by some reviewers to be of major importance to the well-being literature. The relationship dimensions assess the degree people in a given setting support one another and feel free to express themselves openly. The personal development dimensions assess basic goals of a given setting and how personal development and self-enhancement occur in that setting. The

system maintenance and system change dimensions assess the clarity with which an environment states its goals, how it maintains control, and how it responds to change. The TWA need-reinforcer dimensions may be mapped onto Moos's three cross-cutting categories. Structural analysis of the six TWA work values suggest that they may be grouped into internal, social, or environmental reinforcer areas, categories whose interpretation echoes those of the cross-cutting categories proposed by Moos.

### Value Contrasts

Further structural analysis suggests that the six TWA values form contrasts. Achievement contrasts with comfort. On one hand, it is often not possible to attain difficult goals without stress, sacrifice, and discomfort. On the other hand, a comfortable, stress-free life may come at the cost of giving up ambitions. Altruism contrasts with status. Altruism focuses on the well-being of others, whereas status focuses on self-advancement and self-promotion. Finally, autonomy contrasts with safety. A highly autonomous person depends upon him- or herself independent of environment. A person with high safety needs depends on the environment to provide order and structure, while also depending on retaining control over the choice of environment to be in. These value contrasts have the potential to help individuals understand value conflicts, experienced both internally and in interaction with environments, and highlight that choices and/or compromises may need to be made when seeking either job or general life satisfaction.

Donald E. Eggerth

*See also* Happiness/Hardiness (v2); Minnesota Importance Questionnaire (v4); Person–Environment Fit (v4); Physical Health (v2); Positive Psychology (v2); Psychological Well-Being, Dimensions of (v2); Theory of Work Adjustment (v4); Work–Family Balance (v4)

### Further Readings

- Dawis, R. V. (2001). Toward a psychology of values. *The Counseling Psychologist*, 26(3), 458–465.
- Ryan, R. M., & Deci, E. I. (2000). Self-determination theory and the facilitation of intrinsic motivation, social development and well-being. *American Psychologist*, 55(1), 68–78.



- Ryan, R. M., & Deci, E. I. (2001). On happiness and human potentials: A review of research on hedonic and eudemonic well-being. In S. T. Fiske, D. L. Schacter, & C. Zahn-Waxler (Eds.), *Annual review of psychology* (Vol. 52, pp. 141–166). Palo Alto, CA: Annual Review.
- Swindle, R. W., & Moos, R. H. (1992). Life domains in stressors, coping and adjustment. In W. B. Walsh, K. H. Craik, & R. H. Price (Eds.), *Person–environment psychology: Models and perspectives* (pp. 1–33). Hillsdale, NJ: Lawrence Erlbaum.
- Tait, M., Padgett, M. Y., & Baldwin, T. T. (1989). Job and life satisfaction: A reevaluation of the strength of the relationship and gender effects as a function of the date of study. *Journal of Applied Psychology*, 74(3), 502–507.
- Walsh, W. B., & Eggerth, D. E. (2005). Vocational psychology and personality: The relationship of the five-factor model to job performance and job satisfaction. In W. B. Walsh & M. L. Savicas (Eds.), *Handbook of vocational psychology* (3rd ed., pp. 267–295). Mahwah, NJ: Lawrence Erlbaum.

---

## JOB SHARING

---

Job sharing, sometimes called work sharing, generally refers to the practice of having two or more people share a single full-time position, each working part-time. It can also refer to two or more people sharing a single budget line, but doing unrelated work.

Job sharing has been applied as a solution to several different situations that influence the availability or desirability of full-time employment. It has been identified as a way to help people balance work and family commitments, to provide access to employment for people with disabilities, to ease the transition of retirement and the training of new replacement employees, and to help employers minimize layoffs. There is some evidence that job sharing is efficacious in terms of economic impact as well as beneficial to employee morale and productivity.

### Job Sharing for Work–Family Balance

The impact of work–family conflict has received considerable attention, particularly in the last 20 years as women have increasingly entered the workplace and more families have become dual-career or dual-earner families. Research has generally demonstrated that increased conflict between work and family demands has been associated with decreased satisfaction across the work, family, and marriage domains.

Job sharing is one of several workplace family-supportive policies that have demonstrated appeal among workers who are attempting to minimize family–work conflict. There is some evidence that women view job sharing as a more important option than do men. However, family-supportive work resources appear to increase both job and family satisfaction ratings for both men and women. Furthermore, job sharing and other family-supportive practices have been viewed by parents as most important in dealing with work–family conflicts that interfered with job goals rather than with family goals.

Although family-supportive workplace practices have been examined in recent research and calls have been made for further study of job sharing and flextime practices, the specific option of job sharing has received limited attention. This may be due at least in part to the relative infrequency of job sharing. In a national survey of 1,057 employers, the Families and Work Institute found that 37.5% of responding companies provided job share opportunities, compared to 55% that allowed employees to periodically work from home and 68% that allowed flexible scheduling. However, job sharing was the most frequent flexibility option under consideration for future implementation, suggesting that it may become more generally available for employees seeking to balance work and family demands.

*The Chronicle of Higher Education* has run several stories on job sharing options in the past decade, noting the increased demand for family accommodations among faculty and the benefits to college administrators who need to attract faculty couples. There is anecdotal evidence of increased job sharing among faculty members, particularly in smaller colleges. Testimonials about these experiences suggest that the costs, which include reduced salaries and challenges to earning tenure, are outweighed by the benefits of flexible employment for the majority of job sharers. Research into the experience is certainly warranted.

### Job Sharing to Accommodate Restricted Work Schedules

In addition to seeking more time to accommodate family–work conflict, many workers need to decrease or have limited work hours to accommodate health or ability factors. Other workers are able to use less than full-time employment to transition into or out of the workplace. Job sharing can be an important option in both of these situations.



One population that is likely to benefit from the accommodation of flexible or reduced work hours is that of disabled workers. According to a 2003 report of the U.S. Census Bureau, approximately 18.5 million disabled Americans are employed, which is about 56% of all disabled people between 16 and 64 years of age. The U.S. federal government identifies job sharing as one of several strategies to accommodate employees with both psychiatric and physical disabilities. Employers have also indicated a willingness to consider job sharing in the hiring of people with disabilities.

Increasing unemployment rates in the late 1990s prompted some European countries to develop creative solutions to work transitions among older and younger workers. In Nordic countries, a system of job sharing was established to support phased retirements. Older workers cut down their weekly work hours, and new employees are hired in part-time positions to fill the remaining hours. In addition to providing employment opportunities to more workers, there is initial evidence that this strategy also provides some economic benefits.

### **Job Sharing as an Alternative to Employee Layoffs**

Several national and state governments recognize work sharing programs as a way of preserving employment for all (or at least more) workers during temporary decreases in productivity or economic downturns. Although these job share programs result in fewer hours for previously full-time employees, they generally do not reduce employee benefits. In addition, employees are frequently eligible to apply for unemployment insurance to compensate for the amount of hours reduced by the work share, although this is regulated by individual state and/or national governments. This kind of work share program differs from other job sharing arrangements in that it is typically monitored by government agencies and initiated by the employer, whereas other job sharing strategies are more often individually negotiated arrangements and most frequently initiated by the employee(s).

In a national evaluation of work share programs, Human Resources Development Canada found that an average of 10,302 (ranging from 2,264 in 1999–2000 to 32,524 in 1990–1991) layoffs were averted annually between 1990 and 2002 due to work share program participation. The International Labor Office identified several advantages and considerations for

both employers and employees in work share situations. For employers, advantages include greater ability to adjust to fluctuations in market demands and less time in retraining new employees when economic downturns reverse; disadvantages include the need to attend more carefully to employee scheduling and communication in order to avoid confusion and lowered productivity. For employees, advantages include job security; disadvantages include decreased wages.

### **Opportunities and Challenges**

Regardless of the specific nature of the arrangement, several advantages and opportunities are presented by job sharing. An important benefit of job sharing is the flexibility allowed the participants in the share. Assuming good communication and coordination of duties, job sharers are able to synchronize their schedules in a way that allows maximum productivity at work as well as adequate time to attend to other matters. Successful job sharing arrangements are likely to contribute to higher employee morale as well. Job sharing also allows employers to attract more talented employees and to organize work assignments to maximize individual worker skills. Job sharing also provides a way for employers to make work accessible to people who might otherwise be at a disadvantage.

Job sharing also brings with it several potential challenges. In situations in which two people are sharing a single job, good communication and complementary work skills are essential. Some overlap in hours is generally necessary, and this can reduce some of the flexibility that comes with the arrangement. Other employees might perceive job sharing employees as less involved or invested in the workplace, as might some supervisors. This could result in negative evaluation or lost opportunities, suggesting that organizations need to set up very clear expectations for job sharing employees so that everyone knows the criteria by which they are to be reviewed. Job sharing employees might themselves feel as if they need to put forth more time and effort, thus negating some of the benefits of the arrangement, reinforcing the need to have very clear expectations for all involved parties.

### **Future Directions**

Job sharing is one of several strategies for making the workplace more accessible and/or welcoming for workers with a diverse set of employment and personal needs. Further research is necessary to determine



how job sharing compares to other practices, such as compressed work weeks and flexible scheduling. In addition, claims that job sharing results in higher productivity and employee morale need to be further explored. Given that there is increasing interest in job sharing by both employees and employers, this area of vocational development warrants greater attention by scholars and clinicians in the counseling and psychology professions.

Cindy L. Juntunen

*See also* Career Development Inventory (v4); Job Loss (v4); Life-Role Balance (v4); Part-Time Work (v4); Persons With Disabilities (v4); Work-Family Balance (v4); Vocational Identity (v4)

### Further Readings

- Brough, P., O'Driscoll, M. P., & Kalliath, T. J. (2005). The ability of organizational "family-friendly" resources to predict work-family conflict and job and family satisfaction. *Stress and Health, 21*, 223-234.
- Families and Work Institute. (1998). *Business work-life study, executive summary*. Retrieved June 27, 2006, from <http://www.familiesandwork.org/summary/worklife.pdf>.
- Human Resources Development Canada. (2004, February). *Evaluation of the work sharing program: Final report*. Retrieved from [http://www11.hrdc-drhc.gc.ca/pls/edd/SP\\_AH\\_212\\_02\\_04\\_402000.htm](http://www11.hrdc-drhc.gc.ca/pls/edd/SP_AH_212_02_04_402000.htm)
- International Labour Office Geneva. (2004, August). *Work-sharing and job-sharing* (Information Sheet No. WT-17). Retrieved from <http://www.ilo.org/public/english/protection/condtrav/pdf/infosheets/WT-17.pdf>
- Kossek, E., & Ozeki, C. (1998). Work-family conflict, policies, and the job-life satisfaction relationship: A review and directions for organizational behavior-human resources research. *Journal of Applied Psychology, 83*, 139-149.
- U.S. Department of Labor. (2006, March). *Maximizing productivity: Accommodations for employees with psychiatric disabilities*. Retrieved from <http://www.dol.gov/odep/pubs/fact/psychiatric.htm>

1993, the first issue was published. Walsh was the first editor of the journal. The main thrust of the journal is to publish methodologically sound, empirically based studies focused on the process and techniques by which counselors and others gain understanding of the individual faced with the necessity of making informed career decisions. The term *career assessment*, as used in this journal, covers various techniques, tests, inventories, rating scales, interview schedules, surveys, and direct observational methods used in scientifically based practice and research to provide an improved understanding of career decision making. The focus is not just testing, but all those means developed and used to assess and evaluate individuals, organizations, and environments in the field of career psychology, counseling, and development. *Assessment* is broadly defined to include the full range of assessment perspectives (objective, subjective, projective, behavioral, interactional, and developmental). A real strength of *JCA* is the focus on career assessment as it reflects the convergence of theory, research, and practice in diverse cultures throughout the world.

A change for the journal occurred in 2002. Sage Publications in Thousand Oaks, California, agreed to commence publication of *JCA* beginning with volume 10, issue 1, 2002. Since 1965, Sage has been devoted to publishing a number of journals in the fields of education and psychology. They are known for their flexibility, extensive worldwide marketing, proficient editing and production, and expertise in collaborating with professional organizations. It was a good fit for the journal.

The journal is abstracted or indexed in *Abstract Journal of the Educational Resources Center*, *Current Contents: Social & Behavioral Sciences*, *Current Index to Journals in Education*, *Psychological Abstracts*, *PsycINFO*, *Scopus*, and *Social Sciences Citation Index*. The *Social Sciences Citation Index* consistently ranks *JCA* among the top journals in the field of career psychology and assessment. The *Social Sciences Prestige Factor* also ranks *JCA* among the top journals in the field of counseling and vocational psychology.

Over the years the journal has published a number of special issues on topics such as career assessment for women, the assessment of interests, the use of personality inventories in career assessment, career assessment with racial and ethnic minorities, theory and career assessment, career assessment and the Internet, cognitive career assessment, qualitative career assessment, and career assessment and self-efficacy.

---

## JOURNAL OF CAREER ASSESSMENT

---

The concept for the *Journal of Career Assessment* (*JCA*) was developed in 1989 by W. Bruce Walsh of Ohio State University. On June 7, 1991, Robert Smith of Psychological Assessment Resources accepted the proposal to become the publisher of *JCA*. In January



The journal continues to be published 4 times a year with an average of 125 pages per issue. The editorial board consists of about 25 professional counseling psychologists. A blind review process is used to evaluate manuscripts.

W. Bruce Walsh

**See also** Assessment (v4); Career Counseling (v4); Career Counseling Process (v4); *Career Development Quarterly* (v4); Career Interventions (v4); International Approaches (v4); *Journal of Career Development* (v4); *Journal of Vocational Behavior* (v4); Multicultural Career Assessment Models (v4); Walsh, W. Bruce (v4)

### Web Sites

*Journal of Career Assessment*: <http://jca.sagepub.com>

---

## JOURNAL OF CAREER DEVELOPMENT

---

The first issue of the *Journal of Career Development* (vol. 1, no. 1) was published in the fall of 1972 under the title *Journal of Career Education*. The following statement of purpose appeared in the first issue:

This publication will endeavor to support and summarize the thrust of current trends in career education, with a special focus on the integrated approach to vocational and technical education. This will be done by documenting in journal form efforts which signify exemplary leadership in promoting these concepts.

The next issue of the *Journal of Career Education* (vol. 1, no. 2) did not appear until the fall of 1974. H. C. Kazanas served as editor. From then on the journal has been published quarterly. In the fall of 1978, Norman C. Gysbers was appointed editor beginning with volume 5, number 1. At that time it became an official publication of the College of Education, University of Missouri–Columbia. Copyright was held by the Curators of the University.

A major change for the journal occurred in 1984. The name was changed to the *Journal of Career Development*. The reason the name was changed was the need to broaden the purpose, scope, and content of the journal beyond K–12 education to focus on the life span, early childhood through the adult years. The

new purpose emphasized journal content that featured career development theory, research, and practice covering such topics as adult career development, the career development of special needs populations, career development and the family, career development in organizations, and career and leisure.

From 1972 until 1985, the journal was published and marketed in-house on the campus of the University of Missouri–Columbia. When Gysbers became editor in 1978, a fully operational editorial board was put into place and the use of blind reviews. Also, during this time period, extensive efforts were made to increase subscriptions, particularly library subscriptions, using subscription agencies.

In 1985, the editor, in consultation with the University of Missouri officials, made the decision to respond to a proposal from Human Sciences Press to assume the task of publishing and marketing the journal. A contract was signed in 1985. As a result, the first issue published under this new arrangement was the fall 1985 issue, volume 13, number 1. What had been an in-house publishing and marketing operation became a professionally published and marketed journal. The authority to appoint editors and editorial board members and to decide on editorial policy remained with the University of Missouri–Columbia.

The contract to publish the *Journal of Career Development* with Human Sciences Press (now Springer) remained in effect through volume 31, number 4. In 2004, the University of Missouri–Columbia signed a contract with Sage Publications to publish and market the journal. The first issue published by Sage was volume 32, number 1, 2005. In another change, Lisa Flores became the editor beginning with volume 33, number 1.

Norman C. Gysbers

**See also** Career Counseling (v4); Career Counseling in Schools (v4); Career Counseling Process (v4); Career Development Inventory (v4); *Career Development Quarterly* (v4); Career Education (v4); *Journal of Career Assessment* (v4); *Journal of Vocational Behavior* (v4)

### Further Readings

- Gysbers, N. C., Heppner, M. J., & Johnston, J. A. (2003). *Career counseling: Process, issues, and techniques* (2nd ed.). Boston: Allyn & Bacon.
- Hood, A. B., & Johnson, R. W. (2002). *Assessment in counseling: A guide to the use of psychological assessment procedures* (3rd ed.). Alexandria, VA: American Counseling Association.



---

## JOURNAL OF VOCATIONAL BEHAVIOR

---

The *Journal of Vocational Behavior* (*JVB*) publishes empirical, methodological, and theoretical articles that expand knowledge about vocational choice and work adjustment across the life span. Studies of vocational choice typically examine topics such as career choice; occupational interests; the relation of abilities, needs, values, interests, and personality to occupational aspirations and the career decision-making process; vocational development tasks and career stages; the effects of culture, demographic variables, and experiential factors on career decision making and occupational attainment; career indecision and vocational maturity; occupational stereotyping; and career exploration and job search. Studies of work adjustment typically investigate topics such as job performance and success; job satisfaction; mentoring; work adjustment; organizational commitment and job involvement; work–family relations and multiple role management; work–leisure relations; midlife career change; occupational reentry; and transitions from work to retirement. *JVB* also publishes articles about career interventions and conceptual articles that address career theory. Psychometric research is also represented, particularly manuscripts that report the construction and initial validation of new instruments, but also studies that evaluate the reliability and validity of widely used instruments that measure central concepts in vocational choice and work adjustment. Articles that report meta-analyses and research integration of the topics noted above are highlighted in the journal.

*JVB*'s distinctiveness arises from its emphasis on publishing research that deals with vocational behavior from the perspective of the individual rather than the perspective of the organization. Studies of organizational behavior and of variables more highly related to the welfare of organizations than to the individual ordinarily do not appear in *JVB*. Thus, *JVB* does not publish research on organizational topics such as leadership or management. Intermittently, the journal publishes special issues that explore a single topic in depth. Often these special issues relate to significant anniversaries in the field of vocational psychology such as the 40th anniversary of John L. Holland's theory of vocational personalities and work environments

(August 1999) and the 30th anniversary of *JVB*'s founding (October 2001). Special issues are also used to highlight emerging perspectives and to assemble articles on a single topic. Recent special issues have addressed technology and careers, careers in academe, social constructionism, career specialty choice, and longitudinal studies of development in context. The list of most-downloaded articles reflects strong interest in the topics of emotional intelligence, person–organizational fit, work–family relations, organizational commitment, mentoring, career success, and career decision making.

*JVB* was founded in 1971 by Samuel H. Osipow, then a professor of psychology at Ohio State University who sought an outlet for research on vocational psychology. Osipow has been succeeded by Lenore W. Harmon, Nancy E. Betz, Howard E. A. Tinsley, and since 1999 Mark L. Savickas. *JVB* publishes 1200 pages each calendar year in the form of six issues divided equally into two volumes. Originally published by Academic Press, *JVB* is now published by Elsevier. Abstracts and the full text of all articles published in volumes 1–70 are available on Science Direct.

Mark L. Savickas

*See also* *Career Development Quarterly* (v4); *Career Indecision* (v4); *Decision Making* (v4); *Journal of Career Assessment* (v4); *Journal of Career Development* (v4); *Society for Vocational Psychology* (v4); *Theory of Work Adjustment* (v4)

### Further Readings

- Savickas, M. L. (2004). Vocational psychology. In C. Spielberger (Ed.), *Encyclopedia of applied psychology* (pp. 655–667). Boston: Elsevier Academic.
- Savickas, M. L., & Baker, D. B. (2005). The history of vocational psychology: Antecedents, origin, and early development. In W. B. Walsh & M. L. Savickas (Eds.), *Handbook of vocational psychology* (3rd ed., pp. 15–50). Mahwah, NJ: Lawrence Erlbaum.

### Web Sites

Science Direct: <http://www.sciencedirect.com>









---

## KRUMBOLTZ, JOHN D. (1928– )

---

John D. Krumboltz, Ph.D., has demonstrated throughout his life and work that counselors can help clients with career, academic, and personal problems to explore and expand their learning experiences; challenge unhelpful beliefs; embrace unanticipated opportunities; and take positive actions to create more satisfying lives for themselves. He received from the American Psychological Association the Award for Distinguished Professional Contributions to Knowledge (2002) and the Leona Tyler Award (1990), the nation's foremost award in the field of counseling psychology. A leading theorist in career development, in 1979 Krumboltz proposed a social learning theory of career decision making. In 1996, he expanded this into a learning theory of career counseling and has since added the concept of planned happenstance.

Krumboltz views career indecision as a consequence of ineffective learning (e.g., unsatisfactory or insufficient learning experiences). He maintains that the role of career counselors is to use career assessment tools and cognitive-behavioral counseling methods to help clients expand their learning about current and potential interests, skills, values, beliefs, personal qualities, and work habits. To progress beyond the counseling goal of insight, Krumboltz developed the Career Beliefs Inventory and a workbook titled *Exploring Your Career Beliefs* to help clients not only think and talk about their assumptions that might facilitate or impede their career development, but also take action to test out these assumptions and learn more helpful behaviors.

Furthermore, in order to create a satisfying life in the context of a constantly changing work environment, Krumboltz posits that career counselors can teach their clients to generate and transform unplanned events into opportunities for learning. He notes that unanticipated events attributed to luck are often a result, at least in part, of effective behavior that can be taught. Although the concept of planned happenstance pairs seemingly contradictory terms (i.e., how does one plan for chance events?), Krumboltz suggests that clients can learn to act in ways that maximize the frequency of beneficial chance events as well as plan to be receptive to and capitalize on chance opportunities.

Readily admitting that his own career path was not totally the result of rational planning, Krumboltz has shared that he was undecided in selecting an undergraduate major when he attended Coe College. He had explored one option (economics) that he learned was not satisfying for him. When the coach of his varsity tennis team, who also happened to be a professor of psychology, suggested that he major in psychology, Krumboltz did so. Since then, he has capitalized on this chance opportunity to expand his learning in psychology, explore fascinating questions in counseling psychology and career development, and make significant contributions to the science and practice of counseling.

After earning a bachelor's degree in psychology from Coe College and a master's degree in guidance from Teachers College, Columbia University, Krumboltz worked as a high school counselor and taught algebra in Waterloo, Iowa. Dissatisfied with the nondirective counseling approach that he had been taught to apply and seeking more scientific and practical



methods, he obtained a Ph.D. in counseling and educational psychology from the University of Minnesota. Then he served as a research psychologist when called to active duty in the Air Force. He continued to pursue his interest in behavioral psychology as an assistant professor at Michigan State University. At Stanford University since 1961 and currently a professor of education and psychology, Krumboltz has served as a revolutionary role model for lifelong, challenging, and positive learning.

*Margo A. Jackson*

*See also* Career Beliefs Inventory (v4); Career Counseling (v4); Career Counseling, History of (v4); Career Indecision (v4); Career Planning (v4); Cognitive-Behavioral Therapy and Techniques (v2); Krumboltz Happenstance Learning Theory (v4); Social Cognitive Career Theory (v4)

### Further Readings

- Krumboltz, J. D. (1994). Improving career development from a social learning perspective. In M. L. Savickas & R. W. Lent (Eds.), *Convergence in career development theories: Implications for science and practice* (pp. 9–31). Palo Alto, CA: Consulting Psychologists Press.
- Krumboltz, J. D. (1996). A learning theory of career counseling. In M. L. Savickas & W. B. Walsh (Eds.), *Handbook of career counseling theory and practice* (pp. 55–80). Palo Alto, CA: Davies-Black.
- Krumboltz, J. D., & Levin, A. S. (2004). *Luck is no accident: Making the most of happenstance in your life and career*. Atascadero, CA: Impact.

---

## KRUMBOLTZ HAPPENSTANCE LEARNING THEORY

---

A theory is simply an explanation for understanding how things happen and why. A learning theory about career development explains how people discover their current occupations through a variety of different learning experiences. Within the learning theory framework, how occupations—accountant, senator, plumber—developed from life's learning experiences can be explained. Our society advocates that people plan and declare an occupational goal early in life. A common question asked of children is, "What do you

want to be when you grow up?" Paradoxically, very few adults are doing exactly what they planned at age 18. Unplanned events play a major role in everyone's career development. If serendipity is included as a crucial part of the learning process, we have what can be called a *happenstance learning theory*.

Throughout life people have innumerable learning experiences. Every minute people are engaged in learning activities whether they know it or not. Some experiences are planned, many are not. Every time a person talks to another person, he or she learns something. Every time a person watches TV, listens to the radio, or plays a game, he or she learns something. The happenstance learning theory categorizes learning experiences into two major categories: *instrumental* and *associative*.

Instrumental learning experiences are those in which people take some action and observe the consequences. For example, if a child is playing a game of baseball, comes up to bat, and hits well enough to get on base, the child has succeeded in an activity and has positive feelings as a result. Another child may come to bat and be unable to hit the ball at all, striking out. The happenstance learning theory posits that it is more likely that the first child would develop greater aspirations for a baseball career than the second child. The more children actively engage in activities, the more likely they are to encounter valuable learning experiences. Every time people do something—that is, engage actively—they find out what happens as a result and discover how they feel about it.

All instrumental learning experiences take place in a cultural and opportunity context. Baseball is a popular sport in the United States. Cricket is popular in England and India. In some other countries both sports are virtually unknown. The environment in which one is born and raised provides only certain types of learning opportunities.

Associative learning experiences occur as people watch, listen to, or read about others. For example, listening to a rock concert might inspire some people to become a rock singer. Reading about a science experiment might inspire some people to train to become chemists or biologists. Watching a carpenter at work may inspire others to discover the glories of wood working.

All of these associative learning experiences also depend on cultural context. For example, the opportunity to read about a scientist's experience depends on access to books. Some people live far from the nearest public library. Some families subscribe to magazines



and newspapers that children might spontaneously browse; other families may not. Some parents read to their children at a young age, opening a world of imagination and early literacy; other parents may not.

As a result of these continuous learning experiences, people form generalizations about their own interests, abilities, values, and beliefs. Some experiences might generate memorable interests and passions; others may not. People tend to gravitate naturally toward activities that yield emotional, social, and financial benefits. They tend to avoid activities that are distasteful and yield few benefits. Over time these tendencies lead people to engage in various types of occupations. For example, if through skillful instruction, often in a problem-based learning style, some children learn the fun of working with numbers, they might be more likely to gravitate toward occupations like accounting. Other children, enduring inadequate pedagogy in schools, might come to fear mathematics and gravitate far away from occupations that involve manipulation of numbers.

Innumerable unplanned events influence the experiences of each child. There is no way to know in advance what experiences a child might stumble across and what the consequences will be. However, it is known that the more a child is encouraged to be curious, to take risks, and to engage actively in learning opportunities, the more valuable the learning is likely to be. Learning occurs whether the opportunity is planned or unplanned. Children benefit from having multiple opportunities to observe others and to engage themselves in a variety of tasks and activities.

There is sometimes a misunderstanding that the word *happenstance* means that luck will occur if one waits passively for something to happen. That is far from the truth. One increases the probability of a happenstance event occurring by engaging in new activities. If one does nothing, nothing happens.

Sometimes people are told that they should complete their education. The happenstance learning theory advocates that one should never complete an education. People should continue learning throughout life. People can create their own luck by putting themselves in environments in which they can try activities and learn from them. People can change their occupational endeavors at any time in their life. Now, most people change career direction a number of times over their lifetimes. There are many advantages to keeping one's options open through active engagement in new experiences.

One no longer has to answer the question, "What are you going to be when you grow up?" Since one never knows what opportunities may be just around the bend, one can now respond, "I'm open and prepared for whatever is down the road." Contemporary career advice encourages people to keep an eye open for opportunities and to follow up on opportunities when the time is right. Past experience is not investment that must be continued when it is no longer satisfying. Remaining open to opportunities provides a better strategy for creating a satisfying life.

In the 1990s, "follow your bliss" became a well-known phrase in the popular career literature and was promoted as the secret to pursuing satisfying career and life experiences. However, under this premise those without a defined passion are left adrift. Passions are learned. When people do something that they enjoy and think it is important, they develop a passion for it. Through active engagement in new experiences, one learns what activities resonate personally as interesting, fun, and worthwhile. No one is born knowing that they will become a passionate singer. People who listen to others sing, begin singing themselves, and find it inspiring may well develop a passion for singing. However, one has to engage in singing first in order to develop a passion for it.

The happenstance learning theory has roots in behavioral psychology, ties to emotion theory, and moves in the direction of positive psychology in terms of resilience and adaptation to a rapidly changing world. The emphasis is on perpetual openness to new opportunities over a lifetime.

Work in the 21st century is destined to be a tremendous adventure, dynamic, fluid, and global, with a level of variety over the life span that could have never been imagined in prior centuries. Successful people will demonstrate a certain occupational resiliency characterized by flexibility, optimism, lifelong learning, daily networking, and a clever eye for opportunity. The happenstance learning theory explains how a lifetime of active involvement provides learning opportunities that may have been planned or unplanned. It is neither possible nor desirable to predict exactly what people will be when they grow up. The process continues throughout life, so people need to keep their options open at all times. Perhaps it is therefore more productive to ask children, "What are you enjoying and learning to do right now? What would be fun to try next?"

*John D. Krumboltz and Sheila J. Henderson*



*See also* Brown's Values-Based Career Theory (v4); Career Construction Theory (v4); Career Counseling (v4); Career Education (v4); Career Exploration (v4); Career Indecision (v4); Career Planning (v4); Krumboltz, John D. (v4); Social Cognitive Career Theory (v4)

### Further Readings

- Henderson, S. J. (2000). "Follow your bliss": A process for career happiness. *Journal of Counseling and Development*, 78(3), 305–315.
- Henderson, S. J., & Chan, A. (2005). Career happiness among Asian-Americans: The interplay between individualism and interdependence. *Journal of Multicultural Counseling and Development*, 33, 180–192.
- Krumboltz, J. D. (1979). A social learning theory of career decision making. In A. M. Mitchell, G. B. Jones, & J. D. Krumboltz (Eds.), *Social learning and career decision making* (pp. 19–49). Cranston, RI: Carroll Press.
- Krumboltz, J. D. (1996). A learning theory of career counseling. In M. L. Savickas & W. B. Walsh (Eds.), *Handbook of career counseling theory and practice* (pp. 55–80). Palo Alto, CA: Davies-Black.
- Krumboltz, J. D., & Henderson, S. J. (2002). A learning theory for career counselors. In S. G. Niles (Ed.), *Adult career development: Concepts, issues, practices* (pp. 41–58). Tulsa, OK: National Career Development Association.
- Krumboltz, J. D., & Levin, A. S. (2005). *Luck is no accident: Making the most of happenstance in your life and career*. Atascadero, CA: Impact.

---

## KUDER, FREDERIC (1903–2000)

---

Frederic (Fritz) Kuder is best known as the author of the Kuder Preference Records, four distinctly different forms of an interest inventory that since their introduction in 1938 have been taken by millions of people worldwide.

As a transfer student at the University of Arizona, Kuder came late to a required orientation meeting for new students and was seated next to another late-comer, a son of James McKeen Cattell, with whom he became a close friend. Cattell—who is credited with introducing mental measurements in the United States and later with the founding of the Psychological Corporation—at the time led Science Press, a company that published *American Men of Science*. After Kuder graduated with his degree in English, this

association led to a job as an editorial assistant at Science Press. Kuder was interested in vocational guidance and earned a master's degree at the University of Michigan under George E. Meyers, who was an early president of the National Vocational Guidance Association, now National Career Development Association.

After a period of employment in the personnel department of Procter & Gamble Company, where he worked on selecting sales personnel, Kuder continued his studies at Ohio State University under Herbert Toops, who was known for the development of a college entrance examination, Ohio State Psychological Examination. Several of Kuder's publications from this era concerned test development and the use of the IBM tabulating machines to perform statistical computations.

With his doctoral degree completed, Kuder went next to the University of Chicago, where he worked under the direction of L. L. Thurstone preparing placement and comprehensive exams for students. Here he began work on the Kuder Preference Record—Vocational, an interest inventory unique for using a triad of activities from which the inventory taker selected the most and least preferred activities. It was first scored for 8 and later 10 kinds of interests, which he developed with statistical techniques not unlike factor analysis, all using hand and electrically operated computation machines. He also developed a personality inventory for use in personnel selection, which enjoyed some popularity in the post–World War II years. These inventories became well known among test takers as the pin punch tests, owing to the scoring system that required that responses to items be punched into an answer pad with a pin, facilitating scoring by clerks or the inventory takers themselves.

After employment during the World War II years with the federal government, Kuder taught statistics at Duke University, where he developed his Occupational Preference record, which yielded scores reflecting the inventory taker's similarity with individuals in a variety of occupations.

In 1977, Kuder published a paper advancing a new concept of vocational assessment, which instead of matching the inventory takers with groups of people in various occupations, matched them with individuals in a wide range of occupations, and more specifically in a variety of careers. Now available exclusively online, Kuder Career Search in its first decade of



publication had been taken by more people than by those who took the previous Kuder inventories in their first 60 years.

Kuder was, with John G. Darley and E. G. Williamson, one of the founding members of the Division of Counseling Psychology of the American Psychological Association and was the group's second president. Kuder founded and was editor for a long period of *Educational and Psychological Measurement* and cofounded *Personnel Psychology*. He received the award for distinguished service to measurement from Educational Testing Service and is listed in the book he once helped produce, *American Men and Women of Science*. He was one of the several prominent 20th century psychometricians who brought psychological testing to its present high state. But in the years before his death, he liked to say that he mainly tried to help young people find satisfying careers.

Donald G. Zytowski

*See also* Assessment (v4); Career Counseling (v4); Career Counseling Process (v4); Kuder Career Search (v4); Quantitative Methodologies (v1)

### Further Readings

Zytowski, D. G., & Holmberg, K. S. (1988). Preferences: Frederic Kuder's contributions to the counseling profession. *Journal of Counseling and Development*, 67, 150–156.

---

## KUDER CAREER SEARCH

---

Kuder Career Search (KCS) represents the third generation of interest inventories known as the Kuder Preference Records. First was the Kuder Preference Record—Vocational, which gave scores on 10 vocational interest scales. Next was the Occupational, which reported occupations that were similar to the inventory takers' interests.

The KCS consists of two kinds of scales. One, the Kuder Career Clusters, reveals the similarity of the inventory taker's activity preferences to those of people in certain clusters of occupations. The unique second score gives Person Matches, which reflects the similarity of the inventory taker's interest profile to each person in a pool of some 2,000 employed adults.

Available only online at [www.kuder.com](http://www.kuder.com), the KCS is suitable for middle and high school students, 2- and 4-year college students, and adults. Individual purchases are available, but the inventory is typically administered in school as part of a career development program. The reading level is approximately sixth grade, and administration time averages 15 to 20 minutes. The inventory consists of 60 triads of activities: draw sketches of birds, build boats, sort mail in a post office, and so on, which the respondent rank-orders by preference. Scoring is instantaneous with the last response, and an online report yields a profile of cluster scores plus the job titles of the top 12 Person Matches.

Supporting materials for the KCS include two other assessments, the Kuder Skills Assessment, in both school and college or adult levels and the Super's Work Values Inventory, occupational and college information, a portfolio that can be made to generate a college or job application and an administrator's management system.

The KCS report emphasizes ranks, not scores. Mature users who are motivated to study their results and seek further information may use their results independently. High school and middle school students, especially those who are little motivated to consider their future careers, will benefit from competent attention.

The materials lend themselves to both individual and group applications. They may be used in individual counseling, in school settings as a component of an ongoing advising or career development program, or as an instructional unit in the regular classroom. Individual or small group interpretation may facilitate students in identifying diverse ways of realizing an occupational goal, such as nursing, teaching nursing, or becoming a nursing administrator.

Lower reliabilities for interest measurement at middle school ages suggest that the KCS is best used to develop or clarify an occupational self-concept or to prioritize several possible career paths. In high school, the KCS supports more refined career exploration such as making plans for a college major and selecting valid occupational possibilities. At the college level, the inventory may be used with individuals who have not chosen a major field of study or with those who need to replace an unsatisfactory choice. Among adults, the KCS may suggest career possibilities to replace a lost job or to suggest more satisfying occupational roles.



## Kuder Career Clusters

Kuder Career Cluster scales may appear on the surface to be homogeneous types of interest scales. In fact, they are criterion group scales formed from clusters of related occupations from a pool of employed adults, roughly representing the breadth of career opportunities in the United States. The KCS is scored for six clusters, corresponding to the well-known Big Six interest dimensions: Outdoor/Mechanical, Science/Technical, Arts/Communication, Social/Personal Services, Sales/Management, and Business Operations. Scales customized to other schema, such as the States' 16 Clusters, have been constructed as well. Clusters are presented on-screen in rank order of their percentile scores, based on a general norm group of 8,791 males and females from middle school to adult. It is suggested that users give primary consideration to their top two ranking clusters.

## Person Match

Person Match compares the activity preference profile of the inventory taker with those of each of the individuals in the Person-Match Pool and selects by means of correlational analysis the individuals who are most similar. The yield may be of persons all in the same occupational field, although with differing job titles, or it may consist of individuals in several occupations. Nevertheless, all of the people involved, the interest inventory taker and the person matches, all have relatively similar reported interests.

## Job Sketches

If a person's similarity to another person is the fundamental information yielded by the KCS, that information must be more fully developed than a simple job title. Thus, inventory takers are provided with job sketches of their top matches. In general, these sketches offer a first-person account of what the individual does at work, sources of satisfaction and dissatisfaction, previous occupations, and plans for the future. The job sketches are far from uniform, emphasizing aspects that have personal meaning to the incumbent and presumably engaging the interest of the inventory taker in the possibility of the represented career.

Although no empirical test of the utility of job sketches compared to occupational titles from other interest assessments has been undertaken, their potential value is underscored by the proliferation of books offering interview materials with satisfied workers.

The text of the report for the KCS contains many links to information that elaborates the content of the on-screen report. Users may click on any cluster to obtain a definition of that cluster or click on any job title to open the corresponding entry in the *Occupational Outlook Handbook*, which offers additional information such as income levels, the employment outlook, and links to college majors, financial aid, and the like.

Further technical details and psychometrics of the KCS are available in the user manual available at [www.Kuder.com](http://www.Kuder.com).

## Interpretation

Users of interest inventories often are heard to say, "The test says I should be a . . . ." In the case of the KCS, the test says two things, but never as a *should*. One is activity preferences, which might be best represented as, "Your top preference appears to be (name of highest-ranking Kuder cluster), and your next preference is (name of second-ranking cluster)." The other concerns person matches, about which the counselor may say, "You have interests like those of . . ." naming several job titles (all of which may or may not be in the same occupation) and "You really can learn a lot about yourself by giving their job sketches a reading." Emphasis should always be given to the theme, "These people like the same things you like; they are similar to you," and followed up, "Why don't you see what else you can find out about their careers?"

Donald G. Zytowski

**See also** Campbell Interest and Skill Survey (v4); Career Counseling (v4); Career Counseling in Colleges and Universities (v4); Career Counseling in Schools (v4); Career Education (v4); Career Occupational Preference System (v4); Jackson Vocational Interest Inventory (v4); Kuder, Frederic (v4); Person Matching (v4); Unisex Edition of the ACT Interest Inventory (v4)

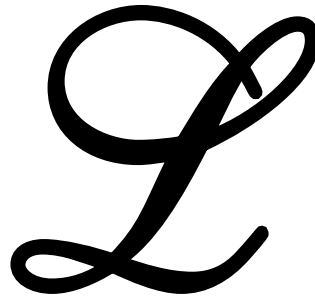
## Further Readings

Zytowski, D. G. (2006). *Kuder Career Search, user manual*. Adel, IA: Kuder. Retrieved from <http://www.kuder.com/PublicWeb/kcs.aspx>

## Web Sites

Kuder Career Planning System: <http://www.Kuder.com>





---

## LIFE-ROLE BALANCE

---

Life-role balance refers to the construction of a desired life structure that reflects a person's own definition of a balanced life. Work occurs within a person's overall life structure, and addressing this basic fact in career theory and practice fosters life-role integration or balance. Helping clients clarify their desired life structure and empowering clients to move toward life-role participation that reflects their definition of a balanced life is an increasingly important component of the career intervention process. When career practitioners help clients examine how their involvement in multiple life roles provides a sense of meaning and identity, they provide holistic career assistance that reflects life as people live it and increases the probability of living a life in balance.

### Challenges to Life-Role Balance

Changes in the nature of work, the influence of technology, demands created by dual-career parenting or single parenting, and lifelong learning requirements represent some of the challenges confronting contemporary workers. Workers today also work longer and earn less than their counterparts did several decades ago. Many workers experience heightened anxiety about the prospect of being laid off from work as record downsizing occurs throughout the world. Technological advances also displace many workers and often make it necessary to work more hours.

These are not benign challenges confronting adults. For example, in Japan the second leading

cause of death, after cancer, is referred to as *karoshi*, which is defined as death from overwork. Overwork is not gender biased. Many women report a lack of family time as their greatest concern. Many dual-career parents experience conflict trying to find time to express their work and family commitments. The stress associated with such conflict often creates marital tension with negative outcomes for family systems. Managing decisions about life-role participation can become overwhelmingly complex in the face of such challenges.

Unfortunately, career practitioners and theorists tend to operate as if lives are lived in compartmentalized silos. Choices regarding work are conceptualized as if they occur in isolation from other domains in a person's life. This approach represents a false scenario and is ineffective practically and theoretically. It fosters life-role conflict rather than life-role integration and balance.

### Acknowledging Life-Role Interactions in Career Development

When practitioners and theorists acknowledge the challenges to achieving a balanced life, they begin to approach career as it is lived. They link career development with human development and embrace the fact that there are few things more personal than a career choice. This fact raises an important point concerning life-role balance: defining a balanced life occurs at the level of the individual.

Defining what constitutes a balanced life, or a satisfying life structure, requires substantial self-awareness. Being aware of which life roles are important and



which are peripheral helps to prioritize time and commitments. It is essential to effective time management, which is a core skill related to achieving a balanced life.

Knowing which life roles are important in the present, however, is insufficient. Knowing which life roles will be important in the future helps guide the planning behavior of children and adolescents. Because life-role self-concepts evolve over time, adults must also maintain a high level of self-awareness pertaining to which life roles are most salient in the present and which are likely to be most salient in the future.

Thus, a prerequisite to achieving life-role balance is developing crystallized life-role identities. The crystallization process commences with the beginning of life as infants are exposed to multiple learning experiences (e.g., having nurturing parents vs. less nurturing parents, engaging in enjoyable leisure activities, experiencing success as a learner) and continues throughout life as adult life-role identities evolve.

People are exposed to life-role models in the home, community, school, and workplace. The accumulation of life-role experiences leads to general life-role beliefs (e.g., “lifelong learning is essential”) and self-referent life-role beliefs (e.g., “I enjoy participating in competitive team sports”). These cumulative learning experiences reflect numerous interactions between the person and the environment and shape four significant aspects of life-role identity development. Specifically, these are (1) role expectations, (2) role conceptions, (3) role acceptance, and (4) role performance.

Role expectations are the historical and cultural prescriptions that are generally assigned to a role (e.g., the role of *worker* in the United States in the 1800s was defined very differently than it is defined today in the United States). Role conceptions involve the way in which people actually perceive or interpret the role-related expectations (e.g., to be a “good” parent, I need to be a good provider, behave in a nurturing way to my children, and be fair and consistent in disciplining my children). At times, people can inherit, from society and/or from the family, role conceptions that can become dysfunctional (e.g., “I would love to be a stay-at-home father, but that is not a role that is acceptable for men”). Role acceptance involves the willingness of the individual to become involved in the role. Role performance involves the actual behavior of the individual in the role situation. Collectively, these aspects of life-role identity

development influence whether a person moves toward or away from participating in a specific life role and guide the person in constructing a balanced life structure. Understanding a person’s life-role beliefs fosters a deeper understanding of a person’s motivation, goals, and obstacles relative to life-role behavior and life-role balance.

In this sense, it is important to note that life roles are enacted rather than occupied because life roles reflect interactions among personal determinants, situational determinants, and societal expectations as well as the individual’s expression of those expectations. Occupying a role suggests that roles are fixed positions that are stagnant and rigid, a description that is not the case. Two individuals can enact the same life role differently because of their unique contexts. Finding outlets for expressing one’s life-role self-concepts is essential for experiencing satisfaction in life. Although temporary departures from what the individual defines as a balanced life are normative, extended deviations are problematic. Thus, managing one’s life structure in a way that is consistent with one’s values becomes an essential career development task for career and life satisfaction.

### **Career Interventions to Address Life-Role Identity Development**

Career interventions that address life-role identity emerge from the work of Donald Super. Values clarification activities provide a starting point for achieving an acceptable level of life-role balance. Beyond values assessment, Super used the life career rainbow to help clients examine their life-role behavior in the past, present, and future. Individuals can use the rainbow to plot their previous and current life-role activities. They can discuss the values they seek to express in each life role and their level of satisfaction with their current life-role activities. Future scenarios can also be clarified as individuals identify future life roles they hope to participate in and the values they hope to express in those life roles. The rainbow also highlights the fact that various personal (e.g., values, needs, and interests) and situational determinants (e.g., community, school, and social policies) influence when and how people play particular life roles.

Constructing a family genogram can be a useful strategy for exploring the interaction between family background, cultural prescriptions, and career planning. The family genogram provides the opportunity



to focus on the career and life-role beliefs passed down through the generations. This information can also be used to contrast influences on life-role salience emanating from group-oriented cultures with influences from more individualistic cultures. The effects of sex-role stereotyping on life-role salience can also be examined in these discussions. The goal of this intervention is to increase awareness as to the factors influencing peoples' beliefs about the primary roles of life.

Career practitioners can also help their clients explore life-role participation by encouraging them to consider questions such as the following: How do I spend my time during a typical week? How important are the different roles of life to me? What do I hope to accomplish in each of the life roles that will be important to me in the future? What do my family members expect me to accomplish in each life role? Answers to these questions help clients consider behavioral, affective, and cognitive dimensions of life-role behavior.

Collectively, these interventions help clients acquire an understanding of their life structure. This understanding then becomes the catalyst for constructing a desired life structure that increases the probability of living a balanced life as each person defines it.

*Spencer G. Niles*

**See also** Career Interventions (v4); Career/Life (v4); Job Satisfaction and General Well-Being (v4); Job Sharing (v4); Parenting (v1); Part-Time Work (v4); Stress (v2); Stress Management (v2); Super, Donald Erwin (v4); Super's Theory (v4); Work–Family Balance (v4); Work Stress (v4)

### Further Readings

- Allport, G. W. (1963). *Becoming: Basic considerations for a psychology of personality*. New Haven, CT: Yale University Press.
- Niles, S. G. (1998). Developing life-role readiness in a multicultural society: Topics to consider. *International Journal for the Advancement of Counseling*, 30, 79–87.
- Niles, S. G., Herr, E. L., & Hartung, P. J. (2002). Adult career concerns in contemporary society. In S. G. Niles (Ed.), *Adult career development: Concepts, issues, and practices* (3rd ed.). Tulsa, OK: National Career Development Association.
- Super, D. E., Savickas, M. L., & Super, C. M. (1996). The life-span, life-space approach to careers. In D. Brown & L. Brooks (Eds.), *Career choice and development: Applying contemporary theories to practice* (3rd ed., pp. 121–178). San Francisco: Jossey-Bass.

## LOFQUIST, LLOYD HENRY (1917–1996)

Lloyd Henry Lofquist was more than the prototypical University of Minnesota–trained psychologist—he devoted the greater part of his life to the university and to the field of counseling psychology. Born in Minneapolis in 1917 into a tradesman's family, Lofquist spent his entire life in the Minneapolis–St. Paul, Minnesota, area, except for the period 1942–1946 when he was abroad in the military where he earned the rank of captain and a bronze star. For 2 of those years, 1943–1945, Lofquist was a psychologist in the Personnel Branch of the U.S. Army's Adjutant General's Office and applied the counseling and personnel skills he had learned while completing his master's degree in 1941 at the University of Minnesota, one year after completing his B.A., also at Minnesota.

When Lofquist returned from World War II, he took a position as Counseling Psychologist at the Minneapolis Veterans Administration hospital, where he rose to become its chief while at the same time completing his Ph.D. at Minnesota in 1955. In that year, his graduate adviser, Donald G. Paterson, the architect of applied psychology, recruited Lofquist to return to the Minnesota Psychology Department to become the head of its new Counseling Psychology Program, which focused on vocational rehabilitation counseling and vocational psychology.

Shortly after Lofquist arrived back at his alma mater, he secured a 2-year research grant from the then U.S. Office of Vocational Rehabilitation for a follow-up study of rehabilitation counselees, which then resulted in funding the Work Adjustment Project from 1959 through 1972. It was this project, in conjunction with working with his colleagues George W. England, René V. Dawis, and David J. Weiss that gave rise to the theory of work adjustment and to an empirical research program that lasted 30 years.

Lofquist's research productivity, all focused on vocational psychology and work adjustment, consisted of 15 published journal articles, five books, and 49 book chapters and research monographs. While on the University of Minnesota faculty, from which he retired in 1989, Lofquist served as the Co-Principal Investigator of the Work Adjustment Project for its entire existence and as the first Director of the Counseling Psychology Program; at the same time, Lofquist was also responsible for beginning and



managing for many years the Department's Rehabilitation Counseling Graduate Student Training Grant and for founding (with René V. Dawis) the University's Vocational Assessment Clinic, which today still provides vocational counseling services based on the theory of work adjustment to Minnesota residents.

Like many Minnesota-trained psychologists, Lofquist's professional activities included a balance of theory, research, and applications. In addition to these professional accomplishments, Lofquist found time to serve the university as well—he was Associate Dean of the College of Liberal Arts from 1967–1970, Associate Vice President for Academic Affairs from 1970–1973, and Chair of the Department of Psychology from 1975–1985. His contributions to the field of vocational psychology, through the theory of work adjustment and the research and instruments that it spawned, continue to influence the field through his many former graduate students, their students, and future generations of students.

David J. Weiss

*See also* Dawis, René Villanueva (v4); Minnesota Importance Questionnaire (v4); Person–Environment Fit (v4); Theory of Work Adjustment (v4); Trait-Factor Counseling (v4)

### Further Readings

- Dawis, R. V., England, G. W., & Lofquist, L. H. (1964). A theory of work adjustment. *Minnesota Studies in Vocational Rehabilitation* (No. XV). Retrieved from <http://www.psych.umn.edu/psylabs/vpr>
- Dawis, R. V., & Lofquist, L. H. (1984). *A psychological theory of work adjustment*. Minneapolis: University of Minnesota Press. Retrieved from <http://www.psych.umn.edu/psylabs/vpr/twa1.htm>
- Dawis, R. V., & Lofquist, L. H. (1993). From TWA to PEC. *Journal of Vocational Behavior*, 43, 113–121.
- Lofquist, L. H., & Dawis, R. V. (1984). Research on work adjustment and satisfaction: Implications for career counseling. In S. D. Brown & R. W. Lent (Eds.), *Handbook of counseling psychology* (pp. 216–237). New York: Wiley.
- Lofquist, L. H., & Dawis, R. V. (1991). *Essentials of person-environment-correspondence counseling*. Minneapolis: University of Minnesota Press.





---

## MINNESOTA IMPORTANCE QUESTIONNAIRE

---

The Minnesota Importance Questionnaire (MIQ) is a measure of work needs and work values. Work needs are a person's requirements for satisfaction in work. Job satisfaction results when the conditions in work (work reinforcers) correspond to one's work needs.

The MIQ measures work needs by asking the person how important the following 20 work reinforcers are to one's job satisfaction: ability utilization, achievement, activity, advancement, authority, company policies and practices, compensation, coworkers, creativity, independence, moral values, recognition, responsibility, security, social service, social status, supervision—human relations, supervision—technical, variety, and independence.

Work values are basic dimensions of what is important to the person. Work values underlie work needs and are measured from them. The MIQ measures these six work values:

1. achievement—the importance of using one's abilities and having a sense of accomplishment;
2. altruism—the importance of harmony with, and being of service to, others;
3. autonomy—the importance of being independent and being in control;
4. comfort—the importance of being comfortable and avoiding distress;

5. safety—the importance of predictability, stability, and order; and
6. status—the importance of recognition, prestige, and being important.

The MIQ is a self-report questionnaire that is available in two forms. In the Paired Form, each need is paired with every other need, and the respondent picks the need in each pair that is the more important. Most respondents complete this form in 30 to 40 minutes. In the Ranked Form, needs are presented in blocks of five, and the respondent rank orders the five needs within each block according to importance. This form requires a 21st need: autonomy. This form is usually completed in 15 to 25 minutes.

The MIQ is appropriate for persons who read at the fifth-grade level or higher. Test materials and manuals are available from the MIQ's publisher, Vocational Psychology Research, University of Minnesota. The *MIQ Manual* provides information needed for test administration, score interpretation, and counseling use of the MIQ. A more technical manual that details the research about the development of the MIQ is also available. A Spanish-language MIQ is available.

Scoring services are provided by Vocational Psychology Research. The MIQ Report lists the respondent's need and value scores and presents the scores in a profile. A validity score—consistency of response—is included.

The MIQ Report also details how well the respondent's work needs correspond to the work reinforcers present in various occupations as estimated by



supervisors or incumbents in these occupations. The Standard MIQ Report gives correspondence information for 90 benchmark occupations representative of the full occupational range. The Extended MIQ Report provides the same information for 185 occupations. For each occupation, a prediction is made of the likelihood that the respondent will be satisfied in the occupation.

*René V. Dawis*

*See also* Lofquist, Lloyd Henry (v4); Person–Environment Fit (v4); Person Matching (v4); Theory of Work Adjustment (v4); Trait-Factor Counseling (v4); Values Scale (v4); Work Values (v4)

### Further Readings

Rounds, J. B., & Armstrong, P. I. (2005). Assessment of needs and values. In S. D. Brown & R. W. Lent (Eds.), *Career development and counseling: Putting theory and research to work* (pp. 305–329). Hoboken, NJ: Wiley.

---

## MULTICULTURAL CAREER ASSESSMENT MODELS

---

Career assessment involves an ongoing process of gathering information to assist clients to make career-related decisions. Useful information to gather in career assessment includes but is not limited to understanding a person's personality, values, skills, interests, life roles, and career history. Assessment information is typically gathered via intake interviews, standardized tests and inventories, and non-standardized methods such as card sorts, career genograms, and career lifelines. The data that are obtained can be used to inform both the career counselor and the client and to help set appropriate goals and strategies for achieving the goals in career counseling. Multicultural career assessment incorporates information about the client's cultural background such as race, ethnicity, gender, social class, and sexual orientation and uses this information to understand how these factors may have shaped one's career development. In essence, in contrast with traditional career assessment, the cornerstone of multicultural career assessment is understanding a person's career issues within a cultural context.

Recent advancements in area of career assessment with culturally diverse groups are apparent in the growth of multicultural career counseling models and multicultural career assessment models that have been formulated. An integral element to effective career counseling with culturally diverse individuals includes accurate and valid career assessment. Several models and frameworks have been developed to guide the career assessment process and to understand the career needs of culturally diverse individuals. Some of these models, which are described below, have focused solely on assessment, while others have attended to assessment issues within the context of career counseling with culturally diverse clients.

### Healy's Career Appraisal Model

Healy's model served as one of the early forerunners of career counseling models that incorporated cultural variables. Healy criticized traditional career models for the hierarchical counselor–client relationship and the lack of emphasis on environmental barriers in the implementation of career goals. As an alternative to the traditional approaches, Healy proposed a reformed career appraisal model that explicitly recognized contextual issues. Furthermore, this model advocated for collaboration with clients, empowerment of clients to take an active role in their career development, and follow-up with clients to help them implement goals.

### Career Assessment Models for African American Clients

In this model from Swanson and Bowman, four steps for tasks and decisions for the career assessment of African Americans were outlined. The four steps include establishing rapport, choosing a formal assessment process, determining the type of assessment and assessment instrument, and providing an effective test interpretation by emphasizing the counselor's experience.

### Career Assessment Models for Racial/Ethnic Minority Women

Feminist theories highlight the importance of understanding the impact of sexism and the oppression of women's lives. These feminist tenets have served as a foundation for the development of career assessment



models for women of color, whereby the influence of gender socialization and social barriers in the career development of women are emphasized and acknowledged. One approach to career assessment by Forrest and Brooks identifies four important aspects of this process that are grounded in feminist ideology. First, the client and the counselor are considered equal. Second, an awareness of sociocultural conditions that have limited women's experiences and opportunities is critical, and these factors contribute to women's career problems. Third, women must understand how these career problems affect their own social, economic, and political environment. Finally, the goal of feminist therapy is to enable women to be independent, which is essential for their mental health.

Feminist writers have also emphasized the role of client-generated information in counseling. Ward and Bingham offered a framework for the career assessment of ethnic minority women using the clinical interview as the primary assessment tool. They recommended that the career counselor do additional preparation before encountering a diverse client and needs to continuously work on establishing rapport throughout counseling. In addition, counselors should assess the impact of the culture, family influences, racial/ethnic issues, and finances of the client that are presenting concerns. The counselor may prepare for working with culturally diverse clients by using the Multicultural Career Counseling Checklist for Counselors, which was designed to encourage counselors to assess personal multicultural counseling competencies.

Later, Bingham and Ward incorporated the assessment of self-efficacy variables in addition to general cultural variables such as worldviews and structure of opportunity and gender variables as important areas of assessment with women of color. Incorporating this information with data obtained through traditional career assessment variables, such as career interests and work values, comprises the core components of Bingham and Ward's career assessment model.

### **Culturally Appropriate Career Counseling Model**

Fouad and Bingham developed the culturally appropriate career counseling model (CACCM) because mainstream theories did not mention cultural factors and offered minimal attention to factors related to career assessment with racial/ethnic minorities. The

assessment component of the model proposes the appraisal of five spheres that affect career issues, including the individual, gender, family, racial or ethnic group, and dominant group. Relevant constructs within each sphere that are expected to influence career should be evaluated. For example, personality, gender roles, family expectations, cultural values, and structural barriers are variables that may be considered for each of the respective spheres. This model is unique because it incorporates culture into every phase of the career counseling process, including career assessment. Assessing how multiple factors may affect the career self-efficacy, interests, options, and decision making of culturally diverse individuals is important because each of these realms is believed to have unique effects on individual career choices.

Recently, the concept of metacognitive awareness was integrated to the CACCM to explicitly address the counselor's cultural context. Specifically, active engagement in a self-reflective process, or metacognition, is believed to help counselors to maximize their ability to evaluate and address personal cultural backgrounds when working with culturally diverse clients.

### **Integrative-Sequential Framework**

This framework by Leong and Hartung includes five stages for assessing career concerns: (1) the emergence of career and vocational problems, (2) help-seeking and career service utilization behaviors, (3) evaluation of career and vocational problems, (4) career interventions, and (5) outcomes of career interventions. This model is distinct from prior frameworks because it includes defining the client's problem in a cultured context; and by doing so, it highlights the transition from identifying the problem to utilizing career counseling services.

### **Culturally Appropriate Career Assessment Model**

The culturally appropriate career assessment model, developed by Flores, Spanierman, and Obasi, consists of four interrelated steps for evaluating career clients: gathering culturally encompassing information, selecting culturally appropriate career assessment instruments, administering culturally sensitive instruments, and interpreting data in a culturally appropriate manner.



## Future Directions

Many of the current career assessment models point to the importance of understanding personal variables that influence career development. Multicultural career assessment models look beyond person variables and take into account the context and environmental variables that affect career decisions and career development. Current multicultural models also suggest that one theory or technique may not be suitable or culturally valid to all clients. In other words, a general approach to assessment with all clients disregards relevant factors affecting the career issues of culturally diverse clients. Important environmental and contextual factors include an individual's family influence, cultural background, racial/ethnic identity, acculturation, socioeconomic status, gender role expectations, worldview, environmental factors including societal barriers, and perceived personal strengths. These factors aid in the career assessment process by helping the client identify factors that may contribute to or influence his or her thoughts, feelings, or actions in the career development process. It is important for career counselors to be aware of their own perceptions and beliefs about environmental factors that influence their own lives to prevent these from biasing their understanding of the concerns experienced by their culturally diverse clients.

Investigating the validity of current measures in use for research and practice has been one of the major thrusts in the recent past. The issue of whether career assessments need to be culturally valid or culturally specific remains a question for future multicultural career assessment research and practice. To continue to advance the area of multicultural career assessment, research is needed to examine whether these multicultural career assessment models are effective with culturally diverse clients.

*Lisa Y. Flores, Monique M. Mendoza,  
and Elif Celebi*

**See also** Cultural Accommodation and Negotiation (v3); Cultural Values (v3); Culture (v3); Culture-Free Testing (v3); Decision Making (v4); Ethnic Identity (v3); Multicultural Career Counseling Checklist (v4); Multicultural Counseling (v3); Multicultural Counseling Competence (v3); Multiculturalism (v3); Multicultural Personality (v3); Multicultural Psychology (v3); Racial Identity (v3)

## Further Readings

- Bingham, R. P., & Ward, C. M. (1994). Career counseling with ethnic minority women. In W. B. Walsh & S. H. Osipow (Eds.), *Career counseling for women*. (pp. 165–195). Hillsdale, NJ: Lawrence Erlbaum.
- Bingham, R. P., & Ward, C. M. (1997). Theory into assessment: A model for women of color. *Journal of Career Assessment*, 5, 403–418.
- Byars-Winston, A. M., & Fouad, N. A. (2006). Metacognition and multicultural competence: Expanding the culturally appropriate career counseling model. *Career Development Quarterly*, 54, 187–200.
- Flores, L. Y., Spanierman, L. B., & Obasi, E. M. (2003). Ethical and professional issues in career assessment with diverse racial and ethnic groups. *Journal of Career Assessment*, 11, 76–95.
- Forrest, L., & Brooks, L. (1993). Feminism and career assessment. *Journal of Career Assessment*, 3, 233–245.
- Fouad, N. A., & Bingham, R. P. (1995). Career counseling with racial and ethnic minorities. In W. B. Walsh & S. H. Osipow (Eds.), *Handbook of vocational psychology: Theory, research, and practice* (pp. 331–365). Hillsdale, NJ: Lawrence Erlbaum.
- Healy, C. C. (1990). Reforming career appraisals to meet the needs of clients in the 1990s. *The Counseling Psychologist*, 18, 214–226.
- Leong, F. T. L., & Brown, M. T. (1995). Theoretical issues in cross-cultural career development: Cultural validity and cultural specificity. In W. B. Walsh & S. H. Osipow (Eds.), *Handbook of vocational psychology: Theory, research, and practice* (pp. 331–365). Hillsdale, NJ: Lawrence Erlbaum.
- Leong, F. T. L., & Hartung, P. (1997). Career assessment with culturally different clients: Proposing an integrative-sequential conceptual framework for cross-cultural career counseling research and practice. *Journal of Career Assessment*, 5, 183–202.
- Swanson, J. L., & Bowman, S. L. (1994). Career assessment with African-American clients. *Journal of Career Assessment*, 2, 210–225.
- Ward, C. M., & Bingham, R. P. (1993). Career assessment of ethnic minority women. *Journal of Career Assessment*, 1, 246–257.

---

## MULTICULTURAL CAREER COUNSELING CHECKLIST

---

As societies, especially in the United States, have become more diverse, counselors are expected to be



able to deliver competent services to a wide variety of clients. Such competency concerns call for measures that facilitate professionals collecting and managing the data needed for meaningful and successful interventions in cross-cultural career counseling. The Multicultural Career Counseling Checklist (MCCC) is a 48-item precounseling instrument designed for counselors to use as they prepare to see a client who is seeking career counseling and is especially valuable if the client is of a different race or ethnicity from the counselor. The MCCC was designed by Connie Ward and Rosie Phillips Bingham to assist counselors during initial interventions with ethnic and racial minority clients. The instrument is arranged in three sections: Counselor Preparation, Exploration and Assessment, and Negotiations and Working Consensus.

First, the counselor completes the sections under the heading of Counselor Preparation. The questions are designed to help the counselor focus on issues of the counselor's worldview, racial identity development, socioeconomic status, and political views. The section also asks counselors to review their general knowledge of and stereotypes about the client's ethnic or racial group.

Under Exploration and Assessment the counselor is challenged to conceptualize the client's presenting career questions. This section prods the counselor to sort through the cultural and familial issues that might be interacting with basic career concerns. The counselor must further explore the extent to which the client has already been exposed to career exploration material and role models. These aforementioned steps enable the counselor to determine the appropriate intervention and whether or not the intervention should focus on traditional career intervention methods, familial concerns, self-efficacy questions, or issues of societal structural barriers such as sexism and racism.

The third section on Negotiations and Working Consensus enables the counselor to reflect on the extent to which the client has been involved in framing the presenting career issue. One statement directly addresses whether or not the client and counselor have agreed on that career question. Furthermore, the counselor is challenged to make sure that he or she understands the client's career aspirations, expectations, and level of confidence. The section ends with statements regarding the type of career assessment instrument the counselor will use while working with the client.

The MCCC is a simple and straightforward self-analysis instrument that requires no specialized training beyond that acquired in most appropriate graduate programs. Practitioners, educators, and students can use this instrument to assess their deficits or questions around multicultural career counseling as well as provide a map to better understanding career issues for diverse clientele.

*Rosie P. Bingham*

**See also** Cultural Accommodation and Negotiation (v3); Cultural Values (v3); Culture (v3); Culture-Free Testing (v3); Diversity Issues in Career Development (v4); Multicultural Career Assessment Models (v4); Multicultural Career Counseling Checklist (v4); Multicultural Counseling (v3); Multicultural Counseling Competence (v3); Multiculturalism (v3); Multicultural Personality (v3); Multicultural Psychology (v3)

### Further Readings

- Bingham, R. P. (2000). Multicultural career counseling: Awareness, knowledge, and skills for the changing face of the work place. In J. M. Kummerow (Ed.), *New directions in career planning and the workplace* (2nd ed., pp. 247–271). Palo Alto, CA: Davis-Black.
- Ward, C. M., & Bingham, R. P. (1993). Career assessment of ethnic minority women. *Journal of Career Assessment*, 1(3), 246–257.

---

## MY VOCATIONAL SITUATION SCALE

---

The My Vocational Situation (MVS) scale is a self-report screening tool developed for use with high school, college, and adult career counseling clients. The MVS was authored by John L. Holland, Denise Daiger, and Paul G. Power. After a 10-minute administration time, it provides information on clients' vocational identity status, knowledge of career information, and applicable career barriers.

The majority of the inventory is comprised of the Vocational Identity subscale, which is made up of 18 true and false items. Vocational identity is one of the secondary constructs within Holland's popular theory of careers and defined as stable and clear goals, interests, and abilities. The MVS also includes an Occupation Information subscale, which assesses for



lack of vocational training or knowledge of career information through 4 yes or no items. The third subscale, Barriers, is a 4-item yes or no scale that assesses for environmental and personal barriers related to career decision making.

The results from the three scales can be used to determine if a client's difficulty in the career development process stems from low vocational identity, a lack of appropriate information, multiple barriers to his or her goals, or a combination of these issues. The results can inform the interventions that a career counselor may use with a client. Scores are based on the sum of all *false* and *no* answers. Therefore, higher scores on this measure are positive, indicating more stable vocational identity.

The norm group for the MVS comprises just over 1,000 individuals, including high school students, college students, full-time workers, and a few graduate students and university faculty. The test authors admit that the normative data were gathered haphazardly. The Vocational Identity Scale has the most acceptable psychometric properties, with some rather questionable reliability data reported for the other two scales. Some validity evidence is available for the MVS. This evidence is most inconsistent for the Occupational Information and Barriers subscales. Therefore, the reliability and validity evidence does not support the use of the Occupational Information and Barriers subscales to make decisions about individuals' career development status.

The MVS is published and available for purchase through Consulting Psychologist Press in its paper and pencil form. It is available for purchase in computerized format from Psychological Assessment Resources when bundled with the Self-Directed Search.

Emily E. Bullock

**See also** Assessment (v4); Career Barriers Inventory (v4); Career Counseling (v4); Holland, John L. (v4); Holland's Theory of Vocational Personalities and Work Environments (v4); Occupational Information (v4); Vocational Identity (v4)

### Further Readings

- Holland, J. L., Gottfredson, D. C., & Power, P. G. (1980). Some diagnostic scales for research in decision making and personality: Identity, information, and barriers. *Journal of Personality and Social Psychology*, 39, 1191–1200.
- Lunneborg, P. W. (1985). Test review of the My Vocational Situation. In J. V. Mitchell, Jr. (Ed.), *The ninth mental measurements yearbook*. Retrieved June 6, 2007, from the Buros Institute's *Test Reviews Online*: <http://www.unl.edu/buros>
- Westbrook, B. W. (1985). Test review of the My Vocational Situation. In J. V. Mitchell, Jr. (Ed.), *The ninth mental measurements yearbook*. Retrieved June 6, 2007, from the Buros Institute's *Test Reviews Online*: <http://www.unl.edu/buros>





---

## NARRATIVE CAREER COUNSELING

---

Narrative career counseling represents a shift from the 20th-century focus on objective interventions for career decision making toward a 21st-century concern for interpretive approaches. It is sited in postmodern developments where previous grand theories overemphasize either social structures (e.g., Marxism) or individual psychology (e.g., psychoanalysis). Narrative career counseling moves away from a scientific approach that is exemplified by the matching of relatively static personality traits with job factors. Narrative approaches recognize that as dynamic social actors individuals speak, act, and interpret events through their particular contexts and cultures. In other words, it views career decision making as a holistic process, recognizing that the career story is shaped by the increasing complexities of life in a diverse social world.

To assist individuals make career decisions, many narrative practitioners use techniques that seek to reveal life-career themes. By focusing on aspects such as key events, early memories, favorite characters from stories, and role models, the stories that are re-collected give an indication of the dominant themes that are the preoccupations for the individual. This process situates the self as the main character in the story, where individual meaning rather than historical fact is placed in the foreground. The aim is to develop the story by recognizing the themes, exploring the related career interests, and helping the individual to draft future possibilities. Narrative approaches recognize

that as part of the sequence of moving from the past and present to the future, a period of indecision is necessary where potential career ideas can be tested. It is the action taken in the testing and enactment stages that moves the story on; without this action, the approach could be stuck in reflective storytelling. This approach provides a reality-testing element where the potential new story is evaluated in regard to its fit with the rest of the individual's life and includes recognizing the part that significant others play in career decision making.

The approach is empowering since the individual takes an active part in defining career roles that fit into his or her own understanding of meaningful life events. It provides a telling way of assessing an individual's career counseling needs, revealing more than objective assessment methods. Many practitioners will incorporate objective methods at a later stage, once the individual has developed a self-concept. Inevitably what the person recounts when telling his or her story is subjective, but life is subjective and people understand their own experience and that of others through the medium of storytelling. Such subjective exploration leads to the identification of goals and actions that are more meaningful for the individual and consequently more likely to be successful.

*Hazel L. Reid*

*See also* Assessment (v4); Career Counseling (v4); Career Counseling in Schools (v4); Career Counseling Process (v4); Career Style Interview (v4); Constructivist Theory (v2); Personality Assessment and Careers (v4)



### Further Readings

- Cochran, L. (1997). *Career counseling: A narrative approach*. Thousand Oaks, CA: Sage.
- Savickas, M. L. (2005). The theory and practice of career construction. In S. D. Brown & R. W. Lent (Eds.), *Career development and counseling: Putting theory and research to work* (pp. 42–70). Hoboken, NJ: Wiley.

---

## NATIONAL CAREER DEVELOPMENT ASSOCIATION

---

The National Career Development Association (NCDA) is the oldest nonprofit counseling professional organization in the United States. Its mission is “to promote the career development of all people over the life span.” It currently has about 4,000 members that include career counselors, consultants, counselor educators, students, and career service providers such as career development facilitators (CDF), career coaches, and human resource personnel. The following describes the history and governance, professional services, and future directions of the organization.

### History and Governance

NCDA was established in 1913 as the National Vocational Guidance Association and changed to its current name in 1985. It is one of the founding divisions of the American Counseling Association (ACA). There are four individual membership categories: regular (joining NCDA directly), professional (joining through ACA), student or new professional, and retiree. In addition, three special membership categories recognize individual members who (a) have made significant contributions to the field of career development (Fellows), specialize in career counseling (Master Career Counselors), or specialize in career development services (Master Career Development Professionals). Professional organizations in other countries with missions similar to NCDA’s can join as international affiliates.

NCDA’s members have the authority to elect officers and vote for major decisions such as bylaws changes. The executive body is the board of directors comprising elected officers including the president, president-elect, past-president, secretary, treasurer, ACA governing council representative, two trustees-at-large, and four regional trustees. Day-to-day

operations are handled by the NCDA headquarters, which include an executive director and several staff members. There are more than 30 committees or task forces that implement special projects of the organization. Finally, there are 28 state career development associations that have a similar mission as NCDA, and their bylaws are approved by NCDA.

### Professional Services

NCDA provides a variety of professional services to its members, nonmember professionals and students, the general public, and international entities. These services include (a) professional community and networking (conferences, newsletter, Web site, electronic forums, mentoring program, international collaborations); (b) professional ethics, standards, and guidelines (for practice, education, and accreditation); (c) recognitions (awards, special membership categories); (d) publications and media (journal, books, Web-based magazine, DVDs, videotapes, audiotapes); (e) professional development and training (conferences, professional development institutes, continuing education programs, CDF training); (f) research (grants and awards, research projects); and (g) public relations and advocacy (marketing, press and media, consumer guidelines, national career development month, diversity, government relations, public policy making). These services are funded by membership fees, product or service revenues, grants, donations, or contracts. Three signature products of NCDA are its official journal (*The Career Development Quarterly*), Web-based magazine (*Career Convergence*), and CDF training curriculum.

### Future Directions

Currently NCDA is heading toward the following directions: (a) multiculturalism and internationalization, (b) collaborations with other organizations, (c) social advocacy and public policy making, (d) online curriculum (e-learning) for CDF training, and (e) revising and creating professional guidelines.

*Y. Barry Chung*

**See also** Career Counseling (v4); Career Counseling Process (v4); *Career Development Quarterly* (v4); International Approaches (v4); International Association for Educational and Vocational Guidance (v4); Multiculturalism (v3); Society for Vocational Psychology (v4)



### Further Readings

Pope, M. (2000). A brief history of career counseling in the United States. *The Career Development Quarterly*, 48, 194–211.

### Web Sites

National Career Development Association: <http://www.ncda.org>

---

## NATIONAL SURVEY OF STUDENT ENGAGEMENT

---

The National Survey of Student Engagement (NSSE) obtains, on an annual basis, information from tens of thousands of students at hundreds of colleges and universities nationwide. The NSSE survey, administered during the spring academic term to randomly selected first-year students and seniors, asks about their participation in programs and activities that institutions offer for learning and personal development. The results provide an estimate of how undergraduates spend their time and what they gain from attending college.

The voluminous research on college student development shows that the time and energy students devote to educationally purposeful activities is the single best predictor of their learning and personal development. Those institutions that more fully engage their students in the variety of activities that contribute to valued outcomes of college can claim to be of higher quality compared with other colleges and universities where students are less engaged.

Survey items on NSSE represent empirically confirmed “good practices” in undergraduate education—behaviors by students and institutions that are associated with desired outcomes of college. Toward this end, NSSE asks students to report the frequency with which they participated in dozens of activities that represent good educational practices, such as interaction with faculty members and advisors, special programs, and other opportunities for learning and development that the college provides. Additional items assess the amount of reading and writing students did during the current school year; the number of hours per week they devoted to schoolwork, extracurricular activities, employment, and family matters; the nature of their examinations and coursework; and whether

they took part in a learning community, an internship, community service, study abroad, or research with a faculty member.

In addition, students report their perceptions of the college environment, such as the extent to which the institution offers the support they need to succeed academically and the quality of relationships among various groups, such as faculty and students. Students also estimate their educational and personal growth since starting college in the areas of general knowledge; intellectual skills; written and oral communication skills; personal, social, and ethical development; and vocational preparation. Students also provide information about their background, including age, gender, race or ethnicity, living situation, educational status, and major field.

Institutions receive a series of comparisons that allow them to review their performance alongside that of peer institutions, their Carnegie type, and national norms. Also, schools get a data file with their students’ responses so that they can conduct additional analyses if they have local institutional review board approval to do so.

Institutions use NSSE data to identify aspects of the undergraduate experience inside and outside the classroom that can be improved through changes in policies and programs. This information can also be used by prospective college students, their parents, college counselors, academic advisers, institutional research officers, and researchers who wish to learn more about how students spend their time at different colleges and universities and what they gain from their experiences.

*George Kuh*

*See also* Assessment (v4); Career Counseling in Colleges and Universities (v4); Career Counseling in Schools (v4); College Student Experiences Questionnaire (v4); Environmental Assessment Technique (v4); Process and Outcome Research (v4); School Counseling (v1)

### Further Readings

- Kuh, G. D. (2001). Assessing what really matters to student learning: Inside the National Survey of Student Engagement. *Change*, 33(3), 10–17, 66.
- Kuh, G. D. (2003). What we’re learning about student engagement from NSSE. *Change*, 35(2), 24–32.
- Kuh, G. D. (2005). Imagine asking the client: Using student and alumni surveys in accountability in higher education.

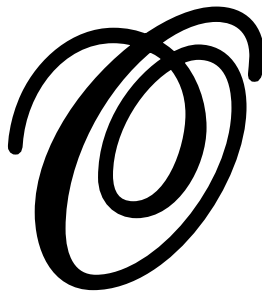


In J. Burke (Ed.), *Achieving accountability in higher education: Balancing public, academic, and market demands*. San Francisco: Jossey-Bass.

Kuh, G. D. (2007). What student engagement data tell us about college readiness. *Peer Review*, 9(1), 4–8.

National Survey of Student Engagement. (2006). *Engaged learning: Fostering success of all students*. Bloomington: Indiana University Center for Postsecondary Research. Retrieved from [http://nsse.iub.edu/NSSE\\_2006\\_Annual\\_Report/index.cfm](http://nsse.iub.edu/NSSE_2006_Annual_Report/index.cfm)





---

## OCCUPATIONAL HEALTH PSYCHOLOGY

---

The goal of occupational health psychology (OHP) is to improve the quality of work life, and to protect and promote the health of workers and of their families. OHP is interdisciplinary, involving most areas of psychology and drawing upon fields such as public health, sociology, medicine, and industrial engineering. OHP is typically characterized as having a three-fold focus on the work environment, the individual worker, and the interface between work and family. Interventions and/or research range across all three levels (primary, secondary, and tertiary) of the public health model of prevention.

### Historical Roots

In many respects, OHP grew out of efforts to understand, and later to remediate, the impact of the widespread application of Frederick Taylor's management principles on workers in both the United States and Europe. Nearly a century ago, Taylor argued that industrial productivity can be improved by simplifying, compartmentalizing, and standardizing worker tasks. Thinking about work was considered the domain of managers, while doing the work (without thinking) was the role of the mass of workers. At its most extreme, the Taylor approach aims to make workers interchangeable and the emotional responses or perceptions of workers are considered irrelevant.

Although the Taylor approach has always had detractors, particularly among organized labor, it wasn't until the 1960s that researchers began to investigate

the links between one's work life and one's physical and emotional health. Much of this seminal research was conducted in Europe, particularly in Scandinavian countries. Prominent among these efforts were Robert Karasek's studies demonstrating that workers who experience high job demands and have low decision-making latitude tend to experience poorer mental health and are at increased risk for cardiovascular disease. Researchers began focusing on ways to redesign jobs to improve worker health and satisfaction. Others investigated the impact of un- and/or underemployment on workers. Contrary to the precepts of the Taylor management approach, it is now recognized that many of the same factors associated with physical and mental health (stimulation, variety, task control, autonomy, etc.) are also associated with higher levels of job performance.

In the United States, the National Institute for Occupational Safety and Health (NIOSH) has been a leader in researching work-related stress. Although occupational safety and health often seems to concern itself only with traumatic injuries and toxic exposures, it is significant that the Occupational Safety and Health Act of 1970 that created NIOSH specifically recognized the need to investigate the role of psychological factors related to occupational safety and health. In 1990, NIOSH partnered with the American Psychological Association (APA) to fund the initial development of OHP curriculum at 12 universities in the United States. This partnership also led to a series of conferences on topics related to work organization and work-related stress. Recently, the newly formed Society for Occupational Health Psychology joined NIOSH and APA as a conference sponsor and plans



have been formalized for future conferences to be held biennially. In 1996, the partnership between NIOSH and APA also gave birth to the *Journal of Occupational Health Psychology*.

### Areas of Emphasis

As was discussed earlier, OHP can trace its roots to investigations of the impact of Taylor management principles on the emotional and physical health of workers. However, this early focus has broadened considerably in the last 25 years. During this time, there have been significant changes in the structure of work in both the United States and Europe. Many manufacturing jobs were lost and economies shifted toward service jobs. In the last 2 decades, corporate mergers and downsizing efforts left many workers needing to switch employment, if not careers, often accepting lower incomes, in their 40s and 50s—ages that previously were associated with stable employment and peak earning potential. Companies have moved away from making long-term commitments to employees, relying instead upon temporary workers and/or contractors. Correspondingly, there has been an increase in the number of self-employed people. All of these changes were accompanied by stress, both for workers losing or changing jobs and for those retaining employment, but needing to adapt to new contingencies.

### Work Organization

In addition to the structural changes discussed above, to remain competitive, many employers significantly changed management systems, supervisory practices, and production processes. Among these changes are compressed work schedules, flexible work schedules, home-based work, lean management, and an increased reliance on technology. These practices are intended to increase the ability of companies to respond quickly and efficiently to changing production demands without compromising quality. However, employees are working longer and harder and often bear greater responsibility for outcomes, though not always with increased decision-making latitude. Learning new processes and new technologies places increased cognitive demands on workers, leading to stress that has been tied to negative health effects.

### Gender

Women continue to make inroads into previously nontraditional occupations ranging from construction sites to corporate boardrooms. In addition to the stress of entering occupations whose cultures and practices have been shaped almost exclusively by men, working women must weigh the impact and timing of having children on career. Despite major changes in perceptions regarding gender roles, women continue to bear major responsibility for child rearing and household functioning, thereby increasing stress related to balancing the conflicting needs of work and family.

### Aging Workers

The workforce is aging. In part, this shift simply reflects the demographics of the baby boom and in part people working longer, either by choice or by necessity. In Europe, this shift has been driven by declining birthrates. There are simply not enough replacement workers being born. Consequently, there is great interest in keeping older workers healthy and satisfied enough to remain working. In some European countries this has been a major factor in the development of OHP. Although older workers are more reliable, bringing the wisdom and skills of decades to jobs, they also tend to be less physically robust than younger workers. They are more sensitive to changes in the work environments such as extremes of temperature and poor lighting. In instances where an older person is working in a low-level service job (to supplement retirement income), supervisors are often years younger. This can lead to stress when the older worker is subjected to stereotypes about the elderly or is held in low regard because of the unskilled nature of the work.

### Race and Ethnic Diversity

It is estimated that by the year 2050, 15% of the American workforce will be Hispanic. Areas of the United States, such as the Southeast and the Midwest, that have not traditionally been destinations for Hispanic immigrant workers have experienced explosive growth in the size of their Hispanic communities. In addition to political issues and legal consequences related to some immigrants' undocumented status, Hispanic immigrants in these "new settlement areas"



are further socially marginalized and subject to exploitation due to lack of a Spanish-speaking public and/or social services infrastructure. These immigrants tend to be employed in the least desirable, poorest paid, and most dangerous occupations, so they are at increased risk to suffer from negative health consequences. However, even when working side by side with Americans, Hispanics immigrants suffer from significant occupational health disparities. For example, Hispanic immigrants working in construction are killed at 2–3 times the rate of American-born workers performing the same jobs. Contrary to popular perceptions, less than 1% of Hispanic immigrants work as day laborers. The remainder work for companies ranging in size from small businesses to international corporations.

Within the European Union, most legal barriers to the flow of workers from one country to another have been eliminated. Consequently, more prosperous economies have seen an influx of nonnative workers. For example, Ireland, with a population of less than 5 million, has the same proportion of nonnative workers as does the United States. Whereas the United States is challenged to simply meet the needs of Spanish speakers, Ireland must attempt to overcome barriers of language and culture for a half dozen nationalities.

### Influencing Change

Although the rapidly changing world of work seems a moving target, there are many opportunities for OHP to influence change for both the employer and the individual. On the employer level, the spiraling of health insurance costs offers a strong economic argument for employers to redesign jobs and to develop interventions aimed at reducing work-related stress (and its associated illnesses). Employers also need help adjusting to an increasingly diverse workforce. On the individual level, workers are expected to take increasing responsibility for their career trajectories. Making a good initial choice of career represents solid primary prevention of work-related stress. However, many workers need assistance with adjusting to ongoing change in their jobs. Workers and employers need assistance in preventing new communication technologies from blurring the boundaries between work and home to the detriment of family life.

*Donald E. Eggerth*

*See also* Career/Life (v4); Chronic Illness (v1); Chronic Pain (v1); Community-Based Health Promotion (v1); Job Satisfaction and General Well-Being (v4); Life-Role Balance (v4); Physical Health (v2); Work–Family Balance (v4); Work Stress (v4)

### Further Readings

Quick, J. C., & Tetrick, L. E. (Eds.). (2002). *Handbook of occupational health psychology*. Washington, DC: American Psychological Association.

### Web Sites

European Academy of Occupational Health Psychology:  
<http://www.ea-ohp.org>

National Institute for Occupational Health: <http://www.cdc.gov/niosh>

Society for Occupational Health Psychology: <http://sohp.psy.uconn.edu>

---

## OCCUPATIONAL INFORMATION

---

Occupational information is one of the major components needed to make effective career decisions. Occupational information refers to the collection of details about occupational and educational opportunities. Gathering and using occupational information is essential if an individual is to select options that fit his or her interests, values, aptitudes, and skills. Occupational information can include details about the employment outlook, salary, related occupations, education and training, and job duties.

Occupational information can be classified using three types of classification systems. Classification allows individuals to communicate more effectively with students about occupations that share common characteristics. The most widely used occupational classification systems include the Standard Occupational Classification (SOC) System, Holland's Hexagon, and the World-of-Work Map (WWM). The SOC system classifies occupations based on the nature of the work performed and on the occupational skills, education, and training requirements for the job. Holland's hexagon classifies occupations in terms of six personality dimensions based on Holland's theory of personality and work environments: Realistic (R),



Investigative (I), Artistic (A), Social (S), Enterprising (E), and Conventional (C). A basic premise of Holland's theory is that individuals will find more satisfaction when their work personalities are congruent with the characteristics of their work environment. The WWM was developed by ACT, Inc., and can be used to suggest occupations to users who enter the map with a set of attribute scores. The position of occupations on the WWM is based on the degree to which an occupation requires working with data, ideas, people, and things. Similar to Holland's hexagon, individuals can also be located on the WWM based on the degree to which they express an interest in working with data, ideas, people, and things.

Another important component of occupational information is the source from which the information can be obtained. Major sources of occupational information include print materials and computerized information systems.

Printed sources of occupational information include Occupational Information Network (O\*NET) and the *Occupational Outlook Handbook (OOH)*. O\*NET is a comprehensive system for organizing, describing, distributing, and collecting data on occupations and the workforce. The *OOH* includes information about the nature of work, working conditions, the distribution of work, training required for occupational entry and advancement, average earnings, and projected 5- to 7-year employment outlooks.

Computerized sources of occupational information such as SIGI PLUS and DISCOVER are computer-assisted systems used to learn about oneself and the world of work. SIGI PLUS includes modules on self-assessment, search strategies, information, skills, preparing, coping, deciding, and career planning. Similar to SIGI PLUS, DISCOVER includes self-assessment inventories, searchable academic and occupational databases, and information to help students explore themselves and the work of work.

In order to make quality educational and career choices, students should engage in gathering accurate occupational information. Through the use of occupational classification systems and various sources of occupational information, students will find it easier to form realistic pictures of the career opportunities that are available in various occupations.

Levon T. Esters

*See also* Career Education (v4); Career Decision-Making Difficulties Questionnaire (v4); Career Exploration (v4); Career Planning (v4); *Dictionary of Occupational Titles* (v4); DISCOVER (v4); Holland's Theory of Vocational Personalities and Work Environments (v4); Occupational Information Network (v4); System of Interactive Guidance Information (v4)

### Further Readings

- Gore, P. A. (2005). *Facilitating the career development of students in transition*. Columbia: University of South Carolina, National Resource Center for the First-Year Experience and Students in Transition.
- Niles, S. G., & Harris-Bowlsbey, J. (2002). *Career development interventions in the 21st century*. Upper Saddle River, NJ: Prentice Hall.
- Reardon, R. C., Lenz, J. G., Sampson, J. P., & Peterson, G. W. (2006). *Career development and planning: A comprehensive approach* (2nd ed.). Mason, OH: Thomson Custom Solutions.
- Sears, S. J. (2002). *Building your career: A guide to your future*. Upper Saddle River, NJ: Prentice Hall.

---

## OCCUPATIONAL INFORMATION NETWORK

---

The Occupational Information Network (O\*NET) is the United States Department of Labor's online successor to the *Dictionary of Occupation Titles (DOT)*. The O\*NET is intended to provide a reference responsive to the rapidly changing world of work. The O\*NET is an ever-evolving resource due to ongoing data collection efforts intended to expand its information coverage and regular updates to ensure an accurate reflection of the current economy and labor market. Consequently, information available online may differ according to date of access.

Unlike the *DOT*, which focused on very careful descriptions of specific job titles, the O\*NET organizes information to facilitate identification of commonalities across jobs. The Crosswalk system allows users to reference occupational information across several classification systems. Within the O\*NET, occupations are organized using the Standard Occupational Classification (SOC) system, which clusters similar jobs. Consequently, for a given job



some descriptions may be less precise than in the *DOT*, as the descriptions reflect an entire SOC cluster, not just that specific job.

The O\*NET classifies occupations along the major dimensions of vocational interests, work values, and ability requirements. Drawing upon major person–environment fit models, the O\*NET characterizes vocational interests using Holland’s theory of vocational personalities and work environments and work values using the theory of work adjustment. This organization was directly influenced by the counseling model used by the Vocational Assessment Clinic at the University of Minnesota, a model intended to operationalize the most important elements of the theory of work adjustment.

### O\*NET Database

The O\*NET database is intended to be a comprehensive source of descriptors for the occupations (approximately 950) considered most important to the United States economy. These descriptors include ratings of importance, level, frequency, or extent for the following variables: skills, abilities, knowledge, tasks, work activities, work context, experience levels required, job interests, and work values–needs. The methods used to generate these descriptors include expert judgments, field observations, and worker self-report. Although the database is of great interest to researchers, average information seekers would find it very difficult to access.

### O\*NET OnLine

The O\*NET OnLine is a Web-based viewer intended to provide access to O\*NET information for a broad range of users (from students and job seekers to human resource professionals). Its uses include finding and exploring occupations, searching for occupations that use designated skills, viewing occupation summaries and details, cross-referencing other occupational classification systems, identifying related occupations, and linking with other online resources, such as current wage and employment outlook information.

### O\*NET Career Exploration Tools

The O\*NET Career Exploration Tools are a set of assessment tools intended to facilitate career exploration

by helping individuals to identify their vocational interests, work values, and abilities. The Career Exploration Tools include the *O\*NET Interest Profiler*, the *O\*NET Work Importance Locator*, the *Work Importance Profiler*, and the *O\*NET Ability Profiler*.

Donald E. Eggerth

*See also* Career Education (v4); Career Decision-Making Difficulties Questionnaire (v4); Career Exploration (v4); Career Planning (v4); *Dictionary of Occupational Titles* (v4); DISCOVER (v4); Holland’s Theory of Vocational Personalities and Work Environments (v4); Occupational Information Network (v4); System of Interactive Guidance Information (v4); Theory of Work Adjustment (v4)

### Further Readings

- Eggerth, D. E., Bowles, S. M., Tunick, R. H., & Andrew, M. E. (2005). Convergent validity of O\*NET Holland code classifications. *Journal of Career Assessment*, 13(2), 150–168.
- U.S. Department of Commerce. (2000). *Standard occupational classification system manual*. Lanham, MD: Bernan Associates.
- U.S. Department of Labor. (1991). *Dictionary of occupational titles* (4th ed.). Indianapolis, IN: JIST Works.

### Web Sites

Occupational Information Network Resource Center: <http://www.onetcenter.org>

---

## OSIPOW, SAMUEL H. (1934– )

---

Samuel H. Osipow is one the pioneers of vocational psychology in the United States. Graduating with a Ph.D. from Syracuse University in 1959, Osipow worked for 6 years as a counseling psychologist at Pennsylvania State University before taking a faculty position in the Psychology Department at Ohio State University. He spent the bulk of his academic career at Ohio State University from 1967 to 1998, 13 years of which he served as its chair. Within his academic career, Osipow published over 200 journal articles and book chapters and 18 books and monographs. He was a Fellow of the American Psychological Association



(Divisions 13, 15, 17, & 35), the Association for Psychological Science, and American Association for the Advancement of Applied and Preventive Psychology. His 13 years as Chair of the Psychology Department at Ohio State University as well as his numerous accomplishments within the American Psychological Association are also a testament to his unusual leadership abilities as well as his true integration of the scientist and practitioner aspects of his own career.

He wrote one of the first textbooks in the field of vocational psychology, *Theories of Career Development*, which was first published in 1968 and revised three times, most recently with Louise Fitzgerald in 1996. His numerous professional accomplishments and achievements include serving as the founding editor of the *Journal of Vocational Behavior*, editor of the *Journal of Counseling Psychology*, and editor of *Applied and Preventive Psychology*. With W. B. Walsh, he also coedited the first and second edition of the *Handbook of Vocational Psychology*.

Osipow also made significant contributions to career assessment. With some students, he developed the Career Decision Scale, one of the first career decision-making measures for the field. This work was then expanded in his collaboration with his colleague, Itamar Gati from Israel, in the development of the Career Decision-Making Difficulties Questionnaire. With the assistance of Arnold Spokane, he also developed the Occupational Stress Inventory, a comprehensive measure of occupational stressors, strains and coping resources published by Psychological Assessment Resources.

Osipow was also very active within the Counseling Division and within the American Psychological Association's (APA) governance. He served for many years on the Executive Board of the Division of Counseling Psychology (Division 17), culminating in

his election to the Division's Presidency in 1977. The Counseling Division also bestowed upon Osipow its highest honor by awarding him the Leona Tyler Award in 1989. Within APA, Osipow was elected to the APA Council of Representatives for two terms, served as Chair of the Education and Training Committee, Chair of the Council of Editors, Chair of the Publications and Communications Board, and on the Board of Directors. He was also Chair of the National Register of Health Service Providers in Psychology Board of Directors. In recognition of his significant and lifelong contributions to career counselors, the National Career Development Association awarded Osipow its Eminent Career Award in 2000.

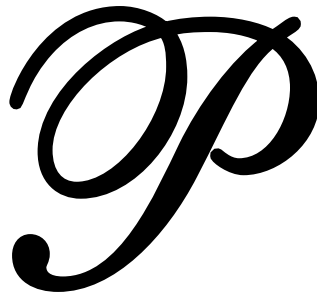
Frederick T. L. Leong

**See also** Career Decision Scale (v4); Career Decision-Making Difficulties Questionnaire (v4); *Journal of Vocational Behavior* (v4); Society for Vocational Psychology (v4)

### Further Readings

- Leong, F. T. L., & Barak, A. (Eds.). (2001). *Contemporary models in vocational psychology: A volume in honor of Samuel H. Osipow*. Mahwah, NJ: Lawrence Erlbaum.
- Osipow, S. H. (1987). *Manual for the Career Decision Scale*. Odessa, FL: Psychological Assessment Resources.
- Osipow, S. H. (1990). Convergence in theories of career choice and development: Review and prospect. *Journal of Vocational Behavior*, 36, 122–131.
- Osipow, S. H., Carney, C. G., Winer, J. L., Yanico, B., & Koschier, M. (1976). *The Career Decision Scale* (3rd rev.). Odessa, FL: Psychological Assessment Resources.
- Walsh, W. B., & Osipow, S. H. (Eds.). (1983). *Handbook of vocational psychology*. Hillsdale, NJ: Lawrence Erlbaum.





---

## PARSONS, FRANK (1854–1908)

---

School leavers in the late 19th century in the United States faced a multitude of unfamiliar job opportunities in the developing industrial economy of the Gilded Age. Although a few schools attempted to provide occupational guidance, only one individual, Frank Parsons, established the first vocational guidance clinic and articulated the basic principles of vocational guidance from which the profession of vocational counseling developed.

Parsons, born in 1854, attended Cornell University and studied to become a civil engineer, a vocational goal in that era as prestigious as becoming a computer engineer is today. He succeeded in finding employment with a railroad industry, again the equivalent today of going to work for a major software company. But in the economic depression of 1873, his employer was forced into bankruptcy and Parsons found himself out of a job. After a period of working as a manual laborer, he was able to find several successive positions teaching art and literature in the public schools. Ultimately he “read” for the law and became a member of the Massachusetts Bar.

In the 1890s, Parsons was very active in Populist and Progressive causes while teaching classes at Boston’s YMCA as well as at Boston University Law School and Kansas State University. He was recruited to teach the class *The World’s Best Books* at Civic Service House, one of the new settlement houses that offered support to Boston’s Italian, Jewish, and other immigrants. He became director of their program called the Breadwinner’s Institute, a kind of evening

high school, and he soon conceived the Vocation Bureau to help Boston’s citizens find careers for which they were best fitted.

Opening in 1908 with three staff members, one a woman, and an advisory board drawn from Boston’s civic leadership, Parsons reported that in its first 4 months the bureau served 80 young men and women ages 15 to 39 years. And, “according to their own spontaneous statements, all but two . . . received much light and help, some even declaring that the interview with the Counsellor [sic] was the most important hour of their lives” (Parsons, 1909, p. 30).

Parsons died before the first year of the bureau was completed, but in a book compiled from his papers, he stated the principles of vocational choice as follows: (1) a clear understanding of yourself and your aptitudes, interests, ambitions, resources, and limitations and their causes; (2) a knowledge of the requirements and conditions of success, advantages and disadvantages, compensation, opportunities, and prospects of different lines of work; and (3) true reasoning on the relation of these two groups of facts. The first two of these principles are highly developed contemporary components of vocational counseling (or career development) practice. Standardized ability tests were being developed in Parsons’s time, and interest inventories followed in the next decade. Today, the Web and every library offer a multitude of occupational information sources. Parsons did not elaborate on his concept of true reasoning. Probably it is equivalent with decision making and career planning as we now know it and is much of what the process of career counseling and development is about.



Parsons should be celebrated as the founding father of vocational psychology. The principles he articulated in support of it continue to be valid a century later.

*Donald G. Zytowski*

*See also* Career Counseling (v4); Career Counseling, History of (v4); Career Counseling in Schools (v4); National Career Development Association (v4); School-to-Work Transition (v4); Society for Vocational Psychology (v4); Trait-Factor Counseling (v4)

### Further Readings

Parsons, F. (1909). *Choosing a vocation*. Boston: Houghton Mifflin.

---

## PART-TIME WORK

---

Part-time refers to work performed by laborers who work less than the standard number of hours and who are often ineligible to participate in an organization's benefit plans. Many organizations need part-time workers to be successful. Organizations use part-time workers for several reasons: to meet the demands of the labor-intensive economy and cyclical economic patterns, to provide flexible scheduling, and to lower labor costs. According to the U.S. Department of Labor's Bureau of Labor Statistics there were over 24 million part-time workers in the United States in both 2004 and 2005, consisting of approximately 16% of the civilian labor force. The increasing number of part-time workers is also apparent in other parts of the world such as Europe and New Zealand. Because of their importance, organizations must retain part-time workers, a need that opens the door for acknowledging the importance of career counseling for, working with, and helping part-time workers, specifically in terms of their retention in organizations.

### Uniqueness of Part-Time Workers

#### *Characteristics of Part-Time Workers*

The classification of worker as full-time or part-time is determined by the standard used by the reporting government. In general, part-timers work less than 40 hours per week. Most part-time workers are paid

by the hour (the median weekly earnings for part-time workers in 2005 was \$201) and are not part of their organization's benefit plans that include vacation, pension, insurance, and other benefits. Two thirds of part-time workers are female. One third of part-time workers are in sales and office occupations (e.g., sales and administrative support); another 25% are in management, professional, and other related occupations; and another 25% are in service occupations.

Not only do part-time workers differ from full-time workers, but they also differ among types of part-time workers. Part-time workers may be permanent or temporary, organization- or agency-hired, year-round or seasonal, voluntary or involuntary, or they may moonlight. Additionally, part-time positions may be classified according to cyclical businesses (e.g., construction), secondary work (e.g., fast-food services), or retention-oriented jobs.

Many part-time workers are highly skilled, career-committed, and want career development, but a variety of reasons necessitate these people work part-time. According to the Bureau of Labor Statistics, approximately 12.5% of all part-time workers believe that economic reasons drive their need to work part-time, which includes business conditions, seasonal work, and the unavailability of full-time work. The majority of people who work part-time give noneconomic reasons for their position, such as child care problems, retirement, other family or personal obligations, or school or training obligations.

### *Part-Time Workers*

Part-time workers obviously work less than the standard number of hours that full-timers work. However, the differences between part-time and full-time workers cover much more than just this simple classification distinction. People with certain job attitudes and behaviors may be drawn toward part-time work. The goals, attitudes, motivations, and outcomes associated with part-time workers can be very different from those associated with full-time workers. This difference can be crucial in terms of career counseling and working with part-timers, especially when the topic is their retention in organizations. In other words, practices and methods used for the retention of full-time workers may be quite different from those used for part-time workers. A definite difference exists between part-time and full-time workers. Career counselors and others who work with part-time



workers such as managers and supervisors or those working in the human resources and training fields must understand that part-time workers cannot be treated the same as full-time workers. Part-time workers have a definite psychology of work that is different from that of full-time workers. Those who work with part-time workers must understand these differences and apply this information in order to effectively counsel and work with a part-time worker population, especially when considering their retention in the workplace.

Retention rates of part-time workers are far less than those of full-time workers. Thoughts of quitting, job satisfaction, expectation of finding alternatives, and intention to quit were highly related to retention rates of full-time workers; however, none of these variables were related to retention of part-timers. In effect, part-time workers do not make decisions regarding their retention in organizations the same way as full-time workers; part-time workers have a different psychology of work. Therefore, management policies and practices geared specifically for part-time workers need to be considered.

### **Social Exchange Theory**

Several researchers believe part-time workers feel less included, less connected, and less involved in their organization, or they do not feel they are tied to or part of the organization like their full-time counterparts. Social exchange theory may give insight into retaining part-time workers. In short, social exchange theory explains that relationships are built upon a fair exchange of goods or currency. Relationships start when one person gives or does something for another person and continue when the other person reciprocates. This theory may also be used as the basis for working with part-time workers. If organizations can make part-time workers feel as if they are part of the organization through pay; through support of and care for their well-being; through valuing their work, thoughts, and opinions; and through relationship building, those same part-time workers may feel obligated to repay the organization by staying with the organization.

### **Researcher Recommendations**

As one can see, part-time workers are a different entity than full-time workers. Some have said that temporary, involuntary, agency-hired, and seasonal

part-time workers who are working two jobs will be less involved and committed to their work and organization than those part-time workers who are working only one job that is permanent, year-round, and organization-hired. Moreover, differences among part-time workers themselves bring the need to treat and work with part-time workers appropriately. For instance, older workers may prefer work arrangements that are organization-hired, while females may want work arrangements that are agency-hired.

Over the years, researchers have given several recommendations for dealing with part-time workers. For instance, part-time workers may not be worried so much about salary as they would be with scheduling flexibility and recognition for their work. Part-timers want work that is satisfying, challenging, and interesting and that enhances their development as employees in the organization and people. Part-time workers want autonomy and a sense that they control things. Part-time workers want to feel they contribute to the organization and that their thoughts and opinions are heard and taken into consideration in decisions. Part-time workers also enjoy social interaction with their fellow workers, including interaction with their supervisors.

From a social exchange theory perspective, to increase retention of part-time workers, organizations must care for the development and well-being of their part-time workers. Part-time workers will then feel obligated to reciprocate and pay back the organizations by staying with the organization. Compensation and benefits are obvious ways to increase retention of part-time workers. However, as previously discussed, feeling part of the organization is very important to part-time workers. Organizations must provide programs to help part-time workers feel valued and wanted by the organization. Organizations must support the career development of their part-time workers. Organizations must strive to treat their workers fairly and must consider their interests when making decisions. Organizations must also consider work-life balance policies because many part-time workers are students or have family issues.

Management is also important in the retention of part-time workers. Management must attempt to give their part-time workers a voice at work in solving problems and in decisions that affect work. Management must communicate with their part-time workers about changes and other pertinent information. Management must also believe in giving part-time



workers responsibility and autonomy and must readily give recognition and praise for their work.

Organizations, management, and those working in training and human resources need to acknowledge that part-time workers are important to organizational success. Policies and practices geared toward their retention must attempt to make them feel tied to the organization or make them feel wanted. Career counselors must also be cognizant of this information. Part-timers have a variety of reasons for working the hours they do, from economic necessity, to family issues, to preference. Career counselors must understand the motivation of the part-timers they are helping. Career counselors must stress different ways to help part-timers feel connected to their organization to increase their retention. Career counselors can also work directly with organizations in implementing practices and policies that will increase the retention of part-time employees. By finding the right fit in terms of scheduling flexibility, autonomy, and support, career counselors can be helpful in making part-timers feel tied to their organization to increase their retention in organizations.

William A. Gentry

**See also** Bureau of Labor Statistics (v4); Career Advancement (v4); Career Counseling in Organizations (v4); Job Loss (v4); Job Satisfaction and General Well-Being (v4); Job Sharing (v4)

## Further Readings

- Bennett, N., Carson, P. P., Carson, K. D., & Blum, T. C. (1994). A comparison of "traditional" and "atypical" workers: Demographic, behavioral, and attitudinal differences. *Journal of Business and Psychology*, 8, 467–474.
- Cook, K. S., & Rice, E. (2003). Social exchange theory. In J. Delameter (Ed.), *Handbook of social psychology* (pp. 53–76). New York: Kluwer Academic/Plenum.
- Feldman, D. C. (1990). Reconceptualizing the nature and consequences of part-time work. *Academy of Management Review*, 15, 103–112.
- Feldman, D. C., & Doeringhaus, H. I. (1992). Missing persons no longer: Managing part-time workers in the '90s. *Organizational Dynamics*, 21, 59–72.
- Hammers, M. (2003). Wanted: Part-timers with class. *Workforce*, 82, 18.
- Jackofsky, E. F., & Peters, L. H. (1987). Part-time versus full-time employment status differences: A replication and extension. *Journal of Occupational Behavior*, 8, 1–9.
- Lee, T. W., & Johnson, D. R. (1991). The effects of work schedule and employment status on the organizational commitment and job satisfaction of full versus part-time employees. *Journal of Vocational Behavior*, 38, 208–224.
- Martin, T. N., & Hafer, J. C. (1995). The multiplicative interaction effects of job involvement and organizational commitment on the turnover intentions of full- and part-time employees. *Journal of Vocational Behavior*, 46, 310–331.
- McPherson, M. (2005, April). Part-time work—The new norm? *Human Resources Magazine*, 10, 16–21.
- Miller, H. E., & Terborg, J. T. (1979). Job attitudes of part-time and full-time employees. *Journal of Applied Psychology*, 64, 380–386.
- Peters, L. H., Jackofsky, E. F., & Salter, J. R. (1981). Predicting turnover: A comparison of part-time and full-time employees. *Journal of Occupational Behavior*, 2, 89–98.
- Rotchford, N. L., & Roberts, K. H. (1982). Part-time workers as missing persons in organizational research. *Academy of Management Review*, 7, 228–234.
- Sightler, K. W., & Adams, J. S. (1999). Differences between stayers and leavers among part-time workers. *Journal of Managerial Issues*, 11, 110–125.
- Tagliabue, J. (2006, May 11). 4 hours a day, 3 days a week. *New York Times*, pp. C1–C6.
- Thorsteinson, T. J. (2003). Job attitudes of part-time vs. full-time workers: A meta-analytic review. *Journal of Occupational and Organizational Psychology*, 76, 151–178.
- Tilly, C. (1991). Reasons for the continuing growth of part-time employment. *Monthly Labor Review*, 114, 10–18.
- U.S. Census Bureau. (1992). *Federal, state, and local governments 1992 government finance and employment classification manual*. Retrieved November 18, 2007, from <http://www.census.gov/govs/www/class.html>
- U.S. Department of Labor's Bureau of Labor Statistics. (n.d.). Retrieved September 1, 2006, from <http://www.bls.gov/cps/>
- Werbel, J. D. (1985). The impact of primary life involvements on turnover: A comparison of part-time and full-time employees. *Journal of Occupational Behavior*, 6, 251–258.
- Wetzel, K., Soloshy, D. E., & Gallagher, D. T. (1990). The work attitudes of full-time and part-time registered nurses. *Health Care Management Review*, 15, 79–85.

---

## PAY EQUITY

---

Pay equity is based on the principle that the payment an employee receives from the employer should be



proportional to his or her contributions to the organization. Otherwise, inequity results. Historically, pay equity has been approached by two somewhat separate perspectives: (1) the individual or psychological perspective, which focuses on how individuals form pay equity perceptions and the consequences associated with feeling inequity; and (2) the social or economic movement perspective, which concentrates on documenting objectively existing pay inequity at the societal level and on advocating its eventual elimination.

### **The Individual-Psychological Perspective**

According to J. S. Adam's equity theory, when forming pay equity perceptions, an individual evaluates the payment (broadly defined, including salary, benefits, promotion, social status, etc.) that he or she receives relative to the inputs (e.g., education, skills, experience, and effort) that he or she brings to a job and then compares his or her ratio of payment to inputs with other employees in a similar job. Two types of pay inequity result from the above social comparison: (1) overpayment, when the individual perceives that his or her ratio is larger than others; and (2) underpayment, when the individual perceives that his or her ratio is smaller than others.

Perceptions of overpayment lead to guilt. However, research suggests that this guilty feeling does not last long, and overpaid individuals quickly become accustomed to it, implying a fundamental self-serving bias. On the other hand, perceptions of underpayment lead to resentment, anger, and personal distress. These negative affects prompt underpaid individuals to restore equity. Due to the subjective nature of equity theory, it is difficult to predict specific strategies that underpaid individuals will adopt. However, a bulk of research shows that many of the strategies actually taken are detrimental to the organization: for instance, decreased motivation and productivity and product quality, lowered organizational commitment and pay-job satisfaction, increased counterproductive behaviors (theft, sabotage, and absenteeism), elevated intention to quit, and actual voluntary turnover.

Research suggests that some individual difference variables (e.g., positive affectivity and negative affectivity) as well as situational variables (e.g., participation in pay decisions) influence the formation of pay equity perceptions. There is also some evidence that individuals have varying degrees of equity

sensitivity that moderates the severity of their reactions to inequity perceptions. In addition, although individuals typically choose employees in a similar job as their comparison referent, D. M. Cowherd shows that many low-level employees also compare their rewards to those received by upper management.

### **The Social-Economic Movement Perspective**

Beyond the pay equity perceptions is the well-established fact that in the United States there has been a substantial wage gap across gender with men being paid more than women, aggregated on the national level. The past several decades saw one of the major social and economic movements attempting to eliminate such a gap. The ideological foundation of this movement is the principle of comparable worth, meaning jobs with similar worth to an organization should be paid equally, regardless of gender. Accompanying this movement were various legislative efforts to outlaw wage discrimination (e.g., Equal Pay Act of 1963, Civil Right Act of 1964, Title VII) and the establishment of the Equal Employment Opportunity Commission to enforce these acts. The size of the observed gender wage gap, or the ratio of women's wages to men's wages, has since shrunk slowly from 63% in 1979 to 77% in 2002.

Two schools of thought have tried to explain the persistence of the gender wage gap. The human capital explanation argues that the wage gap can be at least partially attributed to the differential amount of human capital men and women bring to the workplace. For instance, as compared to women, men tend to have more job qualifications in terms of education, skill, and experience and are more likely to have longer, more continuous careers. The discrimination explanation blames societal factors that place women in relatively disadvantageous positions in the workplace. For instance, gender segregation has been dominant throughout the American labor force, with women less likely than men to possess more prestigious, higher-paid jobs; to enter industries with strong trade unions; and to have few senior female managers in the organization hierarchy to serve as role models.

*Jinyan Fan and Jennifer Nieman-Gonder*

**See also** Civil Rights (v3); Discrimination (v3); Diversity Issues in Career Development (v4); Job Satisfaction and General Well-Being (v4); Occupational Stress (v1); Sexism (v3); Social Discrimination (v4)



### Further Readings

- Cowherd, D. M., & Levine, D. I. (1992). Product quality and pay equity between lower level employees and top management: An investigation of distributive justice theory. *Administrative Science Quarterly*, 37, 302–320.
- Dale, C. V., & Levine, L. (2004). Pay equity legislation in the 108th Congress. *Congressional Research Service Reports*. Retrieved from <http://digital.library.unt.edu/govdocs/crs>
- Pinder, C. C. (1998). Equity, justice, and fairness in the workplace. In *Work motivation in organizational behavior* (pp. 286–236). Upper Saddle River, NJ: Prentice Hall.
- Summers, T. P., & Hendrix, W. H. (1991). Modeling the role of pay equity perceptions: A field study. *Journal of Occupational Psychology*, 64, 145–157.

---

## PERFORMANCE MODELING

---

Performance modeling refers to the complex process of describing and defining job performance and facilitating the consequent goal of accurate prediction of job performance. It is a concept of particular significance in the area of industrial-organizational psychology as a measure of evaluation for the individual worker and the organization as a whole. Performance modeling also has a connection to the area of vocational psychology as well (i.e., the theory of work adjustment). It is this connection to vocational psychology that makes this concept additionally relevant to the practice of career and vocational counseling.

The idea of performance has generally been viewed from two perspectives: as the behavior of a person in the work setting and the extent to which this behavior produces a given output or result for the organization related to its goals. Job performance is a complex combination of several components and a concept to be distinguished from the related ideas of effectiveness (evaluation of performance results) and productivity (the cost-to-effectiveness ratio).

The classic model of job performance prediction fails to effectively predict performance due to weakness of predictor variables, confusing measures of these variables with the attribute being measured, and problems with the statistical analyses of this model. Campbell's model focuses on eight performance components across all jobs: job-specific task proficiency, nonjob-specific task proficiency, written and oral communication tasks, demonstrating effort, maintaining personal discipline, facilitating peer and team performance, supervision, and management-administration.

Borman and Motowidlo's model describes two components of performance: task performance and contextual performance. Task performance pertains to technical aspects of the job necessary to complete it, while contextual performance refers to activities contributing to the organizational environment and supporting its goals. Hesketh adds the dimension of adaptive performance to a model for job performance. According to Hesketh, this addition adds a cognitive component (related to a person acquiring new skills on the job) and a noncognitive component (related to coping skills and self-efficacy for change).

William S. Froilan

*See also* Assessment (v4); Industrial/Organizational Psychology (v1); Theory of Work Adjustment (v4)

### Further Readings

- Borman, W. C., & Motowidlo, S. J. (1993). Expanding the criterion domain to include elements of contextual performance. In N. Schmitt, W. C. Borman, & Associates (Eds.), *Personnel selection in organizations*. San Francisco: Jossey-Bass.
- Campbell, J. (1990). Modeling the performance prediction problem in industrial and organizational psychology. In M. D. Dunnette & L. M. Hough (Eds.), *Handbook of industrial and organizational psychology* (2nd ed., Vol. 1, pp. 687–732). Palo Alto, CA: Consulting Psychologists Press.
- Hesketh, B. (2001). Prevention and development in the workplace. In S. D. Brown & R. W. Lent (Eds.), *Handbook of counseling psychology* (3rd ed., pp. 471–498). New York: Wiley.
- Williams, R., & Fletcher, C. (2002). Performance management and organizational effectiveness. In I. T. Robertson, M. Callahan, & D. Bartram (Eds.), *Organizational effectiveness: The role of psychology* (pp. 135–158). New York: Wiley.

---

## PERSONAL AND CAREER COUNSELING

---

Personal counseling and career counseling share a significant history. Vocational or career counseling started with the work of Frank Parsons and his staff at the Vocation Bureau of Boston in 1908. Parsons would die shortly after the bureau began operations, but not before the term *counseling* emerged to describe the



services provided to clients of the Vocation Bureau. His book, *Choosing a Vocation*, would be published a year after his death, cementing the legacy of career counseling. Thirty years later Edmund G. Williamson would introduce the first counseling theory, which was based on the original work of Parsons.

Much of the description of counseling found in definitions ascribed to counseling by professionals and professional organizations can also apply to the definition of career counseling. Career counseling is a specialization of personal counseling much like other specialty areas of counseling (i.e., school, family, rehabilitation, etc.), which implies a particular emphasis, population, or setting for its practice. Counseling is a process that assists individuals in gaining helpful information about themselves, others, and the world around them as they problem solve or make decisions to improve their quality of life. Counseling emphasizes the value of individuals being able to make their own decisions. Counseling and its specialties, which include career counseling, provide their professional services for individuals, groups, or families. Counseling professionals may provide services through institutions such as schools, colleges, and universities, as well as in public agency and private practice settings. At the same time, personal counselors, including career counselors, may work in consultation with institutions or organizations.

As with any other counseling specialty, career counselors rely upon theory, research, and a set of specific skills (e.g., active listening) to assist their clients. Career counselors can assist clients with issues related to career information, decision making, and career or work adjustment related issues. Likewise, they can help clients deal with career-related changes and transitions such as pursuing a new occupation, retirement, or a career-related crises (e.g., downsizing). Career counselors use resources such as career information, technology, and assessment instruments to enhance their work with clients as clients acquire critical personal and occupational information during the career counseling process. Career counseling and other counseling specialties are typically viewed as briefer or shorter interventions than more clinically focused approaches (e.g., psychotherapy) found among professionals and professional settings where more pronounced clinical issues and diagnoses may be found (i.e., addiction settings, partial hospitalization programs, etc.).

The various kinds of personal counselors, including career counselors, have professional organizations

(e.g., American Counseling Association, American Psychological Association's Division 17: Society of Counseling Psychology, National Career Development Association) who advocate for professional standards, licensure, and certification. There are also accrediting bodies (e.g., Council for the Accreditation of Counseling and Related Education Programs, Council on Rehabilitation Education) to ensure that professional preparation standards are met by academic training programs. In accordance with professional organizations and accrediting bodies, minimum educational requirements (e.g., master's degree) and competency levels are suggested for various kinds of counselors, including career counselors, with a strong emphasis on ethical standards and practices.

*William C. Briddick and Hande Sensoy Briddick*

**See also** Career Counseling (v4); Career Counseling, History of (v4); Career Counseling Process (v4); Counseling, Definition of (v1); Counseling, History of (v4); National Career Development Association (v4); Society for Vocational Psychology (v4); Specialization Designation (v1); Williamson, Edmund Griffith (v4)

## Further Readings

- Capuzzi, D., & Stauffer, M. D. (2006). *Career counseling: Foundations, perspectives, and applications*. Boston: Pearson Education.
- Corey, G. (2005). *Theory and practice of counseling and psychotherapy* (7th ed.). Belmont, CA: Brooks/Cole.
- Nystul, M. S. (2003). *Introduction to counseling: An art and science perspective* (2nd ed.). Boston: Allyn & Bacon.
- Parsons, F. (1909). *Choosing a vocation*. Boston: Houghton Mifflin.
- Sharf, R. S. (2006). *Applying career development theory to counseling* (4th ed.). Belmont, CA: Wadsworth.
- Subich, L. M. (Ed.). (1993). How personal is career counseling? [Special section]. *Career Development Quarterly*, 42, 129–191.
- Williamson, E. G. (1939). *How to counsel students*. New York: McGraw-Hill.

## Web Sites

- American Counseling Association: <http://www.counseling.org/>
- National Career Development Association: <http://www.ncda.org/>
- Society of Counseling Psychology Division 17: <http://www.div17.org/>



## PERSONALITY ASSESSMENT AND CAREERS

The term *personality* typically refers to one's characteristic pattern of thinking, feeling, and behaving. In addition to the stable, trait-like features often evoked by this construct (e.g., sociability, dominance, modesty), many theories also emphasize the roles of culture, family, and other environmental factors involved in personality expression and development. This predominant individual differences variable has informed career assessment practices. Unlike many traditional personality assessments, which emphasized pathological functioning, contemporary career applications tend toward neutral to positive traits. Both quantitative and qualitative assessments based in personality theory are employed to assist clients with numerous career concerns. A growing body of research has shown important connections between personality constructs and a broad array of career behaviors including individuals' approach to learning, vocational interests, career choices, self-esteem, confidence in performing tasks, career counseling interactions, job searches, and subsequent work performance, satisfaction, and tenure.

### Foundations Connecting Personality and Careers

#### *The Big Five*

Building on decades of research within the lexical tradition, Paul Costa and Robert McCrae recently popularized the idea that there are five broad domains of personality traits, known as the Big Five: Neuroticism, Extraversion, Openness to Experience, Agreeableness, and Conscientiousness. This empirical approach describes relationships between personality descriptors that have been encoded into language systems. The NEO Personality Inventory-Revised is frequently used to assess the Big Five and 30 more specific facets (e.g., Fantasy, Impulsiveness, Order) relevant to career choice and performance. Many personality assessments comprise different aspects of the Big Five related to career counseling.

Individually, these broad domains affect how clients might interact with counselors or approach work tasks and settings. For example, extraverts, who tend to be more sociable and active, might prefer people-oriented occupations and are more likely to be

talkative and enthusiastic during counseling sessions. Those high on Openness frequently have wide interests, which may interfere with their ability to commit to one career option. Their openness to new ideas and imaginative qualities also increase receptivity to novel counseling interventions. Given their attention to details and dutiful approach to tasks, conscientious individuals often demonstrate greater job performance. Moreover, highly conscientious individuals likely show greater motivation to engage in the challenging tasks involved in planning a career. By combining two or more of the Big Five domains, even more refined insights are possible. For example, levels of Openness and Conscientiousness can inform one's approach to learning. Those high on both may flourish in an academic setting because they are naturally curious, have greater aspirations, and are motivated to seek high goals. However, those high on Openness, but low on Conscientiousness, might struggle to realize their imaginative ideas due to lesser diligence or achievement motivation.

#### *Holland's Typological Theory*

John Holland's prominent personality theory of vocational types has generated almost 50 years of research informing career assessment. Holland identified six broad types of individuals and postulated that people will achieve greater work satisfaction by selecting work environments that match their vocational personality type. These six types, briefly summarized below, represent syndromes that include qualities related to individuals' preferred activities, goals, work values, and perceived abilities:

**Realistic:** Mechanical or hands-on tasks including agriculture, nature, operating machines/tools, and manufacturing, often in outdoor settings.

**Investigative:** Analytic tasks involving math, science, or research.

**Artistic:** Creative, unstructured tasks including music, fine art, drama, or writing.

**Social:** Helping, supporting, or teaching others.

**Enterprising:** Leading or persuading others.

**Conventional:** Structured tasks involving organizing data in office or financial settings.



These six types have been operationally defined by Holland's Vocational Preference Inventory in 1958 and the Self-Directed Search in 1985. Most major interest inventories now incorporate measures of Holland's types (e.g., Kuder Career Search, Strong Interest Inventory). Holland's theory is a foundation for career counseling and taxonomies for organizing occupational information, including for the *Dictionary of Occupational Titles* and the Occupational Information Network (O\*NET). Counselors assist clients in identifying their top Holland scores and then in exploring occupational possibilities that match their work personality. Other important factors considered include abilities, work values, and needs. Astute counselors help clients integrate information across these important life domains to construct a meaningful career path through maximizing overlap between their personality and opportunities.

### ***Linking the Big Five With Holland's Big Six***

An accumulation of studies examining areas of convergence between the Big Five and Holland's Big Six yielded numerous connections. Extraversion relates to Holland's Social and Enterprising themes, Openness relates to Artistic and Investigative, and Agreeableness slightly relates to Social. Taken together, these two theories can enhance career counseling by noting their similarities and differences. The Big Six may be more useful for selecting occupations, whereas the Big Five inform how one approaches occupational tasks.

### **Assessing Personality to Inform Career Counseling**

Most personality measures used in career counseling are quantitative and present results comparing the test taker's scores with those from a normative sample. For example, a client may score at the 95th percentile on a measure of Extraversion compared to other adults. The counselor can compare this result with the vast literature on typical career choices and behaviors of extraverts. Other approaches emphasize the unique patterning of scores of specific individuals incorporating their sociocultural context. Combining quantitative scores from standardized measures with insights gained from qualitative approaches such as sentence completion or narrative techniques examining clients'

individual strivings and work values can elucidate unique career stories. Together, counselors and clients can explore how personality features affect career/life decisions and concerns. The following prominent personality assessments have been applied to career counseling.

The Myers-Briggs Type Indicator (MBTI) is the most widely used personality assessment applied to nonclinical populations. Based on Carl Jung's earlier ideas on personality, Katherine Briggs and Isabel Briggs Myers developed this measure in the 1940s to assign individuals to one of 16 MBTI types based on four dichotomies separating (1) one's source and direction of energy (Extraversion vs. Introversion), (2) information gathering style (Sensing vs. Intuition), (3) decision-making style (Thinking vs. Feeling), and (4) planning orientation (Judging vs. Perceiving). The MBTI highlights people's strengths and is commonly used in organizational settings for leadership development and to examine group dynamics. Although frequently used for occupational selection, its validity for this purpose is uncertain. Nonetheless, these dichotomies naturally relate to various career planning and work-related tasks. The authors of the MBTI stress that it can provide important insights into work motivations and approach to changes in the workplace. Numerous publications examine using the MBTI for managing careers.

The California Psychological Inventory (CPI) was developed by Harrison Gough in 1948 to emphasize normal personality using everyday language. It comprises 20 Folk scales that relate to four clusters of content including (1) interpersonal functioning, (2) normative orientation and values, (3) cognitive and intellectual functioning, and (4) role and personal styles. In addition, three broad scales, Internality-Externality, Norm Questioning-Norm Favoring, and Self-Realization, are compared to assign clients to classification types with career implications. There are 13 special scales, largely relevant to career counseling, including Managerial Potential, Work Orientation, Creative Temperament, Leadership, Law Enforcement Orientation, and Tough-Mindedness.

The Sixteen Personality Factor Questionnaire (16 PF) was developed in 1949 to assess 16 primary factors identified by Raymond Cattell's empirical analyses of personality traits. Some factors directly related to career counseling include Abstractedness, Dominance, Openness to Change, Perfectionism,



Self-Reliance, Sensitivity, and Warmth. The 16 PF also reports five broad scales assessing the Big Five, Holland theme scores, and four facets of leadership. A computer-generated career development report is available that addresses problem-solving resources, coping patterns, interpersonal styles, organizational role and work setting preferences, interests, and other lifestyle considerations. This profile also compares clients' scores with members of specific occupations.

The five Personal Style Scales of the Strong Interest Inventory include Work Style, Learning Environment, Leadership Style, Risk Taking, and Teamwork. These dimensions reflect personality features related to how individuals approach learning, work, and leisure.

### Building on Strengths

Among other activities, career counselors assist their clients in increasing self-understanding and in exploring career possibilities suitable to their self-concepts. These functions afford great potential for optimizing clients' work lives. Insights from personality theory, research, and assessment can facilitate this process through identifying relevant tendencies and nurturing clients' strengths. General personality assessments and those germane to career decision making have potential to help individuals seek goals that consider their inclinations, thereby allowing clients to strategically manage their careers and enhance their overall life satisfaction.

*Patrick J. Rottinghaus*

**See also** Holland's Theory of Vocational Personalities and Work Environments (v4); Kuder Career Search (v4); Personality Theories (v2); Personality Theories, Five-Factor Model (v2); Roe's Theory of Personality Development and Career Choice (v4); Self-Directed Search (v4); Strong Interest Inventory (v4)

### Further Readings

Holland, J. L. (1997). *Making vocational choices: A theory of vocational personalities and work environments* (3rd ed.). Odessa, FL: Psychological Assessment Resources.

Judge, T. A., Heller, D., & Mount, M. K. (2002). Five-factor model of personality and job satisfaction: A meta-analysis. *Journal of Applied Psychology*, 87, 530–541.

Larson, L. M., Rottinghaus, P. J., & Borgen, F. H. (2002).

Meta-analyses of Big Six interests and Big Five personality factors. *Journal of Vocational Behavior*, 61, 217–239.

Lowman, R. L. (1991). *The clinical practice of career assessment: Interests, abilities, and personality*.

Washington, DC: American Psychological Association.

Tokar, D. M., Fischer, A. R., & Subich, L. M. (1998).

Personality and vocational behavior: A selective review of the literature, 1993–1997. *Journal of Vocational Behavior*, 53, 115–153.

---

## PERSON–ENVIRONMENT FIT

---

Person–environment fit models are among the most widely used and influential models in vocational psychology. Ultimately, these models trace their lineage to Frank Parsons's suggestion that job outcomes could be improved by carefully matching the attributes of an individual with the characteristics of an occupation. In the 1930s, advances in statistics and psychometrics allowed Parsons's concepts to be operationalized using individual assessment and occupational classification systems, an approach known as *trait-factor counseling*. Overall, trait-factor counseling was criticized as being atheoretical, and its matching process as being too static. Current person–environment fit models, such as Holland's theory of vocational personalities and work environments and the theory of work adjustment, evolved from trait-factor counseling and represent fully fleshed and dynamic theories of career choice and adjustment.

There are a number of assumptions common to all person–environment fit models used in vocational psychology. These assumptions are (1) within an occupation, the well-adapted incumbents share certain psychological attributes; (2) there are measurable and practically significant differences between people and between occupations; (3) individual differences interact with occupational differences to positively or negatively affect outcomes; and (4) person attributes and occupational characteristics show sufficient consistency across both time and setting to justify the prediction of long-term outcomes. It is implicit in these assumptions that if workers and work environments can be reliably measured, then the quality of the match (or fit) between the two may be a useful predictor of outcomes ranging from job satisfaction to productivity.



## Historical and Theoretical Influences

The core concepts of person–environment fit models can be traced to a number of sources. As stated above, Parsons’s template matching approach and trait-factor counseling models were important influences on the evolution of person–environment fit models. Another important influence is captured in Kurt Lewin’s famous formulation of the interaction of person with environment:  $B = f(P, E)$ . Lewin proposed that behavior does not arise from a purely mechanistic interaction of person with environment, but rather it is influenced by the weight and value an individual gives to elements of the environment. Individuals bring unique learning histories to a given situation. These histories impact their interpretations and valuing of environmental features. Consequently, different individuals will behave differently given the same environment features. Another influence is found in Hans Selye’s conceptualization of stress as arising from a mismatch between organism and environment. In occupational settings, a mismatch between worker and workplace is expected to give rise to job dissatisfaction and/or poor job performance. It should be noted that person–environment fit models have been successfully applied to a wide range of behavior settings. However, applications to vocational psychology are the most sophisticated, both in terms of the variables assessed and the psychometric models used, and the most widely used.

## Subjective or Objective Environment Debate

As might be expected given the influence of Lewin’s field theory, many researchers working with person–environment fit models choose to assess the work environment as it is perceived by the worker. In keeping with Lewin’s thinking, it is argued that the *perceived* or *subjective environment* is what individuals are actually responding to in a given setting. However, it is important to note that some person–environment fit researchers reject operationalizing work settings subjectively for the very same reasons put forward by others arguing for its primacy. These researchers argue that because an individual’s perception of an environment is so colored by that individual’s unique learning history, the perceived environment is too variable and too subjective to be meaningfully applied

across groups of individuals. These researchers argue that the environment should be defined only by objectively determined and directly measurable attributes such as behaviors and physical features. Roger Barker’s behavior setting theory represents the best articulated and operationalized approach to the objective assessment of environments.

Many vocational models of person–environment fit fall somewhere in between subjective and objective measures of the environment. For example, the Environmental Assessment Technique defines environments in terms of the qualities (Holland types) of the individuals inhabiting a given setting. The theory of work adjustment defines individuals using self-appraisal methods, but categorizes work environments using pooled supervisor ratings.

## Measurement Assumptions

The choice of which person attributes and occupational characteristics to measure is challenging from both a theoretical and a psychometric perspective. For example, Holland’s career types have great intuitive appeal and seem to be supported by structural analyses. However, their exact configuration and perhaps more importantly their efficacy in predicting job satisfaction have been the topics of spirited controversy.

The following have been put forward as measurement assumptions for person–environment fit models: (1) the measurement of environmental characteristics and person attributes should utilize commensurate dimensions and units, (2) the level of measurement for the environmental characteristics and the person characteristics should be at least interval, and (3) the measurement of person attributes should be independent of the measurement of environmental characteristics. However, given current methods and measurement technologies, these assumptions represent ideals to aim for rather than goals attained.

## Assessing Fit

Ultimately, the crux of any person–environment fit model is how well it predicts relevant outcomes. This prediction is influenced by a number of factors: the assessment of the person, the assessment of the environment, the assessment of the outcome, how fit between person and environment is operationalized, and how fit is related (in a predictive manner) to



outcome. In vocational psychology models of person–environment fit, the assessment of the individual is generally well validated. As discussed above, the best method for assessment of the environment is not agreed upon. In vocational psychology, the outcome frequently measured is job satisfaction. When assessing global job satisfaction, this construct is robust enough that a single item is often used. However, it has been argued that job satisfaction is more meaningfully discussed in terms of its two facets—intrinsic and extrinsic job satisfaction. Depending upon the specifics of a given person–environment fit model, different fit indices may be possible and/or desirable. For example, fit indices for Holland’s theory of vocational personalities and work environments frequently factor in the hexagonal arrangement of the types. In addition, these indices typically weight for the relative importance of first, second, or third highest Holland types. In contrast, many of the fit indices proposed for use with the theory of work adjustment face problems classic to the quantitative comparison of psychological profiles. For example, difference scores, although simple to calculate, seldom can meet the measurement assumptions inherent in their use and perhaps more to the point tend not to perform any better than fit indices making less rigorous assumptions—that is, a correlation coefficient. Holland uses the term *congruence* to describe the fit between person and environment. The theory of work adjustment uses the term *correspondence*. Regardless of the fit index used, it is typically related to the outcome measure (typically, job satisfaction) using a correlation coefficient. Early literature reviews suggested that studies using Holland’s model had a relationship between congruence and job satisfaction of around  $r = 0.30$ . However, more recent reviews and meta-analyses have revised this figure ever downward with some arguing that the true value was in the 0.20s and with others that it was closer to 0.10. Similar studies using the theory of work adjustment have consistently found relationships of  $r = 0.30$  to 0.40 between correspondence and job satisfaction.

### Ongoing Influence

Although person–environment fit models have been criticized along similar lines as the trait-factor counseling approaches they grew out of, these models have been and continue to be very widely used. This use is due in part to the intuitive appeal of these models and

in part to the psychometric rigor that was devoted to developing both individual assessment instruments and occupational classification systems. Perhaps the strongest indication of the ongoing influence of person–environment fit models was the adoption of the core variables of Holland’s theory of vocational personalities and work environments and of the theory of work adjustment by the Occupational Information Network and the United States Department of Labor’s online database that is the successor to the *Dictionary of Occupational Titles*.

Donald E. Eggerth

**See also** Environmental Assessment Technique (v4); Holland’s Theory of Vocational Personalities and Work Environments (v4); Job Satisfaction and General Well-Being (v4); Occupational Information Network (v4); Person–Environment Interactions (v2); Person Matching (v4); Theory of Work Adjustment (v4); Trait-Factor Counseling (v4)

### Further Readings

- Dawis, R. V., & Lofquist, L. H. (1984). *A psychological theory of work adjustment*. Minneapolis: University of Minnesota Press.
- Holland, J. L. (1997). *Making vocational choices: A theory of vocational personalities and work environments* (3rd ed.). Odessa, FL: Psychological Assessment Resources.
- Rounds, J. B., Dawis, R. V., & Lofquist, L. H. (1987). Measurement of person-environment fit and prediction of satisfaction in the theory of work adjustment. *Journal of Vocational Behavior*, 31, 297–318.
- Walsh, W. B., Craik, K. H., & Price, R. H. (Eds.). (1992). *Person-environment psychology: Models and perspectives*. Hillsdale, NJ: Lawrence Erlbaum.
- Walsh, W. B., Craik, K. H., & Price, R. H. (Eds.). (2000). *Person-environment psychology: New directions and perspectives* (2nd ed.). Hillsdale, NJ: Lawrence Erlbaum.
- Zytowski, D. G., & Borgen, F. H. (1983). Assessment. In W. B. Walsh & S. H. Osipow (Eds.), *Handbook of vocational psychology* (Vol. 2, pp. 2–40). Hillsdale, NJ: Lawrence Erlbaum.

---

## PERSON MATCHING

---

One of the first and even now most-used tools of career counselors is the interest inventory. Inventories



currently in use may be described as taking either of two approaches. One tells a person the relative strengths of his or her interests; the other tells the person what occupations have similar interests as his or hers. The first approach reports, "Your interests are strongest in science." The other matches a person with occupations, reporting, "You have interests like those of engineers (or doctors, or other scientific occupations)."

Frederic Kuder, a long-time author of interest inventories of both kinds, speculated that a person can be similar to, say, an engineer, but in reality is more similar to a particular engineer engaged in a particular job. Kuder suggested replacing occupation matching with person matching. In the person-match approach, the interest inventory results answer the question "What are people with interests like mine doing for a living?" instead of offering an occupational title. As well, the inventory taker is presented with a number job sketches, reflecting what several people, not necessarily all engineers, who have similar interests as the inventory taker actually do every day. Kuder's assertion is that this should be more informative, and perhaps more motivating, to people seeking career options than a single occupational title.

Kuder and his associates developed the Kuder Career Search with Person Match to replace his Kuder Preference Record and the Kuder Occupational Interest Survey. Like the earlier interest inventories, it consists of triads of activities from which the respondent must choose the most and least preferred. Person matches are assessed by comparing the inventory taker's own interest profile with the profiles of approximately 2,000 adults in a wide variety of occupations using a mathematical rubric similar to those used for book purchase or movie rental recommendations.

The results of the Kuder Career Search are presented in two forms. One is a score profile in percentages of the relative strengths of six types of activity preferences. The novel Person Match report consists of the self-assigned occupational titles of a dozen members of the personal match pool whose interest profiles are most similar to that of the interest inventory taker. The inventory taker may open a self-reported, one-page job sketch from their top matches.

The job sketches are much like an interview. Questions are asked by the Kuder Career coach, such as, "What's a typical day at work for you?" "How did you get into this line of work?" "What are the positives and negatives in your job?" and "What are your

plans for the future?" Finally, the Kuder coach offers observations, pointing out unique aspects of the person's work or features of the person's career pattern.

Many persons would be well-served by learning of the careers of older individuals who have interests like their own: middle school students who are just beginning to make career plans, high school students who are selecting college programs, college students who are nearing graduation, older workers who are experiencing job displacement, and even retirees who are seeking to continue at work.

Donald G. Zytowski

*See also* Campbell Interest and Skill Survey (v4); Career Counseling Process (v4); Jackson Vocational Interest Inventory (v4); Kuder, Frederic (v4); Kuder Career Search (v4); Person-Environment Fit (v4); Strong Interest Inventory (v4); Unisex Edition of the ACT Interest Inventory (v4); Vocational Identity (v4)

### Further Readings

Zytowski, D. G. (2006). *Kuder Career Search, user manual*. Adel, IA: Kuder. Retrieved from <http://www.kuder.com/PublicWeb/kcs.aspx>

---

## PERSONS WITH DISABILITIES

---

Counseling interventions are considered a resource to support full functioning and participation of people with disabilities in their communities or specified environments of choice. The World Health Organization's (WHO) International Classification of Functioning, Disability and Health (ICF) considers disability to result from a person with a health condition's interaction with his or her environment where a person is restricted in his or her ability to engage in activities typical of others in the same or a similar environment. The functions of an individual with a disability are impaired by any disease, disorder, or health condition, and the severity of impairment contributes to the extent of disability or activity restrictions. The environment can enable or hamper participation. For example, an enabling environment for a person with mobility limitations would include access to mobility aids while, by contrast, environmental barriers



would include inaccessible buildings. Additional limiting factors such as negative attitudes, stigma, and power relations arise from social environments, and these factors often influence the organization of and delivery of support services. Persons with disabilities are restricted from activities typically open to others by environmental restrictions more than by the objective qualities of their specific disability. This raises the question whether persons with disabilities need counseling, and if they do, (a) what the rationale is for providing counseling services, and (b) what would the counseling address.

### Historical Considerations

Persons with disabilities are and have historically been denied recognition as a socioculturally oppressed minority due to the restrictions to activities and lifestyle ordinary to typically developing others. For instance, people with disabilities have limited access to basic social amenities compared to typically developing others because of negative social prejudice against them. They also tend to be socioculturally disadvantaged and ascribed negative characteristics because of their disability-related differences (e.g., incompetent, poor, suffering).

### *Sociocultural Deprivation*

Historically, people with significant disabilities were detained in institutions for (a) cosmetic reasons because they were considered an unpleasant sight from which persons without disabilities should be protected, (b) political reasons in the sense of their being denied basic humanness and citizenship, and (c) cultural reasons in the sense that their life experiences and needs were regarded too different from those of ordinary persons to warrant social concern. Acts of genocide were also committed against persons with disabilities in that they could be castrated without their consent and be denied the right to marry or procreate. Persons with disabilities have also been treated as commodities by charitable organizations, some of which made fortunes for their founders and directors by marketing the unmet needs of persons with disabilities. Counseling was rarely an option for this population about which there was considerable ambivalence regarding their role and function in the community.

### *Influence of Disability Rights Movements*

With the internationalization of civil rights for cultural minorities, persons with disabilities were perceived by the civic community, state, and federal governments to benefit from counseling that would enable their participation to the extent possible in typical activities and environments for others. Disability rights movements resulted in several national laws and international conventions to enable people with disabilities in their entitlement to equal and fair access to resources and a preferred life style. It may seem paradoxical that people with disabilities are regarded as in need of counseling when the evidence suggests that they are victims of societal oppression.

### Goals

Counseling may enhance a sense of personal and environmental control in people with disabilities by helping them (a) identify the particular goals they seek to achieve and the methods of achieving them, (b) access the resources in the environment that they may need in order to achieve their self-selected goals, and (c) learn more effective self-management skills. Counseling approaches for people with disabilities need to consider that disability is not an intrinsic feature of the individual, but the result of interactions with his or her environment. There are no universal counseling needs or processes that will address the counseling needs of people with disabilities in their diversity. However, the WHO ICF provided guidelines on functioning with disability, including types of domains of activity restriction and participation in nine areas of health and well-being.

### Guidelines

The WHO ICF guidelines enable identification of the disability-related type of activity or participation restriction, taking into account social and physical environmental factors. Some counseling professionals are of the view that the WHO ICF guidelines provide a practical framework for conceptualizing counseling needs in people with disabilities. For example, mental impairment from depression can restrict opportunities for beneficial interactions with others through self-isolation. Others may perceive self-isolation negatively, increasing the chances that the socially isolated



person will be avoided or rejected in the social environment. The cycle of social isolation and social rejection could spiral into a more severe depression, anxiety, learned helplessness, and passivity for which counseling would be a resource.

## Influences

The counseling needs of individuals with disabilities may also depend on the particular type of disability. A disability from a chronic, progressive condition such as renal failure presents unique counseling needs as compared to a stable disability like a healed and rehabilitated leg injury or amputation. The need for dialysis treatment associated with chronic renal failure often results in significant disruptions to routine or typical lifestyle and choices. Routine adds predictability to life by enhancing a sense of control over one's environment. Some disabilities are associated with chronic health conditions with unpredictable symptom expression, which would pose significant challenges to the way individuals manage their lives. For example, people with psychiatric disability may experience acute phases of severe symptoms and/or persistent symptoms of mental illness, and these symptoms tend to disrupt most aspects of their lives. Many face the additional challenge that stigmatizing attitudes of society presents. By comparison, a stable disability such as a healed amputation may present different kind of challenges. Thus, counseling needs in people with disabilities depend on the (a) effects or product of the interaction between personal, environmental, and disability-related characteristics; and (b) the relative severity of the environmental, disability, and personal factors.

## Future Directions

Counseling needs of people with disabilities are those whose resolution would enable them to have greater control over their lives. Specific counseling needs of individuals are influenced by the personal, disability type, and environmental characteristics, and often these characteristics are interrelated in their impact. The WHO ICF framework that considers disability in the context of personal, environmental, and disability type factors is particularly relevant to understanding counseling needs in people with disabilities.

*Elias Mpofu and Lynda Matthews*

*See also* Americans with Disabilities Act (v1); Career Counseling, History of (v4); Chronic Illness (v1); Chronic Pain (v1); Individuals with Disabilities Education Act (v1); Low-Incidence Disabilities (v1); Mental Retardation and Developmental Disabilities (v1); Physical Health (v2); Social Discrimination (v4); Traumatic Brain Injury and Rehabilitation (v1)

## Further Readings

- Finkelstein, V., & French, S. (1997). Towards a psychology of disability. In J. Swain, V. Finkelstein, S. French, & M. Oliver (Eds.), *Disabling barriers—enabling environments* (pp. 27–33). Thousand Oaks, CA: Sage.
- Funk, R. (1987). Disability rights: From case to class in the context of civil rights. In A. Gartner & T. Joe (Eds.), *Images of the displaced/disabling images* (pp. 7–30). New York: Praeger.
- Hahn, H. (1999). The political implications of disability: Definitions and data. In R. Marinelli & A. E. Dell Orto (Eds.), *The psychological and psychosocial impact of disability* (pp. 3–11). New York: Springer.
- Mpofu, E., & Conyers, L. M. (2004). A representational theory perspective of minority status and people with disabilities: Implications for rehabilitation education and practice. *Rehabilitation Counseling Bulletin*, 47, 142–151.
- Mpofu, E., Thomas, K. R., & Thompson, D. (1998). Cultural appropriation and rehabilitation counseling: Implications for rehabilitation education. *Rehabilitation Education*, 12, 205–261.
- Murphy, R. (1987). *The body silent*. New York: Holt.
- Swain, J., Gillman, M., & French, S. (1998). *Confronting disabling barriers: Towards making organisations accessible*. Birmingham, UK: Venture Press.
- World Health Organization. (2001). *ICF: International Classification of Functioning, Disability and Health*. Geneva, Switzerland: Author.
- Wright, B. A. (1991). Labeling: The need for person–environment individuation. In C. R. Snyder & D. R. Forsyth (Eds.), *Handbook of social and clinical psychology: The health perspective* (pp. 469–487). New York: Pergamon.

---

## PREScreening, IN-DEPTH EXPLORATION, AND CHOICE MODEL

---

The prescreening, in-depth exploration, and choice (PIC) model, proposed by Gati and Asher in 2001,



provides a practical systematic framework for making career decisions based on decision theory. The PIC model consists of three stages: (1) prescreening the potential set of career alternatives to locate a small and thus manageable set of promising alternatives; (2) in-depth exploration of the promising alternatives, resulting in a list of a few suitable alternatives; (3) choice of the most compatible alternative, based on a detailed comparison between the suitable alternatives.

### Theoretical Background

Decision theory has been regarded as a potential frame of reference for career decision making for almost half a century. This perspective conceptualizes career choices in terms of the cognitive processes used to locate the career alternatives most compatible with the individual's preferences and capabilities. Career decision making is a complex task. The number and variety of alternatives is often very large, and many attributes (e.g., traveling, teamwork) are required for adequately describing the potential alternatives and the individual's characteristics. Therefore, comparing among the alternatives and evaluating their compatibility to the individual is a nontrivial task.

### The Three Types of Decision-Making Models

Three types of decision-making models have commonly been cited as potential theoretical frameworks for the career decision-making process. *Normative models* specify procedures for making optimal rational decisions, aimed at maximizing the subjective (expected) utility, based on an overall evaluation of the alternatives. *Descriptive models* focus on characterizing the ways individuals actually make decisions in real life and document biases and inconsistencies in individuals' natural decision behaviors that lead to less than optimal decisions.

*Prescriptive decision models* bridge the theoretically oriented normative models and the reality-oriented descriptive ones by providing a systematic framework for decision making while taking into account individuals' bounded rationality and intuitive thinking. Since it translates theoretical knowledge from decision theory into career counseling interventions, this type of model appears the most relevant for

facilitating career decision making. The PIC model is a prescriptive model that outlines a systematic and practical framework for making career decisions.

### The Three Stages of the PIC model

The PIC model aims at reducing the complexity of career decision making by separating the process into three distinct stages, each focusing on a well-defined task: prescreening, in-depth exploration, and choice.

### Prescreening the Potential Alternatives

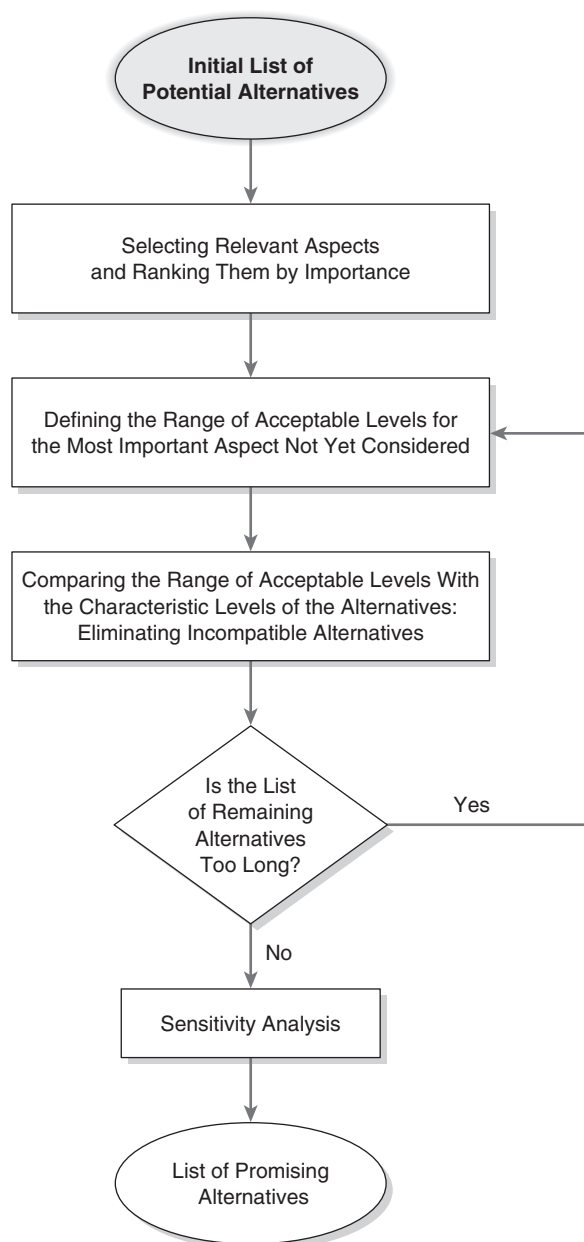
The goal of the prescreening stage is to deal with the overload of information in career decision making by helping the individual focus on the most relevant information. The goal is to locate a manageable set of promising alternatives that deserve further, in-depth exploration, using *sequential elimination*. The idea of sequential elimination is based on Tversky's 1972 elimination-by-aspects model, which has been shown to be compatible with the intuitive ways individuals make decisions when faced with a large array of alternatives.

The search for promising alternatives is based on the individuals' preferences in career-related aspects that are most important to them. *Career-related aspects* are all variables that can be used to characterize either individuals' preferences and abilities or career alternatives. The list of important aspects that should guide the prescreening process includes objective constraints (e.g., disability), competencies (e.g., creativity, technical skills), and core preferences (e.g., teamwork). The model distinguishes among three facets of the individual's preferences: (1) the importance of the aspect, (2) the level regarded as optimal (e.g., "only outdoors"), and (3) additional, less desirable but still acceptable level(s), representing the individual's willingness to compromise (e.g., "mainly outdoors").

The process of sequential elimination is a within-aspect, across-alternatives search: It is conducted aspect by aspect, starting from the most important one. For each aspect, the characteristics of all potential alternatives are compared with the individual's preferences, and incompatible alternatives are eliminated. The process is repeated for the remaining aspects in descending order of importance until the number of remaining promising alternatives is manageable (i.e., seven or less). To decrease the possibility that potentially suitable alternatives might be eliminated



because of a minor mismatch, the prescreening stage ends with a reexamination of the effects of potential changes in the individual's inputs on the outcome—the list of promising career options; this process is called *sensitivity analysis*. These steps are summarized in Figure 1.



**Figure 1** The steps of the prescreening stage

Source: Adapted with author's permission from Figure 1 in Gati, I. (1986). Making career decisions: A sequential elimination approach. *Journal of Counseling*, 33, 408–417. Copyright by the American Psychological Association.

### *In-Depth Exploration of the Promising Alternatives*

The goal of this stage is to confirm that a promising alternative is indeed suitable for the individual. During this stage, the analysis focuses on a within-occupation, across-aspect evaluation. This involves zooming in on one promising alternative at a time and collecting additional, comprehensive information on it to find out (a) whether the occupation is indeed compatible with the individual's preferences, (b) whether the individual is willing and able to satisfy the demands involving the essence of the occupation (i.e., its core aspects, e.g., physical treatment of people and working in shifts for a paramedic), and (c) the probability of actualizing that choice, taking into account the prerequisites of the occupation and the requirements for success in it. During this in-depth exploration, some promising alternatives will be eliminated, and thus this stage will end in a short list of suitable alternatives.

### *Choice*

The goal of this stage is to choose a few most suitable alternatives, rank ordered by priority of implementation. It involves a refined, detailed comparison between the alternatives under consideration, focusing on the differences among them. The small number of alternatives still relevant at this stage makes it possible to use the principles of rational normative models, and in particular the principle of compensation (i.e., trade-offs between the advantages and disadvantages of each alternative). The process that can be advocated is based on comparing pairs of alternatives from the short list of final options. It involves canceling out the relative advantages of the compared alternatives in each pair until the decision maker remains with only the net advantages of one of the alternatives. This process is repeated until only one alternative remains. Finally, the congruence between the outcome of the systematic decision process and previously intuitively appealing occupational alternatives should be examined: it may strengthen the individual's confidence in the choice or indicate the need for a reexamination of the decision process in order to locate the sources for incompatibilities and try to reconcile them.



## Research Findings

Research has supported the rationale underlying the PIC model and its descriptive validity. It has shown that individuals' information-seeking behavior is compatible with the stages of the PIC model. Specifically, when faced with a large array of career options, people tend to use a small number of significant criteria, one at a time, to reduce the number of alternatives to a few; but when faced with a small number of alternatives, people can compare them using compensatory principles. Interventions based on the PIC model, such as MBCD (an Internet-based career planning system; ), has demonstrated its effectiveness: (a) decreasing individuals' career decision-making difficulties, (b) helping them advance toward making a decision, and (c) increasing the probability of greater occupational satisfaction in the future.

## Using the PIC Model in Career Guidance and Counseling

The role of career counselors includes guiding clients through the stages of the decision-making process while encouraging them to play an active and dominant role in each stage. During prescreening, career counselors should help clients explicate their preferences (and their willingness to compromise, if needed), and take notice of actual or perceived constraints. During the in-depth exploration, counselors should direct clients to relevant sources of information, highlighting the quality of various sources in terms of accuracy and biases. During the choice stage the counselor can assist the client through the complex task of evaluating the suitable alternatives. Finally, counselors can guide clients in exploring ways to increase the probability of actualizing the most preferred alternative. The PIC model can serve as a framework for a dynamic counselor–client dialogue as well as for monitoring the client's advancement in the process. In addition, PIC can serve as a blueprint for designing computer-assisted career guidance systems, such as MBCD.

## Future Directions

Dealing with career indecision has long been a focus of theory and research, and helping clients to overcome their indecision is among the core roles of career counseling. The PIC model demonstrates the

potential in adopting decision theories for designing interventions aimed at fulfilling that role. However, there is still a need to reinforce the mutual enrichment between theoretical knowledge about decision making and the hands-on experience of career counselors. Future efforts to combine the normative and descriptive models for career decisions are likely to yield a more comprehensive prescriptive approach for facilitating the career decision-making process. The challenge is to design systematic guidelines that allow adaptive and active career decision making in the face of uncertainty, fuzziness, and change that characterize the 21st century's world of work.

*Itamar Gati and Shiri Tal*

**See also** Career Counseling Process (v4); Career Decision-Making Difficulties Questionnaire (v4); Career Decision Scale (v4); Career Decision Self-Efficacy Scale (v4); Career Exploration (v4); Career Indecision (v4); Career Occupational Preference System (v4); Decision Making (v4); Person–Environment Fit (v4); Tiedeman's Decision-Making Theory (v4)

## Further Readings

- Gati, I. (1986). Making career decisions: A sequential elimination approach. *Journal of Counseling Psychology*, 33, 408–417.
- Gati, I., & Asher, I. (2001). The PIC model for career decision making: Prescreening, in-depth exploration, and choice. In F. T. L. Leong & A. Barak (Eds.), *Contemporary models in vocational psychology* (pp. 7–54). Mahwah, NJ: Lawrence Erlbaum.
- Gati, I., & Asher, I. (2001). Prescreening, in-depth exploration, and choice: From decision theory to career counseling practice. *Career Development Quarterly*, 50, 140–157.
- Gati, I., Gadassi, R., & Shemesh, N. (2006). The predictive validity of a computer-assisted career decision-making system: A six-year follow-up. *Journal of Vocational Behavior*, 68, 205–219.
- Gati, I., & Tal, S. (2008). Decision-making models and career guidance. In J. Athanasou & R. Van Esbroeck (Eds.), *International handbook of career guidance* (pp. 157–185). Berlin, Germany: Springer.

## Web Sites

Making Better Career Decisions (MBCD): <http://mbcd.intocareers.org>



---

## PRIVATE PRACTICE CAREER COUNSELING

---

Career counselors working in private practices typically provide services to individual and organizational clients. The services most often rendered to individuals include assistance with career decision making and planning, coaching, and securing employment. Organizations most often retain private practitioners to assist with staffing decisions, developing succession plans and programs, and outplacement.

Many career counselors' private practices evolve and are market driven. Some have, for example, developed specialized practices related to corporate employment selection (evaluating candidates being considered for new hire or promotion), partner relocation (assisting "trailing partners" in dual-partner relationships with career transitions after their partners' job transfers necessitated relocation), and forensic expert services (providing analyses in disputes related to earning capacity). A counselor's talents and interests—along with local market needs and other business factors—typically shape the complexion a private practice assumes.

Private practice services are rendered on a fee-for-service basis and in addition to providing services counselors operate for-profit businesses. Since a practice's viability depends upon a counselor's ability to consistently maintain a business volume that generates fees higher than costs while also allowing the counselor to realize compensation goals, private practitioners must be astute businesspeople. As in any business, the delivery of quality services, marketing, pricing, operations management, and other business functions are central to private practice success. Simply put, a private practice career counselor must be skilled technically, professionally, and entrepreneurially.

Because private practitioners must be competent businesspeople and have experience in a for-profit business, preferably in a consulting organization, business-related training is also recommended. Most career counselors transition into full-time private practice via part-time initiatives, after having maintained another, allied, source of employment. They then transition into full-time private practitioners as their practices become established. This helps minimize risk and enables practitioners to adapt resources and business development strategies as market factors

are tested. A sound business plan, with ongoing refinement, is essential to career counselors considering private practice venues.

Clients who seek private practitioners' services can greatly benefit from specialized, on-demand, and individualized career development assistance—provided a competent, ethical practitioner renders the services. Many unqualified individuals, however, purport to offer quality career guidance services. Consumers are cautioned to conduct due diligence before engaging a private-practice career counselor. The National Career Development Association maintains guidelines to help consumers select appropriate services and to understand standards of practice essential to effective service delivery.

*Michael Shahnasarian*

*See also* Career Counseling (v4); Career Counseling in Organizations (v4); Career Counseling in Schools (v4); Career Counseling Process (v4); Career Planning (v4); Contract Work (v4); National Career Development Association (v4); Standards and Competencies (v4)

### Further Readings

- Bellman, G. M. (2001). *The consultant's calling: Bringing who you are to what you do*. San Francisco: Jossey-Bass.
- Gelardin, S. (Ed.). (2007). *Starting and growing a business in the new economy*. Broken Arrow, OK: National Career Development Association.
- Gerber, M. (2001). *The e-myth revisited: Why most small businesses don't work and what to do about it*. New York: HarperCollins.
- Hafer, A. (Ed.). (1992). *The nuts and bolts of career counseling: How to set up and succeed in private practice*. Tulsa, OK: National Career Development Association.

---

## PROCESS AND OUTCOME RESEARCH

---

Process and outcome research are two interconnected research methodologies that identify the processes that go on in counseling sessions and the effectiveness of these processes in outcomes for clients. Specifically, process research identifies the counseling variables involved in client change, while outcome research identifies the actual changes that occur.



Moreover, following the definition of psychotherapy process, *career counseling process* denotes the overt and covert thoughts, feelings, and behaviors of both the client and the counselor during a career counseling session. *Outcome* denotes changes that occur directly or indirectly as a result of career counseling as measured in terms of immediate effects, intermediate effects, or distal effects.

Within process and outcome research, there may be several process variables that are contributing to the outcome of the client. Process and outcome research is necessary in career research because career counseling involves psychological and emotional components that require counselors to use many of the same therapeutic skills that are used in psychological counseling. Thus, the majority of research designs and process and outcome variables of interest in career counseling are parallel to those investigated in personal or therapeutic counseling.

### **Process Research in Career Counseling**

Process inquiry may include both the covert and overt variables of therapists and clients (such as thoughts, feelings, and behaviors) that take place in a counseling session or over the course of several sessions. Process career research has been conducted through the use of two major approaches: naturalistic settings and analogue inquiry. Naturalistic settings are actual counseling sessions with real clients. Forms of naturalistic inquiry include case study (e.g., a detailed focus on one or a few clients to identify process variables), conversational analysis (e.g., analysis of conversation between therapist and client to identify process variables), client's expectations about career counseling, and process variables in group career counseling. Analogue inquiry involves the use of artificially created counseling situations to identify process variables. Analogue research usually involves watching a videotape of a mock session or reading a transcript that resembles an actual counseling session. Most analogue research has focused on counselor variables that may influence the process, such as verbal responses or behavior. Analogue inquiry has examined such variables as counselor verbal responses, counselor in-session behavior, and the process variables in initial interviews. Naturalistic settings allow the researcher to easily generalize findings about the career counseling process, but offer the

researcher little control over confounding influences on process variables being measured. While analogue research allows a greater control over the processes being measured, the results are also more difficult to generalize to other individuals outside of the study.

There are four major design decisions that have been identified in the literature that will determine the format of the process research inquiry: (a) what specific processes are being measured, (b) the number of counseling session(s) that will be used to examine the specific processes, (c) the perspective or vantage point from which the specific processes will be measured, and (d) how the gathered data on processes will be evaluated. While there are many processes occurring during a counseling session (e.g., the formation of the working alliance between the counselor and the client), the researcher determines which specific process variables will be focused on and measured, as well as the level on which they will be measured. Examples of focuses of specific processes include content of session(s), what is done in session(s), style of session(s), and quality of the session. This focus may be measured on the microlevel (words stated) to the macrolevel (counseling relationship). For both naturalistic and analogue settings, most process research utilizes trained raters who identify and code the processes of interest taking place in the counseling session(s), thus providing a vantage point of how processes are measured. Traditionally, process data analyses have been correlational, but it is possible to use other forms of statistical analyses.

### **Outcome Research in Career Counseling**

Outcome research seeks to evaluate the effectiveness of specific career interventions or general career counseling services. Outcome inquiry measures the effects of career counseling or interventions by comparing different career interventions to each other and to control groups. In career counseling, effects are measured by comparing (a) individual counseling to group counseling, (b) brief counseling to long-term counseling, and (c) career counseling to control groups. The effects are identified through the use of quantitative instruments that measure specific outcome criteria. Outcome criteria are variables that indicate the amount of change in a specific area—such as client satisfaction, realism or career choice, and career self-efficacy—as a result of the provided career service.



Outcome criteria data may be measured while a client is still in counseling, after counseling has been completed, and during a follow-up measurement.

Increasingly fine-tuned meta-analyses have been conducted over the past 2 decades that demonstrate that effect sizes of career counseling varied, with some studies indicating it to be as high as .87 and others as low as .41. These varying effect sizes have prompted researchers to call for more thorough inquiry into career counseling as an intervention specifically and to examine a range of potential outcomes. Although it is important to know that most studies indicate that career counseling is effective with most clients, most of the time, learning more about the particular mechanisms that lead to positive outcomes is a critical research area.

As with process research, the researcher determines which outcome criteria to measure and selects appropriate instruments for this measurement. The outcome measures, or effects of career counseling, are highly influenced by the methods used in the study. Career outcome research utilizes both recruited participants who are given career counseling for the sole purpose of measuring outcome and actual clients who are receiving career counseling services. As with outcome research in personal counseling, not having random assignment and a control group will inhibit the researcher's ability to attribute the measured effects to career counseling. Thus, within career counseling research the utilization of actual clients and comparison control groups is recommended for greatest ability to measure outcome effects.

### Combined Use of Process and Outcome Research in Career Counseling

Process and outcome research have not been conducted in career counseling to the same extent as in psychotherapy. This lack of process career counseling research has been highly influenced by the former view that career counseling is void of psychological elements and thus not in need of process information.

In addition, career counseling is generally viewed as being effective, a view that does not prompt researchers to spend time conducting labor-intensive process inquiry that breaks down known effectiveness element by element. Outcome research is essential for career counseling because it has the power to measure the specific effect career counseling has on clients, while process research identifies the mechanisms taking place in career counseling that lead to that outcome. Recently a research agenda has been outlined in order to guide researchers to more systematic inquiry into the process and outcome of career counseling.

Mary J. Heppner and Shiloh E. Jordan

**See also** Career Counseling (v4); Career Counseling Process (v4); Career Interventions (v4); Counseling Process/Outcome (v2); Counseling Skills Training (v2); Job Satisfaction and General Well-Being (v4); Mixed Methodology Research (v1); Outcomes of Counseling and Psychotherapy (v2); Performance Modeling (v4); Qualitative Methodologies (v1); Quantitative Methodologies (v1); Standards and Competencies (v4)

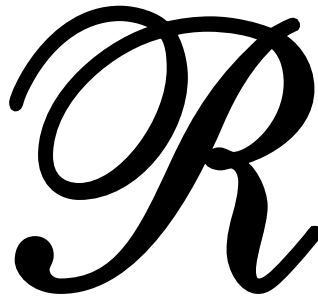
### Further Readings

- Heppner, M. J., & Heppner, P. P. (2003). Identifying process variables in career counseling: A research agenda. *Journal of Vocational Behavior*, 62, 429–452.
- Hill, C. E., & Williams E. N. (2000). The process of individual therapy. In S. D. Brown & R. W. Lent (Eds.), *Handbook of counseling psychology* (3rd ed., pp. 670–710). New York: Wiley.
- Swanson, J. L. (1995). The process and outcome of career counseling. In W. B. Walsh & S. H. Osipow (Eds.), *Handbook of vocational theory and practice: Theory, research, and practice* (2nd ed., pp. 217–260). Thousand Oaks, CA: Sage.
- Wiston, S., Sexton, T. L., & Lasoff, D. L. (1998). Career-intervention outcome: A replication and extension of Oliver and Spokane. *Journal of Counseling Psychology*, 45, 150–165.









---

## RETIREMENT

---

Modern life can be viewed as calling for a predictable series of developmental stages. Donald E. Super, a vocational psychologist, has identified five, each one named for its main activity: growth, exploration, establishment, management, and disengagement. Development through these stages requires a series of transitions: from childhood to school, from school to employment (and/or marriage and parenthood), then to increasingly responsible jobs, and finally to retirement.

Up until the 20th century, the notion of retirement as we now know it hardly existed. Most people simply worked until they could not anymore. But in the early 1900s, certain occupations—teachers, municipal workers, and especially police officers and firefighters—sought mandatory retirement and benefits. In 1935, the U.S. Federal Government passed the Social Security Act, which paid benefits to all workers who had reached the age of 65. (The actual law and its modifications since that time are greatly more complex than this simple statement.) At that time there were about 7 million men and women age 65 and older. In 2000, the number was closer to 35 million. Presently, the population surge of retiring baby boomers will swell this number. Clearly, retirement has become a significant aspect of modern life.

There are a number of issues to be considered in the transition to retirement. Finances typically receive serious attention, since for many people retirement means reduced income. Health, complicated by the simple process of aging, is probably the second-ranking retirement issue. Another issue that is gaining attention

is use of time—the opportunity to do whatever one wants: traveling, grandparenting, renewing old hobbies, volunteering, continuing education, and even a new career, among other things.

Counseling Psychologist Nancy Schlossberg has studied retirees and sees coping with the retirement transition as depending on a number of variables: financial security and health, of course, but also the role that employment and careers has played in the life of the individual and his or her family, at what age one retires, whether the individual has liked his or her career, and the degree of planning for retirement, among many others.

More importantly, Schlossberg has found a number of ways of dealing with retirement. Among them is one she calls “continuers,” which is Schlossberg herself, who exchanged her professorship in adult and career development for her present role as a retirement transition facilitator. Another role is the “easy glider,” who doesn’t plan, but simply lets each day of retirement unfold. There are also “adventurers,” who start entirely new activities—a new career, a commitment to a volunteer cause, earning a degree that was not achieved earlier, researching one’s family history, and the like.

Overall, the transition to retirement merits careful thought and attention to possibilities—and opportunity for the counseling profession.

*Donald G. Zytowski*

*See also* Adult Development (v1); Adults in Transition (v4); Aging (v1); Career/Life (v4); Life-Role Balance (v4); Retirement, Implications of (v1); Super, Donald Edwin (v4); Super’s Theory (v4)



### Further Readings

- Schlossberg, N. (2004). *Retire smart, retire happy: Finding your true path in life*. Washington, DC: American Psychological Association.
- Super, D. E. (1990). A life-span, life-space approach to career development. In D. Brown, L. Brooks, & Associates (Eds.), *Career choice and development: Applying contemporary theories to practice* (pp. 197–261). San Francisco: Jossey-Bass.

---

## ROE, ANNE (1904–1991)

---

Working at a time when few women were active as researchers, Anne Roe provided a different perspective on career choice and adjustment and is now credited as being the forerunner of a psychodynamic perspective. Roe was particularly interested in individual psychological differences between people and utilized research and statistical methods. From the 1930s, she engaged in a range of clinical psychology research, for example, in investigating intelligence and learning disability, the correlates of alcoholism, the personality of artists, and the psychology of creativity. This diversity and working separately from the mainstream of counseling psychology enabled her to approach the topic of career choice in a fresh way.

In 1956, she wrote *The Psychology of Occupations*, which outlined her understanding of the role of occupations in both society and individual lives, early experiences and their influence on career patterns, and occupational groups. This work evolved from a systematic study of well-known research scientists and artists, where she gathered extensive retrospective developmental accounts to enable her to identify factors involved in career choice. The book publicized the two main strands of her theorizing about careers: the classification of occupations and the origins of career needs and interests.

Roe sought a scheme for categorizing occupations and was dissatisfied with those in existence because they were lists rather than being underpinned by an organizing rationale. She therefore considered research that had used factor analysis and developed eight occupational groups titled service, business contact, organization, technology, outdoor, the sciences, general culture, and arts and entertainment (labeled as groups I–VIII). Roe postulated that the first three and last two groups were careers orientated toward people, whereas groups IV, V, and VI were more orientated

away from people. She arranged these eight groups into a circle rather than into a list. She developed this work further by suggesting six levels of occupation depending on level of responsibility, aptitudes, and skills, which she represented as layers below the circle (in a cone shape). Level 6 (the lowest) represented unskilled jobs that she believed were less differentiated than the higher levels, with level 1 representing professional and managerial jobs. Her classification groups were used both in many practical applications (e.g., to develop interest tests, group college programs, and as a basis for careers education) and generated research into a number of aspects (e.g., career aspirations of high school pupils, occupational change, and sex-role stereotyping).

Roe's ideas about the links between occupational choice and developmental (especially parental–family) determinants have led to extensive debate in the field, with limited research support. Roe focused on the influence of personal experiences of varied parental attitudes in the early years to propose the individual channeling involuntary attention toward people or toward other phenomena. She believed that the degree to which parents concentrated emotions on the child (being overprotective or overdemanding), accepted (in either a loving or casual way), or avoided the child (via emotional rejection or neglect) determined the way in which the child's subsequent needs and interests would be channeled and affected communication and organizational skills.

Over a number of years, Roe and her associates developed two versions of the Personal-Child Relations Questionnaire to enable parental attitudes to be investigated, leading to scores on scales (two bipolar and one unipolar): loving–rejecting, casual–demanding, and overt attention. The complexity of differences in influence between two parents, differences over time, differences depending on sex of parent and child, and the limitations of retrospective accounts have all had an impact on the challenges of using this approach in career counseling. Roe herself acknowledged that her theories were less applicable to the complexities of women's and minority groups' career development. Many career counselors credit Roe with highlighting of familial determinants and considerations of life history in career choice processes. In her later work, she devised a formula that was inclusive of a wider range of variables that enter career choice processes and allowed for the shifted weighting of these over the life span.

Jacqueline E. Akhurst



*See also* Career Counseling (v4); Career Exploration (v4); Career Interventions (v4); Career Occupational Preference System (v4); Parent–Adolescent Relations (v1); Parenting (v1); Personality Assessment and Careers (v4); Roe's Theory of Personality Development and Career Choice (v4)

### Further Readings

- Brown, M. T., Lum, J. L., & Kim, V. (1997). Roe revisited: A call for the reappraisal of the theory of personality development and career choice. *Journal of Vocational Behavior*, 51, 283–294.
- Roe, A., & Lunneborg, P. W. (1990). Personality development and career choice. In D. Brown & L. Brooks (Eds.), *Career choice and development* (2nd ed., pp. 68–101). San Francisco: Jossey-Bass.
- Sharf, R. S. (2007). *Applying career development theory to counseling*. Belmont, CA: Thomson.
- Simpson, E. L. (1980). Occupational endeavour as life history: Anne Roe. *Psychology of Women Quarterly*, 5(1), 116–126.
- Wrenn, R. L. (1985). The evolution of Anne Roe. *Journal of Counseling and Development*, 63(5), 267–275.

## ROE'S THEORY OF PERSONALITY DEVELOPMENT AND CAREER CHOICE

Anne Roe (1904–1991) was born and raised in Denver, Colorado. Upon graduating from the University of Denver, she attended Columbia University, following the recommendation of Thomas Garth. At Columbia, Roe worked in the office of Edward Lee Thorndike, graduating with her Ph.D. in experimental psychology under the supervision of Robert S. Woodworth. The publication of *The Psychology of Occupations* would introduce Roe's theory of personality development and career choice, her most enduring scientific contribution.

Roe's theory can be separated into two key areas: theoretical aspects of personality and classification of occupations. Inspired by Maslow's hierarchy of needs, Roe incorporated the psychological needs that develop out of parent–child interactions in her conceptualization of personality. Roe classified parent–child interaction patterns into three categories, each with two subcategories: (1) emotional concentration on the child, further classified as being overprotective or overdemanding, (2) avoidance of the child, further classified as emotional rejection or neglect, and (3) acceptance of the child, further classified as casual or loving. Roe's interest in parent–child interactions

led to the development of the Parent–Child Relations Questionnaire and its revision as a means of accurately assessing such interactions. Out of parent–child interactions, Roe thought that children went on to develop an orientation either toward or not toward people.

Roe was dissatisfied with existing classification systems for occupations, including the benchmark *Dictionary of Occupational Titles*. In order to compare the individual to a full spectrum of occupations, Roe set out to develop a comprehensive classification system that would allow her to engage her inquiry. The result was a two-dimensional, eight by six classification system with eight categories of occupations (service, business contact, organization, technology, outdoor, science, general culture, and arts and entertainment) and six levels (professional and managerial, levels 1 and 2; semiprofessional and small business, level 3; skilled, level 4; semiskilled, level 5; and unskilled, level 6) within each category.

Research into the impact of parent–child interactions on career choice has not resulted in significant support for Roe's theory. Concerns with subject recall of parent–child interactions, differences in parenting styles between parents and over time, and sample sizes, among other issues, have been cited. Roe openly acknowledged the criticisms of her theory and expressed concerns that her classification system did not adequately address the experiences of women and minorities. In addition, Roe stated that her theory was developed with little forethought in regard to its application. Still, research support can be found for Roe's classification system, and a minimal amount of support has been found related to the impact of early interactions upon the work-related behaviors and activities within certain areas of occupational specialization. The impact of Roe's theory has been realized across the various facets of activities of career development professionals such as teaching, counseling, placement, and research. Roe's classification system has proven particularly useful to career counselors in the influence it has had in the development of career assessment instruments and in its overall contribution to the mapping of the world of work.

William C. Briddick

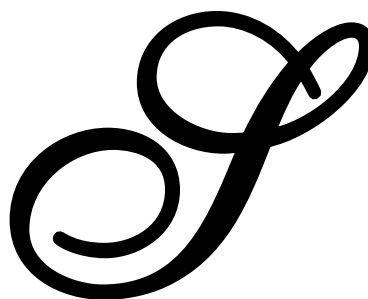
*See also* Career Counseling (v4); Career Exploration (v4); Career Interventions (v4); Career Occupational Preference System (v4); Parent–Adolescent Relations (v1); Parenting (v1); Personality Assessment and Careers (v4); Roe, Anne (v4)



**Further Readings**

- Osipow, S. H., & Fitzgerald, L. F. (1996). *Theories of career development* (4th ed.). Boston: Allyn & Bacon.
- Roe, A. (1956). *The psychology of occupations*. New York: Wiley.
- Roe, A. (1957). Early determinants of vocational choice. *Journal of Counseling Psychology*, 4, 212–217.
- Roe, A., & Lunneborg, P. W. (1990). Personality development and career choice. In D. Brown & L. Brooks (Eds.), *Career choice and development: Applying contemporary theories to practice* (2nd ed., pp. 68–101). San Francisco: Jossey-Bass.
- Tinsley, H. E. A. (Ed.). (1997). [Special section on Anne Roe]. *Journal of Vocational Behavior*, 51, 280–318.





---

## SCHOOL-TO-WORK TRANSITION

---

Most people will encounter the developmental task of making the transition from school to work, as the assumption of the worker role is one of the hallmarks of adulthood. However, the school-to-work transition generally refers to the transition made by those youth who are moving directly from high school to work, frequently with minimal support. Because it is a part of the adolescent-to-adult transition, the move from school to work presents the individual with several challenges and opportunities. Because it is integral to the mission of the central social institutions of education and employment, the school-to-work transition is also a major policy and reform issue.

### **School to Work as a Developmental Transition**

Transitions of any type bring with them periods of uncertainty and stress. In the transition from school to work, that stress is exacerbated by the fact that work is necessary to meet basic survival needs. In the United States, youth who do not attend college are more likely to be unemployed or to be employed in transient jobs with little opportunity for advancement. The lack of a college education results in significant decreases in lifetime earnings as well. These issues are particularly problematic for youth who are African American, Hispanic, and American Indian, all of whom have substantially higher unemployment rates, lower college attendance rates, and lower high school graduation rates than do White Americans.

A primary task of this time of transition is to develop the skills necessary to be an effective worker. Historically, this has involved learning specific skills related to trades or occupations and then moving into an entry-level job for which one has specifically prepared, similar to the training of an apprentice. However, in the current labor market, occupation-specific skills are often not as critical as transferable work skills. Employers report that they are seeking workers with broad skills in reading, writing, math, and communication (listening and speaking); the ability to work well with others, be creative, solve problems, and be organized; and an attitude of responsibility, self-management, and integrity.

This set of skills provides a foundation from which potential employees can learn job-specific skills more readily. It also emphasizes the need for career counselors to prepare students to be work ready rather than job ready. This need is reinforced by the reality that most people will change jobs multiple times over the course of their lives, leading many career theorists to point out that the most important task of career counseling may be to prepare young workers to be adaptable to changing labor and market demands. Essentially, the task of this developmental transition is to assume the skills and attitudes necessary to negotiate a rapidly changing work environment.

### **School to Work as a Policy and Reform Initiative**

In response to a landmark report published in 1998 by the William T. Grant Foundation, *The Forgotten Half: Pathways to Success for America's Youth and Young*



*Families*, educators and policy makers began to look closely at the needs of work-bound or noncollege-bound youth and determined that the school-to-work transition in the United States was in significant need. In fact, former U.S. Secretary of Labor Ray Marshall remarked, in the early 1990s, that America had the worst school-to-work transition process of any of the industrialized nations. In contrast to other countries, particularly in Europe, that provide structured apprenticeship models to transition youth into work, the United States has very few services in place for work-bound youth, resulting in longer periods of struggle with part-time, low-paying jobs. In fact, work-bound youth receive approximately 10% of the values of services that college-enrolled youth receive.

Policy efforts to address the concerns raised in *The Forgotten Half* resulted in federal legislation, the School to Work Opportunities Act (STWOA) of 1994, that codified several major components of school-to-work programs. The STWOA provided block grants for states to design school-to-work programs that included the following components: school-based learning, workplace-based learning, an integration of the two through coordinated efforts between teachers and employers, and stakeholder support in the form of parents, community groups, employers, and other concerned parties. From these grants emerged a number of types of school-to-work programs, including tech preps, career academies, occupation-academic cluster programs, school-based enterprise, cooperative education, and youth apprenticeship programs. The initiation of STWOA programs was not without controversy, however. Several states ultimately passed laws that banned or modified school-to-work programs as described in the federal guidelines.

Evaluations of the federally funded school-to-work programs have provided mixed findings. Several evaluations of single programs (i.e., programs in a single school district) have suggested that students who participate in a school-to-work programs are more likely to earn better grades, complete more high school credits, and attend college than those who do not participate. This finding has been more robust for boys than it has been for girls. Large evaluation studies of the impact of STWOA legislation have suggested that only a small number of students have actually been able to complete the linked school-work activities that STWOA intended to provide. However, there is also evidence that participation in work-related activities did increase among work-bound youth who participate in school-to-work programs.

## Effective School-to-Work Programs

Several challenges to establishing effective school-to-work programs have been identified: workplace learning requires significant support from school staff, accompanied by expense to the schools; employers who are willing to assume some of the costs for school-to-work programs may not benefit if participants decide to go on to college, thus reducing employer motivation to participate; and workplace activities and academic success sometimes conflict with each other, particularly in terms of time demands.

Successful school-to-work programs have several characteristics that allow them to address these challenges. First, they gather input from a number of local constituents, including employers and parents, to meet the needs of local students. Second, school personnel are invested and the program is integrated into the school environment. Similarly, employers who are invested early are more likely to continue as partners, even if some students do not remain on as full-time employees. Finally, there is some indication that beginning career activities early in elementary school contributes to greater success, as does developing a school-work curriculum that is strong enough to prepare participants for both 2- and 4-year colleges.

## Future Directions

Although legislative attention to the school-to-work transition and the needs of work-bound youth has diminished, the needs of the population remain significant. For example, work-bound youth continue to earn significantly less income than do those who go to college. The U.S. Census Bureau reported in 2005 that the mean income for earners of the bachelor's degree was \$51,206, those with high school diplomas earned \$27,915, and those who did not graduate from high school earned an average of \$18,734. Furthermore, the Economic Policy Institute reported that approximately 33% of workers with a high school diploma were not covered by health insurance in 2005, compared to approximately 18% of those with college degrees.

Of course, economic outcomes are not the only evidence of work or career success. Nonetheless, these indicators make it clear that greater attention must be paid to a successful school-to-work transition for youth who are most likely to be disadvantaged and are ultimately most likely to stay in a less advantaged state as they mature. Continued attention to career and vocational education, leading to the development of



effective work readiness strategies, is essential to meaningful education reform and to the well-being of workers in the United States.

Cindy L. Juntunen

**See also** Academic Achievement, Nature and Use of (v4); Career Advancement (v4); Career Counseling (v4); Career Counseling in Colleges and Universities (v4); Career Counseling in Schools (v4); Career Development Inventory (v4); Career Education (v4); School Counseling (v1); Transition Behavior Scale (v4); Work-Bound Youth (v4)

### Further Readings

- Blustein, D. L. (1999). A match made in heaven? Career development theories and the school-to-work transition. *Career Development Quarterly*, 47, 348–352.
- Blustein, D. L., Juntunen, C. L., & Worthington, R. L. (2000). The school-to-work transition: Adjustment challenges of the forgotten half. In S. D. Brown & R. W. Lent (Eds.), *Handbook of counseling psychology* (3rd ed., pp. 435–470). New York: Wiley.
- Dykeman, C., Herr, E. L., Engram, M., Pehrsson, D., Wood, C., & Charles, S. (2001). *A taxonomy of career development interventions that occur in US secondary schools*. Columbus, OH: National Dissemination Center for Career and Technical Education.
- Krumboltz, J. D., & Worthington, R. L. (1999). The school-to-work transition from a learning perspective. *The Career Development Quarterly*, 47, 312–325.
- Lent, R. W., Hackett, G., & Brown, S. D. (1999). A social cognitive view of school-to-work transition. *The Career Development Quarterly*, 47, 297–311.
- Lent, R. W., O'Brien, K. M., & Fassinger, R. E. (1998). School-to-work transition and counseling psychology. *The Counseling Psychologist*, 26, 489–494.
- Lent, R. W., & Worthington, R. L. (1999). Introduction: Applying career development theories to the school-to-work transition process. *The Career Development Quarterly*, 47, 291–296.
- Rojewski, J. W. (2002). *Preparing the workforce of tomorrow: A conceptual framework for career and technical education*. Columbus, OH: National Dissemination Center for Career and Technical Education.
- Savickas, M. L. (1999). The transition from school to work: A developmental perspective. *The Career Development Quarterly*, 47, 326–336.
- Swanson, J. L., & Fouad, N. A. (1999). Applying theories of person-environment fit to the transition from school to work. *The Career Development Quarterly*, 47, 337–347.

- William T. Grant Foundation Commission on Work, Family, and Citizenship. (1988). *The forgotten half: Non-college youth in America*. Washington, DC: Author.
- Wilson, W. J. (1996). *When work disappears: The world of the new urban poor*. New York: Vintage Books.

---

## SELF-DIRECTED SEARCH

---

The Self-Directed Search (SDS) is an interest inventory based on John Holland's RIASEC theory that people, work, and educational environments can be classified according to six basic types: Realistic, Investigative, Artistic, Social, Enterprising, and Conventional (RIASEC). According to the SDS's publisher, Psychological Assessment Resources, Inc., the SDS is the most widely used interest inventory in the world and has been translated into 25 languages. The SDS helps individuals identify occupations and fields of study that best match their self-reported interests and abilities. The SDS is based on the assumption that individuals whose job and work environments closely match their personality and interests usually consider themselves satisfied and successful with the career choices they have made.

The most commonly used version of the instrument is the SDS Form R (SDS R). In the Form R *Assessment Booklet*, individuals list their occupational aspirations in the Daydreams section, which can be scored separately to generate a daydreams summary code, or expressed interest code. Users are initially asked to review the *Occupations Finder* to locate a three-letter RIASEC code for each occupation listed, which immediately engages them in an occupational exploration activity. Additional sections include self-ratings of activity preferences, competencies, and occupations. In the last section, users rate their abilities across the six RIASEC areas. The SDS R has a self-scoring system that produces a three-letter summary code. The summary code, also called the assessed code, reflects the three RIASEC personality types an individual most closely resembles.

The SDS is a stand-alone career planning simulation that imitates an interest inventory, as well as a psychological test. The original paper and pencil SDS R has been revised 4 times, most recently in 1994, and includes the *Assessment Booklet*, the *Occupations Finder* (1,335 occupations employing 99% of U.S. workers and updated with additional information technology and Internet occupations in 1999), and the



*You and Your Career* booklet, which includes a brief review of scientific ideas supporting the SDS, guidelines for interpreting scores and codes, the personality characteristics associated with each RIASEC type, and some suggestions for successful career planning. Normative data for the 1994 edition of SDS R can be found in the *Professional User's Guide and Technical Manual* available from the publisher.

Although most counselors are familiar with the SDS R paper version, the other varied SDS formats and versions are less widely known. A computer-based version of SDS R provides for faster administration and more efficient use of the inventory. The computer generates a 10- to 12-page Interpretive Report for users based on SDS summary scores and a 1- to 3-page professional summary for counselors that includes additional diagnostic information. A sample report is available at [www.self-directed-search.com](http://www.self-directed-search.com).

Besides these various formats of SDS R, other versions of the SDS include Form E (Easy) for persons with poor English language or reading skills, Form CP (Career Planning) used with adults working in organizations, and Career Explorer designed for middle school students. These alternative formats of the SDS have the same basic features of SDS R. An Internet version of the SDS is also available, but it omits the Daydreams section, and there is no professional summary generated. The Internet version can be accessed at [www.self-directed-search.com](http://www.self-directed-search.com). In addition, as noted previously, the SDS is available in many other languages including French, Icelandic, Japanese, Korean, Spanish, Vietnamese—to name a few.

## Using the SDS in Practice

### **Expressed Interests**

From the very beginning, Holland urged counselors to pay close attention to what persons say about the occupations they are considering. Specifying occupational goals has been shown to be very predictive of a person's future occupational activity, in some cases achieving the prediction rate of assessed interests obtained from various standardized inventories.

An important innovation in the measurement of aspirations in the SDS Daydreams section was the coding of a person's occupational daydreams using the RIASEC typology. This procedure enables a counselor to examine not only the occupation named, but also its RIASEC code. When the first two or three

aspirations belong in the same RIASEC category, the predictive power of the first aspiration equals or exceeds the efficiency of an interest inventory.

### **Assessed Interests**

The SDS has been described as a simulated career planning experience because it reflects what might actually happen when a person is interviewed by a career counselor. For example, it is not uncommon for career counselors to ask individuals seeking career assistance, "What do you enjoy doing?" "What kinds of things do you do well?" and "What occupations have you thought about?" The *SDS Assessment Booklet* sections provide a way for counselors to observe how persons view themselves and their prior experiences in relation to their current educational and career decision making. The SDS is also a standardized career assessment instrument. The items in the *Assessment Booklet* have desired psychometric properties and are based on Holland's RIASEC theory. The SDS has been subjected to the same rigorous test development standards as other professionally published tests, and the SDS manuals describe a complex, theory-based test development process begun in 1970.

The Activities section of the SDS R *Assessment Booklet* has 11 items for each of the six RIASEC types. The items cover activities and hobbies that are done for fun or leisure, and users can endorse them as *like* or *dislike*. These items are included in the SDS because they effectively measure interests in relation to RIASEC theory.

In the Competencies section, users describe their skills, the kinds of things that they learned to do in the past, and indicate the skills they might want to develop in the future. This kind of information is practically important because it is reasonable to assume that persons completing a career assessment will want to consider their prior skills and accomplishments, as well as future skills they hope to develop. The Competencies section of the SDS R includes 11 items that are marked *yes* or *no* for the six RIASEC areas.

The next section of the SDS R is Occupations. It is longer than the previous two sections and includes 14 items (occupational titles) that are endorsed *yes* or *no* for each RIASEC area. Holland included this section because he wanted to make sure he obtained a good measure of the person's RIASEC typology and because he wanted to get a sense of a person's likes



and dislikes with respect to various occupational titles.

The final section of the SDS R *Assessment Booklet* is Self-Estimates. It includes the six RIASEC scales, which are rated twice (from 1 to 7) with respect to ability and skill. Users are asked to rate themselves “as you really think you are when compared with other persons your own age.”

### Implications

When the SDS was initially introduced, some critics scoffed at it and called it simplistic. More recent reviews have noted that the use of Holland’s inventories is extensive. The SDS is unique in several ways: (1) it is self-administering, self-scoring, and self-interpreting; (2) it is based on Holland’s theory; and (3) it is supported by extensive research studies numbering more than 500. The SDS is an inventory with well-documented psychometric characteristics that incorporates a person’s history of vocational daydreams or expressed interests, which in comparison to the assessed results can be used to increase predictive validity about the person’s future occupational choices. Because it is self-scored and can be easily interpreted by most users, it encourages a person’s active participation in the resolution of career problems and questions. After completing the SDS, individuals know more about themselves, more about occupations, and more about how to think about occupations in relation to their personal characteristics, thus gaining a framework for immediate career decisions and future occupational exploration.

*Janet G. Lenz and Robert C. Reardon*

**See also** Assessment (v4); Career Education (v4); Career Exploration (v4); Career Planning (v4); Computer-Assisted Career Counseling (v4); Holland, John L. (v4); Holland’s Theory of Vocational Personalities and Work Environments (v4); Person–Environment Fit (v4)

### Further Readings

Holland, J. L. (1997). *Making vocational choices: A theory of vocational personalities and work environments* (3rd ed.). Odessa, FL: Psychological Assessment Resources.

Holland, J. L., Powell, A., & Fritzsche, B. (1994). *The Self-Directed Search: Professional user’s guide*. Odessa, FL: Psychological Assessment Resources.

Lumsden, J. A., Sampson, J. P., Reardon, R. C., Lenz, J. G., & Peterson, G. W. (2004). A comparison study of the paper and pencil, personal computer, and Internet versions of Holland’s Self-Directed Search. *Measurement and Evaluation in Counseling and Development*, 37, 85–94.

Osborn, D. S., & Zunker, V. G. (2006). *Using assessment results for career development* (7th ed.). Belmont, CA: Brooks/Cole.

Reardon, R. C., & Lenz, J. G. (1998). *The Self-Directed Search and related Holland career materials: A practitioner’s guide*. Odessa, FL: Psychological Assessment Resources.

Spokane, A. R., Luchetta, E. J., & Richwine, M. H. (2002). Holland’s theory of personalities and work environments. In D. Brown & Associates (Eds.), *Career choice and development* (4th ed., pp. 373–426). San Francisco: Jossey-Bass.

---

## SEXUAL HARASSMENT

---

Sexual harassment remains a common occupational hazard for women. It is estimated that over half of all women will experience some form of sexual harassment during college and/or their working lives. Women in male-dominated workplaces, in blue-collar jobs, or who are marginalized due to their race, sexual orientation, or social class often experience higher rates of sexual harassment than the general population. Although the vast majority of all sexual harassment cases involve men harassing women, there are also cases of men being sexually harassed. These cases usually involve same-sex harassment, where a man is targeted as a form of hazing or for perceived violations of hypermasculine gender role stereotypes.

Sexual harassment is both prevalent and harmful for targets and the organizations within which they work. Once harassed, individuals, whether male or female, report a variety of negative outcomes related to their work, health, and psychological well-being. Across a spectrum of outcome measures, harassed men and women fair more poorly than those without a history of harassment. Specifically, research has documented detriment to the job satisfaction, work productivity, supervisor satisfaction, absenteeism, and turnover rates of harassed employees—the costs of which can reach billions of dollars annually for federal and private institutions. The psychological and health-related costs are equally high, with targets



reporting numerous symptoms, such as depression, posttraumatic stress symptoms, and health problems following harassment. Despite the contributions of individual and sociocultural factors, organizations have many strategies at their disposal to reduce the prevalence of sexual harassment within their institutions. These efforts will not only protect employees from the harm of harassment, but also limit employers' legal liability. Ultimately, an equitable work environment that is free of harassment benefits everyone within the institution.

### Definitions

In 1980, the Equal Employment Opportunity Commission identified sexual harassment as a form of sex discrimination that commonly manifests as either a *hostile work environment* or *quid pro quo*. Hostile work environment refers to an environment where sexual harassment is pervasive, and an employee believes that the general workplace milieu has become hostile and/or the ability to do his or her job has been compromised. Quid pro quo can be a single or a recurrent event(s) where an employee is pressured to engage in sexual behaviors due to job-related threats or benefits.

Social scientists define sexual harassment as any unwanted gender-based behavior that is offensive to the target, threatens the target's well-being, and/or overwhelms his or her coping abilities. Subtypes of sexual harassment have also been identified. *Gender harassment* includes a variety of sexist comments or behaviors that are often nonsexual in nature, such as asserting that all women are incompetent or unable to perform certain occupational duties. *Unwanted sexual attention* includes sexual comments, gestures, or physical contact, such as repeated requests for dates or attempts to kiss or touch the target. *Sexual coercion* is equivalent to the legal definition of quid pro quo and includes any job-related threats or benefits that are used to coerce sexual interaction, such as promises that an employee will be promoted or fired based on sexual compliance. Finally, *contrapower sexual harassment* involves any form of sexual harassment perpetrated by a subordinate and targeting a superior.

### Marginalized Populations

The majority of research on sexual harassment has been conducted with heterosexual, middle-class

White women, with little attention to diversity across these domains. Theorists assert that being both people of color and women places women of color at heightened risk for harassment (also known as double jeopardy). Research supports these theories, finding that compared to White women, women of color report being sexually harassed more often, experience harassment that is more severe and more sexualized (e.g., gender harassment versus unwanted sexual attention), and commonly describe racialized sexual harassment, where their sexual harassment is infused with race-based epithets or stereotypes. Similarly, studies document that lesbian women and economically vulnerable women are also subjected to more frequent and severe harassment than that reported in the general population. Women who are marginalized in multiple domains, such as lesbian women of color, are at even higher risk.

### Effects on Work, Health, and Psychological Well-Being

Sexual harassment is associated with a variety of negative consequences for targets. For example, compared to women who have not been sexually harassed, targets of harassment report increased absenteeism and job turnover and lower job satisfaction, work productivity, supervisor satisfaction, and organizational commitment.

Harassed men and women also demonstrate negative changes in almost every domain of physical health, including altered appetite, difficulty sleeping, increased headaches, gastrointestinal distress, and reproductive health concerns. Psychologically, they also report increased depression, anxiety, posttraumatic stress, and disordered eating symptoms. Similar to reactions to other forms of trauma, a subset of harassed employees engage in pathological coping such as increased binge eating and alcohol and drug use, all of which can exacerbate the consequences of other mental health concerns. Further, the negative effects of harassment in each of these domains may persist for years after the harassment itself has ended.

### Individual, Sociocultural, and Organizational Causes

Sexual harassment is the result of a variety of individual, social, and organizational factors. There is considerable variability across men with some being



more likely to sexually harass than others. Those who sexually harass others, compared to men who do not engage in harassment, frequently score lower on measures of empathy and higher on measures of sex-role stereotyping and rape myth acceptance. However, it is important to note that the development of these traits is not independent from sociocultural factors. In societies where women are devalued, sex-role stereotypes proliferate, gender-roles are imbalanced, and definitions of femininity and masculinity are separate and rigidly held, men are more likely to endorse sex-role stereotypes and rape myths. Concomitantly, the likelihood that sexual harassment will occur increases.

Organizations also differ in the likelihood that their employees will participate in sexual harassment, regardless of their individual predilections. Specifically, the job–gender context of a work group and the organization’s climate are powerful predictors of whether or not sexual harassment will occur. The job–gender context is determined by the ratio of men to women in a work group and by the extent to which the job is traditionally classified as a male or female occupation. Organizational climate refers to the general milieu within a workplace. Women in organizations that are tolerant of sexual harassment (e.g., demeaning attitudes toward women are modeled by superiors, harassers are not reprimanded) report much higher rates of sexual harassment than women in organizations that denounce gender inequities and sexual harassment in particular.

### How Organizations Can Stop Sexual Harassment

Independent of the expenses related to litigation, sexual harassment costs organizations millions of dollars every year due to factors such as increased absenteeism, job turnover, and reduced productivity. In response, organizations have initiated several strategies to reduce sexual harassment and limit their legal liability. Having a strong antiharassment policy, requiring sexual harassment training, investigating sexual harassment complaints quickly and efficiently, and enforcing penalties when harassment does occur can limit employers’ legal risk by demonstrating that they have exercised reasonable care to prevent, investigate, and remedy sexual harassment. These practices have been shown to reduce harassment within an organization, reduce negative outcomes for harassed

employees, decrease the likelihood of an employee initiating litigation, and reduce the organization’s legal liability.

NiCole T. Buchanan and Krystle C. Woods

*See also* Diversity Issues in Career Development (v4); Organizational Diversity (v3); Psychological Well-Being, Dimensions of (v2); Sexism (v3); Sexual Violence and Coercion (v1)

### Further Readings

- Berdahl, J. L., & Moore, C. (2006). Workplace harassment: Double jeopardy for minority women. *Journal of Applied Psychology, 91*(2), 426–436.
- Buchanan, N. T., & Ormerod, A. J. (2002). Racialized sexual harassment in the lives of African American women. *Women & Therapy, 25*, 107–124.
- Equal Employment Opportunity Commission. (1980). Guidelines on discrimination because of sex. *Federal Regulations, 43*, 74676–74677.
- Faley, R. H., Knapp, D. E., Kustis, G. A., & Dubois, C. L. Z. (1999). Estimating the organizational costs of sexual harassment: The case of the U.S. Army. *Journal of Business and Psychology, 13*, 461–484.
- Fitzgerald, L. F., Swan, S., & Magley, V. J. (1997). But was it really sexual harassment? Legal, behavioral, and psychological definitions of the workplace victimization of women. In W. O’Donohue (Ed.), *Sexual harassment: Theory, research, and treatment* (pp. 5–28). Needham Heights, MA: Allyn & Bacon.
- Hogler, R. L., Frame, J. H., & Thornton, G. (2002). Workplace sexual harassment law: An empirical analysis of organizational justice and legal policy. *Journal of Managerial Issues, 14*, 234–251.
- Ilies, R., Hauserman, N., Schwochau, S., & Stibal, J. (2003). Reported incidence rates of work-related sexual harassment in the United States: Using meta-analysis to explain reported rate disparities. *Personnel Psychology, 56*(3), 607–631.
- Nelson, D. L., & Burke, R. J. (2002). *Gender, work stress, and health: Current research issues*. Washington, DC: American Psychological Association.
- Paludi, M., & Paludi, C. A. (2003). *Academic and workplace sexual harassment: A handbook of cultural, social science, management, and legal perspectives* (pp. 175–198). Westport, CT: Praeger/Greenwood.
- Rospenda, K. M., Richman, J. A., Ehmke, J. L. Z., & Zlatoper, K. W. (2005). Is workplace harassment hazardous to your health? *Journal of Business and Psychology, 20*(1), 95–110.



- Williams, J. H., Fitzgerald, L. F., & Drasgow, F. (1999). The effects of organizational practices on sexual harassment and individual outcomes in the military. *Military Psychology, 11*, 303–328
- Willness, C. R., Steel, P., & Lee, K. (2007). A meta-analysis of the antecedents and consequences of workplace sexual harassment. *Personnel Psychology, 60*, 127–162.

---

## SEXUAL ORIENTATION

---

Sexual orientation describes a person's sexual or affectional attraction to another person specifically identified by gender, either opposite sex (heterosexually oriented), same sex (homosexually oriented), or both sexes (bisexually oriented). This entry focuses on sexual orientation as applied to a same-sex orientation or a bisexual orientation.

### Sexual Orientation and Career Counseling

Only 30 years ago there was little research addressing career counseling with lesbian and gay clients other than literature addressing such clients generally as “deviants.” That is now changing, and for career counseling professionals seeking practical advice on how to provide such counseling services, there is now a growing body of literature.

First, counselors who have lesbian, gay, and bisexual clients must become aware of the client's culture in order to be knowledgeable facilitators of growth and development—aware of the sociopolitical issues, specific knowledge, necessary information, and institutional barriers that confront gay and lesbian clients who seek career counseling, and also aware of the history, language, rituals, traditions, and sense of community that define the gay and lesbian culture. Finally, counselors must take a personal inventory of the ways that their often subtle or unconscious biases may influence the career counseling process.

Discrimination issues permeate all approaches to career counseling with sexual minorities because such discrimination colors the social and personal lives of all sexual, racial, and ethnic minorities. The special needs of this cultural minority arise from the historic discrimination that has helped define the gay and lesbian community and includes lack of civil rights; secret or semisecret lives; oppression,

rejection, or ostracism by family of origin; societal censure; lowered self-esteem due to internalized homophobia; fear and reality of physical violence; and campaigns of hatred and vilification by right-wing political groups and fundamentalist religious groups.

Career counseling with gay or lesbian individuals requires cultural counseling competence. Three seminal documents inform such competence: the Multicultural Counseling Competencies (American Counseling Association and Association for Multicultural Counseling and Development); the Association for Gay, Lesbian, and Bisexual Issues in Counseling Competencies for Counseling Gay, Lesbian, Bisexual and Transgender Clients; and the American Psychological Association's Guidelines for Psychotherapy with Lesbian, Gay, and Bisexual Clients.

Living in communities that routinely discriminate against gay men and lesbian women makes it virtually impossible for counselors to avoid internalizing negative stereotypes or attitudes about this sexual minority culture. Such misunderstanding will quickly be evident to sexual minority clients and may cause them to seek help elsewhere or not to get help at all. Counselors, however, must be familiar with gay and lesbian culture so that they are credible and congruent in their attitudes. Attending workshops, reading the literature, participating in lesbian and gay culture, and talking with former lesbian or gay clients or friends are effective ways to acquire knowledge about gay men and lesbian women and their culture.

Counselors need explicit awareness of their own religious and spiritual nature and beliefs. Counselors never impose their own belief system on their clients, but many lesbian and gay clients have been hurt by religious organizations.

Finally, counselors must confront their own individual prejudice and bias toward lesbian and gay clients and culture. The ethics codes of all the major mental health professional associations offer guidance for individuals who work with clients around issues related to their sexual orientation.

### Coming Out

A central issue for gay, lesbian, and bisexual persons' career development is coming out, the process of identifying as gay, lesbian, or bisexual and recognizing themselves as part of a stigmatized and semi-hidden minority. This identity development is a long



process usually beginning during adolescence, though sometimes considerably later.

There are two different types of coming out. On the one hand, coming out has been discussed as a developmental task for gay and lesbian individuals to successfully complete. This coming out involves a self-acceptance of the individual's own sexual orientation and might be better termed *coming out to self*. On the other hand, coming out has also been discussed as disclosing to others. Such disclosure might be accomplished by verbal or written, private or public statements to other individuals. By this action, individuals inform other persons of their sexual orientation. This might be better termed *coming out to others*.

The traditional stages of coming out to self include initial awareness of attraction to and feelings for the same sex; then experiences of sex; followed by explorations of the gay and lesbian cultural community; then self-labeling as lesbian, gay, or bisexual; and finally the disclosure of one's identity to others (coming out to others). Identity foreclosure, whereby the person stops his or her coming out process, can occur at any stage, or the individual can progress to the last stage with a fully integrated lesbian or gay cultural identity.

As part of effective career counseling, counselors need to address the "how to's" and the "why's" associated with deciding to come out to others, including considering the advantages and disadvantages of coming out in the workplace or school, providing opportunities for behavioral rehearsals to develop strategies for coming out to others, offering special services to meet the career development needs of lesbians and gays such as resume writing workshops (directly addressing issues of how far "out" to be on the resume or how many times the word *lesbian* is mentioned on a resume page, e.g., research on lesbian issues, teaching lesbian topics), and job interviewing workshops (training clients in responding to informational interview and job interview questions like "Are you married?" and "How many children do you have?").

### Job Discrimination

Discrimination against individuals on the basis of their race, ethnic origin, gender, disability, religion, political affiliation, or sexual orientation is a fact of life in U.S. society. Career counselors should recognize this and assist their clients in coping with this reality. In spite of increased visibility and acceptance, gay men and lesbian women continue to experience

discrimination in various aspects of their lives: in the workplace, when buying homes, when trying to adopt a child, and when seeking a marriage license to solemnize their relationships. Issues of dual and multiple discrimination also must be addressed when providing career counseling services. For example, lesbian women may face at least two forms of discrimination—sexism and heterosexism. If they are also a member of an ethnic or racial minority, older, or physically challenged, they may face daunting barriers to achieving their career goals.

For both lesbian women and gay men, discrimination based on sexual orientation is consistently listed among the top three most anticipated career-related barriers and is also expected to provide a moderately high degree of hindrance if encountered. Openly addressing such issues and preparing clients to cope with the more overt manifestations of racism, sexism, heterosexism, ableism, and ageism is an important role of the career counselor. Such discussions lead to improved decision making.

### Other Issues

Other issues that can be addressed in career counseling with gay, lesbian, or bisexual individuals include dual career same-sex couples, career counseling with racial and ethnic minority lesbians and gays, special assessment issues when using psychological inventories, use of gay and lesbian professionals as role models (informational interviews, job shadowing, internships, mentoring, etc.), special workplace services (mentoring programs, diversity workshops, and gay, lesbian, and bisexual affirmative policies such as nondiscrimination policies and domestic partners benefits), preparing special information for distribution to lesbian, gay, and bisexual clients (the geographic location and the size of the gay and lesbian communities in their area, the employment policies and Equal Employment Opportunity statements of local businesses, local and federal antidiscrimination laws), and even social advocacy for such clients (working to change employer-related statements or policies that discriminate, working toward changing the laws that criminalize certain sexual acts between two consenting adults, changing housing laws that do not allow two unrelated persons to live together, or working to stop police entrapment and unequal enforcement of laws).

Mark Pope



**See also** Career Counseling, Gay and Lesbian (v4); Discrimination (v3); Diversity Issues in Career Development (v4); Gay, Lesbian, and Bisexual Therapy (v2); Multicultural Counseling Competence (v3); Organizational Diversity (v3); Social Discrimination (v4)

### Further Readings

- Croteau, J. M., & Bieschke, K. J. (Eds.). (1996). The vocational issues of lesbian women and gay men [Special issue]. *Journal of Vocational Behavior*, 48, 119–255.
- Diamant, L. (Ed.). (1993). *Homosexual issues in the workplace*. Washington, DC: Taylor & Francis.
- Ellis, A. E., & Riggle, J. D. (Eds.). (1996). Sexual identity on the job: Issues and services [Special issue]. *Journal of Gay & Lesbian Social Services*, 4, 1–106.
- Gelberg, S., & Chojnacki, J. T. (1996). *Career and life planning with gay, lesbian, and bisexual persons*. Alexandria, VA: American Counseling Association.
- Human Rights Campaign. (2003). *The state of the workplace for lesbian, gay, bisexual, and transgender Americans*. Available from <http://www.hrc.org>
- Pope, M. (Ed.). (1995). Gay/lesbian career development [Special section]. *Career Development Quarterly*, 44, 146–203.

---

## SIGI

---

**See** SYSTEM OF INTERACTIVE GUIDANCE INFORMATION

---

## SOCIAL CLASS

---

Social class is implicated in almost every facet of the human experience, but for counselors and other mental health care providers, social class is difficult to understand. A lack of theoretical clarity between social class and socioeconomic status, not connecting classism as a function of social class, and psychologists' use of a sociological framework to understand a psychological experience has contributed to this problem. While sociologists typically study macrolevel experiences and tend to use income, education, and occupation to group individuals into discrete social class categories such as upper, middle, and lower class, psychologists are interested in the intrapsychic and interpersonal function and understanding of

social class and classism. Classifying people based on three criteria and then assuming people within that category see the world similarly may prove to be insufficient.

Instead, counselors should examine social class as a descriptor of another psychological construct or experience. For instance, counselors do not study race specifically, but explore racial identity and acculturation. In the case of social class, counselors could examine worldview and identity. Some researchers have embraced a social class worldview approach and advocated for classism to be considered a coconstruct to social class. Much like the study of race, racism is integral to the construction and maintenance of race. For social class, classism is related to the prejudice and discriminatory behaviors that perpetuate social inequalities and economic injustice. That is, societal inequalities are a result of classism in the sociopolitical (e.g., the unequal distribution of power), sociohistorical (e.g., biased and inaccurate histories of peoples), and sociostructural (e.g., legal, education, and economic systems) systems.

For counselors, it is suggested to explore the client's worldview associated with various aspects of social class and classism. First, it would be important to find a common language and understanding between client and counselor for social class that is rooted in theory and to allow for some clarity in the dyad. Second, counselors could explore how clients experience and understand how economic expectations potentially influence their behavior and attitudes. In session, they may explore how clients changed behaviors to fit in with new peer groups or how they negotiate materialistic needs. Third, counselors may examine how clients' classism experiences, either as the subject or perpetrator, have affected their sense of self and relationships with others. Finally, the session may focus on action related to changing attitudes and behaviors related to social class and classism. Future researchers should focus on developing psychologically based measures of social class and develop theory to link social class and classism. Working toward a phenomenologically based understanding of social class would help counselors integrate this cultural construct into their practice.

*William Ming Liu*

**See also** Classism (v3); Deficit Hypothesis (v3); Poverty (v3); Racism (v3); Socioeconomic Status (v3); Third World (v3); Worldview (v3)



### Further Readings

- American Psychological Association, Task Force on Socioeconomic Status. (2007). *Report of the APA Task Force on Socioeconomic Status*. Washington, DC: American Psychological Association.
- Liu, W. M., Soleck, G., Hopps, J., Dunston, K., & Pickett, T. (2004). A new framework to understand social class in counseling: The social class worldview and modern classism theory. *Journal of Multicultural Counseling and Development*, 32, 95–122.

---

## SOCIAL COGNITIVE CAREER THEORY

---

Social cognitive career theory (SCCT) seeks to explain three interrelated aspects of career development: (1) how basic academic and career interests develop, (2) how educational and career choices are made, and (3) how academic and career success is obtained. Developed by Robert W. Lent, Steven D. Brown, and Gail Hackett in 1994, SCCT incorporates a variety of concepts (e.g., interests, abilities, values, environmental factors) from earlier career development theories, employing Albert Bandura's general social cognitive theory as a unifying framework.

Three intricately linked variables—self-efficacy beliefs, outcome expectations, and goals—serve as the basic building blocks of SCCT. *Self-efficacy* refers to an individual's personal beliefs about his or her capabilities to perform particular behaviors or courses of action. Unlike global confidence or self-esteem, self-efficacy beliefs are relatively dynamic (i.e., changeable) and are specific to particular activity domains. For example, people vary in their self-efficacy regarding the behaviors required in different occupational fields. One person might feel very confident of being able to accomplish tasks for successful entry into and performance in scientific fields, but feel much less confident about his or her abilities in social or enterprising fields, such as sales.

*Outcome expectations* refer to beliefs about the consequences or outcomes of performing particular behaviors (e.g., what will happen if I do this?). The choices that people make about the activities in which they will engage, and their effort and persistence at these activities, entail consideration of outcome as well as self-efficacy beliefs. For example, people are more likely to choose to engage in an activity to the extent that they see their involvement as leading to valued, positive outcomes (e.g., social and self-approval, tangible rewards, attractive work conditions).

*Personal goals* may be defined as one's intentions to engage in a particular activity (e.g., to pursue a given academic major) or to attain a certain level of performance (e.g., to receive an A in a particular course). By setting goals, people help organize and guide their own behavior and sustain it in the absence of more immediate positive feedback and despite inevitable setbacks. Social cognitive theory posits that goals are importantly tied to both self-efficacy and outcome expectations: People tend to set goals that are consistent with their views of their personal capabilities and of the outcomes they expect to attain from pursuing a particular course of action. Success or failure in reaching personal goals, in turn, becomes important information that helps alter or confirm self-efficacy beliefs and outcome expectations.

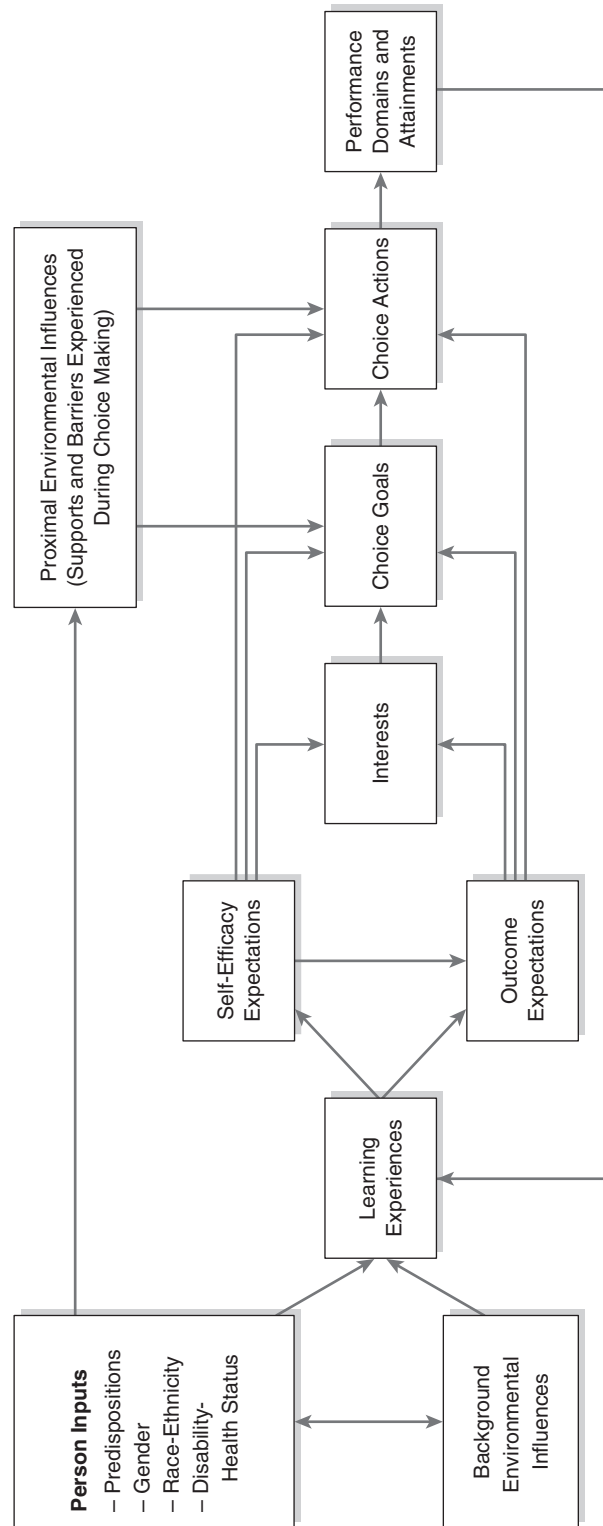
### Interest Model

As shown in Figure 1 (center), interests in career-relevant activities are seen as the outgrowth of self-efficacy and outcome expectations. Over the course of childhood and adolescence, people are exposed, directly and vicariously, to a variety of occupationally relevant activities in school, at home, and in their communities. They are also differentially reinforced for continuing their engagement, and for developing their skills, in different activity domains. The types and variety of activities to which children and adolescents are exposed are partly a function of the context and culture in which they grow up.

Through continued activity exposure, practice, and feedback, people refine their skills, develop personal performance standards, form a sense of their efficacy in particular tasks, and acquire certain expectations about the outcomes of activity engagement. People are most likely to develop interest in activities at which they both feel efficacious and expect positive outcomes. As people develop interest in an activity, they are likely to develop goals for sustaining or increasing their involvement in it. Further activity involvement leads to subsequent mastery or failure experiences that in turn help revise self-efficacy, outcome expectations, and ultimately interests within an ongoing feedback loop.

In sum, people are likely to form enduring interest in an activity when they view themselves as competent at performing it and when they expect the activity to produce valued outcomes. Conversely, interests are unlikely to develop in activities for which people doubt their competence and expect negative outcomes.





**Figure 1** A simplified view of how career-related interests and choices develop over time, according to social cognitive career theory

Source: Adapted from R. W. Lent, S. D. Brown, and G. Hackett (1994).



Furthermore, SCCT posits that for interests to blossom in areas for which people have talent, their environments must expose them to the types of direct, vicarious, and persuasive experiences that can give rise to robust efficacy beliefs and positive outcome expectations.

### Choice Model

SCCT's model of the career choice process, which builds on the interests model, is also embedded in Figure 1. Arising largely through self-efficacy and outcome expectations, career-related interests foster particular educational and occupational choice goals (e.g., intentions to pursue a particular career path). Especially to the extent that they are clear, specific, strongly held, stated publicly, and supported by significant others, choice goals make it more likely that people will take actions to achieve their goals (e.g., seek to gain entry into a particular academic major, training program, or job). Their subsequent performance attainments (e.g., successes, failures) provide valuable feedback that can strengthen or weaken self-efficacy and outcome expectations and ultimately help to revise or confirm choices.

As illustrated in Figure 1, SCCT also emphasizes that choice goals are sometimes influenced more directly and potently by self-efficacy beliefs, outcome expectations, or environmental variables than they are by interests. Interests are expected to exert their greatest impact on academic and occupational choice under supportive environmental conditions, which enable people to pursue their interests. However, many adolescents and adults are not able to follow their interests either unfettered by obstacles or with the full support of important others. The choice making of these persons is constrained by such experiences as economic need, family pressures, or educational limitations. In such instances, people may need to compromise their interests and instead make their choices on the basis of such pragmatic considerations as the type of work that is available to them, their self-efficacy beliefs ("Can I do this type of work?"), and outcome expectations ("Will the job pay enough to make it worthwhile?"). Cultural values (e.g., the degree to which one's choices may be guided by elder family members) may also limit the role of personal interests in career choice.

SCCT posits conditions that increase the probability that people will be able to pursue their interests as

well as conditions where interests may need to be compromised in making career-related choices. Collectively labeled environmental influences in Figure 1, these conditions refer to the levels of support (e.g., family financial and emotional support), barriers (e.g., lack of finances, inadequate levels of education), and opportunities available to the individual. Simply put, SCCT hypothesizes that interests will be a more potent predictor of the types of choices people make under supportive rather than under more restrictive environmental conditions. Under the latter conditions, one's interests may need to be bypassed or compromised in favor of more pragmatic, pressing, or culturally acceptable considerations.

### Performance Model

SCCT's performance model is concerned with predicting and explaining two primary aspects of performance: the level of success that people attain in educational and occupational pursuits and the degree to which they persist in the face of obstacles. SCCT focuses on the influences of ability, self-efficacy, outcome expectations, and performance goals on success and persistence. Ability (as reflected by past achievement and aptitudes) is assumed to affect performance via two primary pathways. First, ability influences performance and persistence directly. For example, students with higher aptitude in a particular subject tend to do better and persist longer in that subject than do students with lesser aptitude. Second, ability is hypothesized to influence performance and persistence indirectly through the intervening paths of self-efficacy and outcome expectations.

In other words, performance involves both ability and motivation. SCCT emphasizes the motivational roles of self-efficacy, outcome expectations, and performance goals. Specifically, SCCT suggests that self-efficacy and outcome expectations work in concert with ability, in part by influencing the types of performance goals that people set for themselves. Controlling for level of ability, students and workers with higher self-efficacy and more positive outcome expectations will be more likely to establish higher performance goals for themselves (i.e., aim for more challenging attainments), to organize their skills more effectively, and to persist longer in the face of setbacks. As a result, they may achieve higher levels of success than those with lower self-efficacy and less positive outcome expectations. Thus, favorable



self-efficacy, outcome expectations, and goals help people to make the best possible use of their ability.

## Research and Practical Applications

A substantial body of research has accumulated suggesting that SCCT is a useful framework for explaining various aspects of educational and vocational interest development, choice making, and performance. The theory has also recently been extended to the understanding of academic and work satisfaction. SCCT has sparked a number of efforts to design and test interventions aimed at various facets of career development. It has also been applied to the study of career behavior in a number of countries and cultural contexts.

*Robert W. Lent, Gail Hackett,  
and Steven D. Brown*

**See also** Bandura, Albert (v2); Brown's Values-Based Career Theory (v4); Career Decision Self-Efficacy Scale (v4); Expressed, Manifest, Tested, and Inventoried Interests (v4); Holland's Theory of Vocational Personalities and Work Environments (v4); Job Satisfaction and General Well-Being (v4); Krumboltz Happenstance Learning Theory (v4); Roe's Theory of Personality Development and Career Choice (v4); Self-Efficacy/Perceived Competence (v2); Self-Esteem (v2); Theory of Work Adjustment (v4)

## Further Readings

- Bandura, A. (1986). *Social foundations of thought and action: A social cognitive theory*. Englewood Cliffs, NJ: Prentice Hall.
- Bandura, A. (1997). *Self-efficacy: The exercise of control*. New York: Freeman.
- Brown, S. D., & Lent, R. W. (1996). A social cognitive framework for career choice counseling. *Career Development Quarterly*, 44, 354–366.
- Lent, R. W. (2005). A social cognitive view of career development and counseling. In S. D. Brown & R. W. Lent (Eds.), *Career development and counseling: Putting theory and research to work*. New York: Wiley.
- Lent, R. W., Brown, S. D., & Hackett, G. (1994). Toward a unifying social cognitive theory of career and academic interest, choice, and performance [Monograph]. *Journal of Vocational Behavior*, 45, 79–122.
- Lent, R. W., Brown, S. D., & Hackett, G. (2000). Contextual supports and barriers to career choice: A social cognitive analysis. *Journal of Counseling Psychology*, 47, 36–49.

## SOCIAL DISCRIMINATION

Discrimination is a complex social problem that affects individuals, groups, organizations, and society as a whole. Scholars describe discrimination as consisting of types (e.g., subtle or overt), occurring across levels (e.g., individual, institutional, cultural), and in relation to its targets (e.g., racial or ethnic, sexual, sexual orientation). The focus of study in many disciplines and a common element across definitions is that discrimination is an unfair action or behavior that results in negative outcomes for targeted social groups or their members.

Discrimination can be experienced as a major event or as a chronic condition, such as an ongoing barrier to resources. The cause of discrimination is the subject of much social science research and has been conceptualized in various ways, but is typically linked to prejudice and stereotyping, which are thought of as the attitudinal and cognitive components, respectively, that underlie discrimination. A widespread phenomenon, discrimination can be observed by asking individual targets for their perceptions of discriminatory experiences or through its impact on targeted groups. Proposed remedies for discrimination are numerous and may vary by target group.

## Historical Perspective

The United States has a lengthy, discreditable history of legally sanctioned discrimination toward targeted social groups. A few examples are the forced relocation of Native American peoples, enslavement of African Americans, denial of voting and reproductive rights to women, the Chinese Exclusion Act of 1882, internment of Japanese Americans during World War II, and the criminalizing of same-sex sexual behavior. Although legal protections have been extended to some oppressed groups (e.g., Civil Rights Act of 1964, Age Discrimination in Employment Act of 1967, Americans with Disabilities Act of 1990), discrimination is far from being eliminated as a social problem. Target groups continue to experience economic, political, and social disadvantages.

A few examples from the work world include significantly lower rates of pay for Hispanics, Native Americans, and African Americans compared to Whites; substantially higher rates of unemployment for people with disabling conditions compared to



those without; more frequent and severe sexual harassment for women when compared to men; and the lack of legal protections on the basis of sexual orientation for lesbians and gay men (e.g., organizational policies and practices can explicitly deny employment on the basis of sexual orientation).

### Levels and Types

Discrimination at a structural or institutional level, also called differential effect, appears to be neutral, but has the effect of disadvantaging target groups or advantaging majority groups. It can operate in social or organizational policies and practices that result in an adverse impact on target groups. Currently, legal protections in the workplace are provided on the basis of an employee's race, color, national origin, sex, religion, age, and disability status. However, prior to such protections, targeted groups (e.g., women, minorities, immigrants) could be hired, fired, and treated differently on the job on the basis of group characteristics such as sex, race, national origin, or religion. This history of legally sanctioned discrimination had the effect of segregating target groups into low-paying, low-prestige jobs with few opportunities for advancement. Although former practices such as advertising women's and men's jobs are legally prohibited, current practices such as word-of-mouth advertising can have the effect of getting the word out to those who are in one's social category, thus excluding others.

Cultural discrimination also operates at the macro level and refers to privileging a particular social group's cultural values. Examples can be seen in media representations that negatively skew a target group's values and cultural expressions or that present culture only from a majority viewpoint.

At an individual level, discrimination is behavior that benefits a majority group or group member or disadvantages a target group or group member. Such behavior, also referred to as differential treatment, is often typed as overt or subtle. Overt discrimination is intentional and explicit and has become less acceptable today than it was prior to the passage of Civil Rights legislation. However, this old-fashioned type continues to exist and includes a range of behaviors such as denial of employment to a person with a disability, hostile verbal harassment directed to an ethnic minority person, or physically assaulting a gay man. Associated with beliefs in the superiority of one's own social group, overt discrimination is behavior aimed

at maintaining power over a social group or individual from a group that is regarded as inferior.

Subtle discrimination, the more common type, is covert and is often unintentional behavior that can operate at an unconscious level. An example is a male manager who regularly invites his male colleagues and subordinates to golf outings after work because he feels he has a lot in common with them, an activity that creates opportunities for the male subordinates, but not for the female, to engage in informal networking, thus gaining access to work and advancement information and to potential mentors.

There is a rich literature about the complex causes of discrimination. One commonly cited view suggests that discriminatory behavior stems from biased attitudes, judgments, and feelings about a social group or an individual based on group membership. Subtle forms are thought to take place when majority members hold prejudices or ambivalent feelings about a target group, perhaps unconsciously, but may view themselves as nonprejudiced. Overt expressions of discrimination are socially unacceptable and run counter to self-image, thus biases are expressed subtly (e.g., nonverbal behavior, endorsing beliefs that appear neutral but that disadvantage a target group).

Harassment in the workplace, a subtype of discrimination, includes behaviors that create a hostile, offensive, or intimidating work environment that unreasonably interferes with an individual's work performance. Sexual harassment also includes behaviors that coerce sexual cooperation by threat of job detriment or promises of advancement. The antecedents of sexual harassment in the workplace that have received the most empirical support are an organizational climate that is tolerant of such behavior and a skewed gender context (i.e., gender of immediate supervisor, gender ratio of the workgroup, and gender typing of the occupation).

### Targets, Extent, and Consequences

Discrimination is often described in terms of its target groups. Although all targeted groups experience discrimination, there is variability within groups in individual members' perceptions of discrimination and the degree to which they experience harm. There are also between group differences that can affect how experiences of discrimination are conceptualized in each group. Groups differ in the degree to which they are visible to others. For example, sexual minorities and people with certain disabling conditions may not be identifiable unless they choose to disclose. Civil rights



protections have been extended on the basis of some target characteristics (e.g., race, color, national origin, sex, religion, age, and disability status) but not others (e.g., sexual orientation, stigmatizing conditions). Groups also have unique histories with discrimination (e.g., slavery, Holocaust) that can influence current experiences of personal or institutionalized discrimination. Historical experiences can also influence behavior or group identity over successive generations. Discrimination takes place within arenas or domains such as labor markets (e.g., job segregation, glass ceiling), education (e.g., graduation rates, placement in special education), housing and lending markets (e.g., access to home loans), criminal justice (e.g., arrest rates, sentencing, policing), and health care (e.g., access, quality). There are differences in how target groups fare with respect to access and function in each domain. The two groups most often studied are African Americans and women, and research about these two groups has influenced research on other groups. One consideration in the literature is whether there is a general model, applicable across groups, to explain discrimination and its resulting harm or whether the factors associated with discrimination are group specific.

It is difficult to determine the presence or extent of discrimination because it is typically observed indirectly, for example, through individual perceptions of discrimination or by an inferential process such as examining differential outcomes (e.g., lower rates of pay) for a target group. Estimates of perceived discrimination depend on the time frame (e.g., 12 months, lifetime), the questions that are asked (e.g., "Have you experienced sexual harassment?" vs. "Have you experienced unwanted sexual advances?"), and the context for the behaviors (e.g., work, housing, medical care). Lifetime prevalence estimates for African Americans that examine discrimination across contexts suggest that 98% have experienced discrimination. Research about work-related discrimination suggests 60% of African Americans experience work-related discrimination. Sexual harassment is estimated as affecting 50% of women employees. Between 25% and 66% of lesbian and gay male employees are thought to experience discrimination or harassment based on sexual orientation in the workplace (e.g., derogatory jokes, termination of employment). Sometimes referring to it as double jeopardy, research finds that the frequency of discrimination is greater if an individual is a member of

multiple target groups. For example, minority women are more likely to experience harassment in the workplace than are minority men, White men, or White women. Minority women, compared to White women and minority men, are segregated into lower-paying and lower-prestige jobs.

Field research has been useful in determining whether discrimination takes place in particular contexts, such as the housing market or in hiring. Administrative records can provide evidence of whether complaints of discrimination have been made in a particular setting. Social scientists use statistical analysis of nationally representative datasets or data from a particular organization to determine whether target groups are experiencing adverse impact (e.g., occupational segregation for Hispanic workers). Survey research is used to examine perceived experiences of discrimination. Each of these methods has made contributions to understanding various aspects of discrimination, but no one method provides a complete picture of the extent of discrimination. Ultimately, the best approach is one that uses multiple methods.

## Consequences

A large body of research links discrimination and harassment to decreased psychological and physical well-being and decrements in work-related attitudes for target groups. A number of theoretical models attempt to explain the factors associated with the harm process. A common element across various models is that discrimination acts like a stressor that, when appraised as exceeding the target's ability to cope (stressful or threatening), leads to decreased well-being. Targets employ various coping responses (e.g., assertion, cognitive, or behavioral avoidance) in an attempt to manage the discrimination. Variations of this cognitive appraisal process have been incorporated into theoretical formulations describing how discrimination harms women, African Americans, Asian Americans, and sexual minorities.

Researchers have identified numerous other harm-enhancing or harm-buffering factors that relate to the target of the discrimination (e.g., hardiness; vulnerability; active and passive coping responses; attributions about the behavior, perpetrator, one's self, and one's social group; pride in and identification with one's social group), the behavior itself (e.g., frequent and severe experiences, experiences across types or domains, perpetrator characteristics), or the context in



which it takes place (e.g., how the organization or institution responds to the discriminatory behavior, the target, and the perpetrator). Despite the volume of research in this area, factors associated with discrimination have received differing degrees of empirical support and may be more or less relevant depending on the target group. Thus, it is challenging to point to one set of factors that work in the same manner across groups.

### ***Racial and Ethnic Discrimination***

Perceived racial discrimination in African Americans is associated with increased psychiatric symptoms and psychological distress, lower life satisfaction, negative health behaviors (e.g., cigarette smoking), and decreased physical health (e.g., hypertension). It also influences job-related outcomes for racial and ethnic minorities, such as decreasing satisfaction while on the job. Although the vast majority of studies on racial or ethnic discrimination have focused on African Americans, empirical research makes it obvious that Asian Americans, Hispanics, Native Americans, Arab Americans, and other racial and ethnic target groups experience discrimination and that it affects their psychological and physical health as well as their job attitudes. Additionally, discrimination has been linked to higher morbidity and mortality rates for African Americans, American Indians, and Hispanics compared to White Americans.

### ***Sexual Discrimination***

The majority of outcome research on gender-based discrimination has focused on the consequences of sexual harassment, a form of sexual discrimination. A large body of research links sexual harassment to negative and costly outcomes for both individuals and organizations. It is associated with psychological and health outcomes such as alcohol abuse, increased risk of eating disorders, health problems, distress, posttraumatic stress disorder, and symptoms of other mood and anxiety disorders. Job-related consequences, such as decreased job satisfaction and organizational commitment, increased job and work withdrawal, and job turnover, are also well documented. Although much of the research focuses on harmful consequences to targets, sexual harassment is also damaging to employers. Job turnover and the subsequent need to recruit, hire, and train new personnel are costly to organizations as are increased usage of health care and employee absences.

### ***Discrimination Based on Sexual Orientation***

Disclosure of sexual identity is linked to workplace harassment and discrimination, with some scholars hypothesizing a direct link between disclosure and ensuing experiences of harassment and discrimination while others suggest that perceptions of discrimination drive whether one conceals or discloses. However, research is clear that the discrimination itself is associated with harm to physical and mental health, including increased alcohol and drug usage, psychological symptoms, distress, and perceptions of poor health. Likewise, hate crime victimization outside of the workplace is associated with decreased physical and psychological well-being.

### ***Remedies***

Reducing discrimination is beneficial for target groups and organizations. It reduces costs attributable to discrimination, such as turnover, absenteeism, and legal costs associated with claims of discrimination. It also creates a more diverse workforce, a result that according to research has potential to benefit organizations. Research about harassment suggests that the attitudes and behaviors of organizational leaders and top management influence the degree to which harassment is tolerated in an organization. Unbiased attitudes of top management and organizational action in response to harassing behavior can reduce the overall amount of harassment in an organization. Factors thought to reduce harassment and discrimination include bringing target group members to numerical parity with majority group members within work groups, rewarding intergroup cooperation, and creating an organizational climate that supports diversity and does not allow for discrimination. Organizations can also review and eliminate policies and procedures that lead to having an adverse impact on target groups and can institute strong policy statements prohibiting discrimination. They can also provide diversity training and resources for targets of discrimination.

*Alayne J. Ormerod*

**See also** Affirmative Action (v3); Antisemitism (v3); Bias (v3); Classism (v3); Deficit Hypothesis (v3); Discrimination and Oppression (v2); Diversity Issues in Career Development (v4); Ethnocentrism (v3); Prejudice (v3); Racism (v3); Sexism (v3); Sexual Harassment (v4); Social Class (v4); Social Identity Theory (v3); Stereotype (v3); Tokenism (v3)



## Further Readings

- Allison, K. W. (1998). Stress and oppressed social category membership. In J. K. Swim & C. Stangor (Eds.), *Prejudice: The target's perspective* (pp. 145–170). Orlando, FL: Academic Press.
- Berdahl, J. L., & Moore, C. (2006). Workplace harassment: Double jeopardy for minority women. *Journal of Applied Psychology, 91*, 426–436.
- Clark, R., Anderson, N. B., Clark, V. R., & Williams, D. R. (1999). Racism as a stressor for African Americans. *American Psychologist, 54*, 805–816.
- Crocker, J., & Major, B. (1989). Social stigma and self-esteem: The self-protective properties of stigma. *Psychological Review, 96*, 608–630.
- Croteau, J. M. (1996). Research on the work experiences of lesbian, gay, and bisexual people: An integrative review of methodology and findings. *Journal of Vocational Behavior, 48*, 195–209.
- Dansky, B. S., & Kilpatrick, D. G. (1997). The effects of sexual harassment. In W. O'Donohue (Ed.), *Sexual harassment: Theory, research, and treatment* (pp. 152–174). Boston: Allyn & Bacon.
- Dipboye, R. L., & Colella, A. (2005). *Discrimination at work: The psychological and organizational bases*. Mahwah, NJ: Lawrence Erlbaum.
- Equal Employment Opportunity Commission. (1980). Guidelines on discrimination because of sex (Sect. 1604–11). *Federal Register, 45*, 74676–74677.
- Fitzgerald, L. F., Drasgow, F., Hulin, C. L., Gelfand, M. J., & Magley, V. J. (1997). The antecedents and consequences of sexual harassment in organizations: A test of an integrated model. *Journal of Applied Psychology, 82*, 578–589.
- Herek, G. M., Gillis, J. R., & Cogan, J. C. (1999). Psychological sequelae of hate-crime victimization among lesbian, gay, and bisexual adults. *Journal of Consulting and Clinical Psychology, 67*, 945–951.
- Jones, J. M. (1997). *Prejudice and racism* (2nd ed.). New York: McGraw-Hill.
- National Research Council. (2004). Measuring racial discrimination. Panel on methods for assessing discrimination. In R. M. Blank, M. Dabady, & C. F. Citro (Eds.), *Committee on National Statistics, Division of Behavioral and Social Sciences and Education*. Washington, DC: National Academies Press.
- Reskin, B. (1998). *The realities of affirmative action in employment*. Washington, DC: American Sociological Association.
- Schmitt, M. T., Branscombe, N. R., Kobrynowicz, D., & Owen, S. (2002). Perceiving discrimination against one's gender group has different implications for well-being in women and men. *Personality and Social Psychology Bulletin, 28*, 197–210.
- Schneider, K., Hitlan, R. T., & Radhakrishnan, P. (2000). An examination of the nature and correlates of ethnic harassment experiences in multiple contexts. *Journal of Applied Psychology, 85*, 3–12.
- Schneider, K. T., Swan, S., & Fitzgerald, L. F. (1997). Job-related and psychological effects of sexual harassment in the workplace: Empirical evidence from two organizations. *Journal of Applied Psychology, 82*, 401–415.
- U.S. Merit Systems Protection Board. (1987). *Sexual harassment of federal workers: An update*. Washington, DC: Government Printing Office.
- Waldo, C. R. (1999). Working in a majority context: A structural model of the antecedents and outcomes of heterosexism in the workplace. *Journal of Counseling Psychology, 46*(2), 218–232.

---

## SOCIETY FOR VOCATIONAL PSYCHOLOGY

---

The Society for Vocational Psychology is a professional organization that has as its purpose to encourage, promote, and facilitate contributions to research, teaching, practice, and public interest in vocational psychology and career intervention. The society is one of several interest groups within the Society of Counseling Psychology (Division 17) of the American Psychological Association. Society membership includes psychology graduate students, faculty, researchers, consultants, and practitioners.

The society promotes its goals by sponsoring presentations at the annual meeting of the American Psychological Association, by publishing and distributing information relevant to its members via a Web site and an electronic newsletter, by representing the interests of career development and vocational psychology within the Society of Counseling Psychology and the American Psychological Association, and by sponsoring and cosponsoring national and international conferences.

The Society's Biennial Conference Series has sponsored eight conferences since its inception in 1992. Conference themes have addressed diverse issues from prospects for convergence in career theory and practice, to advances in interest measurement, to reflections on the construct of self in career psychology. Two of the society's biennial conferences have been international conferences (Coimbra, Portugal, and Vancouver, British Columbia, Canada), and several of the conference



themes were captured in print (Savickas & Lent, *Convergence in Career Development Theories: Implications for Science and Practice*, 1994; Savickas & Spokane, *Vocational Interests: Meaning, Measurement, and Counseling Use*, 1999). The society also advances its goals by working closely with related organizations such as the National Career Development Association, the International Association for Educational and Vocational Guidance, and the American School Counselor Association.

The society traces its origins to a Special Interest Group (SIG) within the Society of Counseling Psychology. Founded in 1987 by Mark Savickas (Northeastern Ohio Universities College of Medicine), the SIG quickly grew in size. In 1994, a committee chaired by Linda Subich (University of Akron) and consisting of Nadya Fouad (University of Wisconsin–Milwaukee), Thomas Krieshok (University of Kansas), Ellen Lent (George Washington University), Robert Lent (University of Maryland), Scott Solberg (University of Wisconsin–Milwaukee), Jane Swanson (Southern Illinois University), Tony Tinsley (Southern Illinois University), Don Zytowski (Ames, Iowa), and Bruce Walsh (Ohio State University) petitioned the Society of Counseling Psychology for status as a section. The society gained section status in August 1996.

Today the society enjoys a student and professional membership of over 400 individuals. The society has thrived under the leadership of past chairpersons (Linda Subich, Nadya Fouad, Jane Swanson, Bruce Walsh, David Blustein, and Paul Gore) and continues to advance research, practice, and theory in vocational psychology and career development through scholarship, education and training, and mentorship.

*Paul A. Gore*

**See also** Career Counseling (v4); Career Intervention (v4); International Association for Educational and Vocational Guidance (v4); National Career Development Association (v4)

### Further Readings

- Savickas, M. L., & Lent, R. L. (Eds.). (1994). *Convergence in career development theories: Implications for science and practice*. Palo Alto, CA: CPP Books.
- Savickas, M. L., & Spokane, A. R. (Eds.). (1999). *Vocational interests: Meaning, measurement, and counseling use*. Palo Alto, CA: Davies-Black.

- Savickas, M. L., & Walsh, W. B. (Eds.). (1996). *Handbook of career counseling theory and practice*. Palo Alto, CA: Davies-Black.

### Web Sites

- Society for Vocational Psychology: <http://www.div17.org/vocpsych/>

---

## SPIRITUALITY AND CAREER DEVELOPMENT

---

Career counseling is a dynamic process of helping clients explore how aspects of their identity may relate to their career decision making or ability to cope with work difficulties. Although researchers have examined how a wide range of personal and relational variables relate to career development, few studies have explored how spirituality, which can be a unique and often powerful component of an individual's life, may relate to the career development process. In fact, most major theories of career counseling do not address the role of spirituality explicitly, and counselors may be overlooking a variable that may be critical to many clients' career development. Thus, counselors are encouraged to simply ask their clients if they are spiritual and if so to explore how this component of their life may relate to their career process.

Based on research in the fields of vocational psychology and spirituality, it is proposed that a client's spirituality may interface with a client's career in at least three ways: as a means of support, as an influence on career-related interests and values, and as a motivator of career choice by way of a calling or vocation. However, it is likely that the uniqueness of a client's spirituality may be matched by the uniqueness in which it relates to his or her career. By addressing these connections, counselors may have a deeper understanding of a client's identity and also normalize the notion that spirituality may be important in career-related tasks. This entry discusses the various ways spirituality may be linked to career development and how counselors can use these relationships to provide more effective counseling.



## What Is Spirituality?

Prior to discussing the relationship between spirituality and career development, it is necessary to first understand what spirituality means. As research exploring spirituality has grown exponentially over the past 20 years, a number of definitions have emerged. Many scholars view spirituality as distinctly tied to religiousness and define spirituality as the relationship an individual has with a higher power or powers. In general, others define this term as a search for meaning in the pursuit of highest human potential. In this case, spirituality entails striving to attain or achieve a goal. Still other scholars consider spirituality a general life force that serves to guide one's decision making and ways of living. Although definitions vary, their commonality is that spirituality, unlike religiousness, tends to be considered unique, individualized, and adaptable. It is likely that no two individuals' spirituality would be exactly alike, that it may vary within and across cultures, that the degree it influences one's life would greatly vary, and that many more people would claim to be spiritual than religious. Recent large-scale studies have found that 40% of people report following religious teachings in everyday life, while 80% report an interest in spirituality and 83% believe in the sacredness of life. Research has shown that regardless of the precise definition, spirituality can have a large impact on one's life, including one's career.

## The Interface of Spirituality and Career Development

The study of spirituality in general has recently burgeoned, and in turn additional investigations have begun to explore how spirituality relates to careers and work. A series of theoretical models have been proposed that link spirituality and career development, and each model emphasizes that individuals' spirituality should be considered in their decision-making process as it may be a critical component of their self-concept. A minimal amount of empirical research has also been completed, addressing the connections between spirituality and specific career-related variables. For example, researchers have found that college students who had greater spiritual awareness or a strong spiritual presence in their lives reported higher career decision self-efficacy and career choice commitment. For working adults, indices of

spiritual well-being have been tied to greater job satisfaction. Other qualitative studies with college students and adults have found that spiritual individuals report a greater desire to serve others, that they feel more supported during career-related struggles, and that they are more likely to view their career as a calling. What this theoretical and empirical work suggests is that spirituality may be inexplicably linked to interest and value development, decision making, and coping in all stages of the career process. This notion may be especially important for career counselors who work with clients in helping them both make career decisions and cope with the world of work.

## Spirituality and Career Counseling

Recent reviews of the career counseling literature have found that career counselors are both retaining many of the older "three sessions and a cloud of dust" principles and also incorporating new techniques that bridge a client's career and relational life. Indeed, career counseling today is ideally a dynamic process through which counselors help clients explore not only their interests, skills, and values, but also their familial influence, work-family conflict, and supports and barriers. Without understanding the full scope of factors that may influence a client's career, including spirituality, counselors may be missing information that could be critical to helping clients make decisions and cope with the world of work. The following sections focus on how a client's spirituality and career may intertwine, with particular focus placed on spirituality as a form of support, as an influence on career interests and values, and as a choice motivator.

### *Support*

For college students in the process of making career decisions, and especially for working adults dealing with career-related stress, having a strong support network can be critical. Typically, counselors have been encouraged to investigate and draw on the support a client receives from friends, family, and significant others. Research has shown that individuals who feel more supported by these sources report higher levels of career decision self-efficacy, career exploration, perceptions of career and educational opportunities, and job satisfaction. These support networks typically provide safety nets to fall back on



during stressful times and are sources of advice and guidance. However, the support individuals may receive through their spirituality has received minimal attention from researchers, and no studies have examined how spiritual support relates to the career development process.

So how can spiritual support be explored in career counseling? First, it is recommended that counselors ask clients if they are spiritual and then encourage them to explain what spirituality means to them. As stated previously, spirituality will likely mean something unique to each individual client and can range from a relationship with a higher power or powers to a belief in a general life force. If a client is spiritual, counselors are encouraged to explore if and to what extent he or she derives support from his or her spirituality. For some clients, this support may come from connecting with a higher being, perhaps in the form of prayer or meditation. For others, support may come from connecting with other individuals in their spiritual community who may share similar beliefs and value systems. Regardless of the exact mechanism through which support is received, spiritual support can be powerful, especially for individuals who view their spirituality as a principal component of their self-concept. Without raising the question of the extent of a client's spirituality, counselors may be overlooking an important piece of the client's overall support network.

### ***Interests and Values***

Two of the most important constructs in the study of career development are interests and values. In nearly all major theories of career counseling, counselors are encouraged to explore with clients their specific career interests and values and, time permitting, discuss how these developed. Through extensive research, vocational psychologists have found that these constructs do not develop in a vacuum, but rather are influenced by a variety of factors including family, personality, gender, quality of education, self-efficacy, and even spirituality. In addition, more limited research suggests that individuals who consider themselves to be spiritual report a greater desire to serve others and are more likely to be found in social jobs.

When working with clients who are spiritual, it is suggested that counselors be aware of how this important component of their life relates to their values and

interests. If a client's spirituality serves as a guiding life force, then these principles will likely affect what he or she desires out of a job or career. For example, if a central component of a client's spiritual beliefs is to positively contribute to society or help others in some way, it would not be surprising if at an early age interests in social careers or altruistic work values developed. Many spiritual clients may have explicitly felt this influence, while for others it may be implicit, with their spiritual values so entrenched within their overall development it would be difficult to isolate them. In sum, it will be impossible to understand the full impact spirituality may have on a client's interest and value development if this possibility is not addressed.

### ***Career Choice***

For students in the process of exploring career options and adults interested in switching jobs or careers, making an informed choice is a critical final step. In fact, in most major theories of vocational development, choice implementation is the desired outcome variable. A variety of factors contribute to the ability to make an effective choice, including, but not limited to, exploration, self-efficacy, interests, values, skills, and support. For some clients, however, their unique spirituality may serve to influence their actual career choice by way of a *calling* or *vocation*. Each of these terms has been defined in a variety of ways. For example, calling has been defined as a summons by God to a certain career, a call to serve God, and as a quest for fulfillment in work and desire to impact society. Similarly, vocation has been described as an overwhelming desire to find meaning in one's life through work and as a call to something larger than oneself. What these terms have in common is the notion that individuals may make career decisions with less of a focus on personal factors such as skills, interests, or prestige and more of a focus on a career they feel pulled to by some external power or societal need.

Because of the scarcity of research on this topic, it is unclear what percentage of clients may feel they have a calling or vocation to a particular career or may be searching for one. It is also unclear the degree to which such a call may emanate from religious or spiritual factors or simply from a desire to serve others. Regardless, it is suggested that counselors explore with spiritual clients the extent to which they feel they



have a calling or vocation and in turn what these terms mean to them. For clients who feel they have a strong calling to a certain career, it is suggested that the counselor assess the degree to which this affects their ultimate career choice. Also, clients who are especially religious or spiritual may be searching for a calling or vocation, and counselors could be particularly instrumental in this process. For clients who are seeking out a calling or vocation, it is suggested that counselors encourage them to explore their own internal interests, abilities, and values, as these may dovetail with an eventual calling or vocation and can guide clients into the areas of work that may be most satisfying for them. Though the constructs of calling and vocation are complicated and perhaps not pertinent to all career clients, it is recommended that counselors be open to exploring these variables, especially with spiritual clients.

Ryan D. Duffy

*See also* Career Counseling (v4); Decision Making (v4); Religion/Religious Belief Systems (v3); Social Support (v2); Spirituality/Religion (v2)

### Further Readings

- Astin, A. W., Astin, H. S., Lindholm, J. A., Bryant, A. N., Calderon, S., & Szelenyi, K. (2005). *The spiritual life of college students: A national study of college students' search for meaning and purpose*. Los Angeles: Higher Education Research Institute, University of California, Los Angeles.
- Colozzi, E. A., & Colozzi, L. C. (2000). College students' callings and careers: An integrated values-oriented perspective. In D. A. Luzzo (Ed.), *Career counseling of college students: An empirical guide to strategies that work* (pp. 63–91). Washington, DC: American Psychological Association.
- Constantine, M. G., Miville, M. L., Warren, A. K., Gainor, K. A., & Lewis-Coles, M. E. L. (2006). Religion, spirituality, and career development in African American college students: A qualitative inquiry. *The Career Development Quarterly*, 54, 227–241.
- Dalton, J. C. (2001). Career and calling: Finding a place for spirit in work and community. *New Directions for Student Services*, 95, 17–25.
- Duffy, R. D. (2006). Spirituality, religion, and career development: Current status and future directions. *Career Development Quarterly*, 55(1), 52–63.
- Duffy, R. D., & Blustein, D. L. (2005). The relationship between spirituality, religiousness, and career adaptability. *Journal of Vocational Behavior*, 67, 429–440.
- Hill, P. C., & Pargament, K. I. (2003). Advances in the conceptualization and measurement of religion and spirituality: Implications for physical and mental health research. *American Psychologist*, 58, 64–74.
- Lips-Wiersma, M. (2002). The influence of spiritual “meaning making” on career behavior. *Journal of Management Development*, 21, 497–520.
- Robert, T. E., Young, J. S., & Kelly, V. A. (2006). Relationships between adult workers' spiritual well-being and job satisfaction: A preliminary study. *Counseling and Values*, 50, 165–175.
- Wrzesniewski, A., McCauley, C., Rozin, P., & Schwartz, B. (1997). Jobs, careers, and callings: People's relations to their work. *Journal of Research in Personality*, 31, 21–33.

---

## STANDARDS AND COMPETENCIES

---

Standards and competencies in counseling represent attempts to articulate tacit knowledge into criteria and to regulate professional behavior. They are also important as the foundation of efforts in personnel certification and program accreditation. Standards are ubiquitous across modern society. Transnational bodies regulate standards through a representation process. The International Organization for Standardization (ISO) creates and manages standards development through technical committees and a six-step process for achieving consensus. The International Accreditation Forum then oversees implementation and conformity across the world through a system of conformity audits managed by disinterested third parties. The American National Standards Institute is the American representative to ISO. Standards, which govern many aspects of technology, exist for quality (ISO-9000 since 1987), for environmental management (ISO-14000 since 1996), and for personnel certification (ISO-17024 since 2003). The ISO/ANSI 17024 standard has implications because certification providers may wish to seek accreditation to document the quality of their programs. An inherent danger of standards and competencies is that they become checklists honored in letter rather than in spirit and replace innovation with adherence.



Nearly a decade ago, standards for career counseling were discussed using a three-C framework of colleagues, competencies, and credentials. Colleagues are often located within professional associations, whereas competencies specify clusters of personal attributes (knowledge, skills, abilities, and attitudes) related to effective performance of counseling duties and tasks. Credentials cover the traditional domains of government licensing and voluntary certification. Brooke Collison, writing in 2001, used a similar framework of professional associations, accreditation standards, and credentialing

Viewed from this perspective, standards and competencies are ways to develop agreements (and occasionally disagreements) about quality products, processes, programs, and personnel within the counseling profession. Standards are statements to which individuals and organizations can compare their actions, for example, in such key areas of professional performance as testing and assessment, ethics, and graduate education and training. Competencies are behavioral clusters reflecting application of knowledge and skill to achieve superior performance. The key assumption involved in creating and using standards and competencies that achieve quality in counseling products, processes, programs, and personnel will translate into improved counseling outcomes. Standards and competencies in counseling are developed by professional associations and groups, such as the American Counseling Association, the National Career Development Association, and the Council on Accreditation in Counseling and Related Educational Professions (CACREP). They are often the foundation of licensing and certification systems for individual counselors and accreditation systems for counselor education and training programs. The personnel credentialing function is fulfilled by the National Board for Certified Counselors together with its partner, the American Association for State Counseling Boards. The accreditation function is undertaken by CACREP.

Equally pivotal for the counseling profession are general standards in ethics and in testing. In ethics, the American Counseling Association issued its latest Ethical Code in 2005 as a set of eight standards. The American Psychological Association released its most recent set of standards in 2002. In testing, the *Standards for Educational and Psychological Testing* were developed jointly by the American Educational Research Association, American Psychological Association, and

the National Council on Measurement in Education and released in 1999 (and are currently under revision). There are 264 testing standards presented with respect to test construction, subgroup bias, and applications of testing. A typical competency system is one developed and validated for Microsoft (by Lominger International), then modified and released free-of-charge to the education sector in six categories of results, courage, organizational skills, individual excellence, operating skills, and strategic skills.

### **Multicultural Counseling Competencies**

In addition to traditional competencies in counselor education and training, a significant emerging set pertains to multicultural counseling competencies (MCC). Thirty-one competencies were developed in 1991 by the Association of Multicultural Counseling and Development and described by Derald Wing Sue, Patricia Arredondo, and Roderick J. McDavis in 1992. These authors and others have called the counseling discipline to action. A sample competency statement is built around culturally competent counselors “seeking to understand themselves as racial and cultural beings and actively seeking a nonracist identity” (Sue, Arredondo, & Roderick, p. 482). The competencies are statements defined in a matrix framework with three psychological dimensions—beliefs and attitudes, knowledge, and skills—crossed with three characteristics: (1) counselor awareness of own assumptions, values, and biases; (2) understanding the worldview of the multicultural client; and (3) developing appropriate intervention strategies and techniques. In 2002, the American Psychological Association adopted a statement titled “Guidelines on Multicultural Education, Training, Research, Practice, and Organizational Change for Psychologists,” which is available at the Web site of that association. Practice and research accomplishments in MCC over the last 15 years are summarized in the 2006 *Handbook of Multicultural Competencies in Counseling and Psychology* edited by Donald Pope-Davis and colleagues. The handbook includes over 30 chapters in six sections of concepts and theories, assessment, research, practice, and teaching. Various authors provide descriptions and evaluations of scales developed to measure MCC, but the research support is not as robust as desired, or as indicated as in the concluding chapter by Donald



Atkinson and Tania Israel. A 2006 meta-analysis reported by Timothy Smith, Madonna Constantine, Todd Dunn, Jared Dinehart, and Jared Montoya, however, shows a consistent effect for multicultural education and a larger effect for theory-based programs.

### Developing Standards and Competencies

Finally, whenever standards and competencies are evaluated worldwide, the processes of creation and revision should be scrutinized. Among the important desiderata of quality are engaged stakeholders, a planned and iterative process, public comments, and an approval process involving the professional membership. Revision process and cycles should be considered as well. For example, the American Psychological Association in the mid-1990s revised the accreditation process and principles to counter critiques of a checklist mentality that had arisen. One response to those revisions was a normative or prescriptive training program in counseling psychology such as the one outlined in 1998 by Nancy Murdock and her colleagues.

A summary of the important sets of standards and competencies for the counseling profession is shown in Table 1.

*James T. Austin*

*See also* Accreditation by the Council for Accreditation of Counseling and Related Educational Programs (v1); Career Counseling (v4); Career Counseling, History of (v4); Career Interventions (v4); Code of Ethics and Standards of Practice (v2); Counseling Skills Training (v2); Credentialing Individuals (v1); Ethical Codes (v1); Multicultural Career Assessment Models (v4); Multicultural Counseling Competence (v3); National Career Development Association (v4); Professional Associations, Counseling (v1); Specialization Designation (v1)

### Further Readings

- American Counseling Association. (2005). *ACA code of ethics*. Washington, DC: Author.
- American Educational Research Association, American Psychological Association, and National Council on Measurement in Education. (1999). *Standards for educational and psychological testing*. Washington, DC: American Educational Research Association.
- Collison, B. B. (2001). Professional associations, standards, and credentials in counseling. In D. C. Locke, J. E. Myers, & E. L. Herr (Eds.), *The handbook of counseling* (pp. 55–68). Thousand Oaks, CA: Sage.
- Fitzgerald, L., & Osipow, S. (1986). An occupational analysis of counseling psychology: How special is the specialty? *American Psychologist*, 41, 535–544.
- Myers, J. E., & Sweeney, T. J. (2001). Specialties in counseling. In D. C. Locke, J. E. Myers, & E. L. Herr

**Table 1** Summary of key sets of counseling standards and competencies

<i>Standard or Competency Title</i>	<i>Year</i>	<i>Developer(s)</i>
Multicultural Counseling Competencies	1992	Association for Multicultural Counseling and Development
Standards for Educational and Psychological Testing	1999	American Educational Research Association, American Psychological Association, National Council on Measurement in Education
Ethical Principles of Psychologists and Code of Conduct	2002	American Psychological Association
Guidelines on Multicultural Education, Training, Research, Practice, and Organizational Change for Psychologists	2002	American Psychological Association
Advocacy Competencies	2003	American Counseling Association
ACA Code of Ethics	2005	American Counseling Association



(Eds.), *The handbook of counseling* (pp. 43–54).

Thousand Oaks, CA: Sage.

Pope-Davis, D. L., Coleman, H. L. K., Lie, W. M., & Toporek, R. L. (Eds.). (2006). *Handbook of multicultural competencies in counseling and psychology*. Thousand Oaks, CA: Sage.

Smith, T. B., Constantine, M., Dunn, T. W., Dinehart, J. M., & Montoya, J. A. (2006). Multicultural education in the mental health professions: A meta-analytic review. *Journal of Counseling Psychology*, 53, 132–145.

Sue, D. W., Arredondo, P., & McDavis, R. J. (1992). Multicultural counseling competencies and standards: A call to the profession. *Journal of Counseling and Development*, 70, 477–486.

### Web Sites

American Psychological Association: <http://www.apa.org>

The Education Competencies: <http://www.microsoft.com/education/competencies/default.aspx>

---

## STRONG, EDWARD KELLOGG, JR. (1884–1963)

---

Edward Kellogg Strong, Jr., born in 1884 in Syracuse, New York, was the first author of the Strong Interest Inventory (Strong). At the age of 40, Strong took a position in the School of Business at Stanford University where he began his research in interest measurement. He remained at Stanford until his retirement in 1949. After his retirement, Strong continued his work in interest measurement in collaboration with his son-in-law, Ralph F. Berdie, who was a professor at the University of Minnesota, and with other Minnesota faculty including Donald G. Paterson, John G. Darley, David P. Campbell, Theda Hagenah, Wilbur L. Layton, Edmund G. Williamson, and Kenneth E. Clark. After Strong's death in 1963, the University of Minnesota established the Center for Interest Measurement Research, now directed by Jo-Ida C. Hansen, and all of Strong's data were moved from Stanford to Minnesota. The most recent revision of the Strong was published in 2004, making it the longest continuously published interest inventory. The longevity of the Strong, which still uses Strong's method of empirical contrast groups to construct occupational scales, is due in large part to the early work of Strong who laid the empirical foundation for the inventory.

### Before Interest Measurement

Strong lived in many parts of the United States during his lifetime. His father was a minister, and when Strong was a child they moved to the Midwest (Bloomington, Illinois, and Bay City, Michigan) where he developed a love for the outdoors. In 1902, the family moved to San Francisco, and Strong attended the University of California, Berkeley where he majored in biology. After college, Strong spent a year with the U.S. Forestry Service. His love for the Sierras and the outdoors was a constant throughout his life, and at the time of his retirement his score on the Strong Nature scale was one of the three highest scores on his profile (the other two were Science and Mathematics). Strong's daughter described his love for nature in a 1987 interview: "He loved his garden and his golf. He especially loved the mountains, the ocean and the desert. He knew the names of the plants and trees and was continually teaching them to us. He also knew the constellations of stars. He loved to be in the outdoors—to hike, to swim, or to fish" (Hansen, 1987, p. 121).

Strong returned to Berkeley and completed an M.A. in psychology in 1909. He then moved back to the East to attend Columbia University. As a graduate assistant working with Harry L. Hollingworth at Bernard College, Strong met an undergraduate, Margaret Hart, whom he married in 1911, the same year that he completed his Ph.D. Strong remained at Columbia until 1914 when he joined the psychology faculty at George Peabody College for Teachers in Tennessee where he published *Introductory Psychology for Teachers*. Strong's early career also focused on research in marketing and advertising. His research in this area resulted in several publications and the book *The Psychology of Selling and Advertising* published in 1925.

As was the case for many applied psychologists of Strong's generation, World War I had a direct impact on his career. He entered the military in 1917 and served on the Committee on Classification for Personnel and as a personnel specialist with duty assignments at Camp Taylor, Kentucky, and Camp Kearny, California. Strong's work with the Committee on Classification led him to appreciate the efficacy of the Army tests for predicting a person's ability to do a job and to understand the need for career guidance.

After his military service, Strong was on the faculty of the Carnegie Institute of Technology where he participated in a faculty–graduate student proseminar run by Clarence Yoakum, which spawned several attempts



by others (e.g., Bruce Moore, J. B. Miner, Max Freyd) to develop instruments to measure vocational interests. When the applied psychology program at Carnegie was dissolved in 1923, Strong moved to Stanford University where he taught courses in business administration, conducted research on the opportunities for Asian Americans in the United States, and eventually was encouraged by his student, Karl Cowdery, to pursue research in interest measurement.

### Contributions to Interest Measurement

Strong published the first version of the Strong, the Vocational Interest Blank, in 1927, and from that time forward his research and publications were almost exclusively in test construction and interest measurement. Throughout his time at Stanford, Strong had connections with the faculty at the University of Minnesota where the foundations of vocational guidance and the trait-and-factor theory of counseling were emerging in response to veterans returning to college. Strong became friends with Donald G. Paterson, one of the two founding faculty members of Minnesota's Department of Psychology (the other was the chair of the department, Richard M. Elliott), through the World War I Committee on Classification. His daughter, Fran Berdie Berninghausen, attended graduate school at Minnesota and later married Ralph Berdie, a faculty member. As a result, Strong occasionally spent summers teaching at the University of Minnesota, visited Minnesota after his retirement to discuss revisions of the Strong, and gave the Walter Bingham Lecture (Satisfaction and Interests) at Minnesota in 1958.

Strong's first publication on interest measurement, "An Interest Test for Personnel Managers," appeared in the *Journal of Personnel Research* in 1926. The first Strong booklet appeared in 1927, and the first manual in 1928. From the start, Strong was interested in the application of interest measurement to career decision making. For example, he wrote in the 1928 manual, "if he [sic] scores high in both law and engineering, he might prepare for both and become a patent attorney, or a lawyer specializing in engineering problems" (p. 2). He also was concerned about evidence of validity for the Strong, acknowledging in the same manual that it will be "some time before the validity of this test can be exactly determined" (p. 2). By 1929 he had published an article that demonstrated

the diagnostic value (i.e., predictive validity) of the Strong, and in 1930 he published a test-retest reliability study that spanned 1.5 years. He also worked with Louis L. Thurstone to find a meaningful way to group the scales using a method of constellation analysis that Thurstone had developed.

Strong's research in interest measurement was a combination of work to revise, improve, and expand his interest inventory and research designed to understand the construct of vocational interests. He published the first women's version of the Strong in 1935, the first major revision of the men's form in 1938, and the first major revision of the women's form in 1946. Additional revisions of the separate-sex Strong, published in 1966 (Men's Form) and 1969 (Women's Form), were developed at the University of Minnesota in consultation with Strong.

In addition to the interest inventory manuals and *Introductory Psychology for Teachers* (1922), *The Psychology of Selling Life Insurance* (1922), *Job Analysis and Curriculum* (1923), *The Psychology of Selling Advertising* (1925), *Japanese in California* (1933), and *Psychological Aspects of Business* (1938), Strong published four books on vocational interests. The first, *Change of Interests With Age*, was published in 1931; *Vocational Aptitudes of Second Generation Japanese in the United States* appeared in 1933; *Vocational Interests of Men and Women* in 1943; and *Vocational Interests Eighteen Years After College* in 1955. These books elaborated on the evidence of reliability and validity for the Strong that Strong himself collected, and the volumes of data presented in each book also provided enormous knowledge about the construct of vocational interests. *Vocational Interests of Men and Women* was published only 15 years after the first Strong inventory was published, yet it is 746 pages long, contains 197 tables and figures, and reports well over 20,000 numbers (e.g., means, standard deviations, correlations) representing thousands of research participants. This book would be an amazing accomplishment even today with the assistance of high-speed computers to crunch the numbers, but it was a phenomenal accomplishment in 1943 when only about six answer sheets could be scored per hour. The 1955 book was a longitudinal study with Stanford University students.

Strong was described by his daughter Fran as an introverted yet socially skilled person who enjoyed the people with whom he worked but also relished his time alone. His research was supported primarily by



scoring fees for tests that people would send to him. His daughter also indicated that he did much of his research at home, where there were no distractions, with the assistance of his two daughters, Fran and Margaret. He often spent the afternoons playing golf or bridge after teaching in the morning and lunching at home. Strong even interjected his interest in golf into his scholarly writing, noting that the correlation of golf scores between the first and second 18 holes in championship play usually is about .30.

John G. Darley, a University of Minnesota faculty member who knew Strong through his summer visits to the Twin Cities of Minneapolis–St. Paul, described him as a grizzly bear who was not hesitant to express his opinions. Darley also reported that Strong himself claimed never to be a theorist but rather a dirty-handed empiricist who even as he worked to develop a theoretical frame for his interest inventory was always ready and eager to go out and collect more data.

*Jo-Ida C. Hansen*

*See also* Assessment (v4); Expressed, Manifest, Tested, and Inventoried Interests (v4); Quantitative Methodologies (v1); Strong Interest Inventory (v4)

### Further Readings

- Campbell, D. P. (1971). An informal history of the SVIB. In *Handbook for the Strong Vocational Interest Blank* (chap. 11). Stanford, CA: Stanford University Press.
- Darley, J. G. (1964). Edward Kellogg Strong, Jr.: 1884–1963. *Journal of Applied Psychology*, 48, 72–74.
- Hansen, J. C. (1987). Edward Kellogg Strong, Jr.: First author of the Strong Interest Inventory. *Journal of Counseling and Development*, 66, 119–125.
- Strong, E. K., Jr. (1928). *Manual for Vocational Interest Test*. Stanford, CA: Stanford University Press.
- Strong, E. K., Jr. (1943). *Vocational interests of men and women*. Stanford, CA: Stanford University Press.
- Strong, E. K., Jr. (1955). *Vocational interests 18 years after college*. Minneapolis: University of Minnesota Press.

---

## STRONG INTEREST INVENTORY

---

The Strong Interest Inventory, published by CPP, Inc., and commonly referred to as the Strong, is one of the most widely used and scientifically grounded tools available for assessing people's career and life interests.

The Strong measures an individual's work and personal interests and compares them to those of people employed in a wide range of occupations. It is used to help people match their interests with compatible occupational, educational, and leisure pursuits. The 2004 edition of the Strong is the product of many years of research that began in 1927 with the research of E. K. Strong, a military psychologist and an academician at Stanford University. The original Strong was titled the Strong Vocational Interest Blank (SVIB), and it consisted of occupational scales that were constructed through comparing item responses from individuals working in particular occupations with item responses of a general reference sample. The SVIB became the first formal interest inventory to be published. At that time, only male samples were used, and in 1933 the first Women's Form of the SVIB was published. Eventually, in 1974, the Men's and Women's Forms were combined; Holland's six dimensions were integrated to provide an organizing structure; and the name was changed to the Strong-Campbell Interest Inventory. Several revisions followed, resulting in additional scales and improved psychometrics. In the 1980s the name of the inventory was changed again, to the Strong Interest Inventory, which remains its current name. The Strong has been updated regularly to reflect changes in the culture of the U.S. workforce and to adapt to shifting career trends. It continues to be one of the leading inventories used by counselors in a variety of settings, including colleges, high schools, career development centers, and business organizations.

### Administration and Interpretation

The Strong requires at least an eighth-grade reading level and fluency in English. It is not appropriate for individuals under the age of 13, and typically is not administered until an individual has reached the age of 16 or 17. The Strong assessment comprises six sections of items with a total of 291 items, each with a 5-point response option (*strongly dislike*, *dislike*, *indifferent*, *like*, and *strongly like*). Individuals' responses are compared to a large general sample of working men and women (2,250 people) who generally are representative of the racial and ethnic diversity of the U.S. workforce.

Administration typically takes between 30 and 45 minutes. Individuals can complete the Strong online through the publisher's SkillsOne Web site



(www.skillsone.com) or manually using mail-in scoring forms. The resulting 9-page Strong Profile is sent to the counselor, not directly to the client. The publisher offers a number of tailored reports and Strong Profile options, such as the Strong College Profile, Strong High School Profile, and Interpretive Report, to tailor results to specific populations and needs. For example, the Strong College Profile provides a 4-page supplement to the profile to help both client and counselor connect the results to college majors, college courses, and campus activities that correspond to the client's top interests.

Counselors need to demonstrate coursework in psychometrics or test interpretation (or to complete a workshop endorsed by the publisher) to qualify for ordering the Strong. The publisher offers a wide array of support materials to assist with interpretation. Both the manual and the several user's guides offer detailed instruction for interpreting various types of profiles with individuals and groups.

### Profile Description

The Strong Profile presents an individual's interests through four sets of scales and uses John Holland's theory of six vocational personality types as an organizing structure. The four sections include the following: the General Occupational Themes, the Basic Interest Scales, the Occupational Scales, and the Personal Style Scales. In addition, a number of administrative indexes are provided to help the counselor detect any unusual response patterns. An individual's scores are compared to both men and women samples, but the majority of scores on the profile draw attention to comparisons with samples of the individual's same gender.

#### **The General Occupational Themes**

The General Occupational Theme scales measure broad interest patterns used to describe an individual's work personality. They comprise items with content corresponding to Holland's description of the six occupational-personality types: Realistic, Investigative, Artistic, Social, Enterprising, and Conventional. Definitions of the themes are provided on the profile. Higher scores result from *like* and *strongly like* responses to items that relate to each of the six themes, and lower scores result from *dislike* and *strongly dislike* responses to these items. The six themes are presented in rank order of interest level on

the individual's profile using interpretive comments that compare the individual to a reference sample of the same gender. These comments range from *very little* to *very high* interest. Standard scores, which compare the individual to a reference sample of both genders, are then used to further rank-order any interpretive comments with similar values. Individuals are given a Summary Code that highlights the combination of the individuals' highest scoring themes to encourage exploration of two or three themes rather than to one alone.

#### **The Basic Interest Scales**

Thirty Basic Interest Scales measure more focused interest areas using the same construction and scoring methods as the ones used for the General Occupational Themes. These scales, such as Culinary Arts, Law, and Office Management, are grouped on the profile according to the six themes. They can be used to break down the General Occupational Themes into specific interest areas related to work, school, or leisure activities that the individual is likely to find interesting and rewarding.

#### **The Occupational Scales**

The Occupational Scales include 122 scales that represent a wide range of occupations representing all six themes. These scales measure how similar an individual's interests are to those of people of the same gender who have been satisfactorily employed in a particular occupation. Scores reflect a comparison of both the dislikes and the likes of an individual with the dislikes and likes of satisfied workers sampled from that occupation. Consequently, the higher the score, the more the individual shares similar interests and disinterests with people from that occupation. The profile highlights the 10 occupations most closely aligned with the individual's interests, and scores are presented for each of the 211 scales using a bar graph that extends from dissimilar to similar. The profile shows only comparisons with samples of the individual's same gender (unlike previous editions of the Strong, which included comparisons to both genders).

#### **The Personal Style Scales**

The five Personal Style Scales describe different ways of approaching work, learning, leadership, risk taking, and team participation. Unlike all other scales



on the Strong, each of the Personal Style Scales is presented as a bipolar continuum and describes the individual's preference for one style versus another in comparison to a reference group of men and women combined. Scores are labeled as *clear* when they fall toward either polarity of the continuum, and as *midrange* when they fall toward the middle. Descriptors are provided at each end of each continuum providing examples of a preference for one style versus the other. For example, the first Personal Style Scale, Work Style, describes scores toward the left pole as "Prefers working alone; enjoys data, ideas or things; reserved," and scores toward the right pole as "Prefers working with people; enjoys helping others; outgoing."

### Profile Summary

A summary page is provided on the last page of the profile. This page summarizes the individual's highest themes, top five specific interest areas, top 10 occupations, and each Personal Style Scale preference. The areas of least interest to the individual also are summarized here. The purpose of this page is to help the individual focus on common interest themes that are consistent throughout the profile.

### Research and Practice

The Strong is one of the most extensively researched inventories available. The developers engaged in significant research to support the current edition, and numerous scholars have published a large body of literature to support the instrument throughout its history. The *Strong Interest Inventory Manual* provides detailed descriptions of the research that led to item selection, scale construction, reference sample collection, and scoring. Evidence for both the validity and reliability for each set of scales on the Strong is impressive and provides strong support for confident use of the Strong with a variety of client populations. Used appropriately, it serves as a dependable tool for helping clients make informed career, academic, and life decisions.

Jeffrey P. Prince

**See also** Campbell Interest and Skill Survey (v4); Career Counseling, History of (v4); Career Counseling in Schools (v4); Expressed, Manifest, Tested, and Inventoried Interests (v4); Holland's Theory of Vocational

Personalities and Work Environment (v4); Jackson Vocational Interest Inventory (v4); Person Matching (v4); Unisex Edition of the ACT Interest Inventory (v4)

### Further Readings

- Donnay, D. A. C., Morris, M. I., Schaubhut, N. A., & Thompson, R. C. (2005). *Strong Interest Inventory manual*. Mountain View, CA: CPP.
- Grutter, J., & Hammer, A. L. (2005). *Strong Interest Inventory user's guide*. Mountain View, CA: CPP.
- Prince, J. P. (2007). *Strong Interest Inventory college edition user's guide*. Mountain View, CA: CPP.
- Prince, J. P., & Heiser, L. J. (2000). *Essentials of career interest assessment*. New York: Wiley.

---

## SUPER, DONALD EDWIN (1910–1994)

---

There are two grand paradigms in vocational psychology. The first perspective for understanding vocational behavior concentrates on how individual differences in ability and interests relate to occupational requirements, routines, and reward. This paradigm, called the *matching model*, asserts that the goodness of fit between an individual's abilities and a job's requirements determines the worker's occupational success. Furthermore, the match between the individual's interests and the job's rewards determines the worker's job satisfaction. Workers who are successful and satisfied with their routines, in other words adjusted, remain in the job for long periods of time, thus achieving occupational stability. This paradigm lies at the heart of professional activities such as vocational guidance, personnel selection, and military classification.

In the 1940s, Donald Edwin Super made two major contributions to the matching model for understanding vocational behavior. In 1942 he published *The Dynamics of Vocational Adjustment*, which described his views on vocational guidance. In 1949 he published an encyclopedic tome, *Appraising Vocational Fitness by Means of Psychological Tests* that analyzed the data on the use of tests in vocational guidance and personnel selection. These two contributions secured his stature as a prominent vocational psychologist, and accordingly in 1949 he was promoted to the rank of professor of psychology and education at Teachers College, Columbia University where in 1940 he had earned



his Ph.D. under the sponsorship of Harry Dexter Kitson and where he worked from 1945 to 1975.

Following his promotion to the rank of professor, Super became more interested in theory construction than in the application of psychology to personnel selection and vocational guidance. A stinging critique of vocational psychology had been published in 1951 by Eli Ginzberg who in effect asserted that the discipline of occupational psychology had been operating without a theory. This critique ushered in the theory building era of vocational psychology during which John Lewis Holland in 1959 consolidated the voluminous research and reflection on the matching model into an elegant theory of vocational personality types and work environments. Super took a different tact. He turned his attention away from how individuals differ from each other in abilities and interest. Instead he concentrated on how an individual differs from himself or herself across time, that is, how individuals develop their careers.

The 1950s was a decade during which hierarchical corporations rose in urban centers of America. The bureaucratic structure of corporations created career paths along which individuals could grow in occupational responsibility and income. Career came to be viewed as the value accompanying bureaucratic form. Rather than remaining in one job for life, many individuals could envision progressing along a predictable sequence of positions. Super became the leading architect of vocational psychology's response to the new social arrangement of occupational lives into career patterns. He added a career development model to the longstanding occupational matching model. His developmental model of how a career progresses over the life cycle became the second major paradigm in vocational psychology, one that, paired with Holland's theory, dominated the field of vocational psychology during the second half of the 20th century.

The first major statement of Super's career development model appeared as a 1953 article titled "A Theory of Vocational Development." This article, published in the *American Psychologist*, presented 10 propositions in what would become known as Super's theory of career development. The conclusions sketched in that article were elaborated in Super's celebrated 1957 textbook titled *The Psychology of Careers*, a title he purposefully selected to highlight the contrast with Anne Roe's 1956 book titled *The Psychology of Occupations*. Dedicated to Kitson, the 1957 book documented the conclusions that Super drew from his decade-long study of careers.

One seminal contribution reported both in his 1953 article and in his 1957 book was a model of career as a sequence of stages. Super conceptualized careers as unfolding in an orderly sequence that begins with a growth stage (ages 4–13) during which an individual formulates a vocational self-concept and rehearses relevant abilities and interests. During the exploration stage (ages 14–25), these occupationally relevant traits are first crystallized during adolescence and then translated into a specific occupational choice that is tried on during early adulthood. After several years of trial and tentative moves, the individual stabilizes into an occupational position. During the establishment stage (ages 26–44), the individual first stabilizes in the position, then consolidates that position through productive and dependable work. If opportunities present themselves, the individual may advance to positions with more responsibility and income. At some point, advancement slows or even terminates, and the individual maintains the success and stature he or she has achieved. During the maintenance stage (46–65), the individual holds onto the position, hopefully by updating and innovating how it is done. The final stage in the sequence is called disengagement because the individual decelerates work activity and gradually turns responsibilities over to younger colleagues as he or she prepares for retirement and in due course begins retirement living.

Implicit in Super's stage model of career development lies the construct of maturity. Career maturity means possession of the readiness and resources needed to cope with the developmental tasks inherent in each career stage. Mastering these tasks, which can be viewed as social expectations, develops the individual and leads to increased success and satisfaction. Difficulties in adapting to these tasks result in failure and frustration. Super conducted a 30-year longitudinal investigation called the Career Pattern Study to examine how adolescents cope with the career development tasks of the exploration stage.

He conceptualized three tasks to linguistically explain the exploration stage. The first task was to crystallize general preferences for a group of occupations at a similar ability level and within similar fields of work. After broad exploration of these general preferences, the individual must select a few for in-depth exploration and finally specify an occupational choice that implements his or her self-concept in a work role. The third task of the exploration years is to convert that occupational choice into a reality by securing a position in the chosen occupation. The initial years in



the chosen occupation are considered a period of trial because the choice is still tentative until the individual decides to stabilize in a position. During the trial period individuals may drift between positions and even flounder in a job or two before stabilizing. This movement is preferable to stagnating, which means stabilizing in a poorly fitting position.

Progress through the tasks of crystallizing preferences, specifying a choice, and implementing that choice can be used to index an adolescent's career maturity. Super conceptualized maturation as dealing with age-appropriate tasks. He viewed career maturity as handling the tasks as well as one's peer group. To examine how well individuals handle the tasks, Super crafted a model of career maturity during adolescence. He operationally defined this model with an instrument known as the Career Development Inventory.

Super's model of career maturity, or career choice readiness, has five components. The fifth component is called realism and occurs later in adolescence or early in adulthood. Thus, he does not use realism in indexing the career maturity of adolescents. The other four dimensions of maturity are divided into two groups. The first two dimensions are attitudinal, and the second two dimensions are cognitive. Super viewed looking ahead and looking around as two critical coping behaviors. Therefore, he conceptualized attitudes toward planning for the future and toward exploring possible selves and occupational opportunities as the two key dimensions in his model of maturity. Knowing what choices need to be made and having explored self and occupations, the individual must apply the resulting fund of information in making life-shaping decisions. Accordingly, the two cognitive dimensions or competencies in the maturity model are information about occupations and skill at making decisions. Stated simply, the idea is that individuals who have planned ahead and explored possibilities have the information required to make fitting decisions in choosing an occupation. Typical variations in the development of these attitudes and competencies lead to predictable problems including unrealism and undecidedness, whereas atypical deviations in their development lead to severe difficulties including apathy and indecisiveness.

Near the end of his own career, Super realized that the social organization of the work was radically shifting as the world began the age of globalization and digitalization. No longer can an individual expect to work 30 years for one employer, progressing along a

predictable career path until it is time to draw a pension. Contemporary workers can expect to occupy 10 or more positions during their careers. Super addressed the decline of organizational careers by explaining that his model of career stages, with minimal modifications, fit the postindustrial career if it is viewed as a sequence of tasks through which individuals recycle as they move from organization to organization and from job to job. Thus, an individual at age 45 who, after working in a job for 10 years, loses that position to outsourcing then needs to recycle through the tasks—not stages—of growth in awareness of new opportunities, exploration of these possibilities, transition to a new position and stabilization in it, followed by a period, say 5 to 7 years, of maintaining or managing that position before disengaging from it and recycling through the tasks once again.

Mark L. Savickas

*See also* Adult Career Concerns Inventory (v4); Adult Development (v1); Aging (v1); Career Construction Theory (v4); Career Development Inventory (v4); Career Exploration (v4); Career/Life (v4); Career Maturity (v4); Career Maturity Inventory (v4); Crites, John O. (v4); Holland's Theory of Vocational Personalities and Work Environments (v4); Super's Theory (v4)

### Further Readings

- Savickas, M. L. (1994). Donald Edwin Super: The career of a planful explorer. *Career Development Quarterly*, 43, 4–24.
- Savickas, M. L. (2001). A developmental perspective on vocational behavior: Career patterns, salience, and themes. *International Journal for Educational and Vocational Guidance*, 1, 49–57.
- Super, D. E. (1996). A life-span, life-space approach to career development. In D. Brown & L. Brooks (Eds.), *Career choice and development* (pp. 197–261). San Francisco: Jossey-Bass.

---

## SUPER'S THEORY

---

Beginning with the first documented vocational counseling attempts of Frank Parsons in 1909, vocational counseling and research focused for nearly half a century on vocational choice—not on how or why one made a particular vocational decision, but rather on what that decision was. Donald Super's theory of



vocational development was therefore unique in being one of the first attempts to explain the process underlying vocational choice and to take a developmental perspective by looking at vocational development across the life span.

In developing his theory, Super drew on the earlier work of Eli Ginzberg, Sol Ginsburg, Sidney Axelrad, and John Herma, who presented a model of vocational choice as part of a developmental process and incorporated Charlotte Beuheler's concept of life stages. Therefore, at the core of Super's theory has always existed the idea of five predictable stages of vocational development that occur as part of a continuous process throughout the life span. The theory was tested and refined based on results from the Career Pattern Study. This large-scale longitudinal study followed the career development of a large group of boys from Middletown, New York, who were in the eighth and ninth grades in 1951. Although the culturally homogenous nature of this sample has led to concerns about the cultural validity of Super's theory, the Career Pattern Study remains one of the most ambitious studies of vocational development.

Super developed and refined the theory over the decades since it was first proposed. His final formulation of the theory, referred to as the life-span, life-space approach, is captured by two models: the life-career rainbow and the archway of career determinants.

### **The Life-Career Rainbow**

According to Super, a career consists of the varying roles people take on during their lives. The life-career rainbow (or career rainbow model) brings together both the roles played in life (the life space) with the five developmental stages or structures of life (the life span).

#### ***Life Space***

Super believed that people play several roles during a lifetime, with the work role as one of many. These roles are included in the life-career rainbow in what is called the life space. Life space is captured in the horizontal arches of Super's rainbow and contains the roles of child, student, leisurite, citizen, worker, and homemaker. Roles can be enacted simultaneously, as when, for example, an individual has an active career, is a parent, and is active in community organizations. Roles that take more time commitment become more central, whereas other roles involving

less commitment become more peripheral. People are defined by the central roles they play. As life transitions occur, central and peripheral roles are changed, added, or dropped. For example, the child and student roles become more peripheral as one becomes established with career and family. Similarly, increasing the number of roles in one's life may mean less commitment to other roles. Roles can also interact, with outcomes in one role affecting outcomes of other roles. Depending on these interactions and the amount of energy and time taken from other roles, the presence of multiple roles may be positive or negative.

#### ***Life Span***

As noted above, the roles played by a person develop and change throughout the course of a lifetime. The life span, symbolized by the top layer of the life-career rainbow, signifies the developmental structure in which the individual adapts to work. This layer shows a progression of life stages, from childhood to old age, that correspond to Super's five career development life stages: growth, exploration, establishment, maintenance and disengagement. Each stage comprises several key career tasks that the individual is challenged to master before progressing to the next stage. Vocational or career maturity refers to how well an individual is able to handle these tasks.

### **Developmental Stages**

During the growth stage, ages 4 to 13, the person achieves the initial steps toward career development, which range from simply caring about a vocational future to achieving appropriate attitudes and behaviors toward work. During this stage, children develop their self-concept as they explore their environment and meet important adult role models. If children encounter a sufficient variety of rewarding experiences during this stage, they will develop not only interests, but autonomy, self-esteem, and a sense of the future as well. A lack of rewarding experiences hinders such development. Thus, children may become innovative or conventional, goal-oriented or purposeless as a result of the learning they encounter in this stage. This growth stage contains the three sub-stages: fantasy, interest, and capacity. Children begin to develop by fantasizing through role-plays, they then develop interests by liking certain tasks over others, and finally they begin to consider their abilities in relation to job requirements.



In the next stage, exploration, which occurs between the ages of 14 and 24, the developmental tasks are to narrow vocational interests in order to make a vocational choice. Open exploration becomes focused, allowing individuals to enact their private views of themselves into a career choice or educational decision. For example, adolescents begin trying out various part-time jobs, and students declare a major in college that is consistent with their interests. During this stage, one may choose a career early without examining other options; such foreclosure may lead to later vocational discontentment. The exploration stage contains the substages of tentative, transition, and trial. Individuals tentatively form decisions in regards to their needs, interests, and abilities and then encounter transition as they move into the reality of the world of work; finally individuals enter a field of work and test the job for its appropriateness, given their needs and abilities.

Once a suitable field of work is chosen, the person enters the establishment stage, ages 25 to 44, in which the salient tasks are to keep and advance in the job. This is done by becoming part of the organizational culture, demonstrating adequate job performance, and getting along with one's colleagues. Success in these tasks then may allow the individual to advance within his or her career.

During the maintenance stage, ages 45–65, individuals face the tasks of maintaining their place at work in the face of changes and competition from younger, more eager and educated workers. This may involve gaining new skills and becoming more aware of current trends; without doing so, one may experience stagnation in one's career.

In the final stage, disengagement, which usually occurs after the age of 65, individuals face the career tasks of disengaging from the work role and planning for and living in retirement. Disengagement from work often occurs due to age-related declines in mental and physical capacities. Such disengagement may be seen by engineers who begin to take on fewer projects or by professors who choose to teach fewer classes. This deceleration may then lead to retirement, in which occupational activities are ceased.

### Maxi- and Mini-Cycles

According to the life-career rainbow, these five stages of development occur in order in what is called a *maxi-cycle*. Future vocational problems may occur when one does not follow the proposed order of

stages. For example, foreclosing early without proper exploration can lead to a less suitable occupational choice. The theory also recognizes that transitions between stages and career interruptions often lead individuals to experience a *mini-cycle* or a recycling through stages. For example, an adult in the maintenance stage of a maxi-cycle might find that with a promotion come the needs to explore new skills and establish new roles with coworkers. Alternately, adults in this stage who lose their job may be forced to recycle through earlier stages and reexplore interests and values to select a new career and then reestablish themselves in the new field.

### The Archway of Career Determinants Model

Explicit in Super's developmental tasks are the ideas (a) that individuals possess different abilities, interests, values, and so on; (b) that these patterns of intrapersonal characteristics make individuals more or less suited to different careers; and (c) these individual differences and the careers available to a person at any one time are shaped by situational factors. Super's second synthesizing model, the archway of career determinants, was created to make more explicit these environmental and intrapersonal determinants of career that are suggested by the developmental tasks of the career rainbow model. Thus, the arch is similar to the rainbow in that it describes Super's career development theory but differs in how it is described.

As its name suggests, the archway model is shaped in the form of an arch, which represents an individual's career. Each stone of the arch symbolizes an influential factor or determinant of career. The most basic determinants are near the base with biology and environment forming the bottom of the base. An individual's personality characteristics (e.g., intelligence, needs, values) form the column on the left. Societal characteristics (e.g., labor market, school, family) form the column on the right. Although not represented graphically, these intrapersonal and environmental factors are assumed to interact with each other in determining an individual's career development. The arch itself sits on these two pillars and signifies the outcomes of the two columns of personality and societal determinants. The two ends of the arch represent the developmental stages, with the left side containing the earlier developmental stages and the right side containing the later stages. Finally the arch culminates to form the keystone, the central piece of the



arch, which represents the person who makes the career decisions.

### Career Development Assessment and Counseling Model

In addition to these well-articulated theoretical models, Super developed counseling applications of these models. His career development assessment and counseling model integrates several useful assessment instruments to explore a client's development, values, interests, and career maturity. Several sequences are possible, but often assessment begins by determining where the client is in the life space, life span, and what the importance of the work role is. The latter may be done with adolescents and young adults using the Career Development Inventory (CDI) or with older adults using the Adult Career Concerns Inventory (ACCI). The CDI measures career decision-making readiness by assessing career decisions in light of the attitudes and knowledge possessed by the adolescent or young adult. The ACCI measures concerns and planning related to the career developmental stages of exploration, establishment, maintenance, and disengagement. The Salience Inventory may be used to assess how important a life role is to an individual in comparison to other life roles. Five life roles (student, worker, citizen, homemaker, and leisurite) are assessed in regards to activity, dedication, and value expectations. If assessment reveals that the work role is not very important, then the counselor may either attempt to better orient the client to the work role or shift the focus from vocational development to development of other roles, depending on the appropriateness of the lack of work role salience. This assessment may also reveal useful information about the interactions among the individual's varying roles. Assessment then proceeds to measuring the client's interests and values, using common tools such as the Strong Interest Inventory and the Values Scale, which assesses 21 intrinsic and extrinsic work values individuals may seek to satisfy within their life space. Often these values underlie the individual's interests, as when, for example, values of altruism are reflected in social interests. Finally, these assessment results are integrated into a narrative interpretation that identifies needed areas of growth (e.g., in work-related attitudes or acquisition of new skills) and suggests ways that counseling may help in such development.

### Criticisms and Future Directions

In the archway model, the column representing situational determinants is equal in size and, ostensibly, importance to the column representing personal career determinants. However, as suggested by the person as keystone, Super's theory is held together by the central salience of the individual. The better able people are to match their interests, values, needs, and abilities to an occupation, the more likely they are to have a satisfying and productive career. This fundamental premise that a successful career choice depends on successful implementation of the self-concept underlies the most significant criticism of Super's theory: that it overemphasizes the role of the individual and underestimates the role of the environment and culture. For example, although Super's theory clearly acknowledges situational determinants of career, some have argued that the theory does not adequately acknowledge the impact of discrimination and circumscribed opportunities faced by many persons of color and others. In addition, the emphasis on individual choice fails to acknowledge the important role of the family or group for individuals from more collectivist cultures or with a more interdependent sense of self, such as Asian Americans.

Despite these criticisms, which Super himself acknowledged, his theory of vocational development remains one of the most influential approaches to understanding vocational development. His developmental approach moved the focus from a one-time adolescent or young adult career choice to an understanding of the multiple influences from birth through death that shape a lifetime of career behaviors. Furthermore, the theory has clear counseling applications. Although aspects of the theory may need to be modified when applied with clients from some cultural groups, Super's developmental approach to understanding career behavior across the life span, refined across several decades, remains of tremendous relevance. Future directions that would increase the relevance and utility of the theory include greater attention to cultural context and to development in the later stages.

*Erin E. Hardin and Femina P. Varghese*

*See also* Adult Career Concerns Inventory (v4); Adult Development (v1); Aging (v1); Career Construction Theory (v4); Career Development Inventory (v4); Career



Exploration (v4); Career/Life (v4); Career Maturity (v4); Career Maturity Inventory (v4); Super, Donald Edwin (v4); Values Scale (v4); Vocational Identity (v4)

### Further Readings

- Ginzberg, E., Ginsburg, S. W., Axelrad, S., & Herma, J. L. (1951). *Occupational choice: An approach to a general theory*. New York: Columbia University Press.
- Leong, F. T. L., & Brown, M. T. (1995). Theoretical issues in cross-cultural career development: Cultural validity and cultural specificity. In W. B. Walsh & S. H. Osipow (Eds.), *Handbook of vocational psychology: Theory, research, and practice* (2nd ed., pp. 143–180). Hillsdale, NJ: Lawrence Erlbaum.
- Super, D. E. (1957). *The psychology of careers*. New York: Harper.
- Super, D. E. (1992). Toward a comprehensive theory of career development. In D. H. Montross & S. J. Shinkman (Eds.), *Career development: Theory and practice*. Springfield, IL: Charles C Thomas.
- Super, D. E., Crites, J. O., Hummel, R. C., Moser, H. P., Overstreet, P. L., & Warnath, C. F. (1957). *Vocational development: A framework for research*. New York: Bureau of Publications, Teachers College, Columbia University.
- Super, D. E., Osborne, W. L., Walsh, D. J., Brown, S. D., & Niles, S. G. (1992). Developmental career assessment and counseling: The C-DAC model. *Journal of Counseling & Development*, 71, 74–80.
- Super, D. E., Savickas, M. L., & Super, C. M. (1996). The life-span, life-space approach to careers. In D. Brown, L. Brooks, & Associates (Eds.), *Career choice and development* (3rd ed., pp. 121–178). San Francisco: Jossey-Bass.

---

## SYSTEM OF INTERACTIVE GUIDANCE INFORMATION

---

The System of Interactive Guidance Information (SIGI) is a computer-assisted career guidance system (CACGS) for university students and adults. It is a computer program designed to help people make informed career decisions via self-assessments and in-depth, current educational and job information. The program also has an educational aspect that teaches users about the career decision-making process. SIGI provides users with realistic choices for educational and career options that are likely to best suit them

based on self-assessment results that are matched to fields of study and occupations that are held in databases that are accessed by the program. SIGI is a career exploration tool students may use to determine how their interests, values, and skills relate to a wide variety of career fields, as well as the education, skills, and background required for these fields.

### History

Donald Super, David Tiedeman, and Martin Katz explored early ideas about computer use in career development in the 1950s and 1960s. SIGI is a computer program that was developed by the Educational Testing Service (ETS) based on Martin Katz's career decision-making theory and was originally released in 1970. SIGI was one of the first computer products of its kind. When ETS introduced SIGI in 1970, the company offered computerized career information and guidance to community colleges, 4-year colleges, and universities across the United States.

During the mid-1980s, SIGI became SIGI PLUS when it was reprogrammed for microcomputers and other enhancements were added. The program was modified for use with Microsoft Windows in 1996, and in 2001 ETS developed the first Web-based version. ETS upgraded and enhanced SIGI over the years, and SIGI PLUS operated both on the Internet and on personal computers.

Valpar International has been creating and marketing vocational assessment instruments since 1973. In July of 2004, Valpar acquired SIGI PLUS from ETS in order to expand its selection of career exploration software. On May 30, 2005, Valpar replaced the Internet version of SIGI PLUS with SIGI<sup>3</sup>, which is a revision of SIGI PLUS that has been updated and expanded. SIGI<sup>3</sup> is a Web-based version of SIGI PLUS that maintains the content and philosophy of the older version, but it provides a more updated and efficient interface. Features of SIGI PLUS remain or have been enhanced, and navigating the software has been made easier. Valpar will be adding features such as a new look to the screens, a more intuitive user interface, improved navigation, expanded occupational database, enhanced student portfolio, management reports, additional assessments such as a personality trait survey, video library, publicity kit, and other changes, but Valpar will not change the values-based career exploration foundation of SIGI PLUS.



## **Review of the SIGI Literature**

SIGI PLUS quickly became one of the leading three career guidance systems on the market in terms of sales and popularity. However, research supporting the effectiveness of SIGI, SIGI PLUS, SIGI<sup>3</sup>, and other CACGSs is relatively scant. These interventions have been utilized with numerous career clients, despite having relatively little research support for their efficacy. Approximately 22 citations related to either SIGI or SIGI PLUS can be found. No recent or research articles on SIGI<sup>3</sup> were found on Valpar's Web site or elsewhere.

### ***Satisfaction With SIGI***

Over the years, a number of researchers have attempted to compare user satisfaction with SIGI to satisfaction with other CACGSs and career counseling methods such as individual and group career counseling.

#### **Comparison of SIGI With Other CACGSs**

When compared with other CACGSs, students and counselors have rated SIGI highly in terms of satisfaction, specifically regarding the program's helpfulness and appeal. Users have expressed satisfaction with both SIGI and SIGI PLUS programs, which in their times have historically been popular and were commonly used CACGSs.

#### **Stand-Alone SIGI Versus SIGI and Individual Career Counseling**

There has been a long-term debate in the literature about how SIGI and other CACGSs should be utilized. Some authors suggest that SIGI can be used as a stand-alone career exploration tool; others argue that career counseling in addition to use of the program enhances outcomes. Some authors have examined whether or not traditional counseling intervention is required to maximize the effectiveness of SIGI use. Multiple studies have indicated that students prefer using SIGI when individual counseling is available as a follow-up to their experience with the program. Counselors thus seem to be a vital and desired component of the computer-assisted guidance process.

A separate question is whether or not SIGI affects changes in career development and decision making. It is this issue to which this entry will now turn.

## ***Effectiveness of SIGI***

A number of studies have examined the effectiveness of SIGI. Overall, SIGI has demonstrated significant positive changes. For example, SIGI users have shown significant positive changes on measures of decision-making stage related to occupation. Brief exposure to SIGI can also have positive effects related to choice of a college major. SIGI's approach to career exploration might create the excitement and motivation needed to facilitate concentration and attention of new users. SIGI also is an individualized approach that is adaptable to user needs, providing personal attention and information to the user.

#### **SIGI Versus SIGI PLUS**

Students have found SIGI and SIGI PLUS to be equally helpful for obtaining information about themselves and the world of work, effectiveness in suggesting career options, and appeal of using a computer for career exploration. Students tend to prefer using SIGI PLUS to SIGI. However, no differences in impact have been found, even when potential moderator variables have been taken into account. Users rated the systems comparably in terms of self- and occupational assessment, generation of options, and general helpfulness, regardless of other factors such as their scores on career decidedness, vocational identity, perceived barriers, information needs, or year in school.

#### **SIGI Versus Group Career Counseling**

Multiple studies have compared the effects of SIGI with group career counseling, with mixed results. At times, both interventions have been found to be effective; at others, only SIGI produced positive results. Regardless, SIGI appears to have a consistently positive impact on career development of users.

#### **SIGI and Individual Career Counseling**

SIGI alone has been found to be somewhat effective in enhancing career outcomes. However, many individuals using SIGI desire access to the combination of SIGI and individual career counseling. There is also some indication that users find that a combination of SIGI and counseling is more beneficial in meeting their needs than SIGI alone.



## The Future of SIGI

More than 30 CACGSs have been developed in the past few decades. However, many of these systems have become obsolete or are simply not commonly used. SIGI seems to have stood the test of time by going through multiple revisions and further enhancements and adaptations for use with current computer technologies. Given its long history and apparent revitalization by Valpar, there appears to be a place for SIGI in the career development of university students and adults in future years to come. SIGI will need to be kept up to date and relevant to remain a competitive product. This seems likely given that Valpar has committed to revising the program regularly, rather than just once a year as it has been in the past.

*Jeanne M. Hinkelman*

**See also** Assessment (v4); Career Education (v4); Career Exploration (v4); Career Counseling in Colleges and Universities (v4); Career Counseling in Schools (v4); Computer-Assisted Career Counseling (v4); Decision Making (v4); DISCOVER (v4); Person Matching (v4)

## Further Readings

- Cairo, P. C. (1983). Evaluating the effects of computer-assisted counseling systems: A selected review. *The Counseling Psychologist, 11*(4), 55–59.
- Chapman, W. (1975). *Counselor's handbook for SIGI*. Princeton, NJ: Educational Testing Service.
- Cochran, D., Hoffman, S., Strand, K., & Warren, P. (1977). Effects of client/computer on career decision-making processes. *Journal of Counseling Psychology, 24*, 308–312.
- College Cares [Press Release]. (2004). Valpar International Corporation acquires popular career exploration product from ETS. Retrieved February 9, 2008, from <http://www.collegecares.com/index.php?s=swartz>
- Crites, J. O. (1973). *The Career Maturity Inventory*. Monterey, CA: McGraw-Hill.
- Hinkelman, J. M. (1998). The effects of DISCOVER on the career maturity and career indecision of rural high school students: A randomized field experiment. *Dissertation Abstracts International, 59*, 8A, 2868. (University Microforms No. AAG9904847)
- Kapes, J. T., Borman, C. A., & Frazier, N. (1989). An evaluation of the SIGI and Discover microcomputer-based career guidance systems. *Measurement and Evaluation in Counseling and Development, 22*(3), 126–136.
- Pyle, K. R., & Stripling, R. O. (1976). The counselor, the computer, and career development. *Vocational Guidance Quarterly, 3*, 137–144.
- Pyle, K. R., & Stripling, R. O. (1977). Counselor vs. computer in career development. *NASPA Journal, 14*, 38–40.
- Reardon, R. C., Peterson, G. W., Sampson, J. P., Ryan-Jones, R. E., & Shahnasarian, M. (1992). A comparative analysis of the impact of SIGI and SIGI PLUS. *Journal of Career Development, 18*(4), 315–322.
- Sampson, J. P., Jr. (1979). *User guide for SIGI*. Princeton, NJ: Educational Testing Service.
- Sampson, J. P., Jr. (1983). An integrated approach to computer applications in counseling psychology. *The Counseling Psychologist, 11*(4), 65–74.
- Sampson, J. P., Jr., & Stripling, R. O. (1979). Strategies for counselor intervention with a computer-assisted career guidance system. *Vocational Guidance Quarterly, 27*, 230–238.
- SIGI [Computer software]. (1970). Princeton, NJ: Educational Testing Service.
- SIGI PLUS [Computer software]. (1997). Princeton, NJ: Educational Testing Service.

## Web Sites

Valpar International: <http://valparint.com/sigitran.htm>









---

## TESTS

---

*See* ACHIEVEMENT, APTITUDE, AND ABILITY TESTS

---

## THEORY OF WORK ADJUSTMENT

---

The Theory of Work Adjustment (TWA) is a person–environment fit (P–E fit) theory that elaborated the P–E fit theories of Frank Parsons, Donald G. Paterson, and John G. Darley into a dynamic model of vocational adjustment. The TWA postulates that optimal vocational outcomes occur when (a) the individual’s abilities match the skills required for success in the occupation and (b) the individual’s needs are satisfied by the occupation. This match between the worker and the occupation, referred to in the theory as correspondence, results in good work adjustment. The TWA specifies the components that are important determinants of correspondence and the dynamic process by which correspondence develops and is maintained.

### Development of the Theory

Development of the TWA occurred in two distinct phases. During the 1960s, Lloyd H. Lofquist and René V. Dawis, University of Minnesota psychologists, formulated a trait-and-factor matching model and in collaboration with David J. Weiss developed instruments to measure the major constructs introduced by the theory. The initial statement of the theory in

1964 provided the conceptual framework for the continuing program of research undertaken by the Minnesota Work Adjustment Project (WAP) from 1964 to 1972. The publication of *Adjustment to Work* 4 years later marked the culmination of this phase of theory building.

Elaboration of the theory continued along two fronts during the 1970s. First, the authors bridged the theoretical gap between vocational needs and work values. Of greater significance, however, was their elucidation of their constructs of personality style and work environment style and the dynamics of the work adjustment process. Integration of the structural and dynamic aspects of the theory during the 1970s transformed the TWA from a static trait-and-factor model to a developmentally oriented model that describes the ongoing interaction between individuals and their work environments.

### Structure of Work Adjustment

According to the TWA, work adjustment is a function of the correspondence (i.e., quality of the match) between an individual’s work personality and the work environment. The work personality consists of the psychosocial needs and abilities of the worker. The salient attributes of the work environment are the rewards provided by the job and the skills required to perform the work tasks successfully. A good match (i.e., work adjustment) results in job satisfaction, satisfactory job performance, and worker tenure. A poor match leads to worker dissatisfaction, poor job performance, and turnover.



Each worker has a unique set of psychological (i.e., secondary or learned) needs. The TWA and the research program it inspired identified 21 needs (i.e., learned preferences for particular stimulus conditions) that influence the individual's reaction to a particular occupational environment. These are ability utilization, achievement, activity, advancement, authority, company policies, compensation, coworkers, creativity, independence, moral values, recognition, responsibility, security, social science, social status, supervision–human relations, supervision–technical, variety, working condition, and autonomy. The WAP developed the Minnesota Importance Questionnaire (MIQ) to measure the importance of each of these needs to the individual.

Each work environment satisfies some of these needs, but not others. For example, the job of elementary school teacher satisfies the needs to make use of your abilities, try out your own ideas, and help others, but it provides little opportunity to tell other workers what to do or to be paid well in comparison to other workers. The degree to which the occupation satisfies the worker's needs determines the degree of correspondence, or more generally the degree of P–E fit. The WAP developed the Minnesota Job Description Questionnaire (MJDQ) to use in determining the rewards provided by an occupation. The pattern of rewards provided by an occupation (i.e., the profile of scores) is called the Occupational Reinforcer Pattern.

The other attribute of the person that forms the work personality is the worker's set of skills and abilities. Examples of job-relevant skills include verbal fluency, manual dexterity, and numerical comprehension. Psychology has focused on ability measurement since the beginning of the 20th century, so it was not necessary for the WAP research scientists to develop a separate instrument to measure worker ability. Broad-band instruments such as the General Aptitude Test Battery (GATB) and narrow-band instruments such as the Number Comparison test of the Minnesota Clerical Test are used to measure worker skills and abilities.

Each occupation requires certain skills for success. Workers who do not have the abilities required by an occupation will not be able to perform well in that work environment. For example, an individual with good verbal skills but poor eye–hand coordination would most likely be successful in a different set of occupations than a worker having the reverse pattern of strengths and weaknesses. The requirements of the work environment can be as simple as the ability to

stack cases on a pallet or as complex as the ability to solve mathematical equations. The better the skills of workers match the requirements of their work environments, the better they can perform their jobs. Performance is termed *satisfactoriness* in the TWA.

The U.S. Employment Service had published data, based on results obtained using the GATB, for more than 1,200 occupations grouped into 62 Occupational Aptitude Patterns (OAP). The WAP scholars developed the Minnesota Job Requirements Questionnaire (MJRQ) for use in obtaining information about the skills needed for success in occupations not included in the OAP data.

### Dynamics Process of Work Adjustment

While the structural model depicted above appears to describe a static state, Dawis and Lofquist actually viewed work adjustment as an ongoing process in which the worker and the work environment continually respond to each other to maintain correspondence. They chose the term *correspondence* to indicate the degree of worker–work environment match to emphasize the responsiveness of the worker and work environment. Work adjustment is the dynamic process by which the person and work environment seek to achieve and maintain correspondence with each other. The personality style of each determines how they respond to the other. The TWA identifies four aspects of personality style.

When an individual and a work environment are not correspondent (i.e., discorrespondent) the individual could leave the work environment voluntarily (i.e., quit) or involuntarily (i.e., be terminated), or could attempt to increase correspondence with the work environment. Workers can use two *modes of adjustment* in attempting to increase correspondence. Consider, for example, workers who find it difficult to work at the same hours every day. Workers who try to increase correspondence by attempting to change their work environment (e.g., negotiate flexible working hours) are using an *active mode of adjustment*. Workers who try to increase correspondence by attempting to change some aspect of their behavior or personal situation (e.g., modifying child care arrangements) are using a *reactive mode of adjustment*. Likewise, the work environment could attempt to increase correspondence by using an active or reactive mode of adjustment.

Dawis and Lofquist refer to these as personality styles rather than as types because they do not expect



individuals or work environments to limit themselves to one or the other. The style used is a function of the specific situation and the user's judgment regarding the approach that is most likely to be successful. Dawis's and Lofquist's work on personality styles illustrates a remarkable convergence with the theoretical views of Tiedeman and Robert O'Hara and V. A. Harren regarding the developmental process that characterizes the implementation of career decisions.

A second aspect of personality style is the *degree of tolerance* displayed by the worker and work environment. Perfect correspondence between the individual and work environment is difficult to achieve and almost impossible to maintain for any length of time. Therefore, correspondence is less than perfect for most persons and work environments most of the time. *Flexible* individuals and work environments are able to tolerate a relatively high level of discordance. *Inflexible* individuals and work environments generally tolerate only low levels of discordance. Most workers and work environments fall somewhere between these polar extremes. Nevertheless, whenever the level of discordance exceeds the worker's or work environment's level of tolerance the discordance is regarded as unmanageable and action is initiated to reduce the discordance or discontinue the relationship.

The third aspect of personality style is the *speed of adjustment*. Once an individual or work environment determines that action is necessary to reduce discordance (i.e., to increase correspondence), those with a *high celerity level* (i.e., fast adjusters) move to achieve correspondence or terminate the relationship quickly. Those with a *low celerity level* (i.e., slow adjusters) move through the process at a more leisurely pace.

### Outcomes of Work Adjustment

Substantially more than 100 scientific investigations have examined aspects of the TWA. The vast majority of the research has examined the relation between worker-need, occupational-reward correspondence and job satisfaction. The results show that need-reward correspondence is positively related to job satisfaction. The greater the correspondence on a specific dimension, the more satisfied the worker is with that aspect of the job. The greater the overall correspondence between the total set of worker needs and environmental rewards, the greater the overall job satisfaction.

Several studies have examined the relation of need-reward correspondence to job tenure. In general, the results reveal a relation between correspondence and job tenure.

In summary, the matching model proposed by the TWA depicted work adjustment as a function of job satisfaction and job satisfactoriness. Job satisfaction results when the rewards provided by the occupation (measured by the MJDQ) satisfy the needs of the worker (measured by the MIQ). Job satisfactoriness results when the abilities of the worker (measured by an ability instrument such as the GATB) match the skills required for success (indicated by OAP data or MJRQ results). Tenure (i.e., longevity in an occupation) results when both satisfaction and satisfactoriness are high. Satisfied workers are more likely to remain in their jobs while dissatisfied workers are more likely to quit their jobs. Workers who perform their jobs poorly are more likely to be fired while those who perform their jobs well are likely to be encouraged to stay.

Howard E. A. Tinsley and Donald E. Eggerth

*See also* Dawis, René Villanueva (v4); General Aptitude Test Battery (v4); Job Satisfaction and General Well-Being (v4); Minnesota Importance Questionnaire (v4); Personality Theories, Traits (v2); Person-Environment Fit (v4); Person Matching (v4); Persons With Disabilities (v4); Rehabilitation Counseling (v2); Tiedeman's Decision-Making Theory (v4); Trait-Factor Counseling (v4); Weiss, David J. (v2)

### Further Readings

- Dawis, R. V., & Lofquist, L. H. (1984). *A psychological theory of work adjustment*. Minneapolis: University of Minnesota Press.
- Lofquist, L. H., & Dawis, R. V. (1969). *Adjustment to work*. New York: Appleton-Century-Crofts.
- Lofquist, L. H., & Dawis, R. V. (1991). *Essentials of person-environment-correspondence counseling*. Minneapolis: University of Minnesota Press.

---

## TIEDEMAN'S DECISION-MAKING THEORY

---

David Valentine Tiedeman received his B.A. in psychology at Union College in 1941. Tiedeman would receive a master's from the University of Rochester in 1943 and go on to Harvard to complete degrees in



educational measurement both his Ed.M. in 1948 and an Ed.D. in 1949. While at Harvard, Tiedeman was mentored by the renowned statistician Philip Justin Rulon. Upon graduation, Tiedeman stayed on as a faculty member at Harvard where he remained for over 20 years. Tiedeman's theory was introduced with the publication of *Career Development: Choice and Adjustment* by Tiedeman and O'Hara in 1963. Tiedeman broke new ground in emphasizing the significance of ego development on career development, particularly career decision making. Healthy ego development resulted from maintaining mastery of crises outlined by Erikson's psychosocial theory and allowing the individual to achieve a favorable view of the self in situational contexts as well as in the larger world around the individual and eventually the world of work. Career development and career decision-making skills also developed, as the individual sought identification and acceptance of his or her evolving self through differentiation and integration. Tiedeman's theory separates the differentiation and integration of decision making into two distinct processes: anticipation or preoccupation and implementation or accommodation. Exploration, crystallization, choice, and clarification comprise the stages of anticipation, while induction, reformation, and integration comprise the stages of implementation.

Among the revisions and adaptations of Tiedeman's original theory are the works of Anna Miller and Tiedeman, Gordon Dudley and Tiedeman, John Peatling and Tiedeman, and Tiedeman and Anna Miller-Tiedeman. Tiedeman's influence can be found in the professional journal literature, text books, and career guidance curriculums. Tiedeman's theory was one of the early entries into computer-based career guidance programs with the development of the Information System for Vocational Decisions (ISVD). As a result of its own achieved identity, Tiedeman's theory would come to be recognized as one of the first constructivist based theories associated with career development. Three of the most enduring contributions of his theory are the emphasis on the role of ego identity development in career development, the role of purposeful action in dealing with discontinuities, and the significance of differentiation and integration in the evolution of career decision making.

Tiedeman's theory has been criticized for being rather complex with ill-defined terminology. There are questions as to how effectively the ISVD actually relates to Tiedeman's theory. Assessment instruments

derived from the theory, such as the Assessment of Career Decision Making by Harren, and research related to the theory itself remain limited at best. The theory also fails to adequately outline the influence of the environment outside of the individual. Finally, Tiedeman's initial sample for the conceptualization of his theory was rather small and homogeneous, thus concerns for its multicultural relevance generally follow.

Tiedeman's theory has recently enjoyed renewed recognition for its early work on meaning making and its relevance as one of the earliest contributions to the constructivist perspective. Tiedeman's spouse Anna Miller-Tiedeman remains active in her work through the New Career Institute.

*William C. Briddick and  
Hande Sensoy Briddick*

**See also** Career Construction Theory (v4); Career Counseling (v4); Career Decision-Making Difficulties Questionnaire (v4); Career Decision Scale (v4); Computer-Assisted Career Counseling (v4); Cognitive Information Processing Model (v4); Constructivist Career Counseling (v4); Constructivist Theory (v2); Decision Making (v4); Meaning, Creation of (v2)

### Further Readings

- Dudley, G. A., & Tiedeman, D. V. (1977). *Career development: Exploration and commitment*. Muncie, IN: Accelerated Development.
- Harren, V. A. (1980). *Assessment of Career Decision Making (ACDM: Preliminary manual)*. Carbondale: Southern Illinois University.
- Miller, A. L., & Tiedeman, D. V. (1972). Decision making for the 70s: The cubing of the Tiedeman paradigm and its application in career education. *Focus on Guidance*, 5(1), 1-15.
- Peatling, J. H., & Tiedeman, D. V. (1977). *Career development: Designing self*. Muncie, IN: Accelerated Development.
- Tiedeman, D. V. (1961). Decision and vocational development: A paradigm and its implications. *Personnel and Guidance Journal*, 40, 15-20.
- Tiedeman, D. V. (1965). Career development through liberal arts and work. *Vocational Guidance Quarterly*, 14(1), 1-7.
- Tiedeman, D. V. (1979). *Career development: Designing our career machines*. Schenectady, NY: Character Research Press.



- Tiedeman, D. V., & O'Hara, R. P. (1963). *Career development: Choice and adjustment*. Princeton, NJ: College Entrance Examination Board.
- Tiedeman, D. V., & Miller-Tiedeman, A. L. (1984). Career decision making: An individualistic perspective. In D. Brown, L. Brooks, & Associates (Eds.), *Career choice and development: Applying contemporary theories to practice* (pp. 281–310). San Francisco: Jossey-Bass.

---

## TINSLEY, HOWARD E. A. (1940– )

---

Howard E. A. (Tony) Tinsley, born July 20, 1940, in Iola, Kansas, is an internationally recognized expert on leisure and vocational psychology and a leading authority on expectations about counseling and research methodology. His more than 150 publications rank him as one of the most prolific scholars in counseling psychology. His contributions to professional psychology include service as President of the Academy of Leisure Sciences, Editor of the *Journal of Vocational Behavior*, and Chair of the American College Personnel Association Commission on Assessment. He has served on the Board of the Council of Counseling Psychology Training Programs, on the Editorial Advisory Board of the Test Corporation of America, and as Director of Doctoral Study of one of the leading counseling psychology training programs. He is a Fellow of numerous professional associations including the Academy of Leisure Sciences, American Psychological Association (APA), and Association for Psychological Science. He is a Diplomat of the American Board of Vocational Experts. Tinsley is currently professor emeritus of psychology at Southern Illinois University Carbondale (SIUC) and a professor in the World Leisure International Center of Excellence and Department of Leisure and Environment at Wageningen University, The Netherlands.

### Early Influences

Tinsley completed his baccalaureate studies (1965) and master's degree (1966) in psychology at Western Washington State College where he had the distinction of being a member of the first class admitted to graduate study in psychology. Numerous experiences during his undergraduate years sparked Tinsley's interest in leisure psychology. He served as director of

the student-owned lakefront recreational facility during his sophomore year, and he established and chaired a research advisory council that conducted extensive research on students' preferences for leisure programming. He was in charge of student-sponsored cultural, recreational, and leisure programs during his senior year. His master's thesis investigated the effects of leisure activity preferences on students' perceptions of leisure activity preferences. These early experiences in applying psychological theory and research methodology to the study of leisure stimulated his lifelong interest in the scientific study of leisure behavior.

Although doctoral students typically study under the direction of a single mentor, Tinsley studied with three renowned psychologists at the University of Minnesota. Lloyd H. Lofquist, Tinsley's official academic advisor, was instrumental in founding the American Rehabilitation Counseling Association. René V. Dawis was a brilliant theoretician whose work on the theory of work adjustment influenced Tinsley's later theory of transcendent leisure experience. Dawis's early advocacy of item response theory prompted Tinsley's selection of a doctoral dissertation topic and encouraged his lifelong interest in scale construction.

David J. Weiss was the research director of the Work Adjustment Project, which had just begun an extensive 7-year program of instrument development and research. Weiss's systematic approach to theory-based research and instrument development provided doctoral students with a meaningful laboratory in which to develop their research and scale construction skills. Tinsley's experiences under the supervision of Lofquist, Dawis, and Weiss stimulated his interest in vocational psychology and psychological measurement and led him to understand the close relation between leisure and work experiences.

### Psychology of Leisure

Tinsley's (and his wife, Diane J. Tinsley's) theory of transcendent leisure experience provides a comprehensive explanation of the causes, attributes, and benefits of leisure experiences and a rich framework for research on leisure motivation. The Tinsleys and their associates have investigated more than 80 leisure activities and identified the psychosocial benefits derived from each. Based on this research, they developed a taxonomy that distinguishes among 11 types of



leisure activities. Their research provides the basis for counseling individuals regarding a variety of leisure-related issues. Extensive research evidence documents the validity and usefulness of this taxonomy. In recognition of his contributions to the study of leisure, Tinsley has been elected a Fellow (and President) of the international Academy of Leisure Sciences.

### **Vocational Psychology and the Person–Environment Fit Model**

Tinsley is a leading expert on the person–environment fit (P–E fit) model and its use in vocational selection and placement. John Holland’s hexagonal congruence model has been the preeminent P–E fit model of vocational choice since the late 1970s. Holland’s theory stimulated a large body of research, and initial results were interpreted as supportive of the theory. As a result, the assessment devices used in vocational choice and in classifying vocational information were modified to use the Holland system.

Tinsley challenged this view. He demonstrated that the research methods used to investigate the hexagonal congruence model were flawed and may have led to spurious conclusions. Tinsley concluded that Holland’s model fails to predict increased job satisfaction and other important vocational outcomes and questioned the validity of Holland’s model as a basis for career counseling. Tinsley’s work should stimulate the development of alternative approaches in the coming decade.

In recognition of his leadership in vocational psychology research, Tinsley was appointed editor of the *Journal of Vocational Behavior*, the leading vocational psychology journal. During his tenure as editor, he expanded the editorial board to include international scholars and pioneered the electronic submission and review of manuscripts. Under his editorship, the journal emerged as the most influential periodical in the field of vocational psychology, indicated by *Social Sciences Citation Index* data.

### **Expectations About Counseling**

Research shows that a limited number of common factors found in most therapeutic approaches are responsible for the benefit clients obtain from therapy. The two most widely acknowledged common factors are the therapeutic relationship and the client’s expectations. Tinsley is the foremost authority on expectations about counseling; his research with his wife and

associates is the most extensive program of research on expectations.

Early in the 1970s, Tinsley developed the Expectations About Counseling—Brief Form (EAC-B), a measure that has been used in over 100 empirical investigations of counseling process and outcome. The EAC-B has been translated into Chinese, French, German, Icelandic, Italian, and Spanish for use in investigations throughout Europe, Asia, and Central and South America. Tinsley’s work on the EAC-B and his research provided a clear operational distinction between expectations and preferences and eliminated a source of conceptual confusion that had troubled the discipline for decades.

Tinsley demonstrated that expectations about counseling are related to students’ level of psychosocial development; that clients having positive expectations about counseling become more interpersonally involved in counseling and discuss more personally meaningful issues beginning with the initial interview; and that unrealistic expectations interfere with success in counseling. However, individuals from different ethnic backgrounds have significantly different expectations about counseling, and they differ in their preferred working style.

### **Research Methodology**

Tinsley’s frequent contributions on statistics, research methods, and assessment have contributed greatly to the methodological sophistication of counseling psychologists. His mid-1970s paper on interrater reliability and agreement is the definitive treatment of that issue. His explanation of discriminant function analysis remains a staple for teaching graduate students this technique. His frequently cited paper on factor analysis, written with Diane J. Tinsley, is noteworthy for making this topic accessible to counseling psychology graduate students and faculty. His procedure used in “Synergistic Analysis of Structured Essays: A Large Sample Discovery Oriented Qualitative Research Approach” illustrates a creative approach to combining the methodological rigor of quantitative research with the flexibility of discovery-oriented qualitative research.

### **Professional Psychology**

Tinsley spent his professional career at SIUC with the exception of visiting appointments during sabbatical leaves and brief stints at the University of Oregon and



University of Florida. He directed the SIUC doctoral training program from 1977 to 1995, during which time the program became one of the most influential programs in counseling psychology. During his tenure, empirical studies demonstrated repeatedly that the program was among the top five in research productivity. Graduates of the SIUC program and junior faculty mentored by Tinsley have established successful careers in research, teaching, and practice and program graduates have been the recipients of APA awards for teaching and for research excellence. Tinsley's most lasting contribution to psychology may well prove to be the students and junior faculty he trained as the next generation of leaders in psychology.

David M. Tokar

**See also** Dawis, René Villanueva (v4); Expectations About Therapy (v2); Holland's Theory of Vocational Personalities and Work Environments (v4); *Journal of Vocational Behavior* (v4); Leisure (v2); Lofquist, Lloyd Henry (v4); Person–Environment Fit (v4); Person–Environment Interactions (v2); Psychometric Properties (v2); Theory of Work Adjustment (v4); Weiss, David J. (v2)

### Further Readings

- Tinsley, H. E. A. (1997). Synergistic analysis of structured essays: A large sample discovery oriented qualitative research approach. *The Counseling Psychologist*, 25, 573–585.
- Tinsley, H. E. A. (2000). The congruence myth: Analysis of the efficacy of the person-environment fit model. *Journal of Vocational Behavior*, 56, 147–179.
- Tinsley, H. E. A., Bowman, S. L., & Ray, S. B. (1988). Manipulation of expectancies about counseling and psychotherapy: A review and analysis of expectancy manipulation strategies and results. *Journal of Counseling Psychology*, 35, 99–108.
- Tinsley, H. E. A., & Brown, S. D. (Eds.). (2000). *Handbook of applied multivariate statistics and mathematical modeling*. San Diego, CA: Academic Press.
- Tinsley, H. E. A., & Eldredge, B. D. (1995). Psychological benefits of leisure participation: A taxonomy of leisure activities based on their need-gratifying properties. *Journal of Counseling Psychology*, 42, 123–132.
- Tinsley, H. E. A., & Tinsley, D. J. (1986). A theory of the attributes, benefits and causes of leisure experience. *Leisure Sciences*, 8, 1–45.
- Tinsley, H. E. A., & Tinsley, D. J. (1987). Uses of factor analysis in counseling psychology research. *Journal of Counseling Psychology*, 34, 414–424.

## TRAINING IN ORGANIZATIONS

Training refers to activities designed to facilitate the acquisition of knowledge, skills, and attitudes relevant to performance in an occupation. Training is a major investment for many organizations, with developmental activities occurring at all levels of the organization and at various career stages. A major goal of training is often to improve organizational outcomes (e.g., efficiency, costs, turnover), but individuals engaged in these developmental opportunities also experience benefits that may extend beyond their current positions. Thus, workplace training can play an important role in individual career development.

Training activities in the workplace can range from informal exchanges among employees to formal programs developed or purchased by the organization. For example, for some jobs most of what is learned comes from informal on-the-job training, where more experienced employees take a primary role in explaining how to complete tasks. Informal training can also take the form of mentorship relationships that develop naturally rather than through formal organizational programs. On the other hand, many jobs require more formal workplace training, involving scheduled training programs or assigned mentorship roles.

Training also varies widely in terms of content and specificity. Many training programs focus on job-specific knowledge and skills. These programs are designed to teach newcomers how to perform the job or to update the knowledge and skills of more experienced employees given changes in the job. Other training programs have a broader focus and thus are more likely to result in individual capabilities that may apply across jobs. For instance, programs focusing on communication skills, diversity issues, managerial competencies, or executive development may enhance not only short-term performance, but also longer-term career development. This type of broader impact may also be seen with training programs explicitly designed to improve employee career management. These career self-management training programs are linked to an increasing trend in which organizations are taking a less central role in employee career management. The programs are intended to encourage employees to take greater responsibility for their career progression and to develop relevant behaviors such as those related to developmental feedback seeking (e.g., seeking feedback on performance) and job mobility preparedness (e.g., being proactive in identifying new career opportunities).



Training programs are more likely to be successful when developed, implemented, and evaluated using a systematic approach. Although a number of systematic approaches to training may be useful, a well-established general framework that often serves as the basis for formal employee development is the instructional systems design approach. This approach specifies an integrated set of processes for the systematic development, delivery, evaluation, and continuous improvement of instructional programs. Thus, the major components of this model consist of needs assessment, training design and delivery, and evaluation.

### **Needs Assessment**

During the needs assessment phase, training developers identify the goals and objectives of the training program. The needs assessment process should consider needs at the organization, job, and person level. At the organization level, short- and long-term goals should be examined along with management expectations and support for the training initiative. Without support from top management, it may be difficult to obtain the resources required to develop and implement an effective training program. At the job level, needs assessment involves identifying the jobs targeted for training and specifying the knowledge, skills, and attitudes required to perform the essential functions of these jobs. Various job analysis methods may be applied at this step. At the person level, individuals are assessed in terms of how well they perform essential job functions and where they stand on the required capabilities underlying task performance established in the job analysis. This individual-level assessment is primarily intended to identify those most likely to benefit from training. The needs assessment phase results in the specification of instructional objectives that serve as input to both training program design and later evaluation of the program.

### **Training Design and Delivery**

After determining objectives of the training program and identifying those individuals who would likely benefit from participating, issues of training design and delivery must be considered. This phase involves examining training methods, media, and learning principles in light of needs assessment outcomes. Numerous training methods may be considered, including one-on-one instruction, lectures, audio-visual

presentations (e.g., videotapes), role-playing, simulations, and on-the-job training. The use of computers and Web-based approaches in training continues to grow as the availability, flexibility, and familiarity with computers increase and the costs of these applications decline. Computer-driven training programs offer standardized administration and in many cases may capture various performance criteria automatically and in real time. Regardless of method, training should be administered in an environment conducive to learning. For example, if training is delivered by an individual (e.g., through lectures), he or she should be organized, knowledgeable, patient, and respectful. At this stage it is again important to consider the individuals receiving the training; one method may be clearly superior given the nature of the material to be learned and the individuals learning it.

Efforts should also be made to integrate well-supported learning principles into the training program. Such principles include the provision of feedback, overlearning, and producing the actual response or behavior. Additional considerations include whether training should be conducted in a single session or divided into several sessions over time (i.e., massed vs. spaced) and whether tasks should be trained as whole units or broken down into simpler parts (i.e., whole vs. part).

### **Evaluation**

Following training design and delivery, program evaluation is essential for examining the extent to which training objectives are being met. Evaluation can come in many forms, from multiple sources, and at various times. However, the process of evaluation generally requires specifying appropriate evaluation criteria given training objectives, designing an approach to collecting data relevant to these criteria, collecting data, and analyzing and interpreting these data.

Several models of training evaluation have been proposed. One popular approach to evaluation includes the assessment of trainee reactions, learning, behavior, and results. Trainee reactions refers to how well participants liked the training program and may involve assessment of affective reactions (i.e., enjoyment) and utility perceptions (i.e., perceptions of usefulness). Learning refers to the knowledge and skills trainees have acquired and is often measured with posttraining performance or paper and pencil assessments. Behavior refers to on-the-job performance and



might be measured with job performance ratings or work samples. Finally, results refer to broader organizational outcomes linked to training (e.g., efficiency gains, cost reduction, sales growth).

Another well-established model of evaluation includes the assessment of cognitive, skill-based, and affective learning outcomes. For cognitive outcomes, the criteria of interest pertain to verbal knowledge (e.g., assessed through multiple-choice exams), knowledge organization (e.g., assessed through judgments of similarity among core concepts), and cognitive strategies (e.g., assessed through measures of metacognitive skills). For skill-based outcomes, the focus is on skill compilation and automaticity, which is characterized by faster and more fluid performance as well as a decrease in the attentional resources required for task performance. For affective outcomes, criteria include attitudes and motivational tendencies such as trainee self-efficacy and goals.

Following evaluation, the training program may be revised to address any deficiencies discovered. Ideally, training should be continuously evaluated and improved, with evaluation results feeding back into needs assessment and influencing subsequent training design and delivery decisions.

*Patrick D. Converse  
and Joshua S. Quist*

*See also* Assessment (v4); Career Advancement (v4); Career Counseling in Organizations (v4); Career Education (v4); Industrial/Organizational Psychology (v1)

### Further Readings

- Baldwin, T. T., & Ford, J. K. (1988). Transfer of training: A review and directions for future research. *Personnel Psychology, 41*, 63–105.
- Barnett, S. M., & Ceci, S. J. (2002). When and where do we apply what we learn? A taxonomy for far transfer. *Psychological Bulletin, 128*, 612–637.
- Ford, J. K., Kozlowski, S. W. J., Kraiger, K., Salas, E., & Teachout, M. S. (Eds.). (1997). *Improving training effectiveness in work organizations*. Mahwah, NJ: Lawrence Erlbaum.
- Goldstein, I. L., & Ford, J. K. (2002). *Training in organizations: Needs assessment, development, and evaluation* (4th ed.). Belmont, CA: Wadsworth.
- Kirkpatrick, D. L. (1976). Evaluation of training. In R. L. Craig (Ed.), *Training and development handbook* (2nd ed.). New York: McGraw-Hill.

Kraiger, K., Ford, J. K., & Salas, E. (1993). Application of cognitive, skill-based, and affective theories of learning outcomes to new methods of training evaluation. *Journal of Applied Psychology, 78*, 311–328.

Salas, E., & Cannon-Bowers, J. A. (2001). The science of training: A decade of progress. *Annual Review of Psychology, 52*, 471–499.

---

## TRAIT-FACTOR COUNSELING

---

Trait-factor counseling approaches assume that career choice may be facilitated and career outcomes optimized through a fairly straightforward process of matching an individual's most relevant work-relevant characteristics (abilities, interests, values, etc.) with information regarding job activities, demands, rewards, and availability. The counseling process for this approach typically starts with a client interview, then proceeds to extensive psychometric assessment of the client's work-relevant characteristics, and is finalized with an interpretation of assessment results with connections being drawn between these results and one or more occupational classification systems. Trait-factor counseling assumes that having been provided with accurate information about self and jobs, most individuals will be able to make a rational choice of career.

### History

Conceptually, the origins of trait-factor approaches to career counseling can be traced to Frank Parsons's pioneering efforts to better match individuals with jobs. This matching process involved using an accurate understanding of an individual's work-relevant attributes (skills, aptitudes, interests, etc.) and a thorough knowledge of both jobs and the employment market to optimize job choice. Parsons proposed that once self-knowledge was coupled with knowledge about jobs, a rational decision could be made regarding the best match between the two for a given individual. One of the greatest challenges to this approach, then and now, involves how to best define individuals and jobs.

It was not until the 1930s that statistical applications and psychometric methods had advanced to the point that the matching dimensions could be empirically derived and quantitatively evaluated. The Minnesota Employment Stabilization Research Institute



was established at the University of Minnesota to assist workers who had lost their jobs due to the Great Depression. The Minnesota researchers operationalized Parsons's basic concepts using the research methods of differential psychology to develop psychometric instrumentation and occupational classification systems. During this decade, Edmund G. Williamson was appointed director of the University of Minnesota Testing Bureau (now the University of Minnesota Counseling and Consulting Center). Williamson successfully adapted the methods developed by the Minnesota Employment Stabilization Research Institute to address the career development concerns of college students. Williamson wrote so prolifically and influentially on this approach that it is sometimes referred to as the Minnesota point of view.

Within a decade, the methods and technologies developed at Minnesota were applied to the monumental task of classifying armed forces recruits and assigning them to appropriate positions as the U.S. military rapidly expanded during World War II. Following the war, these approaches were adopted by both vocational rehabilitation counselors in the Veterans Affairs Medical Centers and by college counselors struggling to cope with the influx of returning veterans needing assistance with their transition to civilian employment. It is not coincidental that John Holland, whose theory of vocational personalities and work environments is the most widely used trait-factor model, spent his war years conducting military classifications and later become a University of Minnesota graduate. It is also not coincidental that another very influential trait-factor approach, the theory of work adjustment, was also the product of University of Minnesota researchers.

### Criticisms

Trait-factor counseling has been widely criticized on a number of fronts. Its harshest critics have labeled trait and factor counseling as "test and tell" and "three sessions and a cloud of dust." Because assessment and interpretation require high levels of counselor expertise and input, the knowledge and power differential between counselor and client tends to be highlighted. This has led some to argue that trait-factor approaches are too prescriptive and too directive. A fundamental assumption of trait-factor models is that given good information, individuals will make good (or rational) decisions. Consequently, much of the counseling

effort is aimed at providing clients with objective information about self and jobs. In response, critics have charged that trait-factor approaches place undue emphasis on testing, that they ignore counseling processes and represent techniques rather than theory. Another major criticism of trait-factor counseling takes aim at the foundational assumption that given good information, individuals will make rational decisions. These critics argue that in addition to factual information, decisions are also influenced by factors such as affective considerations, one's personal history, and the opinions of significant others.

### Legacy

Despite the criticisms discussed above, trait-factor counseling has been and continues to be widely influential. In part this is due to the scientific rigor that was devoted to developing both instrumentation and occupational classification systems. Many of the assessment devices (e.g., Minnesota Importance Questionnaire and Strong Interest Inventory) developed within this framework continue to enjoy widespread usage. Initially, advances in psychometrics allowed the development of instruments to operationalize trait-factor concepts. However, these successes spurred further advances and psychometrics as a field benefited greatly from the testing focus of trait-factor approaches. For example, the empirical keying methodology pioneered by E. K. Strong for the Strong Interest Inventory and its success in differentiating between discrete occupational groups directly inspired and influenced the subsequent development of the Minnesota Multiphasic Personality Inventory, which uses empirical keying to differentiate between normals and those having psychiatric diagnoses.

Also contributing to the ongoing influence of trait-factor models is that even at the end of a thoughtful and thought-provoking career counseling process, there is often still a need for well validated, objective information about how well one could expect to fit into those occupations that are of most interest. Person-environment fit models, such as Holland's theory of vocational personalities and work environments and the theory of work adjustment, represent the evolution of trait-factor counseling from its relatively atheoretical roots to mature and dynamic theories of career choice and adjustment. Although both models have great depth and sophistication, their most basic concepts can easily be explained to clients. Both



benefit by retaining the intuitive, commonsensical appeal of Parsons's original notion that the more similar the gifts and needs of an individual are to the requirements and rewards a job has to offer, the better the outcome. It can be argued that the Occupational Information Network (O\*NET) represents the current pinnacle of trait-factor counseling approaches. From a theoretical perspective, the O\*NET's model clearly draws upon Holland's theory of vocational personalities and work environments and the theory of work adjustment. The O\*NET also represents fulfillment of Frank Parsons's goal of making vocational guidance available to the masses, as its online resources (including tools for self-assessment and a database of occupational information that is periodically updated) are open to all.

*Donald E. Eggerth*

*See also* Holland, John L. (v4); Holland's Theory of Vocational Personalities and Work Environments (v4); Minnesota Importance Questionnaire (v4); Occupational Information Network (v4); Parsons, Frank (v4); Person–Environment Fit (v4); Strong Interest Inventory (v4); Theory of Work Adjustment (v4); Williamson, Edmund Griffith (v4)

### Further Readings

- Chartrand, J. M. (1991). The evolution of trait-and-factor career counseling: A person X environment fit approach. *Journal of Counseling and Development*, 69, 518–524.
- James, R. K., & Gilliland, B. E. (2002). *Theories and strategies in counseling and psychotherapy* (5th ed.). Needham Heights, MA: Allyn & Bacon.
- Rounds, J. B., & Tracey, T. J. (1990). From trait-and-factor to person-environment fit counseling: Theory and process. In W. B. Walsh & S. H. Osipow (Eds.), *Career counseling* (pp. 137–177). Hillsdale, NJ: Lawrence Erlbaum.

---

## TRANSITION BEHAVIOR SCALE

---

The Transition Behavior Scale, Second Edition (TBS-2) has as its intention the identification of behaviors that are thought to interfere with successful societal transition and employment from high school to adult life for special needs students. There are two versions of the TBS-2: a self-report instrument (to be completed by the student) and a school instrument (the identified

student is rated by school personnel who can reasonably observe the student). Each of the versions has subscales to identify work-related skills, interpersonal relations, and social–community expectations. The scales are accompanied by a manual to provide goals, objectives, and interventions for an array of behaviors that may limit successful independent living and work adjustment.

### Reliability and Validity

Each scale is accompanied by a technical manual providing a concise literature review and sections on item development, sampling, reliability, validity, and administration. The technical information is reasonably comprehensive and subscribes to all psychometric standards of instrument development. The samples (over 2,500 students) upon which the data are based appear to be diverse in terms of gender, ethnicity, socioeconomic status, and geography. The students in the sample were randomly selected at the selected school sites and site personnel were given specific instructions not to exclude any student. Measures of reliability include internal consistency, test–retest, and interrater (for the school version). Examples of construct validity (factor analyses), content validity, and criterion related validity were all demonstrated appropriately. Administration guidelines are included.

### Interpretation

Each manual has a brief chapter regarding interpretation. The chapter provides information on scoring each scale's meaning, conversion to a standard score, and developing a scale profile. As well, the chapter suggests that any score more than one standard deviation below a normative mean that is provided indicates that intervention may need to occur. This conclusion and the interventions suggested are based on the literature and assumptions that being below the norm of a group of selected students might require an individualized education plan (IEP).

### Caveat

The TBS-2 as a scale is well supported through the literature. The technical qualities of the scales are generally sound and presented clearly by the authors. The scales to be administered to students directly or used to rate students by site personnel appear to be easy to



use. The IEP and intervention manual are comprehensive and complete with over 200 pages of goals, objectives, and direct interventions.

With the above in mind, one caveat needs to be stressed. As with any measure that leads to recommended intervention, outcomes of that intervention in terms of eventual success go to the validity of the measure itself. Thus, with the TBS-2 a student who scores or is rated one standard deviation below some normative mean is said to need skills to ensure transition or job success. Although the recommended intervention is rational and has a basis in the literature, no direct evidence of success is provided.

*Ric Brown*

**See also** Career Counseling in Schools (v4); Career Transitions Inventory (v4); Mental Health Issues in the Schools (v1); Persons With Disabilities (v4); School Counseling (v1); School-to-Work Transition (v4); Work-Bound Youth (v4)

### **Further Readings**

- Brown, R. (1998). [Review of the Work Adjustment Scale.] In J. C. Impara & B. S. Plake (Eds.), *The thirteenth mental measurements yearbook*. Lincoln, NE: Buros Institute of Mental Measures.
- McCarney, S. B., & Anderson, P. D. (2000). *Transition Behavior Scale* (2nd ed.). Columbia, MO: Hawthorne Educational Services.





---

## UNEMPLOYMENT

---

*See* JOB LOSS

---

## UNISEX EDITION OF THE ACT INTEREST INVENTORY

---

The Unisex Edition of the ACT Interest Inventory (UNIACT) is an assessment designed to identify personally relevant career (educational and occupational) options. Results are intended to help people see the connection between the work world and the activities they like to do. UNIACT is a component of several programs and services offered by ACT, such as the ACT Program, PLAN, EXPLORE, DISCOVER, and the Career Planning Survey. Through these programs and others, UNIACT is administered to about 4 million persons annually. Since 1973, the ACT Interest Inventory has been administered to about 70 million persons, making it one of the most used psychological assessments in the world.

### Instrument Characteristics

#### *Items*

UNIACT items emphasize work-relevant activities (e.g., build a picture frame, conduct a meeting, help settle an argument between friends) that are familiar to persons, either through participation or observation. Item content does not include occupational titles

or specific job duties because persons needing help with career planning may have minimal or inaccurate knowledge about a wide range of occupations. Items are responded to using a three-choice response format (*dislike, indifferent, like*).

UNIACT items were carefully chosen to minimize gender-related differences in responses. Item content avoids activities subject to gender-role stereotypes. This feature of UNIACT minimizes gender divergences in the career options typically suggested to males and females and permits the use of combined-sex norms.

#### *Scales*

UNIACT results are reported for six scales paralleling the six interest and occupational types in John L. Holland's theory of careers. Scale titles and descriptions (with parallel Holland types in parentheses) are listed as follows:

*Science & Technology* (Investigative): Investigating and attempting to understand phenomena in the natural sciences through reading, research, and discussion.

*Arts* (Artistic): Expressing oneself through activities such as painting, designing, singing, dancing, and writing; artistic appreciation of such activities (e.g., listening to music, reading literature).

*Social Service* (Social): Helping, enlightening, or serving others through activities such as teaching, counseling, working in service-oriented organizations, engaging in social-political studies.

*Administration & Sales* (Enterprising): Persuading, influencing, directing, or motivating others through



activities such as sales, supervision, and aspects of business management.

*Business Operations* (Conventional): Developing and/or maintaining accurate and orderly files, records, accounts, and so on; designing and/or following systematic procedures for performing business activities.

*Technical* (Realistic): Working with tools, instruments, and mechanical or electrical equipment. Activities include designing, building, repairing machinery, and raising crops/animals.

## Background

### History

The ACT Interest Inventory was first introduced in 1973. The UNIACT edition of the ACT Interest Inventory was introduced in 1977. Two major revisions of UNIACT, based on both item content considerations and empirical evidence of item performance, were undertaken in 1987–1989 and 2003–2006, leading to the current 90-item and 72-item versions of the inventory. The current versions are available in two levels: Level 1 is intended for students in Grades 8–12, and Level 2 is intended for college students and adults.

### Underlying Theory

According to Holland's theory, relationships among Holland's six types can be represented by a hexagon. Types adjacent on the hexagon (e.g., Social and Artistic) resemble each other most, while types on opposite sides of the hexagon (e.g., Social and Realistic) resemble each other least. Holland's hexagon is a two-dimensional figure, thus suggesting that there are two underlying dimensions.

Numerous studies suggest that two bipolar dimensions of work tasks and work-task preferences underlie Holland's hexagon: data versus ideas, and things versus people. The relationships between these four basic work tasks and the six UNIACT scales are listed as follows:

*Science & Technology*: Work typically involves primarily *ideas*, and secondarily, *things*.

*Arts*: Work typically involves primarily *ideas*, and secondarily, *people*.

*Social Service*: Work typically involves primarily *people*.

*Administration & Sales*: Work typically involves primarily *data*, and secondarily, *people*.

*Business Operations*: Work typically involves primarily *data*, and secondarily, *things*.

*Technical*: Work typically involves primarily *things*.

## Visual Interpretation

One of the special features of UNIACT is that results are presented visually via the ACT World-of-Work Map. This map locates and displays occupational groups on two dimensions according to their involvement with data–ideas and people–things. Based on empirical data from multiple sources, the map provides an overview of the entire world of work, summarizing a large amount of information to facilitate the understanding of basic similarities and differences among occupations.

Because the data–ideas and people–things dimensions underlie Holland's six types, scores on Holland's six types can be expressed as a location on these dimensions—and hence, on the World-of-Work Map. UNIACT scores are transformed to map locations, letting persons see the direction of their work task preferences and identify occupational options having related work tasks. For example, if a person's highest UNIACT scores suggest an interest in working with people, results refer the person to the areas of the map with occupations that primarily involve working with people. In effect, the World-of-Work Map serves as a visual bridge from scores to occupations. The map can be used to link Holland-type scores from any career assessment to occupational options.

## Technical Information

### Norms

Nationally representative norms are based on persons at four age levels: Grade 8, Grade 10, Grade 12, and adult. All norms were obtained from ACT program files. To improve the national representativeness of the samples, individual records were weighted to more closely match the characteristics of the target populations with respect to gender, ethnicity, and region of the country. Samples consisted of more than



250,000 students for the Grade 8–12 levels and more than 2,000 persons for the adult level.

### Reliability

Evidence of reliability and validity is essential in evaluating any psychological assessment. One type of reliability is *internal consistency*—the degree to which the items in a scale are related to each other. For example, internal consistency reliabilities for a large sample of Grade 12 students who completed the 72-item UNIACT ranged from .85 to .91 for males and from .83 to .91 for females. Results were similar for a large sample of Grade 8 students: .82 to .90 for males and .81 to .89 for females.

Judgments about the adequacy of reliability and validity evidence for an assessment should be made in context. Factors such as the purpose of the assessment and the number of items in the scale should be kept in mind.

### Validity

Validity generally refers to the extent to which assessment results measure what they are purported to measure. Thus, validity is evaluated in light of the purpose of the assessment. As mentioned above, UNIACT results are used to identify occupations in line with a person's preferences for basic work tasks. If UNIACT results differentiate various criterion groups—and do so in sensible, meaningful ways—they can be used to identify occupational groups having work tasks that are compatible with a person's preferences.

Evidence of criterion-related validity requires data from criterion groups. Typical methods of determining criterion group membership involve selecting high school seniors with the same occupational choice, college students with the same major, or employed adults with the same occupation. According to Holland's theory, I-type (scientific) interests should predominate among I-type criterion groups, A-type (artistic) interests should predominate among A-type criterion groups, and so on. Across a number of groups, agreement between criterion group membership and measured predominant interests (highest interest score) provides an index of criterion-related validity.

Based on data collected since 1973, using both current and prior editions of UNIACT, agreement rates

(expressed as the percentage of groups with matching predominant interests) were obtained for more than 600 groups representing more than 78,000 persons. The total agreement rate across all groups was 73%. Agreement rates varied by age: 72% for high school seniors, 70% for college students, and 81% for employed adults. These agreement rates far exceed chance (1 in 6, or 17%).

The above evidence represents only a small part of the extensive reliability and validity evidence available on UNIACT. Additional information, based on data from various age groups and racial/ethnic groups, is found in published studies and summarized in manuals and other materials available from ACT. For example, the UNIACT technical manual summarizes reliability and validity evidence for five racial/ethnic groups.

Kyle B. Swaney

*See also* Campbell Interest and Skill Survey (v4); Career Planning Survey (v4); DISCOVER (v4); Expressed, Manifest, Tested, and Inventoried Interests (v4); Holland's Theory of Vocational Personalities and Work Environments (v4); Jackson Vocational Interest Inventory (v4); Person Matching (v4); Strong Interest Inventory (v4)

### Further Readings

- ACT. (1995). *Technical manual: Revised Unisex Edition of the ACT Interest Inventory (UNIACT)*. Iowa City, IA: Author.
- ACT. (2000). *Career Planning Survey technical manual*. Iowa City, IA: Author.
- ACT. (2006). *Research support for DISCOVER assessment components*. Iowa City, IA: Author.
- Day, S. X., Rounds, J., & Swaney, K. (1998). The structure of vocational interests for diverse racial-ethnic groups. *Psychological Science*, 9, 40–44.
- Holland, J. L. (1997). *Making vocational choices: A theory of vocational personalities and work environments* (3rd ed.). Odessa, FL: Psychological Assessment Resources.
- Prediger, D. J., & Swaney, K. B. (1995). Using UNIACT in a comprehensive approach to assessment for career planning. *Journal of Career Assessment*, 3, 429–451.
- Prediger, D. J., & Swaney, K. B. (2004). Work task dimensions underlying the world of work: Research results for diverse occupational databases. *Journal of Career Assessment*, 12, 440–459.









---

## VALUES SCALE

---

The Values Scale (VS) is used to assess values in life roles, largely in relation to work. Items query both values desired in life roles and the place of work in value manifestation. The VS can be used in career counseling to identify areas of values conflict and deficits in career development and to connect values with the career planning process. The VS provides 21 values scores: ability utilization, achievement, advancement, aesthetics, altruism, authority, autonomy, creativity, economic rewards, lifestyle, personal development, physical activity, prestige, risk, social interaction, social relations, variety, working conditions, cultural identity, physical prowess, and economic security. The 21 values can be reported in five subsets: inner-oriented, group-oriented, material, physical prowess, and physical activity. Values assessed are both intrinsic (e.g., creativity, ability utilization) and extrinsic (e.g., economic rewards, security). The VS is intended for use with junior high school students to adults as a tool for research, career commitment evaluation, and individual career counseling. The 2-page, 106-item VS can be group or individually administered in 30–45 minutes and profiles compared to U.S. norms. Responses are captured on a 4-point scale (*little or no importance* to *very important*). The VS can be hand-scored or sent to the publisher for scoring. An individual report is provided in an easily readable profile format.

The VS manual lists internal consistency reliabilities for individual scales in the .6 to .8 range and stability reliabilities from .5 to .8. Support for validity is

claimed from content review during scale development, by structural (factor) analysis, and known-group comparisons (e.g., gender, age differences). Further general support for the validity of the VS has been found by other investigators. There is also research support for use of the VS in career counseling.

The VS was initially developed by an international panel for use in cross-national research. The project's intent was to produce a global knowledge base useful in developmental career counseling. Donald Super, a prominent theorist in the area of career development, was a coordinator of the Work Importance Study, which included research teams of vocational psychologists worldwide. Each national team contributed to the project via literature reviews, providing or revising construct definitions, and writing or reviewing and revising items that led to creation of the VS.

Kathy E. Green

**See also** Adult Career Concerns Inventory (v4); Brown's Values-Based Career Theory (v4); Career Development Inventory (v4); Career Planning (v4); Life-Role Balance (v4); Super, Donald Edwin (v4); Super's Theory (v4); Work Values (v4)

### Further Readings

- Nevill, D. D., & Super, D. E. (1989). *The Values Scale—Theory, applications, and research*. Palo Alto, CA: Consulting Psychologists Press.
- Niles, S. G., & Goodnough, G. E. (1996). Life-role salience and values: A review of recent literature. *Career Development Quarterly*, 45, 65–86.



- Super, D. E. (1995). Values: Their nature, assessment, and practical use. In D. E. Super & B. Sverko (Eds.), *Life roles, values, and careers: International findings of the Work Importance Study* (pp. 54–61). San Francisco: Jossey-Bass.
- Super, D. E., Osborne, W. L., Walsh, D. J., Brown, S. D., & Niles, S. G. (1992). Developmental career assessment and counseling: The C-DAC model. *Journal of Counseling and Development*, 71, 74–80.

---

## VOCATIONAL IDENTITY

---

Vocational identity and career identity are related, but vocational identity as a concept extends beyond career identity. Career identity is indicative of the current career being pursued, whereas vocational identity represents an identity related to work over a long term and is more stable as one develops and becomes more confident in his or her career aspirations. Vocational identity reflects a stable pattern of interests, goals, abilities, and talents. These aspirations, interests, and goals in short provide a good framework of the work and career histories in individuals. So a person with a strong vocational identity would have a clear sense and/or picture of his or her goals, interests, skills, suitable occupational choices, and confidence in making career decisions. Strong vocational identity also refers to the ability to display confidence in the event of unforeseen and ambiguous career-related problems that may arise. Vocational identity can be conceptualized on three main domains. The first is the structural domain, which refers to how the individual negotiates the world of work and could include cognitive factors. The second domain involves relations (social and emotional) and the third attempts to describe behaviors and experiences in which vocational identity is involved. Therefore, vocational identity can be viewed as a complex, multidimensional, and developmental construct.

### Formation of Vocational Identity

Vocational identity is an integral part of human functioning and human development. This is because one of the principal tasks in human development, especially for adolescents, is the formation of various identities. One of these identities includes that which is related to career exploration. This process includes

the formation of career objectives, career goals, career aspirations, and career plans. Regardless of ethnicity, socioeconomic status, education, or age, career is an important aspect of this identity formation.

Vocational identity formation is a pivotal juncture in our lives as it symbolizes the point where we attempt to actualize our emerging self-concepts while integrating our past and present aspects of ourselves in the arena of work and careers. Clearly, vocational identity is an integral part of our functioning in the world of work. Vocational identity is a dynamic construct as it has a developmental quality about it. Vocational identity can be stable for some individuals, but usually it changes for most individuals depending upon factors such as age, experience, career training, occupational development, and stronger ego-strength. Vocational identity is a multidimensional, complex, and developmental construct that captures career and vocations more accurately than other work-related constructs, and therefore, it needs to be further explored and expanded.

### Career Development and Satisfaction

The concept of vocational identity has been linked to the process of career development. However, many authors have also mentioned that there is a gap in the literature and research on vocational identity; therefore, its usefulness has been questioned and has yet to be empirically verified. It is important to establish a relationship between vocational identity and career development for adolescents and early adults as these are the phases when the issues of identity and career are both salient and interrelated.

According to prominent researchers in the field of vocational and career psychology, vocational identity is a better prediction of job satisfaction than investigating the congruence of interests and the environment. Hence, it has been suggested that concepts such as career beliefs, interests and goals be incorporated as a more accurate method of measuring career stability and career changes. A person with a strong vocational identity is more likely to find jobs/occupations that are congruent with his or her personal characteristics and personality in addition to being congruent with a particular work environment. On the other hand, a weak vocational identity would suggest that a person is more likely to make incompatible choices, make frequent job transitions, and transition through a wide set of successive occupations. This



weakness does not bode well for both the well-being of the individual or for the greater good of society in terms of dollar amounts, time, and efforts invested that end up being unfruitful and frustrating. Therefore, these consequences suggest that a vocational identity scale would be both useful in helping individuals find jobs that they are successful at and that make them happy.

### Vocational Identity Scale

John Holland developed a vocational identity scale as part of My Vocational Situation in 1980, nearly 30 years ago. Since then there has not been much development in this area. Most researchers and practitioners have stayed with using Holland's scale. Holland's scale measures constructs on a number of domains, including vocational attitudes, vocational commitment, desirable career beliefs, desirable problem-solving attitudes, and rational career decision-making styles. Items are measured using *true* and *false* statements, and sample items include "I need reassurance that I have made the right choice of occupation" and "I am concerned that my present interests may change over the years."

Holland's scale does have some positive correlations to other scales such as the Career Decision Scale and the Medical Career Development Inventory, but none of the scales came out being superior, including Holland's Vocational Identity Scale. Attempts have been made to demonstrate some of the psychometric properties of Holland's Vocational Identity Scale. For instance, research indicates that the scale has a retest reliability of .75 at about 1 to 3 months' time interval. In addition, the scale has substantial construct and convergent validity and modest discriminant validity. For instance, there has been overlap identified between the Vocational Identity Scale and career maturity ( $r = 0.69$ , 48% of shared variance). Overall, the scale appears to demonstrate some good psychometric properties; however, researchers have concluded that the scale needs further validation in practical settings. Some criticism of the Vocational Identity Scale include that the scale fails to measure the complex, multidimensional nature of the vocational identity construct. For instance, it fails to encompass the personal, social, and emotional dimensions of vocational identity. In addition, the current scale does not capture the developmental nature of vocational identity and it has not been updated since it was developed.

### Future Directions

A stable-strong vocational identity is related to a smaller number of career aspirations as one begins to narrow down the number of occupational goals he or she has. This is because a person with a high-strong vocational identity will have more confidence in his or her career decision-making processes and so will have more satisfaction and contentment related to his or her career aspirations and goals. There are other aspects that are still unknown about the construct of vocational identity. For instance, based upon its definition it could be assumed that vocational identity is related to constructs such as occupational commitment, clarity, and/or stability, but its relationship to phenomenon such as the differentiation of occupational interests still has to be investigated. Clearly, more expansion and investigation with this construct needs to be done in order to get a better understanding and in order to meet the career satisfaction and occupational goals of individuals.

Arpana Gupta

*See also* Assessment (v4); Career Decision Scale (v4); Career Development Inventory (v4); Career Indecision (v4); Career Maturity (v4); Career Planning (v4); Holland, John L. (v4); Holland's Theory of Vocational Personalities and Work Environments (v4); My Vocational Situation Scale (v4); Social Identity Theory (v3)

### Further Readings

- Holland, J. L. (1996). Exploring careers with a typology: What we have learned and some new directions. *American Psychologist*, 51(4), 397–406.
- Holland, J. L., Johnston, J. A., & Asama, N. F. (1993). The Vocational Identity Scale: A diagnostic and treatment tool. *Journal of Career Assessment*, 1(1), 1–12.
- Leong, F. T. L., & Morris, J. (1989). Assessing the construct validity of Holland, Daiger and Power's measure of vocational identity. *Measurement and Evaluation in Counseling and Development*, 22, 117–125.
- Raskin, P. M. (1989). Identity status research: Implications for career counseling. *Journal of Adolescence*, 12, 375–388.
- Savickas, M. L. (1985). Identity in vocational development. *Journal of Vocational Behavior*, 37, 329–337.
- Skorikov, V., & Vondracek, F. W. (1998). Vocational identity development: Its relationship to other identity domains and to overall identity development. *Journal of Career Assessment*, 6(1), 13–35.
- Vondracek, F. W. (1991). Current status of the concept of vocational identity. *Man and Work*, 3(1–2), 80–86.









---

## WALSH, W. BRUCE (1936– )

---

W. Bruce Walsh is one of the leading researchers and writers in the field of vocational psychology. Walsh was born into a family deeply committed to education. He is one of 11 members of his family to attend Pennsylvania State University. Walsh graduated from there with a B.S. degree in Economics from the Smeal College of Business Administration. It is perhaps his training as an economist that helped to develop his research interest in person–environment human behavior. Walsh, however, never worked as an economist. After completing his undergraduate degree, he went directly to Kent State University where he studied sociology and worked in residence halls coordinating programs and advising students.

Walsh continued his work with students as he pursued his doctorate at the University of Iowa. While he worked on the Ph.D. in Counseling and Vocational Psychology he continued his work with college students by advising the fraternity council and conducting academic counseling. It was during his career at the university that Walsh began to foment his identity as a psychologist with his placement as a junior counselor and intern at the Iowa University counseling center. His life also became cemented to vocational psychology as he worked with his major advisor, John Holland.

### Early Research

Walsh's long publishing career began with studies around his work with residence halls and academic

advising. His early research seemed to forecast his later dedication to research on person–environment theories of human behavior in that his very first publication was titled “College Student Residence and Academic Achievement.” At about the same time, Walsh investigated the validity of self-report data. In many ways, the self-report research is seminal because so many researchers then and now use self-report as a primary assessment tool. Walsh's research demonstrated that self-report data are accurate and valid. Although doubt continues to linger about self-report data, Walsh's work was the first systematic inquiry into this assessment methodology and does provide some reassurance to the thousands of researchers who use self-report. Though individuals who know Walsh well remember the self-report studies, most students of psychology will recall Walsh for his person–environment work.

While at the University of Iowa Walsh began his decades-long association with person–environment research. It was perhaps Walsh's early training as an economist and later research with college students that eventually led him to the study of the influence of the environment on the behavior of people and the influence of human behavior on the environment. He published one of his seminal works, *Theories of Person-Environment Interaction*. From there, Walsh conducted numerous person–environment studies and initiated the person–environment book series. Many of the investigations of John Holland's theories are directly attributable to Walsh and his numerous graduate students. With about two dozen articles on Holland's theories, Walsh invigorated the study of this vocational theory as well as inspired the study of other theories.



## Vocational Psychology

Walsh moved from a study of Holland's theory to present a broader view of the specialty of vocational psychology. Walsh's work has helped to shape a complete picture of Vocational Psychology. Walsh pulled together the leading researchers and writers in this field for his various handbook series. He began his initial work with the two-volume set of *Handbook of Vocational Psychology* with Samuel Osipow in 1983 and added four other handbooks that included as coeditor Mark Savickas for the 2005 edition of the *Handbook of Vocational Psychology* and Mary Heppner for the *Handbook of Career Counseling for Women*. Walsh also focused much of his vocational psychology research and publications on African Americans and fostered his colleagues' writings on other racial/ethnic minorities and various economic classes. Because Walsh believed in exploring the entire range of variables in the study of the discipline, he and his colleagues essentially codified the specialty of vocational psychology. Walsh further stimulated the field of vocational psychology through his work in the Society of Counseling Psychology, a division of the American Psychological Association (APA). There Walsh helped found the Society for Vocational Psychology, a section of the Society of Counseling Psychology. Through the Society for Vocational Psychology, Walsh and his colleagues initiated a biennial conference on vocational psychology. The inaugural conference was hosted by Walsh in Columbus, Ohio, home of Ohio State University where Walsh served as a professor for 37 years. True to Walsh's commitment to include the entire range of elements in any profession, the Society for Vocational Psychology held its first international vocational psychology conference in Portugal in 2003.

Although Walsh is one of the primary invigorators and codifiers of the specialty of vocational psychology, his interests and his impact on the field of psychology is much broader. Walsh could easily be called a measurement psychologist. After all, much of his work on Holland's theory included validation studies of the Vocational Preference Inventory and the Self-Directed Search. But his wider work reviewed the entire field of psychological tests and assessments. He coauthored four volumes of tests and assessment books that discussed assessment of personality, cognitive ability, interests and career development, and person–environment. These books are written so that

lay persons, scientists, and practitioners can have access to material that is sometimes considered out of reach because of its perceived difficulty.

## Counseling and Counseling Intervention

Walsh has also been an active author on the subject of the entire field of counseling and counseling intervention methods. He regularly published overviews of counseling, counseling interactions, and counseling methods. In addition, Walsh has provided historical perspectives on the work of counseling psychology as the early adopters of positive psychology. And he has pushed counseling psychologists to be visionaries regarding the future of counseling psychology. He served as President of the Society of Counseling Psychology, Division 17 of the APA in 1998. During his tenure and shortly thereafter, he established a foundation for research in counseling psychology within the American Psychological Foundation and established the Division 17 Past Presidents Council in order to retain the heritage of the division and to push the further development of the field.

## Enduring Legacy

Walsh's most enduring legacy to the field of counseling psychology in general and to vocational psychology in particular is the result of work with legions of graduate students and their subsequent work with their own graduate students. Walsh's students can be found in professorships in higher education, as higher education administrators and practitioners, and organizational and corporate positions as well as in the private practice of psychology. From all of these quarters, numbers of these former students now write in the vocational psychology arena and thus ensure the vibrancy and dynamism of the discipline. For his stellar work, Walsh was honored with Fellowship status in the Division of Counseling Psychology and in the Association for Psychological Science.

Although Walsh is constantly sought after for his sage counsel in numerous areas, including as a book reviewer on topics from "Student Personnel Work in Urban Colleges" to "Measuring Ego Development," his most profound and consistent work is with person–environment behavior. In order to encourage the research and study of careers, vocational psychology,



and environment Walsh founded and edited the *Journal of Career Assessment* in 1991. From its inception through 2007, the journal has steadily grown in prominence. In 2006, the *Journal of Career Assessment* had a citation impact factor of 1.211. In addition, Walsh extended his sphere of influence beyond counseling psychology to a diverse group of colleagues who were working on his early and sustained research interest in human behavior and environments. He became active with Division 34 of the APA, Population and Environmental Psychology, and became the representative to the APA governing council, the Council of Representatives, on behalf of Division 34. Walsh's service on the Council from 2002 to 2008 meant that he was involved in formulating policy and in helping to set direction for the entire field of psychology. His influence on the field of psychology is also reflected in his service as founding editor, acting editor, editorial board member, and/or editorial consultant on 11 major psychological journals. Walsh has published over 150 articles, book chapters, and books and has presented at major conventions nearly 100 times. His articles have appeared in leading academic journals, including the *American Psychologist*, the *Journal of Counseling Psychologist*, the *Journal of Vocational Psychology*, *The Counseling Psychologist*, *Contemporary Psychology*, and the *Journal of College Student Personnel*. His lifetime of sustained and valuable contributions was acknowledged when he received the Leona Tyler Award in 2004. The Leona Tyler Award is the highest recognition given by the Society of Counseling Psychology.

Walsh lives with his wife, Jane, in Columbus, Ohio. He retired from his 37-year career as a professor of psychology in 2002. He remains actively engaged with the psychology department in his role as Professor Emeritus at Ohio State University, and he serves as Executive Director of the W. B. W. Consulting Firm.

Rosie P. Bingham

**See also** Assessment (v4); Career Counseling, History of (v4); Counseling, History of (v4); Holland, John L. (v4); Holland's Theory of Vocational Personalities and Work Environments (v4); *Journal of Career Assessment* (v4); Osipow, Samuel H. (v4); Person–Environment Fit (v4); Person–Environment Interactions (v4); Positive Psychology (v2); Society for Vocational Psychology (v4)

### Further Readings

- Walsh, W. B. (1968). Validity of self-report: Another look. *Journal of Counseling Psychology*, 15, 180–187.
- Walsh, W. B. (1973). *Theories of person-environment interaction*. Iowa City, IA: American College Testing Program.
- Walsh, W. B. (1975). A book review of *Student personnel work in urban colleges* by T. F. Harrington. *Contemporary Psychology*, 20, 357–358.
- Walsh, W. B. (1998). A book review of *Measuring ego development* (Second edition) by Le Xuan Hy and Jane Loevinger, Lawrence Erlbaum Press. *Contemporary Psychology*, 43, 348–349.
- Walsh, W. B., & Betz, N. E. (1985). *Tests and assessment*. Englewood Cliffs, NJ: Prentice Hall.
- Walsh, W. B., & Betz, N. E. (1985). *Tests and assessment: A test item file*. Englewood Cliffs, NJ: Prentice Hall.
- Walsh, W. B., Craik, K. H., & Price, R. H. (Eds.). (1992). *Person-environment psychology: Models and perspectives*. Hillsdale, NJ: Lawrence Erlbaum.
- Walsh, W. B., Craik, K. H., & Price, R. H. (Eds.). (2000). *Person-environment psychology: New directions and perspectives* (2nd ed.). Mahwah, NJ: Lawrence Erlbaum.
- Walsh, W. B., & Osipow, S. H. (Eds.). (1983). *Handbook of vocational psychology* (Vol. 1). Hillsdale, NJ: Lawrence Erlbaum.
- Walsh, W. B., & Osipow, S. H. (Eds.). (1983). *Handbook of vocational psychology* (Vol. 2). Hillsdale, NJ: Lawrence Erlbaum.

---

## WILLIAMSON, EDMUND GRIFFITH (1900–1979)

---

Edmund Griffith Williamson was born on August 14, 1900, in Rossville, Illinois. In 1925, he received a B.A. degree from the University of Illinois. He received a Ph.D. in psychology from the University of Minnesota in 1931. Williamson joined the faculty at the University of Minnesota in 1931 as assistant professor of psychology and was named director of the University of Minnesota Testing Bureau (now the University of Minnesota Counseling and Consulting Center), 1931–1938. During this decade, the Minnesota Employment Stabilization Research Institute was established at the University of Minnesota to assist workers who had lost their jobs during the Great Depression. This effort operationalized Frank Parsons's



concepts of matching the characteristics of workers with jobs using the methods of differential psychology. This approach came to be labeled *trait-factor counseling*. Williamson successfully adapted the methods developed by the Minnesota Employment Stabilization Research Institute to address the career development concerns of college students. Because of Williamson's prolific and influential writings on trait-factor counseling, it was sometimes referred to as the Minnesota point of view. Under Williamson's leadership, the University of Minnesota Testing Bureau became the prototype for all future college counseling centers.

Williamson became the coordinator of student personnel services in 1938 and was promoted to Professor of Psychology and Dean of Students in 1941. During his tenure as dean, he developed the idea of *in loco parentis*—the concept that universities should assume parental responsibility for the behavior of undergraduate students. This concept fell into disfavor in the 1960s, but is now being revisited by some universities. Contrary to the paternalism he was sometimes charged with, Williamson supported the inclusion of students' ideas and opinions in the administration of the University of Minnesota. During his career, Williamson influenced the work of many other researchers in vocational psychology. His influence was particularly strong at the University of Minnesota, which produced leading vocational psychology researchers such as John Holland, Lloyd Lofquist, René Dawis, David Campbell, and Jo-Ida Hanson during his tenure there.

Williamson retired from the University of Minnesota in 1969 and was named a regents professor emeritus. In 1977, a new building housing the University of Minnesota bookstore and student services offices was named for Williamson. Among his other career accomplishments, Williamson was a Fulbright Scholar in Japan in 1956. He served the Advisory Committee on Counseling in Vocational Rehabilitation and Education of the Veterans Administration from 1946–1969 and in leadership positions with the American College Personnel Association from 1941–1954, including serving as president in 1944–1945. He died on January 30, 1979. Williamson's leadership in the field of student counseling and his scholarly accomplishments were such that many consider him the leading figure in the founding of the field of counseling psychology.

Donald E. Eggerth

*See also* Dawis, René Villanueva (v4); Holland, John L. (v4); Lofquist, Lloyd Harry (v4); Person–Environment Fit (v4); Trait-Factor Counseling (v4)

### Further Readings

James, R. K., & Gilliland, B. E. (2002). *Theories and strategies in counseling and psychotherapy* (5th ed.). Needham Heights, MA: Allyn & Bacon.

---

## WORK-BOUND YOUTH

---

The majority of youth enter the world of work prior to receiving postsecondary education or training. By age 26, 85% of youth receive a high school diploma; however, only 27% receive a 4-year college degree. The economic consequences of being in the world of work without a college degree in the United States are staggering. The U.S. Federal Reserve reported that the median income level for individuals without a high school degree was \$17,000 per year, \$34,000 for individuals with a high school degree, and \$41,000 for individuals with some college experience.

Renewed efforts must be made to establish optimal learning environments within school and community settings that effectively prepare all youth to make successful transitions into the world of work. Fortunately, the Secretary's Commission on Achieving Necessary Skills (SCANS) has provided an excellent outline of necessary work readiness skills and dispositions. SCANS identifies a set of five competencies considered to be hallmarks of expert workers, and a three-part foundation of personal qualities and skills considered essential for success in the workplace. The five competencies include the ability to effectively use resources, interpersonal skills, information, systems, and technology. The three foundation skills and qualities include basic skills (such as reading, writing, mathematics, listening, and speaking), thinking skills (such as thinking creatively, making decisions, and solving problems), and personal skills (such as displaying responsibility, self-esteem, sociability, self-management, and integrity).

With this foundation of essential work skills and dispositions, the counseling profession can facilitate the ability of youth to successfully enter the world of work by helping schools and youth-serving community settings establish optimal learning environments.



One of the first models of career development, Parsons's traditional person–environment fit model, argued that individuals and occupations possess relatively stable characteristics, and the goal of career counseling is to establish a match between personal characteristics and occupations that rely on those characteristics. Recent theory and research in developmental psychology and changes in the world of work have cast doubt on the utility of traditional person–environment fit strategies as the only means of establishing work readiness. An alternative perspective is that individuals possess modifiable dispositions, rather than stable trait characteristics. According to Lerner's developmental contextualism, youth are embedded within environments that facilitate or impede their development. For example, the quality of teachers in the classroom influences the development of youth literacy and numeracy skills. It is assumed in this perspective that the vast majority of lower-income youth, urban youth, and youth of color possess the ability to read and perform mathematical operations. Thus, the large achievement gap between these populations and higher income and predominately White youth are accounted for by differences in the quality of learning environments, not ability levels. Establishing optimal learning environments allows youth of all ages to move toward achieving their true potential.

The SCANS skills and dispositions include both cognitive and affective developmental domains. Cognitive development involves traditional academic outcomes such as literacy and numeracy, whereas affective development involves motivation and confidence. Counselors can support educators by helping students become invested in using learning opportunities to develop the range of skills and dispositions needed to achieve their career goals. Counseling as a discipline can help establish optimal conditions for developing work readiness skills and dispositions by focusing attention on the affective development areas necessary for success in school and work, such as motivation, confidence, and social connections.

Motivation is perhaps best described by Deci and Ryan's self-determination theory, which articulates strategies to help youth engage in activities because they find them meaningful and enjoyable rather than because they feel forced to do them or fear letting others down. Performing an activity because it is perceived as meaningful and enjoyable is referred to as internally based motivation while performing an activity because one feels forced to or in order to avoid letting others down is referred to as

externally based motivation. Deci and Ryan argue that optimal learning environments are those that establish strong relational bonds between youth, peers, and adults. These environments are optimal because individuals develop meaning and enjoyment in activities in which they experience a sense of social connectedness or belonging. Therefore, youth are more likely to be motivated to attend school when they feel connected to teachers and peers. An example of interventions based on a counseling perspective designed to improve relational connections is the Hear My Story curriculum developed by Howard and Solberg. The Hear My Story curriculum involves working with a language arts teacher who provides literature and autobiographical writing lessons. The counselor joins in the activity by explaining to the class that everyone will be encouraged to read their writing sample to the class and that the counselor and teacher will be sharing their stories as well. The counselor also establishes the rules for creating a safe sharing environment. By sharing their stories, students and teachers learn about the diverse life experiences that are occurring among and between peers and adults.

Other important areas of affective development are highlighted in Bandura's social cognitive theory, which argues that optimal learning environments include four sources of self-efficacy. Self-efficacy refers to one's confidence in one's ability to successfully perform an activity. The four sources of self-efficacy include mastery experiences, vicarious (role modeling) experiences, verbal persuasion, and anxiety management. Mastery experiences are those that involve successfully performing a challenging activity. Vicarious experiences involve watching someone successfully perform the activity. Verbal persuasion involves adults providing evidence to youth about their ability to perform a challenging activity. Anxiety management involves learning how to manage one's fears about performing a challenging activity. An example of how counselors can incorporate these four sources of self-efficacy into school and community settings is the Career Horizons program developed by O'Brien and her colleagues. As part of the Career Horizons curriculum, a scientist from the community provides an encouraging talk about why girls should consider science careers, and then participates with the girls in a challenging science task. The girls not only receive verbal persuasion, but also the fun activity reduces anxiety and provides both vicarious and mastery experiences.



Additional ingredients that promote the creation of optimal learning environments have been identified by Brown and Ryan Krane's 2000 meta-analysis of career intervention literature. In addition to vicarious feedback, their meta-analysis indicated that curricula involving written exercises, individualized interpretations and feedback, information about the world of work, and guidance on building support networks were found to have a better impact on influencing career development. Curricula that contained multiple ingredients showed stronger outcomes. Howard and Solberg's Achieving Success Identities Pathways Program is one example of a counseling-oriented program creating optimal learning conditions within classroom settings. The program provides youth with individualized work readiness feedback related to academic self-efficacy, motivation, stress and health; includes discussions connecting school success to work success; explores the range and function of informal and formal support systems; and uses written exercises throughout.

In conclusion, SCANS offers an outline of work readiness skills and dispositions necessary to successfully enter the world of work. Integrating research from self-determination theory, social cognitive theory, and Brown and Ryan Krane offers nine ingredients of optimal learning environments that can promote the development of these work readiness skills and dispositions. These ingredients are written exercises, individualized interpretations and feedback, world of work information, modeling opportunities, attention to building support for choices within one's social network, mastery experiences, anxiety management skills, and opportunities for establishing stronger relational connections between youth and their teachers.

*V. Scott Solberg and Neeta Kantamneni*

*See also* Academic Achievement, Nature and Use of (v4); Achievement Gap (v3); Career Counseling in Schools (v4); Career Education (v4); Person–Environment Fit (v4); School-to-Work Transition (v4); School Counseling (v1); Self-Efficacy/Perceived Competence (v2)

### Further Readings

Howard, K. A. S., & Solberg, V. S. H. (2006). School-based social justice: The Achieving Success Identity Pathways Program. *Professional School Counseling*, 9(4), 278–287.

Lerner, R. M. (1995). *America's youth in crisis: Challenges and options for programs and policies*. Thousand Oaks, CA: Sage.

O'Brien, K. M., Dukstein, R. D., Jackson, S. L., Tomlinson, M. J., & Kamatuka, N. A. (1999). Broadening career horizons for students in at-risk environments. *Career Development Quarterly*, 47, 215–229.

Solberg, V. S., Howard, K. A., Blustein, D. L., & Close, W. (2002). Career development in the schools: Connecting school-to-work-to-life. *The Counseling Psychologist*, 30, 705–725.

U.S. Department of Labor, Secretary's Commission on Achieving Necessary Skills (SCANS). (1991). *What work requires of schools: A SCANS report for America 2000*. Washington, DC: Author.

---

## WORK–FAMILY BALANCE

---

Balancing the demands and domains of work and family life presents major challenges for individuals, couples, and families. Career counselors and all counseling professionals must be able to comprehend and assist people to deal with issues of work–family balance. This entry considers work–family balance from the perspectives of history and career intervention.

### History

The relationship between the domains of work and family has undergone many shifts in the United States. Prior to the Industrial Revolution, families tended to work together, usually where they lived (farms, small businesses), in sustainable ways. Although men's and women's roles within those families differed (men engaged in manual labor and trade; women were in charge of sustenance, family needs, and domestic tasks), all of the duties were seen as of equal necessity and importance. Further, the education and care of children was equally divided, as children accompanied their same-sex parent in the performance of work. At this point in history, childhood was short: children became "little adults" as soon as they were able.

The Industrial Revolution and the accompanying geographic shift of work from home to cities resulted in a separation of those two domains. Sustainability was now segregated into two separate spheres and gender-specific roles. Shortly thereafter the ideology of



separate spheres emerged: men's sphere was public and regulated, while the domain of women remained private and unregulated. Men governed the family, social and political institutions, and the economy, while women managed the home, emotions, culture, morality, and children. This doctrine of separate spheres remained dominant until quite recently. Further, ideas about the ideal mother (careworker), ideal father (breadwinner), and the ideal worker (an employee primarily dedicated to his paid job) proliferated.

During and after World War I, women began to express interest in personal satisfaction, and ambition, but their participation in the labor force did not increase until the Great Depression and World War II. Nevertheless, the right of the married woman to work was debated vociferously and was a tenet of early feminism. Ultimately, because of the draft and the war, women were needed to work in factories and businesses. The image of Rosie the Riveter was a patriotically inspiring image, new dignity was conferred on women's wage work, and women liked going to work. Their wage work acquired unprecedented public prominence and contributed significantly to the economy. After World War II, men reclaimed their manufacturing jobs, and women's labor participation reached its lowest level of the century. Women were strongly encouraged to return home, and the passage of the Fair Labor Standards Act of 1938 and the Family Wage Act of 1939 plus the enticement of home ownership and the new domestic labor-saving devices facilitated that choice. Men's earning power grew, and women's work was discouraged. Women's experience at work during the war, however, had altered women's attitudes about work considerably, and even though the economic upturn during the 1950s resulted in the ability of many men to support their families on one income, women were attracted to the labor market. During the last quarter of the 20th century, a number of forces coalesced to change women's labor force participation: (1) increasing access to higher education for women; (2) the Women's Movement, which successfully advocated for equal opportunity for women in the workplace; (3) the introduction of birth control; (4) the increase in the age of marriage; (5) the decrease in the fertility rate; (6) the increasing divorce rate; (7) the steady decline in the earning power of men's wages; and (8) an increase in Americans' material expectations. By the 1960s, the traditional breadwinner-homemaker

lifestyle began to give way to the current normative pattern: the dual-earner couple, in which both members work for pay. Today, more than half of all married couples both work, as do 66.5% (as of 2005) of all parents, and 57% of couples with children under the age of 6. Further, the average amount of time that couples spend at work has increased dramatically (by about 10 hours a week) in the last 20 years.

This new dual-earner arrangement has created both new problems and new opportunities for families, and for the workplace. Working couples are vulnerable to role conflict, work-family spillover, and the problem of "three jobs, two people." Further, the United States lags behind most other developed countries in the provision of state-supported child care and paid leave.

At the same time, working couples often have slightly more disposable income, and both generations X and Y are more egalitarian in their attitudes toward child rearing and child care, challenging the idea of the ideal worker. This shift in attitudes is beginning to pose a problem for some industries, such as law and finance. Turnover among midcareer professionals was growing; this is costly for firms, who estimate that the replacement costs of employees is more than 30% of individuals' salary. This bottom-line impact is of concern to companies, and since around 1980, companies with many employees have both studied work-family issues and implemented policies to address them. And the multidisciplinary study of work-family is increasing dramatically. Since 1977, the year that Rosabeth Moss Kanter published her monograph on work and family, scholarly work has burgeoned. More than 3,500 articles were published in 2000, but few of them have been cited by clinicians in their work.

## Implications for Counseling

### *Ideological Expectations*

The ideological model of intensive mothering among White families began to emerge in the 1930s and pervaded through the 1970s. This model was informed by the changing beliefs about child rearing, the emergence of psychological (Freud, Erikson) and cognitive (Jean Piaget) developmental models, and the increase in availability of mothering "experts" such as Benjamin Spock. Although more women are working, and more women are working full-time,



full-year, this set of beliefs has not changed much, and can result in considerable conflict and guilt for both men and women.

### ***Role Conflict***

Research suggests that despite the increase in egalitarian beliefs among men and women in marriage, traditional gender roles, especially reflected in the division of labor at home, remain powerfully ingrained. The psychological tension embedded in the conflict between work and family roles has been described as occurring bidirectionally: either from work to family or family to work. From a research perspective, they are distinct reciprocal constructs with independent antecedents and outcomes. Further, there is evidence to suggest that the relationship between work–family conflict and job satisfaction is decidedly negative. These conflicts can be time-based (e.g., needing to work late), strain-based (anxiety about a child's illness might interfere with the ability to concentrate at work), or behavior-based (conflict stemming from incompatible behaviors demanded by competing roles, e.g., being appropriately aggressive and unemotional in a specific work role such as litigator is probably not appropriate at home). Further, despite increasing egalitarianism, the burden of care-work continues to fall mostly on women. Nearly 80% (79.9%) of women report having the main or total responsibility for child care in their households, and this statistic does not include caring for ill or aging relatives. Data suggest that even when men participate in domestic work and child care, they tend to choose what they do and the executive function in the household tends to be located in women. This is not to say that men are not involved at home nor is it suggested that men do not experience work–family conflict. From a practice perspective, both kinds of conflict can have implications for male and female clients. Since identity is often embedded in social role, these kinds of conflicts can be quite disturbing to clients. From a couples' perspective, work–family conflict is often associated with differing gender-role expectations rather than with the role demands themselves, that is, the degree to which their gender-role expectations differ and the degree to which their individual work and family roles are ego-dystonic. Because role expectations are so deeply embedded, they can be difficult to discuss for both individuals and couples.

The opposite of work–family conflict is work-to-family facilitation, positively associated with job- and

life-satisfaction, negatively with stress and family-to-work facilitation, positively associated with marital- and family-satisfaction, and negatively associated with organizational commitment. But working mothers report more work–family conflict and stress and less family-, marital-, and life-satisfaction than working fathers.

### ***Role Overload***

Not the same as role conflict, role overload refers to the sheer number of role demands. There is some evidence to suggest that parenting is less effective when role overload occurs in the work domain, but too much work is not in and of itself negative. Rather, schedule fit and control are better predictors of psychological distress.

### ***Spillover***

Multiple role occupancy is, in itself, not necessarily detrimental to individuals. Chait Barnett and Shibley Hyde have suggested that multiple roles are generally beneficial for both men and women, and have positive implications for psychological well-being. This is known as either positive spillover or work–family enrichment.

### ***Work Schedules and Family-Friendly Policies***

Until quite recently, work schedules were, for the most part, rigid, resulting in considerable stress for working parents. In the last 20 years, employers in the United States have demanded more and more time on the job. This is especially true for the service sector. Accountants, lawyers, and finance professionals, for example, are expected to be client-friendly 24 hours a day, 7 days a week. Despite this 24/7 expectation, many employers have recently seen the bottom-line benefit of flexible schedules: reduced turnover, reduced absenteeism, higher organizational commitment, increased productivity, and higher profits. Further, it has become clear that schedule flexibility (the agile workplace) is the single best family-friendly benefit for individuals as well as for organizations. Other family-friendly policies include family medical leave benefits, paid leave, telecommuting, on-site child care, aging and child care resources, and referral services, to name a few. Family-supportive policies seem to be associated with reduced work–family conflict. The question of utilization, however, remains a problem.



The existence of good policies is not necessarily career neutral. There is some evidence to suggest that in firms that value highly driven employees, taking advantage of such policies can derail individuals. *Working Mother Magazine* lists the 100 best companies to work for based on both the existence of formal policies and their utilization. For the individual experiencing conflict, however, the absence of good problem-focused coping strategies and proactivity can result in increased stress. It has been found that stressed individuals who use problem-focused coping exhibit less strain than those who do not, but that emotion-focused coping strategies do not lead to positive outcomes. Research also suggests that the use of informal work accommodations to family can be more effective than rigid work-family organizational policies.

### **Child Care**

The satisfactoriness of child care is directly related to income: the higher one's income, the more likely one is to be able not only to afford child care, but also to have choices about whether that care is delivered at home or in day care. Although for the most part, research has focused on child care for young children, the issue of afterschool care is gaining increased prominence. It is worthwhile to note that the United States is one of the few developed countries whose government does not subsidize some form of child care.

### **Child Outcomes**

The potentially negative effect of maternal employment on children has been studied longer than any other work-family issue. It appears that when mothers engage in paid employment for more than 30 hours per week while their children are younger than 9 months, negative effects on some aspects of cognitive and social development are found. Some of those effects may persist into the school-age years. These data, however, are not universal and are influenced by child gender, ethnicity, child care quality, home environment quality, maternal sensitivity, and socioeconomic status. The equality of the marital relationship appears to be critical to positive child outcomes.

### **Stress and Illness**

Much of the research on stress and illness appears under the rubric of health psychology. Substance abuse has been studied in this domain, as has stress.

The interactions between work and family can provide multiple potential stressors, which in turn can be associated with depression, anxiety, burnout, and role overload. In addition, recent research suggests that parental concern over what children are doing after school is a major source of employee stress. Working mothers lose approximately one night's worth of sleep a week, due to the combined demands of work and family. Husbands whose wives work 40 or more hours a week experience poorer health than do husbands whose wives work shorter hours. Finally, it is important to mention that working nonstandard hours exacerbates almost all work-family difficulties. These findings tend to be associated with low-wage workers and are not independent of ethnicity and socioeconomic status.

### **Off- and On-Ramping**

The U.S. economy incurs a significant loss of human capital in that many highly educated, middle-class mothers leave the workforce (i.e., opt out) because they cannot get career continuous part-time arrangements. How women manage their careers once they have children has been the subject of much interest, but of less research. Sylvia Hewlett and Carolyn Luce found that 37% of women voluntarily leave their careers at some point and that 43% of women who have children do so. Caring for elderly parents also pulls women out of the labor force. But, the "pulls" of children and health are not the only triggers. The "push" of lack of opportunity or understimulation are also proximate causes. For the most part, these women have every intention of returning to the labor force, but they pay a high cost for time out, both financially (a loss of an average of 18% of their salaries, a loss of 37% if they stay out for 3 years) and in terms of career trajectory. Because prime childbearing years coincide with prime career-building years in almost every occupation, the penalty for using alternative work arrangements or for stepping out even briefly can be steep. As corporate employers begin to recognize this brain drain, however, they are funding experimental reentry programs at law and business schools to try to ameliorate the loss to both individuals and industry.

### **Clinical Interventions**

The interface between work and family is an important topic for counseling. Although much of the research cited here is about White, middle-class, heterosexual two-parent families, there is an



increasing body of knowledge about low-wage workers, single parents, lesbian families, and families of color. Further, the research on work and family issues cross-nationally can also inform, especially when one looks at the effects of national policy differences. And, the absence of literature on the relationship between work–family and clinical interventions is notable. Despite the fact that caseloads increasingly include individuals and couples who are struggling with the issue of balancing work and family, little guidance is available for the counselor or therapist. Kelli A. Saginak and M. Alan Saginak recommend giving high priority to helping couples create marital equality and an equitable distribution of labor, while Ada Sinacore-Guinn and colleagues remind counselors to explore family environment when women enter or reenter the labor force, when clients voice job dissatisfaction, and as they engage in family planning. Finally, when engaging in individual or couples counseling when work–family issues are central, there are two foci: the two individuals' career or job voices and how those voices are associated with the home environment.

*Patricia M. Raskin*

**See also** Adult Career Concerns Inventory (v4); Adult Development (v1); Career Counseling (v4); Career/Life (v4); Couple and Marital Counseling (v1); Life-Role Balance (v4); Parent–Adolescent Relations (v1); Parenting (v1); Part-Time Work (v4); Stress (v2); Stress Management (v2); Work Stress (v4)

### Further Readings

- Barnett, R. C., & Hyde, J. S. (2001). Women, men, work, and family: An expansionist theory. *American Psychologist*, 56(10), 781–796.
- Christensen, P. M. (1997). Toward a comprehensive work/life strategy. In S. Parasuraman & J. Greenhaus (Eds.), *Integrating work and family: Challenges and choices for a changing world* (pp. 25–37). Hillsdale, NJ: Lawrence Erlbaum.
- Parasuraman, S., & Greenhaus, J. (1999). *Integrating work and family: Challenges and choices for a changing world*. Westport, CT: Praeger.
- Pitt-Catsoophes, M., Kossek, E. E., & Sweet, S. (Eds.). (2006). *The work and family handbook: Multidisciplinary perspectives and approaches*. Hillsdale, NJ: Lawrence Erlbaum.
- Schneider B., & Waite, L. J. (2005). *Being together, working apart: Dual-career families and the work-life balance*. Cambridge, UK: Cambridge University Press.

Williams, J. (2000). *Unbending gender: Why family and work conflict and what to do about it*. New York: Oxford University Press.

### Web Sites

Sloan Work Family Research Network: <http://wfnetwork.bc.edu/>

---

## WORK STRESS

---

Work now more than ever consumes large portions of people's lives. The importance of work in people's lives, alongside the demands on one's time and energy, can be a tremendous source of stress. Increases in work stress may result from people having longer work hours, threats of job loss due to organization downsizing, or a host of other factors, such as the day-to-day strains in the work environment. Aspects of one's personal life can make dealing with stress at work even more difficult. Although many sources of stress are apparent in everyday life, most people would probably report at least some level of stress at work. In some cases, work stress can be the number one source of stress in people's lives. Work stress can result from a lack of control over work, which can leave a person feeling undervalued and underappreciated, or it can be due to particular issues in the workplace environment, such as shift work, long work hours, time pressures, noise, surveillance and monitoring, and working with hazardous products. Interpersonal conflicts with coworkers and supervisors can also contribute to increases in work stress.

Work stress is perceived and interpreted differently by individuals, and people will cope and respond to stress in different ways. Situations that may impose stress on one individual may not be stressful to others. Individual characteristics such as personality traits and coping style can influence how a person responds to work stress. Although these characteristics can be partly responsible for how people respond to stress, working conditions such as workload demands and pressures, conflicting expectations, or fear of layoffs or being fired can influence the amount of stress that one feels. Individuals with certain personality characteristics, such as type A personality traits or people prone to depression, may respond more often and more intensely to work-related stress. Work stress can also result from an imbalance between a person's



efforts and the personal rewards he or she receives from work: for example, workers who take on responsibilities above and beyond their normal workload but who do not receive the promotion they felt they deserved.

Work stress can depend on a person's developmental stage of life, with sources of work stress being different for a new high school graduate compared to a worker in his or her 60s. Demographic and personal factors can also be associated with work stress and include age, gender, race and ethnic differences, financial problems, family issues (i.e., caring for children or aged parents, dual-career couples). Work stress can result from a poor fit between the worker and the environment. Poor person-environment fit can lead to psychosocial stresses and strains that adversely affect the worker. A poor fit between the person and work environment can be longstanding or brought on by recent changes in the work environment, such as requiring workers to learn new forms of technology (i.e., computers).

### **Importance of Work in People's Lives**

The importance of work in people's lives cannot be underestimated, and work means different things to different people. For some individuals work provides an income and is essentially a means to survive, whereas for others it gives purpose to their lives and is a means to express or fulfill their interests. Some people use work as a means to occupy their time, and there are other individuals for whom work provides self-respect, a sense of identity, and feelings of pride. It is not uncommon to find individuals who live to work, while other people work to live. Both perspectives on the meaning of work in people's lives can be associated with work stress. For example, for individuals who live to work, their identity may be closely tied to work. They may work long hours in order to succeed and be promoted and, therefore, be more regularly exposed to stress-producing aspects of the work environment. For individuals who work to live, fear of losing their job, and therefore their income, may significantly contribute to work stress.

### **Work Stress and Health**

While there may be some benefits to small amounts of stress, such as helping one to remain productive and challenged at work, prolonged stress can have debilitating consequences. Despite work posing an

exciting challenge for people, it can significantly contribute to health problems that include both physical and psychological symptoms. Although work stress is not a disease, work stress is a negative health outcome. Work stress can lead to health problems, including the onset of new health concerns such as cardiovascular disease or it can exacerbate existing conditions such as asthma, irritable bowel syndrome, or high blood pressure. Mood and sleep disturbances, headaches, fatigue, chronic pain, and gastrointestinal problems can be associated with work stress. Depression and anxiety can also be linked to prolonged work stress. These health concerns can lead to increased absenteeism, decreased work performance, and increased health insurance expenditures. Most concerning is the relationship between work stress and behavioral problems, such as anger that can lead to violence in or out of the workplace. Work stress can also contribute to alcohol or other drug abuse, whereby people use alcohol and other drugs to regulate their emotions and cope with difficult and stressful work situations. Increased caffeine consumption and smoking may also result from work stress.

### **Coping With Work Stress**

Given that stress in the workplace may be common and, at times, unavoidable, helping employees cope with stress is an important task for employers. Employee Assistance Programs, known as EAPs, can often serve as a first line of defense for people experiencing unmanageable work-related stress. EAPs may offer different types of educational programs to help employees cope with work stress. EAPs often offer stress management programs, which may help employees learn how to identify forms of stress in their lives; learn relaxation, time management, and coping strategies; and become aware of the effects of stress on health. EAPs also typically offer individual counseling, which can help people with personal skills reduce work stress. Personal counseling is also available to employees whose home life or personal life contributes to work stress. Counselors may help the individual cope, for example, by figuring out ways to reduce work environment conflict or to balance work and family and personal life. A counselor's role may also be to help the individual develop and utilize a supportive network of friends and family and coworkers. Additionally, finding ways to use leisure to cope with work stress may also be helpful. Leisure



time may be especially helpful in decreasing depression and anxiety brought on by work stress.

Work stress can lead to job dissatisfaction and employee turnover as well as to burnout, which is caused by a prolonged imbalance between work and the individual. Coping with stress can hopefully prevent burnout. Individuals who feel that they work in a supportive atmosphere and who feel that their work provides them with challenges are at lesser risk for burnout. Individuals who have strong interpersonal qualities and social supports may be less likely to develop burnout. Developing a person's inner set of strengths through counseling may help to ward off burnout, build resiliency, and help work to be perceived as more satisfying and less stressful. Prevention and intervention strategies should be geared toward the individual.

### Measuring Work Stress

In order to assist individuals with devising coping and intervention strategies to manage work-related stress, it may be helpful to formally assess levels of occupational stress. A tool that can be used to comprehensively measure work-related stress is the Occupational Stress Inventory-Revised Edition (OSI-R). It consists of three questionnaires comprising 140 items (total) designed to measure three domains of occupational adjustment: occupational stress, psychological strain, and coping resources. The OSI-R can be completed in 30 minutes and provides information about the domains using 14 scales. The results can be used to help individuals understand sources of their occupational stress, work roles that contribute to their stress, and outcome information about coping strategies and interventions.

*Nicole J. Borges*

*See also* Coping (v2); Job Satisfaction and General Well-Being (v4); Life-Role Balance (v4); Personal and Career Counseling (v4); Personality Assessment and Careers (v4); Physical Health (v2); Stress (v2); Stress Management (v2); Work-Family Balance (v4); Work Values (v4)

### Further Readings

Barling, J., Kelloway, E. K., & Frone, M. R. (Eds.). (2005). *Handbook on work stress*. Thousand Oaks, CA: Sage.  
Blustein, D. L. (2006). *The psychology of working*. Mahwah, NJ: Lawrence Erlbaum.

Harrison, R. (1978). Person-environment fit and job stress. In C. L. Cooper & R. Payne (Eds.), *Stress at work* (pp. 175–205). New York: Wiley.  
Hepburn, C. G., Loughlin, C. A., & Barling, J. (1997). Coping with chronic work stress. In B. Gottlieb (Ed.), *Coping with chronic stress* (pp. 343–366). New York: Plenum.  
Lazarus, R. S. (1991). Psychological stress in the workplace. In P. Perrewe (Ed.), *Handbook on job stress* [Special issue]. *Journal of Social Behavior and Personality*, 6(7), 1–13.  
Osipow, S. H., & Spokane, A. R. (1992). *Occupational Stress Inventory: Manual research version*. Odessa, FL: Psychological Assessment Resources.  
Savickas, M. L. (2001). Work and health. In D. Wedding (Ed.), *Behavior and medicine* (3rd ed., pp. 209–218). Kirkland, WA: Hogrefe and Huber.

## WORK VALUES

It is generally accepted that there are three or four things that contribute to success and satisfaction at work or in a career. Skills or abilities are foundations of success; interests and work values are the sources of satisfaction. Skills and abilities and interests are generally understood by people seeking jobs; work values are less well understood.

Generally work values have been defined in terms of preferences for jobs, occupations, or careers. Work values differ from interests, which are preferences for activities, such as science, helping others, or selling things. Work values vary from one person to another even in the same job: One person may like a job because it pays well; another may like the same job because it affords many social relationships.

Many work values have been named, and Donald Super has classified them into three categories: the results of work, such as high pay; the concomitants of work, such as the people one works with; and the nature of the work itself, such as challenging assignments. These job characteristics are typically termed as positive attributes. Negative attributes, such as danger, are not valued, but in an occupation like firefighting where danger is inevitable, it is reframed as challenge.

Super's Work Values Inventory-Revised is a popular measure of work values. It was first formulated by Super in the 1950s and published for general use in the 1970s. A revision is now available from Kuder, Inc., that assesses 12 work values using 12 scales: Achievement, Challenge, Co-Workers, Creativity,



Income, Independence, Lifestyle, Prestige, Security, Supervision, Variety, and Workplace. Other measures of work values include additional concepts measured on scales such as Moral Values and Physical Activity. Each scale consists of four statements about jobs, such as “A job in which I work with people I like,” and “. . . have coworkers who are easy to work with” (Co-Workers scale). Responses are made on a 5-point scale from *not important at all* to *crucial*. Percentile scores are used to rank order the importance of the work values. Interpretation is in the form of, “You describe yourself as valuing prestige, creativity, and variety most in a job.”

Some conceptualizations of work values indicate that occupations are homogeneous with respect to work values. That is, one may name a work value and identify all the occupations that are responsive to that value. Super’s Work Values Inventory endorses the concept that the variety of jobs within an occupation may satisfy different values. For instance, an engineer might be self-employed in consulting work because he or she values independence, while another might be employed in a research and development position because he or she values creativity. In its application in the Kuder Career Planning System, Super’s Work Values Inventory users may open several job interviews

that illustrate each work value in the context of a job. For instance, a probation–parole officer for adult offenders values “the capacity to make ninety-five percent of my decisions without approval from others; a realistic statement of Independence” (Super, 1995).

*Donald G. Zytowski*

**See also** Brown’s Values-Based Career Theory (v4); Career Education (v4); Career Exploration (v4); Job Satisfaction and General Well-Being (v4); Kuder Career Search (v4); Super, Donald Edwin (v4); Super’s Theory (v4); Values Scale (v4)

### Further Readings

- Super, D. E., & Sverko, B. (Eds.). (1995). *Life roles and careers: International findings of the Work Importance Study*. San Francisco: Jossey-Bass.
- Zytowski, D. G. (2007). *Manual, Super’s Work Values Inventory-Revised*. Retrieved from <http://www.Kuder.com/PublicWeb/swv.aspx>

### Web Sites

Kuder, Inc.: <http://www.kuder.com>







# Index

---

Entry titles appear in **bold**.

- A. A. *See* **Alcoholics Anonymous** (A. A.)
- AAAPP. *See* American Association of Applied and Preventive Psychology (AAAPP)
- AACD. *See* American Association for Counseling and Development (AACD)
- AACoP. *See* American Academy of Counseling Psychology (AACoP)
- AAMC. *See* American Association of Marriage Counselors (AAMC)
- AAMFC. *See* American Association of Marriage and Family Counselors (AAMFC)
- AAMFT. *See* American Association for Marriage and Family Therapy (AAMFT)
- Aamodt, Michael, **1:256**
- AAMR. *See* American Association on Mental Retardation (AAMR)
- AAPA. *See* **Asian American Psychological Association** (AAPA)
- AASP. *See* Association for Applied Sport Psychology (AASP)
- AAVE. *See* African American Vernacular English (AAVE)
- ABAS-2. *See* Adaptive Behavior Assessment System—Second Edition (ABAS-2)
- Abbreviated Multidimensional Acculturation Scale, **3:943**
- ABCL. *See* Adult Behavior Checklist (ABCL) Achenbach behavior rating scale
- ABCP. *See* American Board of Counseling Psychology (ABCP)
- ABC treatment paradigm
- AD/HD and, **1:32**
  - behavioral observation methods and, **1:37, 1:223**
  - behavior therapy and, **2:471, 2:472–473**
  - cognitive-behavioral therapy and, **2:504, 2:509, 2:823–824**
- Abel, Laura, **3:1057**
- ABGC. *See* American Board of Genetic Counseling (ABGC)
- Abidin, Richard R., **1:328**
- Ability tests. *See* **Achievement, aptitude, and ability tests**
- Ableism
- definition of, **2:574**
  - disability discrimination and, **3:1118**
  - disability legislation and, **2:574**
  - disabled career counseling and, **4:1434–1435**
- About Behaviorism* (Skinner), **2:871**
- ABPP. *See* American Board of Professional Psychology (ABPP)
- Abreu, Jose M., **3:1130**
- ABS. *See* Acculturation and Biculturalism Scale (ABS)
- Abuse, 2:443–448**
- child maltreatment and, **1:69–74**
  - community resources and, **2:446**
  - counseling concerns and sexual assault, **2:446–447**
  - Christine A. Courtois's work and, **1:140–142**
  - domestic violence term and, **2:443**
  - drug, alcohol abuse risk factor of, **2:444**
  - economic independence importance and, **2:445**
  - elder abuse, **2:447–448**
  - empowerment and, **2:445–446**
  - female homelessness result of, **2:444**
  - harm reduction therapy model and, **2:444**
  - intimate partner abuse, **2:443–444**
  - intimate partner abuse, counseling concerns and, **2:445–446**
  - intimate partner abuse, explanations for, **2:444**
  - intimate partner abuse, reasons for leaving or remaining in, **2:444–445**
  - male survivors of, **2:445**
  - male survivors of sexual assault and, **2:447**
  - mental disorder risk factor of, **2:444**
  - negative consequences of, **2:443–444**
  - orders of protection and, **2:445**
  - parental violence risk factor of, **2:444**



patriarchy cultural value risk factor of, **2:444**  
 physical safety importance and, **2:443, 2:445**  
 power and control of abuser and, **2:445**  
 prevalence of, marginalized groups and, **2:443**  
 psychological first aid and, **2:446**  
 psychological stress and, **2:444**  
 PTSD symptoms and, **2:443**  
 safety plans for survivors and, **2:445**  
 sexual assault, intimate partner rape, **2:446–447**  
 sexual assault, sexual orientation and, **2:447**  
 sexual minorities and, **2:445**  
 sexual violence, coercion and, **1:391–393**  
 social support networks importance and, **2:446**  
 terminology use and, **2:443**  
 victimization increase when leaving and, **2:445**  
 ACA. *See* American Counseling Association (ACA); American Counseling Association (ACA): code of ethics  
**Academic achievement, 2:448–455**  
 achievement gap and, **3:952–955**  
 achievement test definition and, **2:448**  
 achievement tests and, examples, **2:452**  
 achievement tests and, norm-referenced vs. criterion-referenced and, **2:451**  
 achievement tests and, standardized vs. nonstandardized, **2:450–451**  
 ACT test and, **2:450**  
 aptitude testing and, **2:448, 2:449–450**  
*Brown v. Board of Education of Topeka, Kansas* and, **3:952**  
 California Achievement Test, Sixth Edition (CAT/6) and, **2:451**  
 California Achievement Test (CAT) and, **2:451**  
 Comprehensive Test of Basic Skills (CTBS) and, **2:451**  
 conclusions regarding, **2:454–455**  
 differential treatment of cultural groups and, **2:454**  
 ethnic pride and, **3:1142**  
 Graduate Records Examination (GRE) and, **2:450**  
 hope, well-being and, **2:634**  
 hybrid testing and, **2:450**  
 individual- vs. group-administered tests and, **2:451–452**  
 intrinsic motivation and, **2:660–666**  
 Iowa Test of Basic Skills and, **2:452**  
 Kaufman Test of Educational Achievement, Second Edition (K-TEA II) and, **2:452**  
 of Latinos, **3:1194**  
 model minority myth and, **3:1211–1214**  
 NCLB and, **2:452–453**  
*Plessy v. Ferguson* and, **3:952**  
 problem-solving appraisal and, **2:789**  
 SAT reasoning test and, **2:450**

statewide achievement testing and, **2:452–453**  
 statewide achievement testing limitations and, **2:453–454**  
 survey achievement batteries and, **2:452**  
 “teaching to the test” concept and, **2:451**  
 Tests of Academic Proficiency (TAP) and, **2:451**  
 Wechsler Individual Achievement Test–Second Wide Range Achievement Test 4 (WRAT4) and, **2:452**  
 Wide Range Achievement Test 4 (WRAT4) and, **2:452**  
 Woodcock-Johnson® III and, **2:452**

*See also* **Academic achievement, nature and use of;** Aptitude testing; **Intelligence**

#### **Academic achievement, nature and use of, 4:1391–1392**

achievement gap and, **4:1391**  
 career development and, **4:1391**  
 development dimension of, **4:1391–1392**  
 The Education Trust and, **4:1392**  
 equity dimension of, **4:1391**  
 intelligence tests and, **3:1179–1182**  
 meaningfulness dimension of, **4:1392**  
 National Center for Transforming School Counseling (NCTSC) and, **4:1392**  
 norm- vs. criterion-referenced tests and, **2:451**  
 positive example of, **4:1392**  
 social mobility and, **4:1391**  
 stereotype threat and, **3:1340**  
 Web site regarding, **4:1392**  
 work-bound youth and, **4:1678–1680**  
*See also* **Intelligence**

ACCI. *See* **Adult career concerns inventory (ACCI)**

#### **Accreditation by the American Psychological Association (APA), 1:1–5**

accreditation process structure and, **1:1–2**  
 CACREP accreditation and, **1:1**  
 Committee on Accreditation (CoA) of, **1:1–2**  
 Council for Higher Education Accreditation and, **1:1**  
 criteria of, **1:2**  
 cultural, individual differences, diversity and, **1:3**  
 eligibility criteria for, **1:2–3**  
*Guidelines and Principles for Accreditation of Programs in Professional Psychology* and, **1:2, 1:4**  
 importance of, **1:4**  
 internship programs, postdoctoral residencies accredited by, **1:1**  
*Policies for Accreditation Governance* (APA) and, **1:1**  
 of postdoctoral training programs, **1:338**  
 predoctoral internships and, **1:342**  
 program philosophy, objects, curriculum plan and, **1:3**  
 program practicum experiences and, **1:3**  
 program resources criteria and, **1:2–3**



- public disclosure and, 1:4
- relationships with accrediting body and, 1:4
- self-assessment and quality enhancement of, 1:4
- site visitors and, 1:2
- student-faculty relations and, 1:3–4
- Accreditation by the Council for Accreditation of Counseling and Related Educational Programs (CACREP), 1:5–8**
- American Counseling Association and, 1:5–6
- American Personnel and Guidance Association and, 1:5
- American School Counselor Association and, 1:5, 1:108
- Association for Counselor Education and Supervision and, 1:5, 1:108
- Commission on Rehabilitation Education and, 1:8
- Council for Higher Education Accreditation and, 1:5
- counselor accreditation credentials and, 1:7, 1:108
- curricular requirements for entry, doctoral programs and, 1:6–7
- future of, 1:7–8
- history of, 1:5–6
- institutional accreditation and, 1:5
- National Board for Certified Counselors and, 1:7
- National Counselor Examination and, 1:7
- National Credentialing Academy and, 1:7
- on-site team review and, 1:7
- postdegree/prelicensure supervision and, 1:334, 1:336
- process of, 1:7
- rehabilitation counseling and, 2:831
- self-study for accreditation and, 1:7
- specialty accreditation and, 1:5
- Standards for Entry Preparation of Counselor and Other Personnel Services Specialists, 1:5
- 2008 Standards revisions and, 1:8
- ACCTA. *See* Association of Counseling Center Training Agencies (ACCTA)
- Acculturation, 3:941–946**
- Abbreviated Multidimensional Acculturation Scale and, 3:943
- Acculturation Rating Scale for Mexican Americans (ARSMA) and, 3:943
- acculturative/cultural stress, health and, 3:943–944
- acculturative stress and, 3:946–952
- adaptation and, 3:956
- adherence to more than one culture and, 3:943
- Arab Americans and, 3:987
- ARSMA-II and, 3:943
- Asian Americans and, 3:996
- assimilation models and, 3:941–942, 3:1003, 3:1230
- behavioral science acculturation theory and, 3:943
- biculturalism and, 3:1018
- bicultural multidimensional scales and, 3:1019–1020
- bicultural unidimensional scales and, 3:1019
- Bidimensional Acculturation Scale (BAS) and, 3:943, 3:1003
- Black psychology and, 3:1033–1036
- client–therapist ethnic matching and, 3:945
- colonialism and, 3:1061–1063
- counseling client acculturation context and, 3:944
- counseling implications of, 3:944–945
- counselor cultural naïveté and, 3:945
- counselor respect and, 3:945
- cultural accommodation and negotiation and, 3:1089–1090
- cultural competency and, 3:944–945
- cultural fusion and, 3:1003
- culture of origin maintenance and, 3:943
- culture shock and, 3:1106–1107
- definition of, 3:941, 3:1003, 3:1230
- discrimination experiences and, 3:942
- distance from origin culture and, 3:942
- dominant minority communities impact and, 3:941
- enculturation and, 3:941, 3:1129, 3:1138–1139
- ethnic enclaves and, 3:941
- ethnic identity and, 3:1018, 3:1136
- ethnicity and, 3:1138–1139
- ethnic pride and, 3:1142
- future research and practice regarding, 3:945–946
- immigration rates and, 3:941
- interracial comfort and, 3:1182–1183
- melting pot concept and, 3:942
- multicultural psychology and, 3:1230–1231
- multidimensional and bilinear acculturation measures of, 3:943
- Native Americans and, 3:973
- orthogonal models emergence and, 3:942–943
- positive cultural buffers and, 3:945
- prevailing assimilation model and, 3:941–942
- progress in theories and methods of, 3:942–943
- psychological stress and, 3:1310
- race relations stabilization and, 3:1003
- resilience factors and, 3:945
- second culture acquisition and, 3:1309–1312
- therapeutic relationship and, 3:944–945
- two-way reciprocal relationship in, 3:1003
- unidirectional cultural change and, 3:941
- See also* **Acculturative stress**; *specific racial, ethnic group*
- Acculturation and Biculturalism Scale (ABS), 3:1019
- Acculturation Rating Scale for Mexican Americans (ARSMA), 3:943
- Acculturation Rating Scale for Mexican Americans-II (ARSMA-II), 3:943



**Acculturative stress, 3:946–952**

acculturation level and, 3:950  
acculturation strategy and, 3:950, 3:1230  
adaptation and, 3:956  
Arab Americans and, 3:985–991  
arrival pattern factor in, 3:949  
assimilation strategy and, 3:947, 3:1310, 3:1311  
bicultural conflict, depression and, 3:944  
client history taking and, 3:951  
cognitive-behavioral coping mechanisms and, 3:947  
cognitive-relational model of stress and, 3:946–947  
comorbidity with psychological outcomes and, 3:948  
cultural competence of therapist and, 3:944–945, 3:951  
cultural values and, 3:1096  
culture shock and, 3:1106–1107  
definition and theoretical model of, 3:946, 3:947  
documentation status factor and, 3:949  
dominant culture rejection and, 3:943  
Harvard Immigration Study and, 3:950  
impact of, 3:947–948, 3:1230  
integration strategy and, 3:947, 3:1309–1310, 3:1311  
intrafamilial acculturation conflicts and, 3:949  
language/cultural brokering and, 3:949, 3:1172, 3:1193  
language use factors and, 3:948, 3:949–950, 3:951  
Latino immigrants and, 3:1193  
marginalization strategy and, 3:947, 3:1310, 3:1311  
mental health services access and, 3:951  
migration trauma and, 3:948–949  
moving beyond counseling role and, 3:952  
physical health and, 3:943–944  
pre-immigration factors and, 3:948  
psychological outcomes and, 3:951  
racism, discrimination and, 3:943, 3:950  
research and practice implications of, 3:951–952  
risk and resilience and, 3:951–952  
risk factors and protective factors associated with, 3:948–951  
separation strategy and, 3:947, 3:1310, 3:1311  
social capital, social support and, 3:950–951  
step migration and, 3:949  
theoretical integration and, 3:947  
theoretical underpinnings of, 3:946–947  
ACES. *See* Association for Counselor Education and Supervision (ACES)  
Ach, Narziss, 2:593  
Achenbach System of Empirically Based Assessment (ASEBA), 1:41  
ABCL scales, 1:46–47  
Adult Self-Report (ASR) scale, 1:47  
CBCL/6-18 scale, 1:45–46

Parenting Stress Index and, 1:330

TRF and C-TRF/1½-5 scale, 1:46

YSR self-report scale, 1:46

**Achievement, aptitude, and ability tests, 4:1392–1397**

abstract reasoning tests and, 4:1395  
academic achievement and, 2:448–455, 4:1391–1392  
academic curricula weakened by, 2:454  
achievement gap and, 3:952–955  
achievement vs. aptitude tests and, 4:1392–1393  
American College Test (ACT) and, 4:1393  
aptitude vs. ability tests and, 4:1393  
Armed Services Vocational Aptitude Battery (ASVAB) and, 4:1393, 4:1395  
Ball Aptitude Battery (BAB) and, 4:1393  
cognitive aptitudes and, 4:1393  
cognitive skills measured by, 4:1395–1396  
common variations among tests and, 4:1393–1395  
composite score measures and, 4:1396–1397  
computer test administration and, 4:1395  
contribution of, 4:1397  
criterion-referenced tests and, 4:1394  
cultural validity in standardized tests issue and, 2:617–618  
curriculum alignment to, 2:454  
Differential Aptitude Test (DAT) and, 4:1393, 4:1395, 4:1396  
differential treatment of cultural groups and, 2:454  
education decisions based upon, 2:454  
Electrical and Electronics Test and, 4:1393  
finger dexterity tests and, 4:1393, 4:1396  
General Aptitude Test Battery (GATB) and, 4:1393, 4:1396  
Graduate Records Examination (GRE) and, 4:1393  
intelligence composite scores and, 4:1396  
intelligence tests and, 3:1179–1182  
Kendrick Cognitive Tests for the Elderly and, 4:1393  
manual dexterity tests and, 4:1396  
motor skills measured by, 4:1393, 4:1396  
Multidimensional Aptitude Battery (MAB) and, 4:1393, 4:1395, 4:1396  
nonstandardized classroom achievement test and, 4:1394  
nonverbal aptitudes measures and, 4:1393  
normative interpretation accuracy and, 4:1394  
norm groups and, 4:1394  
number of aptitudes measured and, 4:1393–1394  
numerical aptitude tests and, 4:1395  
O'Connor Finger Dexterity Test and, 4:1393  
Peabody Individual Achievement Test and, 4:1393  
Peabody Picture Vocabulary Test and, 4:1393



- perceptual organization composite scores and, **4:1397**  
 performance intelligence composite scores and, **4:1396**  
 Personnel Assessment Selection System and, **4:1393**  
 processing speed composite score and, **4:1397**  
 Scholastic Assessment Test (SAT) and, **4:1393**  
 spatial aptitude tests and, **4:1395**  
 standardization and, **4:1395**  
 Stanford-Binet Intelligence Scales, Fifth Edition (SB5)  
   and, **4:1393, 4:1395, 4:1396**  
 statewide achievement test limitations and, **2:453–454**  
 stereotype threat and, **3:1340**  
 students' futures affected by, **2:453**  
 "teaching to the test" and, **2:451, 2:453, 2:454**  
 test administration procedures and, **4:1394–1395**  
 test interpretation and, **2:904–910**  
 Tests of Non-Verbal Intelligence, Second Edition  
   and, **4:1393**  
 theoretical distinction of, **4:1392–1393**  
 verbal and reading abilities and, **4:1393**  
 verbal aptitude and, **4:1395**  
 verbal comprehension composite scores and,  
   **4:1396–1397**  
 verbal intelligence composite scores and, **4:1396**  
 Wechsler Adult Intelligence Scale—Third Edition  
   (WAIS-III) and, **4:1393, 4:1395, 4:1396**  
 working memory composite score and, **4:1397**  
*See also* **Intelligence**
- Achievement gap, 3:952–955**  
 birth weight factor in, **3:955**  
*Brown v. Board of Education of Topeka,*  
   *Kansas* and, **3:952**  
 class, race, education intersection and, **3:1056**  
 class size factor in, **3:954**  
 college education costs and, **3:1056**  
 consequences of, **4:1391**  
 factors contributing to, **3:953–955, 3:1056**  
 health and nutrition factors in, **3:955**  
 intelligence tests and, **3:1179–1182**  
 Latinos and, **3:952–9555, 3:1194**  
 lead poisoning factor in, **3:955**  
 NCLB and, **2:452–453**  
 norm- vs. criterion-referenced tests and, **2:451**  
 parent availability and participation factor in, **3:954**  
*Plessy v. Ferguson* and, **3:952**  
 reading to young children factor in, **3:954**  
 rigor of curriculum and, **3:953**  
 before school and beyond correlates and, **3:954–955**  
 school correlates of, **3:953–954**  
 school safety factor in, **3:954**  
 stereotype threat and, **3:1339**  
 student mobility factor in, **3:954**  
 as a symptom, **3:953**  
 teacher experience and attendance factors in, **3:953**  
 teacher quality and preparation factors in, **3:953, 3:1056**  
 technology-assisted instruction factor in, **3:954**  
 TV watching factor in, **3:954–955**  
 work-bound youth and, **4:1678–1680**
- Achieving Success Identities Pathways program, **4:1680**  
 A-COPES. *See* Adolescent Coping Orientation for  
   Problem Experiences Scale (A-COPES)  
 ACT. *See* American College Test (ACT)  
 ACT, Inc., **4:1511**
- Action theory, 4:1397–1400**  
 action-project-career connection and, **4:1398**  
 action-project method and, **4:1399**  
 alternative epistemology of, **4:1398**  
 community-based action research and, **1:90–93**  
 connecting theory and practice with, **4:1399**  
 constructivist nature of, **4:1515**  
 contextual action theory and, **4:1399**  
 counseling and career development applications  
   of, **4:1398–1399**  
 explanation of, **4:1397–1398**  
 Paulo Freire and, **1:91**  
 guiding framework for understanding human behavior  
   and, **4:1397–1398**  
 joint-action and self-confrontation and, **4:1399**  
 Kurt Lewin and, **1:91**  
 problem-solving action research and, **1:91**  
 social focus of, **4:1398**  
 social justice, social change and, **1:91**  
 working with projects and, **4:1399**
- ADA. *See* **Americans with Disabilities Act (ADA)**  
 Adams, J. S., **4:1595**
- Adaptation, 3:956**  
 acculturation and, **3:941–946**  
 acculturative stress and, **3:946–952**  
 adaptational theory and, **2:546**  
 colonialism and, **3:1061–1063**  
 crisis counseling and, **2:546**  
 cultural paranoia and, **3:1093–1094**  
 culture shock and, **3:1106–1107**  
 definition of, **3:956**  
 empowerment of clients and, **3:956**  
 future directions regarding, **3:956**  
 healthy paranoia and, **3:1153–1154**  
 important distinctions regarding, **3:956**  
 integration vs. marginalization strategy and, **3:956**  
 person-environment fit and, **3:956**  
 psychological vs. sociocultural adaptation and, **3:956**



- psychotherapy goal of, **3:956**
- unhealthy cultural aspects ignored by, **3:956**
- Western individualistic point of view, **3:956**
- See also* **Adaptive behavior testing**
- Adaptive Behavior Assessment System—Second Edition (ABAS-2), **2:456**
- Adaptive behavior testing, 2:455–457**
  - Adaptive Behavior Assessment System—Second Edition (ABAS-2) and, **2:456**
  - American Association on Mental Retardation and, **2:456**
  - application for, **2:456**
  - assessment of, **2:455–456**
  - conceptual, social, practical skills of, **2:455**
  - definition of, **2:455**
  - IDEA and, **2:456**
  - intellectual functioning vs., **2:455**
  - norm-referenced measurement of, **2:455–456**
  - Scales of Independent Behavior-Revised (SIB-R) and, **2:456**
  - Vineland Adaptive Behavior Scales, Second Edition (Vineland-II) and, **2:456**
- Adaptive information processing model.
  - See* **Eye movement desensitization and reprocessing (EMDR)**
- ADHD. *See* **Attention deficit/hyperactivity disorder (AD/HD)**
- Adjustment disorders, **1:100**
- Adjustment to Work* (Minnesota Work Adjustment Project), **4:1655**
- Adler, Alfred, **1:9, 1:327**
  - counseling, psychotherapy influence of, **1:121**
  - See also* **Adlerian therapy**
- Adler, Nancy E., **3:1328**
- Adler, Ronald, **3:1066**
- Adlerian therapy, 2:457–459**
  - child play therapy and, **2:458**
  - classic therapeutic approaches and, **2:458**
  - cognitive-behavioral therapy and, **2:458–459**
  - couples complementarity therapy and, **2:458**
  - current status and future trends of, **2:458–459**
  - Rudolf Dreikurs and, **2:457**
  - family therapy using, **2:458**
  - forms of, **2:458**
  - individual psychology emphasis of, **2:457**
  - International Committee for Adlerian Summer Schools and Institutes and, **2:459**
  - “living as-if” technique and, **2:458**
  - Harold Mosak’s pushbutton technique and, **2:458**
  - North American Society for Adlerian Psychology and, **2:459**
  - paradoxes used in, **2:720**
  - phase 1 of, establishing the therapeutic relationship, **2:457**
  - phase 2 of, semistructured interview, lifestyle assessment process, **2:457–458**
  - phase 3 of, insight of client’s private logic, **2:457–458**
  - phase 4 of, reorient clients from dysfunctional to healthy, meaningful goals, **2:458**
  - Philosophy of As-If* (Vaihinger) and, **2:459**
  - positioning and, **2:721**
  - processes of, **2:457–458, 2:735**
  - pursuit of life’s goals and, **2:457**
  - social interest leads to psychological health and, **2:457**
  - “spitting in the soup” technique and, **2:458**
  - Systemic Training for Effecting Parenting (STEP) model and, **2:458**
  - theoretical basis of, **2:457**
  - unhealthy goal striving and, **2:457**
- Adolescent Coping Orientation for Problem Experiences Scale (A-COPES), **2:528**
- Adoption and Safe Families Act (1997), **3:1234**
- Adult Behavior Checklist (ABCL) Achenbach behavior rating scale, **1:46–47**
- Adult Career Concerns Inventory (ACCI), 4:1400–1401**
  - disengagement stage of occupational cycle and, **4:1400, 4:1646, 4:1649**
  - establishment stage of occupational cycle and, **4:1400, 4:1646, 4:1649**
  - implementation stage of occupational cycle and, **4:1400, 4:1646**
  - specification stage of occupational cycle and, **4:1400**
  - Super’s model of career adaptability in adulthood and, **4:1400, 4:1646, 4:1650**
- Adult development, 1:8–12**
  - activity theory of, **1:10**
  - adults in transition and, **4:1401–1404**
  - bioecological theory of, **1:10**
  - career/life paradigm and, **4:1488–1490**
  - developmental counseling and therapy and, **2:561–568**
  - development definition and, **1:8**
  - engagement theory of, **1:10**
  - epigenetic approach to, **1:10**
  - fourth force theory of, **1:11**
  - future directions in, **1:11–12**
  - gerontology and, **1:231–234**
  - historical synopsis of, **1:9**
  - holistic models of, **1:10–11**
  - integral psychological model of, **1:11**
  - learning process and, **1:9**



- life transitions and, 2:678–681
- maturation process and, 1:9
- multidimensional models, 1:10
- observational learning model of, 1:10, 2:741
- observer effect, quantum theory and, 1:11
- ontogenetic models of, 1:9–10
- psychological, biological, social levels of, 1:8–9
- retirement and, 1:371–375
- sociogenic models of, 1:10
- stream of consciousness model of, 1:11, 2:744
- systems theory of, 1:10–11
- theories of, 1:9
- transpersonal models of, 1:11
- wellness theory of, 1:10
- work-family balance and, 4:1680–1684
- See also Adults in transition; Counseling the elderly*
- Adult Self-Report (ASR) Achenbach behavior rating scale, 1:47
- Adults in transition, 4:1401–1404**
  - aging and, 1:14–17
  - anticipated career transitions and, 4:1401
  - career adaptability concept and, 4:1402
  - career construction theory and, 4:1403
  - career/life paradigm and, 4:1488–1490
  - career maturity concept and, 4:1402
  - career pathing model and, 4:1403
  - counseling implications of, 4:1403
  - globalization demands and, 4:1402, 4:1404
  - health-related changes and, 4:1404
  - immigrants' stress and, 4:1404
  - industrialization and, 4:1402
  - life transitions and, 2:678–681
  - moving in career transition stage and, 4:1402
  - moving through career transition stage and, 4:1402
  - moving out career transition stage and, 4:1402–1403
  - moving in again career transition stage and, 4:1403
  - nonevents and, 4:1401
  - retirement and, 1:371–375, 4:1403–1404
  - Carol D.Ryff's work in, 2:842–843
  - stages of, 4:1402–1403
  - technology development and, 4:1402
  - theoretical background regarding, 4:1402
  - unanticipated career transitions and, 4:1401
  - vocational choice research and, 4:1405
  - women's career development and, 4:1403
- Advanced directives
  - California Natural Death Act and, 1:151
  - living will and, 1:151, 1:245
  - Patient Self-Determination Act (1990) and, 1:151
  - "terminal sedation" and, 1:151
- Adventure therapy, 1:12–14**
  - Association of Experiential Education and, 1:12
  - debriefing importance in, 1:13
  - effectiveness, efficacy of, 1:13–14
  - ethical constraints in, 1:13
  - examples of, 1:12
  - frontloading procedure in, 1:13
  - group psychotherapy and, 1:12
  - history of, 1:12
  - isomorphic connection in, 1:13
  - Moreno's psychodrama innovations and, 1:12
  - nature of, 1:13
  - Outward Bound and, 1:12
  - physical activity counseling and, 2:777–779
  - play therapy and, 1:331–334
  - Project Adventure, 1:12
  - sequence importance in, 1:13
- AERA. *See* American Educational Research Association (AERA)
- Affect (mood states), assessment of, 2:459–465**
  - Beck Anxiety Scale, 2:462
  - Beck Depression Inventory, 2:463
  - bipolar disorder and, 2:477–479
  - broad-band measures of anxiety and, 2:461–462
  - broad-band measures of depression and, 2:462–463
  - broad-band mood survey and, 2:460–461
  - clinical interview, self-report inventory, projective tests and, 2:462–463, 2:490–491
  - Depression index of SCL-90-R, 2:463
  - Depressive Adjective Check List (DACL), 2:462
  - evaluation of scales and, 2:464–465
  - "faked" responses and, 2:460
  - Guilford Zimmerman Temperament Survey (GZTS), 2:460–461
  - Hamilton Depression Scale, 2:463
  - measures of hostility, 2:464
  - measures of mania, 2:463–464
  - Millon Clinical Multiaxial Inventory-III, Anxiety Clinical Scale, 2:461
  - Millon Clinical Multiaxial Inventory-III, depression-related scales, 2:463
  - Millon Clinical Multiaxial Inventory-III, Hypomania clinical scale, 2:464
  - Minnesota Multiphasic Personality Inventory (MMPI-2), Megargee's Overcontrolled Hostility Scale, 2:464
  - Minnesota Multiphasic Personality Inventory-2 (MMPI-2), anxiety-related scales, 2:461
  - Minnesota Multiphasic Personality Inventory-2 (MMPI-2), Bipolar: mania scale of, 2:464



- Minnesota Multiphasic Personality Inventory-2 (MMPI-2), Cook-Medley hostility scale, **2:464**
- Minnesota Multiphasic Personality Inventory-2 (MMPI-2) Depression-related scales, **2:462**
- mood assessment methods and, **2:460**
- narrow-band measures of anxiety and, **2:462**
- narrow-band measures of depression, **2:463–464**
- Personality Assessment Inventory, Anxiety Scale, **2:461**
- Personality Assessment Inventory, Depression scale of, **2:463**
- Personality Assessment Inventory, Mania scale, **2:464**
- probes and, **2:460**
- psychasthenia, neurotic anxiety measurement and, **2:461**
- psychometric properties of tests, scales and, **2:460**
- reliability, validity of instruments and, **2:460**
- Rorschach Inkblot Test, Depression Index, **2:463**
- semi-structured clinical interview of mood assessment and, **2:460**
- Sixteen Personality Factors Questionnaire, **2:461–462**
- structured clinical interview of mood assessment and, **2:460**
- Structured Interview for DSM-IV Personality, **2:460**
- Symptom Check-List-90 Revised, **2:462**
- Symptom Check-List-90 Revised, Depression scale, **2:463**
- Symptom Check-List-90 Revised, Hostility scale, **2:464**
- unstructured interview of mood assessment and, **2:460**
- Affirmative action, 3:957–958**
- Civil Rights Act of 1964 and, **3:1123**
- controversy regarding, **3:957, 3:1117, 3:1122, 3:1224–1225**
- counseling implications of, **3:957–958**
- definition of, **3:1123**
- explanation of, **3:957**
- in higher education, **3:1122–1123**
- model minority myth and, **3:1213**
- multicultural counseling competence and, **3:1123–1124**
- myths regarding, **3:1122, 3:1213**
- NAACP and, **3:1239**
- organizational diversity and, **3:957–958, 3:1122, 3:1123, 3:1249**
- past discrimination vs. diversity and, **3:957, 3:1117, 3:1225**
- preferences for women and minorities and, **3:957**
- President Johnson's Executive Order 11246 and, **3:957, 3:1123**
- President Kennedy's Executive Order 10924 and, **3:1123**
- quotas and, **3:957**
- Regents of the University of California v. Bakke* and, **3:957, 3:1224**
- reverse discrimination argument against, **2:572, 3:957, 3:1117, 3:1224**
- social justice and, **3:957**
- tokenism and, **3:1349–1350**
- Melba J. T. Vasquez and, **1:439–441**
- workplace affirmative action and, **3:1123**
- African Americans, 3:958–963**
- achievement gap and, **3:952–955, 3:1339**
- African National Congress and, **3:1240**
- Afrocentricity/Afrocentrism and, **3:961, 3:963–965, 3:1100**
- Association of Black Psychologists and, **3:1004–1005**
- Rosie Phillips Bingham and, **1:53–55**
- the Black church and, **3:960–961**
- Black English and, **3:1032–1033**
- Black Nationalism and, **3:1240**
- Black psychology and, **3:1033–1036**
- Black Racial Identity Attitudes Scale and, **3:1287, 3:1292**
- Black racial identity development and, **3:1036–1038, 3:1229, 3:1285, 3:1287–1288, 3:1296–1297**
- Black Rage* (Grier and Cobbs) and, **3:1092, 3:1093**
- Blacks native born vs. Black immigrants and, **3:958**
- Brown v. Board of Education of Topeka, Kansas* and, **3:1047**
- career counseling for, **4:1438–1440**
- Civil Rights Act of 1964 and, **3:1238**
- Civil Rights Act of 1991 and, **3:1239**
- civil rights of, **3:1047–1048**
- Kenneth Bancroft Clark and, **3:1050–1052**
- client–therapist ethnic matching and, **3:945**
- cognitive-behavioral therapy, irrational thoughts work and, **3:962**
- collectivistic culture of, **3:1060, 3:1096**
- Congress on Racial Equality and, **3:1238**
- Cross Racial Identity Scale (CRIS) and, **3:1035, 3:1078, 3:1079, 3:1080, 3:1287–1288**
- cultural mistrust and, **3:962**
- cultural paranoia of, **3:962, 3:1093**
- cultural psychoeducation concerns and, **2:801**
- cultural values relevant to, **3:959, 3:1096, 3:1100**
- culture-specific coping and, **3:1297–1298**
- deficit hypothesis and, **3:1109, 3:1110**
- discrimination against, **4:1631, 4:1633, 4:1634**
- doll study of racial identity and, **3:1050, 3:1135, 3:1291, 3:1296**
- drapetomania and, **3:1124–1125**
- W. E. B. Du Bois and, **3:1238**
- education statistics regarding, **3:1328**
- ethnic term history and, **3:958**



- Eurocentrism of mental health professionals and, 3:1148  
 extended family experience of, 2:801, 3:1096  
 families and, 3:959–960, 3:1096  
 family secret issues and, 3:962  
 14th Amendment and, 3:1047  
 future directions regarding, 3:963  
 healthy paranoia and, 3:1153  
 HIV/AIDS, Black women and, 3:1316  
 household, family structure demographics and, 3:1112  
 “inassimility” of, 3:1002  
 inequities faced by, 3:959  
 institutional racism and, 3:959  
 intelligence tests and, 3:1180  
 Jim Crow laws and, 3:1047  
 Martin Luther King, Jr. and, 3:1047, 3:1238  
 Kwanzaa and, 3:1035, 3:1189–1190  
 legacy of enslavement, racism and, 3:959  
*Loving v. Virginia* and, 3:1183, 3:1184, 3:1233  
 Malcolm X and, 3:1048  
 March on Washington (1963) and, 3:1238  
 mental health care needs statistics of, 3:1112  
 mental health disparities regarding, 3:959  
 Montgomery Bus Boycott and, 3:1238  
 multicultural counseling competence and, 2:539, 3:960, 3:961  
 Multidimensional Inventory of Black Identity (MIBI) and, 3:1288  
 NAACP and, 3:1047  
 National Study of Black Americans and, 3:1292  
 Niagara movement and, 3:1238–1239  
 Nineteenth Amendment and, 3:1047  
 one-drop rule and, 3:1027, 3:1028, 3:1183  
 pan-Africanist movements and, 3:1240  
 paranoid schizophrenia overdiagnosis in, 3:962  
 Rosa Parks and, 3:1048, 3:1238  
 People of Color Racial Identity Attitudes Scale (POCRIAS) and, 3:1289  
*Plessy v. Ferguson*, “separate but equal” and, 3:1047  
 poverty statistics regarding, 3:1265, 3:1326  
 prayer coping mechanism and, 3:960  
 psychosocial stressors and, 3:959, 3:960  
 racial category vs. ethnicity and, 3:958  
 racial microaggressions and, 3:962  
 racism related stress and, 3:961  
 referral sources and, 3:962–963  
 resilience of, 3:959, 3:963  
 role flexibility of, 3:1096  
 Scale of Racial Socialization and, Cultural Pride Reinforcement subscale of, 3:1292  
 self-identification and labeling and, 3:958  
 smoking behavior and, 1:93  
 socioeconomic status and, 3:960  
 Southern Christian Leadership Conference and, 3:1238  
 stereotypes regarding, 3:1010, 3:1336  
 stereotype threat and, 3:1339  
 structured clinical interview and, 3:961  
 Student Nonviolent Coordinating Committee and, 3:1238  
 teenage pregnancies and, 2:679  
 therapeutic considerations regarding, 3:960, 3:961–962  
 Thirteenth Amendment and, 3:1047  
 transracial adoption and, 3:1234, 3:1353  
 underutilization of counseling services by, 3:962–963, 3:1157  
 U.S. Census Bureau statistics regarding, 3:958  
 Voting Rights Act of 1965 and, 3:1238  
 within-group differences, cultural identity and, 3:959  
*See also Afrocentricity/Afrocentrism; Black psychology; Career counseling, African Americans; Discrimination; Racial identity; Racial microaggressions; Racism*  
 African American Vernacular English (AAVE), 3:1032  
 African National Congress, 3:1240  
 African Self-Consciousness Scale, 3:1035  
 African Value for Children Scale, 3:1035  
**Afrocentricity/Afrocentrism, 3:963–965**  
   affective inclusive metaphysical epistemology in, 3:964  
   African-centered psychology and, 3:964–965  
   African-centered worldview and, 3:961, 3:964, 3:1100  
   African National Congress and, 3:1240  
   African world civilization periods and, 3:964–965  
   ancestor veneration theme of, 3:964  
   background regarding, 3:964  
   Black English and, 3:1032–1033  
   Black Nationalism and, 3:1240  
   Black psychology and, 3:1033–1036  
   Black racial identity development and, 3:1036–1038  
   Madonna G. Constantine and, 3:1070  
   consubstantiation belief of, 3:1100  
   cultural consciousness of, 3:964  
   explanation of, 3:964–965  
   family values in, 3:1100  
   future directions regarding, 3:965  
   individual and institutional African-centered thought and, 3:965  
   Kwanzaa and, 3:1189–1190  
   pan-Africanist movements and, 3:1240  
   respect of elderly and, 3:1272  
   self-knowledge importance and, 3:1100  
   social collectivity theme of, 3:964  
   *The Souls of Black Folk* (Du Bois) and, 3:964



- spiritual basis of existence theme of, **3:964**  
 Western “different equals deficient” logic vs., **3:965**  
 Afrocentrism Measure, **3:1035**  
 AGCT. *See* Army General Classification Test (AGCT)  
 Ageism  
   definition of, **2:574**  
   power, powerlessness and, **3:1272**  
   against youth, against elderly and, **2:574**  
 Agency for Health Care Policy and Research, **1:173, 1:175**  
 AGHE. *See* Association for Gerontology in Higher Education (AGHE)  
**Aging, 1:14–18**  
   ageism and, **1:15, 2:574, 3:1272**  
   appearance aging and, **1:16**  
   cellular aging and, **1:16**  
   cognitive decline and, **1:17**  
   core self theories and, **1:15**  
   cross-cultural research on, **3:1084–1085**  
   dementia and, **1:17**  
   dynamic theories and, **1:15**  
   elder abuse and, **2:447–448**  
   forgiveness and, **2:606**  
   future directions in, **1:17**  
   genetic aging and, **1:15**  
   gerontology and, **1:231–234**  
   health problems of, **1:16–17**  
   life expectancy context of, **1:14**  
   life transitions and, **2:678–681**  
   psychosocial theories of, **1:15**  
   retirement and, **1:371–375**  
   Carol D. Ryff’s work in, **2:842–843**  
   self-esteem and, **2:866**  
   senses dulling and, **1:16**  
   sexual response and, **1:16**  
   stigmas attached to, **1:154**  
   stratification theories and, **1:15**  
   workforce aging and, **4:1586**  
   “young-old,” “old-old,” “oldest old” and, **1:14**  
   *See also* **Counseling the elderly**  
 AGPA. *See* American Group Psychotherapy Association (AGPA)  
 Ahluwalia, Ekta, **3:1093**  
 AIM. *See* American Indian Movement (AIM)  
 Ajzen, I., **1:287**  
 Akbar, Na’im, **3:964**  
 Akbar’s classification of mental disorders, **3:1034**  
**Alaska Natives, 3:965–971**  
   acculturation stresses experience by, **3:965–966**  
   Alaska Indians, **3:966**  
   alcohol and drug abuse/dependence and, **3:968**  
   Aleuts, **3:966**  
   cultural, economic, and social transition of, **3:967–968**  
   culturally sensitive treatment and, **3:969–970**  
   demographics of, **3:965**  
   economic life of, **3:967**  
   enslavement by Europeans and, **3:967**  
   Eskimos (Inuit), **3:966**  
   eye contact, body language of, **2:539**  
   family and community breakdown and, **3:967**  
   household, family structure  
     demographics and, **3:1112**  
   Indian Health Service and, **3:1174–1176**  
   maladaptive coping strategies of, **3:967–968**  
   mental health issues and, **3:968–969**  
   mental health issues and, future directions  
     regarding, **3:970**  
   Native-based career counseling and, **3:970**  
   poverty statistics regarding, **3:1326**  
   psychological treatment/community action  
     model and, **3:970**  
   social challenges of, **3:967–968**  
   treatment issues and, **3:969–970**  
   Workforce Investment Act and, **3:970**  
 Alcohol abuse. *See* **Substance abuse and dependence**  
**Alcoholics Anonymous (A. A.), 1:18–21**  
   abstinence vs. controlled drinking and, **1:18, 1:19**  
   Al-Anon, Alateen and, **1:19**  
   counseling strategy and, **1:19–20**  
   court ordered attendance and, **1:19**  
   criticisms of, **1:19**  
   downside to, **1:19**  
   dual addictions and, **1:19**  
   Gamblers Anonymous and, **1:229**  
   healing properties of, **1:20**  
   higher power component of, **1:19**  
   medical component of alcoholism and, **1:19**  
   meetings structure and, **1:18**  
   mutual help foundation of, **1:18, 1:19**  
   philosophy of, **1:18**  
   powerlessness over addictions and, **3:1271**  
   sponsorship in, **1:18–19**  
   Twelve Steps foundation of, **1:18, 1:19, 1:20, 2:894**  
 Alcohol Use Disorders Identification Test (AUDIT), **2:896**  
 Aldwin, C., **1:10**  
 Aleuts, **3:966**  
 Alexander, James, **1:327**  
 Alien Land Law (1913), **3:1373**  
 Al-Krenawi, Alean, **3:989**  
 Allen, Frederick, **1:332**  
 All Handicapped Children Act (1975), **1:250**



**Allocentrism, 3:971–972**

- collectivism and, 3:971, 3:1059–1061
- contextualized multidimensional nature of, 3:971
- cross-cultural counseling implications of, 3:971–972
- current research and, 3:971
- definition of, 3:971
- future directions regarding, 3:971–972
- high self-esteem, self-efficacy and, 3:971
- idiocentrism and, 3:971, 3:1168
- INDCOL scale and, 3:971
- individualism-collectivism scales, 3:971
- intergenerational conflict and, 3:972
- multimethod measures of, 3:971
- positive interpersonal relations and, 3:971
- Self-Construct Scale and, 3:971
- vertical and horizontal tendencies in, 3:971

**Allport, Gordon**

- humanistic psychology focus of, 2:782
- Personality: A Psychological Interpretation*  
written by, 2:736
- psychological model of prejudice and, 3:1294
- social cognitive theory of, 3:1114
- trait theory of, 2:736, 2:752, 2:770

**Allport-Vernon-Lindzey Study of Values, 2:906****Alston, Reginald, 3:1093****Altmaier, Elizabeth M., 1:21–22**

- anxiety management for oncology patients and, 1:21
- APA positions held by, 1:22
- Dorothy Booz Black Award received by, 1:21
- counseling psychology career of, 1:21
- health psychology focus of, 1:21
- NCAA activities of, 1:22
- scholarly work produced by, 1:22
- stress and pain management focus of, 1:21

**Alzheimer's disease, 1:17**

- American Psychiatric Association diagnostic  
criteria of, 2:557
- caregiver burden research and, 1:63
- causes of, 2:557
- symptoms of, 2:557
- three stages of, 2:557

**AMCD. *See* Association for Multicultural Counseling and Development (AMCD)****Amerasia Journal, 3:994****American Academy of Counseling Psychology (AACoP)**

- candidate requirements and, 1:144
- education role of, 1:143
- examination process responsibilities of, 1:144
- functions of, 1:143–144
- government advocacy by, 1:143

**oral examination and, 1:144****professional self study, case study requirements of, 1:144****Senior Option and, 1:144****American Academy of Pediatrics, 1:114–115****American Academy of Pediatrics Committee on School Health, 1:288–289****American Association for Counseling and Development (AACD), 4:1447****American Counseling Association name****change and, 1:126****continuing education endorsed by, 1:111****professional identity, commitment focus of, 1:125****American Association for Marriage and Family Therapy (AAMFT), 1:138, 1:206****American Association for State Counseling Boards, 4:1639****American Association of Applied and Preventive****Psychology (AAAPP), 1:347****American Association of Marriage and Family Counselors (AAMFC), 1:138****American Association of Marriage Counselors****(AAMC), 1:137****American Association of Suicidology, 2:899****American Association on Mental Retardation (AAMR)*****Mental Retardation: Definition, Classification,******and Systems of Supports, Tenth Edition* (AAMR)****and, 1:294****American Board of Counseling Psychology (ABCP),****1:143–144, 1:397–398****American Board of Genetic Counseling (ABGC),****1:230, 1:231****American Board of Professional Psychology (ABPP)****American Academy of Counseling Psychology****and, 1:143****American Board of Counseling Psychology and, 1:143****Certified Group Psychotherapist in, 2:621****specialty recognition by, 1:395, 1:396–397****American College Test (ACT), 2:450, 4:1393****ACT World-of-Work Map and, 4:1495, 4:1527, 4:1527****(figure), 4:1528, 4:1587–1588, 4:1668****Career Planning Survey and, 4:1495–1496*****See also* DISCOVER; Unisex Edition of the ACT****Interest Inventory (UNIACT)****American Counseling Association (ACA),****1:5–6, 1:355, 4:1447****ACA Foundation and, 1:353****ACA insurance trust and, 1:353****Patricia Arredondo and, 3:992****career counseling organizations and, 4:1461****continuing education endorsed by, 1:111****conversion therapy opposed by, 1:114–115**



- history of, **1:107, 1:126**  
 International Association of Marriage and Family Counselors (IAMFC) and, **1:206**  
 Allen Ivey and, **1:267**  
 National Board for Certified Counselors (NBCC) and, **1:142**  
 National Career Development Association and, **4:1582**  
 rehabilitation counseling and, **2:831**  
 religion/spirituality issues and, **2:880**  
 specialties and subspecialties within, **1:107**  
 standards and competencies and, **4:1639**  
 supervision ethical guidelines and, **1:409**  
*See also* American Counseling Association (ACA): code of ethics  
 American Counseling Association (ACA): code of ethics, **1:182, 1:183**  
 assessment instrument use (E) and, **1:180**  
 assessment instrument use (E) and, administration of, **1:180**  
 assessment instrument use (E) and, forensic, legal proceedings evaluation and, **1:180**  
 assessment instrument use (E) and, multicultural issues and, **1:180**  
 assessment instrument use (E) and, results interpretation and, **1:180**  
 assessment instrument use (E) and, results security, **1:180**  
 avoiding harm (A) and, **1:177**  
 career counseling of immigrants and, **4:1452**  
 client-counselor relationship (A) and, **1:177, 2:495–496, 3:1046**  
 client-counselor roles (A) and, **1:177**  
 client discrimination (C) issue and, **1:179**  
 client record handling (B) and, **1:179**  
 clients' welfare (A) and, **1:177, 3:1046**  
 confidentiality issue (B) and, **1:178**  
 counselor advertising (C) and, **1:179**  
 counselor consultation services (D) and, **1:179–180**  
 counselor knowledge of standards (C) and, **1:179**  
 counselor professional competence (C) and, **1:179**  
 counselor professional qualifications (C) and, **1:179**  
 counselor relationship with other professionals (D) and, **1:179–180, 2:496**  
 counselor-research participant relationships (G) and, **1:181–182**  
 counselor responsibilities as researcher (G) and, **1:181**  
 counselors' responsibilities to the public (C) and, **1:179**  
 disclosure of client information (B) and, **1:178**  
 disclosure of client information (B) and, content vs. contact and, **2:519**  
 ethical issue resolution (H) and, **1:182**  
 fees, bartering (A) issue and, **1:178**  
 group and family counseling (B) and, **1:178–179**  
 group work (A) and, **1:177**  
 informed consent (A) and, **1:177**  
 informed consent (B) and, **1:178**  
 informed consent (B) and, clients' capacity to give, **1:179**  
 informed consent (E) and, assessment instruments, **1:180**  
 professional relationships of client (A) and, **1:177**  
 research and training issue (B) and, **1:179**  
 research result accuracy (G) and, **1:182**  
 rights of research participants (G) and, **1:181**  
 Section A of, **1:177–178**  
 Section B of, **1:178–179**  
 Section C of, **1:179**  
 Section D of, **1:179–180**  
 Section E of, **1:180**  
 Section F of, **1:180–181**  
 Section G of, **1:181–182**  
 Section H of, **1:182**  
 standards and competencies and, **4:1639**  
 supervision, training, teaching issues (F) and, **1:180–181**  
 supervision, training, teaching issues (F) and, counselor-student relationships and, **1:181**  
 supervision, training, teaching issues (F) and, student evaluation, remediation and, **1:181**  
 supervision, training, teaching issues (F) and, students' responsibilities and, **1:181**  
 supervision, training, teaching issues (F) and, students' welfare and, **1:181**  
 supervision, training, teaching issues (F) and, supervisor's responsibilities and, **1:180–181, 1:409**  
 technology integration (A) issue and, **1:178**  
 terminally ill client issues (A) and, **1:177–178**  
 termination, referral issues (A) and, **1:178**  
 translation guidelines and, **3:1351**  
 American Educational Research Association (AERA), **2:531, 4:1639**  
 American Eugenics Society (1923), **1:193**  
 American Group Psychotherapy Association (AGPA), **2:621**  
 American Indian Civil Rights Act (1968), **3:1048**  
 American Indian Movement (AIM), **3:1048**  
**American Indians, 3:972–977**  
 acculturation and, **3:973, 3:976**  
 American Indian Civil Rights Act (1968), **3:1048**  
 American Indian critical race studies and, **3:1074–1075**  
 American Indian Movement (AIM) and, **3:1048**  
 assimilation era and, **3:973, 3:1002**  
 blood quantum criteria and, **3:973, 3:1045, 3:1183**  
 Bureau of Indian Affairs and, **3:1038–1041**  
 career counseling for, **4:1456–1458**



Certificate of Degree of Indian Blood and, 3:1046  
 civil rights struggle of, 3:1048  
 counseling implications and, 3:976  
 criminal statistics regarding, 3:975  
 cultural genocide experiences of, 3:973  
 cultural paranoia of, 3:1093  
 cultural psychoeducation concerns and, 2:801  
 cultural values of, 3:1100  
 deficit hypothesis and, 3:1109  
 demographics of, 3:973  
 discrimination experienced by, 4:1634  
 elder population of, 3:973  
 federal tribe recognition and, 3:973  
 within group differences and, 3:973  
 health care services and, 3:975–976  
 health issues of, 3:974–976  
 historical and current traumas of, 3:973, 3:976,  
     3:1045, 4:1631, 4:1633  
 household, family structure demographics and, 3:1112  
 Indian Adoption Project and, 3:1353  
 Indian Child Welfare Act (ICWA, 1978) and, 3:974,  
     3:975, 3:1353  
 Indian Health Care Improvement Act (IHCIA) and, 3:1174  
 Indian Health Service and, 3:975–976, 3:1174–1176  
 Indian mascot issue and, 3:1325, 3:1379  
 Indian Reorganization Act (1934) and, 3:1048  
 Indian Territory, 3:1039, 3:1048  
 intelligence tests and, 3:1180  
 Teresa Davis LaFromboise and, 3:1191–1192  
 linguistic diversity among, 3:973  
 Manifest Destiny era and, 3:972–973  
 mental health and, 3:976  
 multicultural counseling and, 2:539  
 myths regarding, 3:974  
 Native Veterans and, 3:976  
 oppression-linked pathologies of, 3:1246  
 pan-Indian organizations and, 3:1048  
 pre-contact history of, 3:972–974  
 PTSD and, 3:976  
 Quarter Blood Amendment Act (1985) and, 3:1045  
 racial identity of, 3:1289  
 respect of elderly and, 3:1272  
 self-determination era of, 3:973  
 socioeconomic disparities of, 3:973, 3:1048  
 spirituality cultural value of, 3:1101  
 termination period and, 3:973  
 traditional interventions and, 3:976  
 Trail of Tears and, 3:1048, 3:1062  
 transracial adoption and, 3:1353  
 tribal diversity, intermarriage and, 3:973, 3:974

tribal enrollments and, 3:973, 3:1045  
 Joseph E. Trimble and, 3:1355–1356  
 urban health and mental health services and, 3:976  
 Urban Indian Health Programs and, 3:1174, 3:1175  
 youth gangs and, 3:975

*See also* **Alaska Natives; Career counseling, Native Americans**

### **American Jews, 3:977–983**

American Jewish identity term and, 3:979  
 antisemitism and fear and, 3:980  
 Ashkenazim lineage of, 3:978  
 bicultural experience of, 3:975  
 common history, ethnocultural heritage and, 3:977  
 conclusions regarding, 3:982–983  
 Conservative Jews, 3:978  
 core Jews construct and, 3:979  
 counseling issues with, 3:981–982  
 definitional terms and, 3:977–978  
 demographics of, 3:977  
 disclosure and identification and, 3:982  
 diversity of denominations and, 3:978–979  
 diversity of heritage and, 3:978  
 dynamic construct and, 3:979  
 empirical research regarding, 3:979–980  
 family importance and, 3:982  
 Sigmund Freud and, 3:981  
 Hasidic Jews, 3:978  
 healthy paranoia and, 3:982  
 identity of, 3:979–980, 3:982  
 immigration and acculturation of, 3:979  
 Jewish Americans vs., 3:975–976  
 Jewish identity term and, 3:979  
 Mizrachim lineage of, 3:978  
 multidimensional construct regarding, 3:979  
 nomadic, Diaspora heritage of, 3:978  
 Non-Hasidic Orthodox Jews, 3:978  
 numerical minority and, 3:981  
 oppression and marginalization of, 3:980, 3:981  
 origins of counseling and, 3:981  
 presenting concerns of, 3:982  
 privilege, passing and, 3:981  
 psychological stressors and, 3:980–981  
 Reconstructionist Jews, 3:978–979  
 Reform Jews, 3:978–979  
 the self-hating Jew and, 3:980, 3:984, 3:985  
 semantic characterization of, 3:975–976  
 Sephardim lineage of, 3:978  
 the Shoah and, 3:980, 3:981  
 therapeutic relationship and, 3:982, 3:985  
*See also* **Antisemitism**



- American Mental Health Counseling Association (AMHCA), **1:125**
- American Music Therapy Association (AMTA), **1:305**
- American National Standards Institute, **4:1638**
- American Personnel and Guidance Association (APGA), **1:5**
- code of ethics of, **1:124**
- divisions of, **1:125**
- formation of, **1:107, 1:123, 4:1447**
- licensure and, **1:125**
- name change of, **1:125**
- American Psychiatric Association
- conversion therapy opposed by, **1:114–115**
- practice guidelines of, empirically based professional practice and, **1:173, 1:174, 1:175**
- psychologist prescription privileges and, **1:347**
- American Psychological Association (APA)
- Ad Hoc Committee of Equality of Opportunity in Psychology and, **1:370**
- annual conference of, **1:103, 1:104**
- Archival Description of Counseling Psychology* (APA) and, **1:127**
- Patricia Arredondo and, **3:992**
- Asian American issues and, **2:994**
- Asian American Psychological Association and, **2:994**
- Albert Bandura and, **2:468–469**
- Boulder Conference (1949) and, **1:342, 1:389–390**
- color-blind racial attitudes and, **3:1063–1064**
- Madonna G. Constantine and, **3:1069**
- consultation clarification by, **2:526**
- continuing education endorsed by, **1:111**
- conversion therapy opposed by, **1:114–115**
- Council of Representatives of, **1:131**
- The Counseling Psychologist* journal of, **1:103–104, 1:124, 1:127, 1:128–29, 1:130–131, 1:263, 1:264**
- counseling psychology defined by, **1:130**
- Christine A. Courtois and, **1:141**
- Division 12, Society for Clinical Psychology, **2:591, 2:684**
- Division 17, Advancement of Women group, **1:212–213**
- Division 17, Division of Counseling and Guidance, **1:127, 1:128**
- Division 17, Division of Counseling Psychology, **1:123, 1:124, 1:127, 1:128, 1:129**
- Division 17, International Special Interests Group, **1:260, 1:264**
- Division 17, Next Decade Project, **1:130–131**
- Division 17, Professional Affairs Committee, **1:130**
- Division 17, Society for Vocational Psychology, **4:1634–1635**
- Division 17, Society of Counseling Psychology (SCP), **1:103, 1:128, 1:132, 1:168–169, 1:267, 3:992**
- Division 17, task force on empirically validated treatments (1993-1995) and, **2:589**
- Division 29, Presidential Task Force on Evidence-Based Practice, **2:590–591, 2:626**
- Division 29, Task Force on Empirically Supported Therapy Relationships, **2:485, 2:589, 2:591–592**
- Division 35, The Psychology of Women, **1:131**
- Division 40, Neuropsychology, **2:695**
- Division 44, Society for the Psychological Study of Lesbian, Gay and Bisexual Issues, **1:369, 1:371**
- Division 45, The Society for the Psychological Study of Ethnic Minority Issues, **1:131, 1:267, 1:402, 3:992, 3:1087, 3:1242, 3:1323–1324**
- Division 52, International Psychology, **1:260**
- Louise Douce and, **1:168–169**
- ethical code standards of, **1:182, 1:183, 2:495, 3:1045–1046**
- evidence-based practice and, **1:391**
- Exercise and Sport Psychology Division of, **1:195**
- formation of, **1:107**
- Myrna L. Friedlander and, **1:219–220**
- Guidelines and Principles for Accreditation of Programs in Professional Psychology* and, **1:2, 1:4, 3:1222**
- Guidelines for Computer-Based Tests and Interpretations* and, **1:188**
- Guidelines for Providers of Psycho-Diverse Populations* and, **3:1087, 3:1222**
- Guidelines for Psychological Practice with Girls and Women* and, **1:131, 1:435**
- Guidelines for Psychotherapy with Lesbian, Gay, and Bisexual Clients* and, **1:435, 4:1624**
- Guidelines on Multicultural Education, Training, Research, Practice, and Organizational Change for Psychologists* and, **1:435, 3:991–993, 3:1064, 3:1086, 3:1087, 3:1088, 3:1222, 3:1231, 3:1351, 4:1639**
- Puncky Paul Heppner and, **2:631**
- Allen Ivey and, **1:267**
- Karen Strohm Kitchener and, **1:270**
- Frederic Kuder and, **4:1569**
- Frederick T. I. Leong and, **3:1201–1202**
- National Latina/o Psychological Association and, **3:1242–1243**
- John C. Norcross and, **1:309**
- Samuel H. Osipow and, **4:1590**
- postdoctoral training and, **1:337–339**
- practice guidelines of, empirically based professional practice and, **1:173, 1:174, 1:175**
- Practice Organization Certificates of Proficiency and, **1:145**



- psychologist prescription privileges and, 1:347, 1:349–350
- psychologists of color in, 3:1222
- Publication Manual of the American Psychological Association, Fifth Edition* and, 3:1364
- recruitment of persons of color and, 1:370
- religion/spirituality issues and, 2:880
- Helen J. Roehlke and, 1:376
- school psychology doctoral accreditation, standards and, 1:385–386
- special interest groups in, 1:369
- specialization designation and, 1:395–398
- specialties and subspecialties within, 1:107
- standards and code of conduct, content vs. contact confidentiality and, 1:435
- statistics on women in psychology and, 1:211
- Derald Wing Sue and, 1:402, 3:1342
- Task force on the Status of Women and, 1:131
- Joseph E. Trimble and, 3:1356–1357
- 2005 Presidential Task Force on Evidence-Based Practice and, 2:590–591
- Leona E. Tyler and, 1:428–430
- university counseling centers graduate training and, 1:434
- Vail Conference (1973) and, 1:337, 3:1087, 3:1222, 3:1228
- validity definition and, 2:531
- Melba J. T. Vasquez and, 1:440
- Bruce Walsh and, 4:1676
- Joseph L. White and, 3:1369, 3:1370
- See also Accreditation by the American Psychological Association (APA); Conferences, counseling psychology*
- American Psychologist* journal, 4:1677
- American Rehabilitation Counseling Association (ARCA), 2:831
- American School Counselor Association (ASCA), 1:5, 1:108, 1:123, 1:382, 4:1450, 4:1635
- American Sign Language, 1:282
- Americans with Disabilities Act (ADA)**, 1:22–26, 4:1450
- accessibility requirements focus of, 1:26
- George H. W. Bush and, 1:23
- Civil Rights Act of 1964 and, 1:23
- disability definition and, 1:23–24, 2:829
- Fair Housing Act and, 1:26
- Family and Medical Leave Act and, 1:26
- Individuals with Disabilities Education Improvement Act of 2004 and, 1:26
- major life activities defined by, 1:25
- mitigating measures defined by, 1:25–26
- Murphy v. United Parcel Service, Inc.* and, 1:25
- otherwise qualified defined by, 1:24–25
- overview and legislative background of, 1:23
- Pacourek v. Inland Steel Co.* and, 1:25
- PGA Tour, Inc. v. Martin* and, 1:25
- physical and mental impairment defined by, 1:24
- reasonable accommodations and modifications defined by, 1:26
- Rehabilitation Act of 1973 and, 1:23
- Shafer v. Preston Memorial Hospital Co.* and, 1:24
- structural barriers focus of, 1:26
- substantial limitations defined by, 1:25
- Sutton v. United Air lines, Inc.* and, 1:25
- Titles I–V of, 1:23
- Zukie v. Regents of the University of California* and, 1:24–25
- See also Low-incidence disabilities; Persons with disabilities*
- American Teachers Association (ATA), 3:1033–1034
- American Vocational Association (AVA), 4:1450
- America's Career InfoNet
- career indecision and, 4:1481
- Web site of, 4:1482
- AMHCA. *See* American Mental Health Counseling Association (AMHCA)
- AMTA. *See* American Music Therapy Association (AMTA)
- Amundson, Norman E., 4:1457
- Ancis, Julie R., 3:1286
- Andersen, Susan, 2:930
- Anderson, Arlene, 1:204
- Anderson, Linda, 3:956
- Anger management
- forensic counseling and, 1:214–215
- stress management and, 2:887
- Ani, Marimba, 3:964
- Annan, J. A., 3:1281
- Anthony, Susan B., 3:1049
- Anti-Defamation League, 3:983–984
- Antisemitism**, 3:983–985
- Anti-Defamation League poll and, 3:983–984
- anti-Jewish prejudice and, 3:984
- anti-Semitism term and, 3:983
- counseling and, 3:982, 3:985
- definition of, 2:573, 3:983
- deicide myth and, 3:984
- examples of, 3:984
- Sigmund Freud and, 2:609
- gender stereotypes and, 3:984
- Holocaust and, 2:573, 3:1132, 3:1240
- Holocaust deniers and, 2:573
- internalized antisemitism and, 3:980, 3:984, 3:985
- Nazi atrocities and, 2:573
- prevalence of, 3:983–984



- stereotypes of, **3:984**
- within-group diversity of Jews and, **3:983**
- See also* **American Jews**
- Antisocial personality disorder (ASPD)
  - characteristics of, **2:730**
  - comorbidity of, **2:733**
  - pathological gambling comorbidity with, **1:228**
- Antonovsky, Aaron, **2:782**
- Anxiety disorder**
  - AD/HD comorbidity with, **1:31**
  - benzodiazepines treatment of, **2:816**
  - bullying victims and, **1:56**
  - childhood anxiety disorder, **1:260**
  - coping efficacy and, **2:855**
  - CT, REBT interventions for, **2:510**
  - dependent personality disorder comorbidity with, **2:733**
  - exercise intervention and, **1:196**
  - Millon Clinical Multiaxial Inventory (MCMI-III)
    - measure of, **2:461**
  - Minnesota Multiphasic Personality Inventory-2 (MMPI-2) measure of, **2:461**
  - panic disorder vs., **2:717–718**
  - pathological gambling comorbidity with, **1:227**
  - Personality Assessment Inventory (PAI)
    - measure of, **2:461**
  - problem solving appraisal and, **2:790**
  - Sixteen Personality Factors (16 PF) measurement of, **2:461–462**
  - State-Trait Anxiety Inventory (STAI) and, **1:420, 2:534–535, 2:884**
  - stress and, **2:883, 2:885**
  - Symptom Check-List-90 Revised (SLC-90-R)
    - measurement of, **2:462**
- Anxiety Disorders Interview Schedule, **2:558**
- Apfelbaum, Bernard, **2:593**
- APGA. *See* American Personnel and Guidance Association (APGA)
- APIC. *See* Association of Psychology Internship Centers (APIC)
- Appraising Vocational Fitness by Means of Psychological Tests* (D. E. Super), **4:1645**
- APT. *See* Association for Play Therapy (APT)
- Aptitude testing, **2:449–450**
  - Armed Services Vocational Aptitude Battery (ASVAB) and, **1:255, 2:449**
  - Mechanical Aptitude Test and, **2:449**
  - Meier Art Tests and, **2:450**
  - multiaptitude batteries and, **2:449**
  - O'Connor Finger Dexterity Test of psychomotor aptitudes, **2:449–450**
  - Seashore Measures of Musical Talents and, **2:450**
  - Sixteenth Mental Measurements Yearbook (MMY) and, **2:450**
  - Wechsler Adult Intelligence Scale (Wais) and, **2:449**
- See also* **Achievement, aptitude, and ability tests**
- Arab Americans, 3:985–991**
  - American Arab Anti-Discrimination Committee and, **3:989**
  - anti-Arab sentiment and, **3:890, 3:988**
  - Arab American Institute (AAI) and, **3:986, 3:989**
  - Arab League nations and, **3:985**
  - collectivism focus of, **3:987**
  - counseling issues and, **3:989–990**
  - current issues regarding, **3:989**
  - definition regarding, **3:985**
  - demographics regarding, **3:985–986**
  - discrimination trauma and, **3:990**
  - educational and economic achievements of, **3:987**
  - ethnic enclaves of, **3:987**
  - ethnic identity and, **3:989, 3:990**
  - gender and family issues of, **3:987–988**
  - history and culture of, **3:986–988**
  - immigration and classification issues and, **3:988–989**
  - immigration patterns of, **3:986–987**
  - Iraq wars and, **3:988, 3:989**
  - Middle East designation and, **3:985**
  - Muslim stereotype and, **3:986**
  - nuclear family importance to, **3:988**
  - Palestine-Israel conflict and, **3:988, 3:989**
  - political leadership of, **3:987**
  - political refugees and, **3:986**
  - religion and values of, **3:987**
  - sociopolitical history of, **3:988–989**
  - stigma of mental health services and, **3:989**
  - terrorist profiling and, **3:989**
  - 2000 U.S. Census and, **3:986**
  - veiling tradition and, **3:988**
  - Web site regarding, **3:991**
- Arab League, **3:985**
- ARCA. *See* American Rehabilitation Counseling Association (ARCA)
- Archer, J., Jr., **1:432, 1:433**
- Area Redevelopment Act (1961), **4:1447**
- Argyle, Michael, **3:1327**
- Aristotle, **1:305, 2:609, 2:821**
- Armed Services Vocational Aptitude Battery (ASVAB), 4:1404–1406**
  - aptitude testing and, **2:449, 4:1393, 4:1395**
  - Career Exploration Program (CEP) and, **4:1405**
  - computer-assisted testing and, **2:939**



- enhanced ASVAB scoring and, **4:1405**  
 evaluation of, **4:1405**  
 Find Your Interests portion of, **4:1405**  
 history of, **4:1404–1405**  
 industrial/organizational psychology and, **1:255**  
 NCLB and, **4:1405**  
 norms by grade and gender of, **4:1405**  
 OCCU-Find and, **4:1405**  
 Occupational Information Network and, **4:1405**  
 test purpose and scoring of, **4:1404–1405**  
 tests of, **4:1405**  
 validity of, **4:1405**
- Army General Classification Test (AGCT), **1:255**
- Aron, Lewis, **2:763**
- Aronson, Joshua, **3:1228, 3:1339, 3:1340**
- Arredondo, Patricia, 3:991–993**  
 childhood of, **3:991**  
 dimensions of personal identity concept of,  
**3:991–992, 3:992 (figure)**  
 Empowerment Workshops, Incorporated and, **3:991**  
 honors and awards received by, **3:992–993**  
 multicultural counseling standards and competencies  
 and, **1:126, 1:131, 1:383, 3:991, 3:992, 3:1219,**  
**3:1225, 4:1639**  
 multicultural counseling training model of, **3:1088**  
 National Latina/o Psychological Association and,  
**3:992, 3:1242–1243**  
 professional associations and leadership of, **3:992**
- ARSMA. *See* Acculturation Rating Scale for Mexican  
 Americans (ARSMA)
- ARSMA-II. *See* Acculturation Rating Scale for Mexican  
 Americans-II (ARSMA-II)
- Artifacts qualitative data collection method, **1:362**
- Art therapy, 1:27**  
 applications of, **1:27**  
 for children with chronic illness, **1:79**  
 communication through, **1:27**  
 emotional, interpersonal, cognitive growth through, **1:27**  
 methods of, **1:27**  
 “milieu therapies” concept and, **1:27**  
 play therapy and, **1:331–334**  
 psychotherapy and, **1:27**  
 therapist–client relationship importance in, **1:27**
- Asante, Molefi Kete, **3:964**
- ASCA. *See* American School Counselor Association  
 (ASCA)
- ASD (autism spectrum disorders). *See* **Autism/Asperger’s  
 syndrome**
- ASEBA. *See* Achenbach System of Empirically Based  
 Assessment (ASEBA)
- ASERVIC. *See* Association for Religious and Value Issues  
 in Counseling (now ASERVIC); Association for  
 Spiritual, Ethical, and Religious Values in Counseling  
 (ASERVIC)
- ASGW. *See* Association for Specialists in Group Work  
 (ASGW)
- Ashby, Homer, **3:1093**
- Asher, I., **4:1605–1606**
- Asian American Psychological Association (AAPA),  
 3:993–995**  
 advocacy efforts of, **3:993, 3:994, 3:1222, 3:1342**  
 anti-Asian sentiment history and, **3:993**  
 APA activities of, **3:994**  
 Asian American issues in psychology and, **3:994**  
*Asian American Psychologist* newsletter of, **3:995**  
 Asian American term and, **3:993**  
 Asian stereotypes and, **3:993**  
 CNPAAMEI member organization of, **3:1242, 3:1324**  
 cofounders of, **3:994**  
 cross-cultural training and, **3:1087**  
 Division of Students of, **3:995**  
 Division on Women of, **3:995**  
 growth of, **3:993**  
 Frederick T. I. Leong and, **3:1201**  
 model minority myth and, **3:993**  
 NIMH activities of, **3:994**  
 “perpetual foreigners” stereotype and, **3:993**  
 structure of, **3:994–995**  
 Derald Wing Sue and, **1:401, 1:402, 3:994, 3:1342**  
 Stanley Sue and, **3:994**  
 U.S. Census and, **3:994**  
 Web site of, **3:995**  
 Joseph L. White and, **3:1370**
- Asian Americans, 3:995–1001**  
 acculturation and, **3:996–997**  
 Asian American acculturation style and, **3:997**  
 Asian American critical race studies and, **3:1074–1075**  
 Asian American movement and, **3:1048**  
 Asian American Psychological Association and,  
**3:993–995**  
 Asian American studies and, **3:1048**  
 authoritarian parenting style of, **3:996**  
 career counseling for, **3:996, 3:997, 4:1440–1443**  
 “Chinatowns” and, **3:1048**  
 Chinese Exclusion Act (1882) and, **3:1048**  
 Civil Liberties Act (1988) and, **3:1048**  
 civil rights of, **3:1048**  
 client–therapist ethnic matching and, **3:945, 3:999**  
 collectivistic culture of, **3:1060**  
 Confucianism and, **3:1067–1068**



counseling implications regarding, **3:995–996**, **3:998–1000**  
 counseling services barriers and, **3:998–999**  
 counselor cultural bias and, **3:998**  
 crisis-, solution-oriented, brief counseling approaches and, **3:996**  
 culturally responsive services and, **3:999–1000**  
 cultural paranoia of, **3:962**  
 cultural psychoeducation concerns and, **2:801**  
 cultural values and worldview of, **3:996**  
 demographics of, **3:1111**  
 depression, anxiety and, **3:943**  
 education statistics regarding, **3:1328**  
 ethnic identity of, **3:997–998**  
 ethnic-specific mental health services for, **3:999**  
 Eurocentrism of mental health professionals and, **3:1148**  
 family and, **3:996**  
 filial piety and, **3:1151**  
 help-seeking attitudes of, **3:997**  
 household, family structure demographics of, **3:1112**  
 Immigration Act (1924) and, **3:1048**  
 immigration history of, **3:995**  
 indigenous coping resources of, **3:998**  
 intelligence tests and, **3:1180**  
 interracial marriages and, **3:1234**  
 Japanese internment camps and, **3:1048**  
 loss of face and, **3:1205**, **4:1435**, **4:1442**  
 marginal person acculturation and, **3:997**  
 model minority myth and, **1:403**, **3:993**, **3:997**, **3:1211–1214**, **4:1435**  
 multicultural counseling and, **2:539**  
 nonparallel mental health services and, **3:999**  
 optimism, pessimism cultural factors and, **2:710**  
 “perpetual foreigners” stereotype and, **3:993**  
 poverty statistics regarding, **3:1265**  
 professional training bias, **3:998**  
 psychological distress, coping mechanisms and, **3:997–998**  
 racial identity of, **3:1289**  
 respect of elderly and, **3:1272**  
 social support and, **3:998**  
 somatic symptoms of, **3:997**  
 traditionalist acculturation and, **3:997**  
 underutilization of health services by, **3:997**, **3:998**, **3:1157**, **3:1213**, **3:1214**  
 U.S. Census data on, **3:995**  
 Western psychotherapy biases and, **3:998–999**  
 within-group differences of, **3:998**, **3:1000**  
 Yellow Power movement, **3:1048**  
*See also* **Career counseling, Asian Americans;**  
 Chinese Americans

Asociación Por La Raza, **3:1087**, **3:1222**  
 ASPD. *See* Antisocial personality disorder (ASPD)  
 Asperger, Hans, **1:34**  
 Asperger’s syndrome. *See* **Autism/Asperger’s syndrome**  
 ASPPB. *See* Association of State and Provincial Psychology Boards (ASPPB)  
 ASR. *See* Adult Self-Report (ASR) Achenbach behavior rating scale  
 Assessment  
   cultural equivalence and, **3:1091–1092**  
   underdiagnosis/overdiagnosis and, **2:935–936**  
*See also* **Affect (mood states), assessment of;**  
   **Assessment** (career assessment); **Behavioral observation methods, assessment;**  
   **Clinical interview as an assessment technique;**  
   **Cognition/intelligence, assessment of;**  
   **Functional behavioral assessment (FBA);**  
   **Language difficulties, clinical assessment of;**  
   **Memory, assessment of;**  
   **Personality assessment;**  
   **Psychopathology, assessment of;**  
   **Self-esteem, assessment of;**  
   *specific measure*  
**Assessment** (career assessment), **4:1406–1410**, **4:1407–1408**  
   Basic Interest Scales (BISs) and, **4:1407**  
   Alfred Binet and, **4:1406**  
   Campbell’s Interest and Skill Survey and, **4:1407**  
   CAPA Assessment System and, **4:1408–1409**  
   CAPA Interest Inventory and, **4:1408–1409**  
   career counselor tools and, **4:1408**  
   career self-efficacy and, **4:1406**  
   comprehensive, multivariate assessment and, **4:1407–1408**  
   Healthy Personality Inventory and, **4:1408–1409**  
   history of, **4:1406**  
   Holland’s six career dimensions and, **4:1407**  
   Holland’s six dimensions and, **4:1407**  
   Life Engagement Scales and, **4:1408–1409**  
   math cognitions and emotions example of, **4:1407**  
   personality, interests, self-efficacy, career development relationship and, **4:1408**  
   psychometrics and career assessment and, **4:1406–1407**  
   social agency and, **4:1406**  
   E. K. Strong’s Vocational Interest Blank and, **4:1406**, **4:1407**  
*See also* **Multicultural career assessment models;**  
   **Personality assessment and careers;**  
   *specific measure*  
 Assessment of Career Decision Making, **4:1658**  
 Assessment reactivity, observable data  
   validity and, **1:41**



**Assimilation, 3:1001–1004**

- acceptance by dominant group and, 3:1002, 3:1003
  - acculturation and, 3:941–946, 3:1002, 3:1003
  - acculturative stress and, 3:946–952
  - adaptation and, 3:956
  - Americanization and, 3:1001, 3:1019
  - Anglo-conformity theory and, 3:1001
  - Arab Americans and, 3:987
  - assimilating group and dominant group changes and, 3:1002–1003
  - colonialism and, 3:1061–1063
  - contemporary term use and, 3:1001
  - culture shock and, 3:1106–1107
  - direction and dominance of, 3:1002–1003
  - discrimination experiences and, 3:942, 3:1120
  - enculturation vs., 3:1130
  - ethnic pride and, 3:1142
  - group isolation and group assimilation and, 3:1002
  - historical background regarding, 3:1001
  - “inassimilable” groups and, 3:1002
  - individual vs. group assimilation and, 3:1002
  - intermarriage and, 3:1001
  - internal and external change and, 3:1002, 3:1003
  - melting pot concept and, 3:942, 3:1001, 3:1019, 3:1120, 3:1251
  - Native Americans and, 3:973
  - political vs. cultural concept of, 3:1001
  - positive orientation toward dominant group and, 3:1001, 3:1003
  - primary, secondary contacts and, 3:1001
  - process of, 3:1001–1002
  - psychological stress and, 3:1310
  - “triple melting pot” theory of, 3:1001
  - unidirectional process of (traditionally), 3:1002, 3:1003
- Assisted suicide**
- euthanasia and, 1:151, 1:245
  - therapist confidentiality and, 2:496
- Association for Adult Development and Aging, 1:369**
- Association for Applied Sport Psychology (AASP), 1:197–198**
- Association for Career and Technical Education, 4:1450**
- Association for Counselor Education and Supervision (ACES), 1:5, 1:108, 1:125**
- Association for Gay, Lesbian, and Bisexual Issues in Counseling, 1:369, 4:1624**
- Association for Gerontology in Higher Education (AGHE), 1:232**
- Association for Multicultural Counseling and Development (AMCD), 1:369**
- Patricia Arredondo and, 3:992
  - formation of, 1:125
  - gay or lesbian career counseling and, 4:1624
  - Multicultural Counseling Competencies self-assessment form of, 3:1218–1219, 3:1247, 3:1382
  - White racial identity development and, 3:1382
- Association for Play Therapy (APT), 1:333**
- Association for Religious and Value Issues in Counseling (now ASERVIC), 1:125**
- Association for Specialists in Group Work (ASGW), 1:125**
- Association for Spiritual, Ethical, and Religious Values in Counseling (ASERVIC), 1:125, 1:353, 2:881**
- Association of Black Psychologists, 1:370, 3:1004–1005, 3:1087**
- advocacy of, 3:1222
  - Asian American Psychological Association and, 3:994
  - Black psychology and, 3:1033–1036
  - CNPAAMEI member organization of, 3:1242, 3:1324
  - cross-cultural psychology and, 3:1081
  - history of, 3:1004, 3:1034
  - international component and network support systems of, 3:1005
  - Journal of Black Psychology* published by, 3:1005, 3:1034, 3:1081
  - local, state, national policies and, 3:1005
  - mission, purpose and goals of, 3:1004–1005
  - monocultural bias of mental health services and, 3:1004
  - research guidelines and standards of, 3:1005
  - self-determination focus of, 3:1004
  - structure, organization of, 3:1005
  - Joseph L. White and, 3:1369
- Association of Computer-Based Systems for Career Information, 4:1512**
- Association of Counseling Center Training Agencies (ACCTA), 1:106, 1:376–377**
- Louise Douce and, 1:168
  - university counseling centers and, 1:434
- Association of Directors of Psychology Training Clinics, 1:408**
- Association of Psychology Internship Centers (APIC), 1:342**
- Association of Psychology Postdoctoral and Internship Centers (APPIC)**
- postdoctoral training and, 1:337
  - predoctoral internships and, 1:342–345
  - Helen J. Roehlke and, 1:377
  - specialization designation and, 1:395
  - supervision competencies focus of, 1:408
  - Web site of, 1:346
- Association of State and Provincial Psychology Boards (ASPPB)**
- Certificate of Professional Qualification in Psychology (CPQ) and, 1:144–145
  - specialization designation and, 1:395, 1:396



Astin, Alexander W., **4:1536, 4:1544**

ASVAB. *See* **Armed Services Vocational Aptitude Battery** (ASVAB)

ATA. *See* American Teachers Association (ATA)

Atkins, M. S., **1:291**

**Atkinson, Donald Ray, 3:1005–1007**

books written by, **3:1007**

early career of, **3:1006–1007**

early life of, **3:1006**

gender, sexual orientation, aging, disability populations  
focus of, **3:1007**

honors and awards received by, **3:1006–1007**

indigenous healing collaboration and, **3:1177**

*Journal of Counseling Psychology* rankings and, **3:1006**

*Journal of Multicultural Counseling and Development*  
rankings and, **3:1006**

major contributions by, **3:1007**

mentoring doctoral students of color and, **3:1006**

minority identity development model of, **3:1229**

multicultural counseling theory of, **3:1007, 4:1639–1640**

published works of, **3:1006**

racial identity model work of, **3:1286**

Atkinson, John, **2:793**

Atlanta Conference of counseling psychology (1987),  
**1:104–105, 1:127**

Attachment theory

attachment therapy and, **2:629**

John Bowlby's work in, **2:629**

child's concepts of self, other, and relationships and,  
**2:629, 2:873, 4:1410**

coercive restraint therapies and, **2:629**

cognitive schemas and, **4:1410**

couple and marital counseling and, **1:138**

social support and, **2:873**

*See also* **Parenting**

**Attachment theory** (career development), **4:1410–1412**

career decision making and, **4:1410–1411**

career exploration and, **4:1410**

cognitive schemas, adaptive outcomes and, **4:1410**

occupational aspirations, expectations, career  
orientation and, **4:1411**

secure base concept and, **4:1410, 4:1411**

summary of, **4:1411**

transitions and, **4:1411**

Attention deficit disorder. *See* **Attention**

**deficit/hyperactivity disorder** (AD/HD)

**Attention deficit/hyperactivity disorder** (AD/HD),  
**1:27–34**

adults affected by, **1:28**

antecedent, behavior, and consequence paradigm

treatment of, **1:32**

behavioral interventions for, **1:32**

Behavior Assessment System for Children-2nd Edition  
and, **1:29**

Behavior Rating Scale of Executive Function (BRIEF)  
and, **1:49**

behavior rating scales of, **1:47–48**

biological component of, **1:31**

birth complications and, **1:31**

broad-band rating diagnosis of, **1:29**

Child Behavior Checklist and, **1:29**

combined subtype of, **1:28, 1:197**

comorbid disorders with, **1:31, 1:49, 1:100, 1:157**

conduct disorder and, **1:100**

Conners' Rating Scales and, **1:29, 1:48, 1:109**

continuous performance tests diagnosis of, **1:29, 1:114**

diagnostic criteria of, **1:28–29**

Diagnostic Interview for Children and

Adolescents-Revised and, **1:29**

Diagnostic Interview Schedule for Children-Version IV  
and, **1:29**

dietary factors in, **1:31**

disasters, impact on children and, **1:162**

*DSM-IV-TR* diagnostic criteria of, **1:197**

environmental variables and, **1:31**

etiology of, **1:31**

externalizing problems of childhood and, **1:197**

features of, **1:30–31, 1:197**

gender differences in, **1:28**

genetic heritability of, **1:31**

hyperactive-impulsive subtype of, **1:28, 1:197**

hyperactivity symptoms of, **1:28, 1:30**

impairment rating scales diagnosis of, **1:29**

impulsivity symptoms of, **1:30**

inattention, impulsivity, hyperactivity symptoms of, **1:28**

inattention symptoms of, **1:28, 1:30**

inattentive type of, **1:197**

interviews diagnosis of, **1:29**

learning disorders comorbidity with, **1:31, 1:49, 1:157**

Likert-type scale diagnosis of, **1:29**

making the diagnosis of, **1:29–30**

material behaviors and, **1:31**

measures for assessment of, **1:49**

not otherwise specified subtype of, **1:28–29**

observational measures diagnosis of, **1:29**

ODD and, **1:317**

parent training programs and, **1:32–33, 1:327**

parent-child conflict and, **1:30**

pathological gambling comorbidity with, **1:227**

peer relationship difficulties and, **1:30**

physiological or laboratory measures diagnosis of, **1:29**

predominately inattentive subtype of, **1:28**



- premature birth, low birth weight factors and, 1:31  
 prevalence of, 1:28  
 problem behavior symptoms of, 1:30  
 psychopharmacological treatments of, 1:31–32, 2:817  
 response cost punishment technique and, 1:33  
 self-esteem affected by, 1:30–31  
 single domain behavior rating scales and, 1:45  
 specific-labeled praise technique and, 1:33  
 stimulant medications treatment of, 1:31–32  
 time-out intervention and, 1:33  
 token economy technique and, 1:33  
 twin studies of, 1:31
- Attitudes.** *See* **Client attitudes and behaviors**
- Attneave, Carolyn, 3:1324
- Attribution theory**  
 causal attributions and, 2:744, 2:854, 2:869  
 cognitive personality theory and, 2:744  
 explanatory style concept and, 3:1200  
 fundamental attribution error and, 3:1199  
 internality, stability, globality components of  
   explanatory style and, 3:1200  
 locus of control and, 3:1204  
 meaning making and, 2:485–486  
 motivation and, 3:1204  
 optimism, pessimism and, 2:708  
 theory of locus of control and, 2:745
- AUDIT.** *See* **Alcohol Use Disorders Identification Test (AUDIT)**
- Auma-Okumu, S. S., 3:1281
- Aurobindo, Sri, 1:11
- Austin, Diane, 1:307
- Authoritarian parenting style.** *See* **Parenting**
- Authoritative parenting style.** *See* **Parenting**
- Autism/Asperger's syndrome, 1:34–36**  
 applied and verbal behavior analysis therapy for, 1:35  
 Autism Diagnostic Observation Schedule and, 1:35  
 autism spectrum, description of, 1:34–35  
 Behavior Rating Scale of Executive Function (BRIEF) and, 1:49  
 changes and challenges of, 1:35–36  
 diagnosis of, 1:35  
 etiology of, 1:35  
 facilitated communication treatment and, 2:629  
 genetic heritability of, 1:35  
 pervasive developmental disorder *DSM-IV-TR*  
   category of, 1:34  
 self-stimulating, “stimming” behaviors and, 1:34  
 social functioning impairment symptom of, 1:34  
 social skills training and, 1:35  
 stereotyped behaviors exhibited in, 1:34  
 treatment of, 1:35
- Autonomy**  
 adolescent autonomy, parent-adolescent relations and,  
   1:322–323  
 duty to warn and protect and, 2:577  
 ethical decision making and, 1:176, 1:183,  
   1:186, 1:191, 2:495  
 intrinsic motivation and, 2:553–554  
 online research and, 1:247  
 self-determination theory and, 2:553–554, 2:662–663  
 therapist interpretation reduction of, 2:911  
 treatment compliance and, 1:425  
 virtue ethics and, 1:441
- AVA. *See* **American Vocational Association (AVA)**
- Aversive racism, 2:573, 3:1294–1295, 3:11015
- Avoidant personality disorder (AVPD), 2:731  
 comorbidity of, 2:732, 2:733  
 treatment of, 2:733–734
- AVPD. *See* **Avoidant personality disorder (AVPD)**
- Axelrad, Sidney, 4:1648
- Axline, Virginia, 1:332
- Azibo, Duadi, 3:1033
- Azibo nosology diagnostic system of psychopathology,  
 3:1034
- BAB.** *See* **Ball Aptitude Battery (BAB)**
- Bailey, Diane, 1:257
- Baker, D. B., 4:1489
- Baker, Nancy Lynn, 3:1326
- Baldwin, J. A., 3:1386
- Ball Aptitude Battery (BAB), 4:1393
- Ballard, J. C., 1:113
- Bandung Conference, 3:1347
- Bandura, Albert, 2:467–469**  
 agency by proxy and, 2:468  
 anxiety management and, 4:1679  
 anxiety vs. self-efficacy expectations and, 2:766, 2:855  
 APA work of, 2:468–469  
 behaviorally oriented psychotherapy and,  
   2:467, 2:541, 2:736  
 Bobo Doll experiments and, 2:741  
 cognitive motivators and, 2:854  
 collective agency and, 2:468  
 collective efficacy and, 2:468  
 early social learning theory of, 2:467  
 guided mastery approach to phobias and, 2:467  
 Health Belief Model influenced by, 1:235  
 honors and awards received by, 2:468–469  
 human agency concept of, 2:468, 4:1406  
 intentionality and, 2:468  
 mastery experiences and, 4:1679  
 modeling and self-regulatory processes and, 2:764



- observational learning and, **2:467, 2:736, 2:741, 2:745**  
 operant conditioning and, **2:745**  
 outcome expectations vs. efficacy expectations and, **2:766, 2:855–856**  
 perceived self-efficacy and, **2:468, 2:852–858**  
 phobic disorder intervention work of, **2:764**  
*Principles of Behavior Modification* written by, **2:764**  
 reciprocal determinism concept of, **2:505, 2:741, 2:746, 2:764**  
 self-efficacy expectations and, **2:467–468, 2:765–767**  
 self-efficacy sources and, **4:1679**  
 self-efficacy theory and, **1:235, 2:467–468, 2:533, 2:594–595, 2:741, 2:745, 2:765–767, 2:852–858, 4:1470, 4:1679**  
 self-reactiveness, self-reflectiveness and, **2:468**  
 social cognitive theory of, **2:468, 2:505, 2:736, 2:745–746, 2:764–765, 2:767, 2:852, 4:1627, 4:1679**  
*Social Foundations of Thought and Action* written by, **2:767**  
*Social Learning and Personality Development* (Bandura and Walters) and, **2:467, 2:764**  
*Social Learning Theory* written by, **2:468**  
 sociogenic adult development model of, **1:10**  
 sources of efficacy information and, **2:468**  
 verbal persuasion and, **4:1679**  
 vicarious experiences and, **4:1679**  
 See also **Self-efficacy/perceived competence**; Social cognitive theory
- Banks, W. C., **3:1385**  
 Barkley, Russell, **1:327**  
 Barlow, David H., **2:786**  
 Barnett, Chait, **4:1682**  
 Barrett-Lennard Relationship Inventory, **2:533**  
**Barriers to cross-cultural counseling, 3:1009–1012**  
 client distrust and fears and, **3:1011**  
 counselor cultural self-awareness factor in, **3:1009**  
 countertransference and, **3:1011**  
 cultural encapsulation and, **3:1090–1091**  
 cultural knowledge factor in, **3:1009–1010**  
 cultural mistrust and, **3:1092–1093**  
 cultural paranoia and, **3:1093–1094**  
 cultural values and, **3:1095–1097**  
 deficit hypothesis and, **3:1109–1111**  
 differences as weaknesses vs. strengths and, **3:1010**  
 enculturation and, **3:1129–1131**  
 espiritismo and, **3:1131–1132**  
 Eurocentrism and, **3:1147–1148**  
 high-low context communication and, **3:1011**  
 kinesics and, **3:1011**  
 kinesthetics and, **3:1011**  
 language barriers and, **3:1010–1011**  
 low-context communication and, **3:1206**  
 multicultural competence skills and, **3:1010**  
 multicultural counseling training factor in, **3:1012**  
 nonverbal communication and, **3:1010**  
 paralanguage and, **3:1011**  
 personal space and, **3:1261**  
 proxemics and, **3:1010–1011**  
 racial identity development and, **3:1011–1012**  
 stereotypes and, **3:1009–1010**  
 transference and, **3:1011**  
 White privilege and, **3:1375–1380**
- BAS. See **Bidimensional Acculturation Scale (BAS)**  
 BASC-2. See **Behavior Assessment System for Children, Second Edition (BASC-2)**  
 Basic Interest Scales (BISs), **4:1407**  
 Bateman, Anthony, **2:734**  
 Bateson, Gregory, **1:203**  
 marriage, family therapy work of, **1:124**  
 radical constructivism work of, **2:523**  
 Battery for Health Improvement 2 (BHI 2) pain assessment, **1:85–86**  
 Baumrind, Diana, **1:324–325**  
 BDI. See **Beck Depression Inventory (BDI)**  
 Beauchamp, Tom, **1:270**  
*The Beauty Myth* (Wolf), **3:1317**  
 Beauvais, Fred, **3:1251**  
**Beck, Aaron T., 2:469–470**  
 arbitrary inference irrational belief and, **2:510**  
 Beck Anxiety Inventory (BAI) and, **2:462, 2:814**  
 Beck Depression Inventory (BDI) and, **1:420, 2:463, 2:534, 2:558, 2:701, 2:727**  
 Beck Depression Inventory-II (BDI-II) and, **2:814**  
 Beck Depression Inventory-H and, **2:470**  
 childhood of, **2:469**  
 cognitive-behavioral therapy and, **2:503, 2:504–505, 2:541, 2:746**  
 cognitive processing errors, irrational beliefs and, **2:510, 2:514, 2:542, 2:708**  
 cognitive specificity hypothesis and, **2:510**  
 cognitive therapy, depression and, **2:469, 2:505**  
 cognitive triad concept of, **2:505**  
 collaborative empiricism and, **2:510**  
 depression research focus of, **2:469, 2:708**  
 father of cognitive therapy and, **2:469**  
 overgeneralization irrational belief and, **2:510**  
 personal construction theory and, **2:509**  
 schemas and, **2:510**  
 selective abstraction irrational belief and, **2:510**



- test construction work of, 2:469–470  
 therapeutic alliance importance and, 2:514  
 transference and, 2:930
- Beck, L. H., 1:112
- Beck Depression Inventory (BDI), 1:420
- Becker, M. H., 1:287
- Becker, Marshall, 1:425–426
- Beers, Clifford  
 mental health counseling work of, 1:121  
*A Mind That Found Itself* written by, 1:121
- Behavioral observation methods, assessment, 1:37–42**  
 anecdotal (ABC) recording and, 1:37  
 assessment reactivity issues and, 1:41  
 baseline data from, 1:42  
*About Behaviorism* (Skinner) and, 2:871  
 common sense parent training program and, 1:327  
 counselor self-disclosure and, 2:852  
 defining behaviors and, 1:42  
 duration recording and, 1:40  
 event or frequency recording and, 1:39–40  
 frequency, magnitude, duration  
   characteristics and, 1:37  
 functional behavioral assessment and, 1:220–225  
 interval recording methods and, 1:37–39  
 William James' self-concept theory and, 2:859  
 latency recording and, 1:40  
 momentary time sampling and, 1:39  
 other methods of observation and, 1:40–41  
 partial-interval recording and, 1:38  
 permanent products from, 1:40–41  
 published instruments used for, 1:41  
 quantitative and objective data from, 1:37  
 reliability issues and, 1:41–42  
 research purposes of, 1:42  
 technology and, 1:41  
 universalist focus of, 3:1359  
 using results of, 1:42  
 whole-interval recording and, 1:38–39
- Behavior Assessment System for Children, Second Edition (BASC-2), 1:42–43**  
 AD/HD diagnosis and, 1:29  
 behavioral observation method of, 1:41  
 Behavioral Symptoms Index of, 1:43  
 coefficient alpha reliabilities of, 1:43, 1:47  
 conduct disorder and, 1:100  
 developmental sensitivity of, 1:47  
 Parent Rating Scale (PRS) of, 1:42, 1:47  
 response scales of, 1:42–43  
 Self-Report of Personality (SRP) of, 1:42, 1:47, 1:49  
 Teacher Rating Scale (TRS) of, 1:42, 1:47
- The Behavior of Organisms* (Skinner), 2:870
- Behavior Rating Profile (BRP-2) behavior  
 rating scale, 1:48
- Behavior Rating Scale of Executive Function  
 (BRIEF), 1:49
- Behavior rating scales, 1:43–49**  
 Achenbach scales, 1:45–47  
 AD/HD, measures for assessment of, 1:49  
 BASC-2, 1:42–43, 1:47–48  
 behavioral observation methods and, 1:37–42  
 Behavior Rating Profile (BRP-2), 1:48  
 Behavior Rating Scale of Executive  
   Function (BRIEF), 1:49  
 BRP-2, BBRS, SEDS-2, 1:48  
 Conners' scales, 1:48  
*DSM* diagnostic criteria and, 1:44  
 multidomain scales, 1:45  
 observer/informant scales, 1:44  
 quantification of behaviors or symptoms by, 1:44  
 self-report scales, 1:44–45  
 single domain scales, 1:45  
 uses of, 1:43–44  
 validity of, 1:44
- Behavior therapy, 2:470–476**  
 acting as if, 2:915–916  
 AD/HD and, 1:32–33  
 antecedent-response-consequence  
   cycle of, 2:471, 2:472–473  
 archival information assessment and, 2:472  
 assertiveness strategies and, 2:473  
 assertiveness training, 2:915  
 attention to emotion in, 2:475–476  
 for autism spectrum disorders, 1:35  
 Albert Bandura's work and, 2:467–469  
 behavioral assessment and, 2:471–472  
 behavioral consultation and, 2:475  
 behavioral groups and, 2:474–475  
 behavioral interventions and, 2:472–474  
 behavioral specificity and, 2:471  
 behavioral theorists and, 2:541  
 brief therapy and, 2:479–483  
 catching oneself, 2:916  
 characteristics of, 2:471–475  
 classical conditioning and, 2:470–471  
 client readiness and, 2:474  
 conclusion regarding, 2:476  
 contingency management and, 2:742  
 counterconditioning/systematic desensitization, 2:915  
 couple and marital counseling and, 1:138  
 cultural sensitivity and, 2:476



- dialectical behavior therapy and, **2:571–572**
- exposure-based interventions, **2:473**
- flexible structure and, **2:474**
- functional behavioral assessment and, **1:220–225**
- humans as complex learners and, **2:470**
- imagery, **2:471–472, 2:916**
- insight and, **2:476**
- issue-specific questionnaires assessment and, **2:472**
- William James' self-concept theory and, **2:858**
- maintenance and relapse prevention in, **2:474**
- modeling, **2:915**
- modeling or observational learning and, **2:471**
- modifying antecedents and, **2:472**
- modifying behavior and, **2:472–473**
- modifying consequences and, **2:473–474**
- naturalistic conditions in assessment and, **2:471**
- negative practice, paradox technique and, **2:720**
- negative reinforcement and, **2:473**
- operant conditioning and, **2:471**
- political advocacy, **2:916**
- PTSD and, **2:787**
- punishment strategy and, **2:473**
- relaxation coping skills and, **2:473**
- role-playing, **2:915**
- self-directed change in, **2:475**
- shame-attacking exercise, **2:915**
- shaping, **2:915**
- simulations assessment and, **2:471**
- social skills training, **2:742, 2:915**
- spitting in the soup, **2:916**
- systematic desensitization and, **2:742**
- therapeutic relationship in, **2:475**
- types of learning and, **2:470–471**
- See also Cognitive-behavioral therapy and techniques (CBT)*
- Behrens, John, **3:1288**
- Beitman, Bernard, **2:649**
- Bell, Derrick, **3:1074**
- Bell, Tyronn, **3:1093**
- Bellak, Leopold, **2:587**
- The Bell Curve* (Hernstein and Murray), **3:1109–1110**
- Belle, Deborah, **3:1329**
- Benbow, C. P., **2:654 (figure), 2:655 (figure)**
- Bene, Eric, **2:926**
- Beneficence
  - change agent and, **3:1046**
  - ethical decision making and, **1:176–177, 1:183, 1:186, 1:192, 2:495**
  - online research and, **1:247**
  - virtue ethics and, **1:441**
- Benet-Martinez, Jana, **3:1020**
- Benevolence self-pertaining virtue, **1:442**
- Benevolent prejudice, **3:1117**
- Benjamin, Jessica, **2:763**
- Berano, Kathryn, **2:489**
- Bereavement, 1:50–53**
  - children's vulnerability to death and, **1:50**
  - classical models of grieving and, **1:51–52**
  - counseling the bereaved and, **1:52–53**
  - daily life rituals and, **1:52**
  - death, dying and, **1:149–152**
  - funerals and, **1:52**
  - hospice care and, **1:243–245**
  - loss of a child and, **1:50**
  - loss of a parent and, **1:50–51**
  - loss of a sibling and, **1:50**
  - loss of a spouse and, **1:51**
  - loss of extended family or friend and, **1:51**
  - making sense of loss and, **1:52–53**
  - miscarriage impact and, **1:50**
  - mortality awareness and, **1:50**
  - mourning vs., **1:50**
  - revised model of grieving and, **1:52**
- Berenson, B., **1:406**
- Berg, Insoo Kim, **1:204**
- Berg, Irwin, **1:104**
- Berger, M. T., **3:1347**
- Berger, Peter L., **2:523**
- Bergin, Allen, **1:174**
- Berlyne, Daniel, **2:673, 4:1475**
- Bernal, Delores Degaldo, **3:1246**
- Bernal, Martha E., 3:1012–1014**
  - APA leadership of, **3:1012, 3:1014**
  - behavioral treatment of children and, **3:1012**
  - childhood of, **3:1012–1013**
  - education of, **3:1013**
  - equity in psychological training work of, **3:1014**
  - honors and awards received by, **3:1014**
  - Latina researcher and, **3:1013–1014**
  - minority psychologist training work of, **3:1014**
  - model of Hispanic children's ethnic identity development and, **3:1012, 3:1014**
  - overcoming sociocultural barriers by, **3:1012**
- Bernard, J., **1:406**
- Berry, John W., **3:946, 3:947, 3:956, 3:1003, 3:1019, 3:1081**
  - acculturation concept and, **3:1129, 3:1130, 3:1230, 3:1309, 3:1310**
  - cultural relativism and, **3:1082–1083**
  - etic–emic distinction and, **3:1083, 3:1145, 3:1146**



- Bertalanffy, Ludwig von  
   general systems theory and, 1:203  
   systems adult development theory and, 1:10–11
- Berzon, Betty, 2:903
- Berzonsky, Michael D., 3:1165, 3:1166
- Best, Deborah L., 3:1084
- Betz, Nancy, 2:767, 3:1165, 4:1406, 4:1408–1409, 4:1470, 4:1563
- Beuheler, Charlotte, 4:1648
- Beutler, Larry, 1:174  
   Donald Ray Atkinson and, 3:1006  
   systematic treatment selection model of, 2:648
- BEV. *See* Black English Vernacular (BEV) term
- Beyond Freedom and Dignity* (Skinner), 2:871
- BHI 2. *See* Battery for Health Improvement 2 (BHI 2)  
   pain assessment
- BIA. *See* Bureau of Indian Affairs (BIA)
- Bias, 3:1014–1016**  
   aversive racism theory and, 2:573, 3:1015, 3:1294–1295  
   “blaming the victim” mentality and, 3:1016  
   cultural encapsulation and, 3:1090–1091  
   cultural equivalence and, 3:1091–1092  
   culture-free testing and, 3:1104–1106  
   deficit hypothesis and, 3:1109–1111  
   definition of, 3:1014  
   DSM diagnostic bias and, 3:1015  
   ethnic identity and, 3:1136  
   Eurocentrism and, 3:1147–1148  
   family bias exposure during childhood and, 3:1015  
   group socialization model of, 3:1016  
   historical summary of racial bias and, 3:1015  
   ingroup–outgroup bias and, 3:1115–1116  
   intelligence tests and, 3:1181  
   justification-suppression model of, 3:1015  
   model minority myth and, 3:1211–1214  
   personality model of prejudice and, 3:1016  
   person X situation model of, 3:1016  
   political correctness and, 3:1015, 3:1263–1264  
   prejudice term and, 3:1014–1015  
   purposes served by, 3:1016  
   racial microaggressions and, 3:1290–1291  
   responses to circumstances and events and, 3:1015  
   self-presentational theory of, 3:1015  
   social dominance theory of, 3:1015  
   stereotypes, stereotype threat and, 3:1015, 3:1333–1339, 3:1340  
   testing and clinical assessment biases and, 3:1015  
   *See also* **Discrimination; Discrimination and oppression; Prejudice; Racism; Stereotype; Stereotype threat**
- Bicultural, 3:1016–1022**  
   acculturation and, 3:1018, 3:1019  
   Acculturation and Biculturalism Scale (ABS), 3:1019  
   “alteration model” and, 3:1018  
   Americanization and, 3:1019  
   assimilation and, 3:1019  
   bicultural competence and, 3:1018, 3:1230–1231  
   bicultural efficacy and, 3:1310  
   Bicultural Identity Integration (BII), 3:1020  
   biculturalism definition and, 3:1016  
   bicultural models and, 3:1018–1019, 3:1230–1231  
   Bicultural/Multicultural Experience Inventory (B/MEI), 3:1019  
   bicultural stress and, 3:1311–1312  
   biracialism and, 3:1027–1032  
   compatible vs. oppositional experiences of, 3:1016–1017, 3:1230–1231  
   counseling implications of, 3:1311–1312  
   cultural accommodation and negotiation and, 3:1089–1090  
   culture, transracial adoption and, 3:1020–1021  
   culture definition and, 3:1016  
   current issues regarding, 3:1021  
   definition of, 3:1016  
   enculturation, assimilation, acculturation vs., 3:1130  
   ethnic belongingness and, 3:1018  
   ethnic identity and, 3:1017–1018  
   frame switching and, 3:1020  
   globalization and, 3:1021  
   identification with both cultures and, 3:1017  
   identity integration and, 3:1020  
   integration mode of adaptation and, 3:1309  
   interracial marriage and, 3:1183–1185  
   multicultural personality and, 3:1226–1227  
   multicultural psychology and, 3:1230–1231  
   multidimensional scales and, 3:1019–1020  
   orthogonal cultural identification theory and, 3:1251  
   pluralism and, 3:1262–1263  
   stereotypes, negative perceptions regarding, 3:1017  
   subjective organization of dual cultural orientations and, 3:1017  
   translation methods and, 3:1350–1353  
   unidimensional scales and, 3:1019  
   *See also* **Bilingual counseling; Bilingualism**
- Bicultural counseling. *See* Bilingualism**
- Bicultural Identity Integration (BII), 3:1020
- Bicultural Involvement Questionnaire, 3:1020
- Bicultural/Multicultural Experience Inventory (B/MEI), 3:1019
- Bicultural Scale for Puerto Ricans, 3:1020



Bidimensional Acculturation Scale (BAS), **3:943, 3:1003**

Big Five personality traits. *See* **Personality theories, five-factor model (FFM)**

BII. *See* Bicultural Identity Integration (BII)

### **Bilingual counseling, 3:1022–1024**

- affective communication content and, **3:1023**
- assessment methods of, **3:1023**
- barriers to cross-cultural counseling and, **3:1009–1010**
- best practices of, **3:1023**
- bilingual interventions and, **3:1023–1024**
- bilingual language development and, **3:1022**
- Bilingual Verbal Cognitive Abilities Tests, **3:1023**
- client–therapist language matching and, **3:1023**
- clinical interviews and, **3:1023**
- counselor self-evaluation and, **3:1023**
- definition of, **3:1022**
- dual sense of self and, **3:1022, 3:1023**
- future directions regarding, **3:1024**
- historical perspective on, **3:1022**
- language dominance and, **3:1022**
- language facilitators and, **3:1024**
- language mixing and, **3:1022**
- language proficiency and, **3:1022–1023**
- language switching, code-switching and, **3:1022, 3:1023, 3:1026, 3:1352**
- multicultural counseling competence and, **3:1022**
- nonverbal communication and, **3:1023**
- processes of, **3:1022–1023**
- translation methods and, **3:1350–1353**
- Woodcock Language Battery-Revised Texts, **3:1023**

*See also* **Bilingualism**

Bilingual Education Act (1968), **3:1221**

### **Bilingualism, 3:1024–1027**

- balanced bilingual and, **3:1025**
- bilingual education and, **3:1223–1224**
- code-switching and, **3:1022, 3:1023, 3:1026**
- controversy regarding, **3:1223–1224**
- diglossia and, **3:1026**
- dominant bilingualism and, **3:1025**
- English-only education and, **3:1224**
- immigrant populations and, **3:1026, 3:1223–1224**
- language ability and, **3:1025**
- language community and, **3:1025**
- language competence and, **3:1025**
- language performance and, **3:1025**
- language use and, **3:1025–1026**
- listening, speaking, reading, writing skills and, **3:1025**
- metalinguistic skills and, **3:1023**
- monolingualism and, **3:1025**
- multilingualism related term and, **3:1024**

myths and cognitive advantages of,

**3:1026, 3:1223–1224**

positive impact of, **3:1224**

semilingualism and, **3:1025**

use vs. ability and, **3:1025**

Bilingual Verbal Cognitive Abilities Tests, **3:1023**

Binet, Alfred, **4:1406**

cognitive ability work of, **4:1430**

intelligence scales work of, **1:121, 2:497**

psychological testing, career counseling and, **4:1445**

### **Bingham, Rosie Phillips, 1:53–55**

academic career of, **1:53–54**

career counseling work of, **1:54, 4:1533**

childhood years of, **1:53**

counseling psychology career of, **1:53**

culturally appropriate career counseling model

(CACCM) co-developed by, **4:1577, 4:1579**

honors and awards received by, **1:55**

professional associations of, **1:54, 3:1342**

scholarly work and research of, **1:54–55**

self-efficacy work of, **4:1577**

student retention work of, **1:54**

Connie Ward and, **1:54, 4:1577**

Binswanger, Ludwig, **3:1366**

### **Biodata, 4:1413–1415**

configural scoring of, **4:1414**

content and specificity variations in, **4:1413**

covert vs. overt items of, **4:1413**

criterion-keying scoring of, **4:1414**

criterion-related validity of, **4:1414**

explanation of, **4:1413–1414**

incremental validity of, **4:1414**

independent sample cross-validation of, **4:1415**

item attributes and, **4:1414**

item content scoring of, **4:1414**

past experience, future work behavior and, **4:1413**

rational and empirical scoring considerations of, **4:1415**

test-retest reliability, internal consistency of, **4:1413**

test-taker reactions to, **4:1415**

Bioecological adult development theory, **1:10**

Biofeedback stress management technique, **2:890–891**

### **Bipolar disorder, 2:477–479**

age of onset of, **2:477–478**

assessment of, **2:478**

biological treatment of, **2:478–479**

biologic and genetic basis of, **2:478**

bipolar affective disorder and, **1:31**

bipolar I vs. bipolar II disorder and, **2:477**

common symptoms of, **2:477**

course and prognosis of, **2:478**



- cyclical mood fluctuations in, **2:477**  
 cyclothymic disorder and, **2:477**  
 depression and, **2:477**  
 drug abuse, schizophrenia and, **2:477–478**  
 etiology and, **2:478**  
 gender differences in, **2:477**  
 hypomania and, **2:477**  
 prevalence of, **2:478**  
 psychotherapy, psychosocial treatment of, **2:479**  
 suicidal behavior and, **2:477**
- Biracial, 3:1027–1032**  
 antimiscegenation laws and, **3:1027, 3:1183**  
 biracial baby boom concept and, **3:1028**  
 biracial offspring myths and, **3:1031**  
 contextual factors and, **3:1030**  
 counseling implications of, **3:1030**  
 definition of, **3:1027**  
 discrimination, negative stereotype effects and, **3:1029**  
 ecological identity model and, **3:1029, 3:1030**  
 future research regarding, **3:1031–1032**  
 historical perspectives on, **3:1027–1028**  
 identity development models of, **3:1028–1029, 3:1229–1230**  
 interracial marriage and, **3:1183–1885**  
*Loving v. Virginia* and, **3:1183, 3:1184, 3:1233**  
 marginal person model of, **3:1028**  
 mixed term and, **3:1027**  
 mulatto census term and, **3:1027**  
 multiethnic term and, **3:1027**  
 multiple identity research and, **3:1031–1032**  
 multiracial families and, **3:1030–1031**  
 multiracial term and, **3:1027**  
 one-drop rule and, **3:1027, 3:1028, 3:1183**  
 psychological functioning in biracial individuals, **3:1029–1030** and  
 quadroon, octoroon census term and, **3:1027**  
 race and ethnicity distinctions and, **3:1027**  
 racial identity and, **3:1183–1884**  
 research sampling and methodology issues and, **3:1031**  
 rule of hypodescence and, **3:1027, 3:1280**  
 stage models of biracial identity development and, **3:1028–1029, 3:1229**  
 strengths and positive aspects of, **3:1030**  
 U.S. Census and, **3:1027–1028**  
 Web sites regarding, **3:1032**  
 youth challenges and benefits and, **3:1029–1030**
- The Birth of the Nation* film, **3:1240**
- Bisexual therapy. *See* **Gay, lesbian, and bisexual therapy (GLB)**
- BISs. *See* **Basic Interest Scales (BISs)**
- Black English, 3:1032–1033**  
 African American Vernacular English (AAVE)  
   term and, **3:1032**  
 Black English Vernacular (BEV) term and, **3:1032**  
 controversy involving, **3:1032–1033**  
 definition of, **3:1032**  
 Ebonics term and, **3:1032**  
 pop culture and, **3:1032**  
 syntax of, **3:1032**
- Black English Vernacular (BEV) term, **3:1032**
- Black Nationalism, **3:1034, 3:1240**
- Black Personality Questionnaire, **3:1035**
- Black Power, **3:1034**
- Black psychology, 3:1033–1036**  
 African philosophy and, **3:1033, 3:1034–1036**  
 African Self-Consciousness Scale and, **3:1035**  
 African Value for Children Scale and, **3:1035**  
 Afrocentrism Measure and, **3:1035**  
 Akbar's classification of mental disorders and, **3:1034**  
 American Teachers Association (ATA) and, **3:1033–1034**  
 Association of Black Psychologists and,  
   **3:1004–1005, 3:1034**  
 Azibo nosology diagnostic system of psychopathology  
   and, **3:1034**  
 Black and African-centered psychology perspectives  
   and, **3:1034–1035**  
 Black families and, **3:1035**  
 Black identity and, **3:1035**  
 Black Personality Questionnaire and, **3:1035**  
 Black Power, Black Nationalism and, **3:1034**  
 Black Racial Identity Scale and, **3:1035**  
*Brown v. Board of Education of Topeka,*  
   *Kansas* and, **3:1034**  
 Cosmology, structure of the universe and, **3:1033**  
 Cross Racial Identity Scale (CRIS) and, **3:1035, 3:1078,**  
   **3:1079, 3:1080, 3:1287–1288**  
 deficient myth and, **3:1034**  
 early Black psychologists and, **3:1033–1034**  
 education and, **3:1035**  
 epistemology, nature of knowledge and, **3:1033**  
 future directions regarding, **3:1035–1036**  
 historical foundations of, **3:1033**  
 Kwanzaa and, **3:1035**  
*Maat* concept and, **3:1035**  
 Multidimensional Inventory of Black Identity (MIBI)  
   and, **3:1288**  
 Nigrescence model of Black identity and, **3:1035,**  
   **3:1078–1079, 3:1287, 3:1364, 3:1380, 3:1381**  
*Ntu* system of health and healing and, **3:1035**  
 ontology and, **3:1033**



- Spirituality Scale and, **3:1035**  
 theory of African self-concept and, **3:1035**  
 understanding human nature focus of, **3:1034–1035**  
 unique cultural concepts and, **3:1035**  
 Web site regarding, **3:1036**  
 Joseph L. White and, **3:1369–1371, 3:1383–1384**
- Black Racial Identity Attitudes Scale (RIAS-B),  
**3:1287, 3:1292**
- Black racial identity development (BRID), 3:1036–1038**  
 Afrocentricity/Afrocentrism and, **3:963–965**  
 Black counselor and client example of, **3:1037–1038**  
 Black psychology and, **3:1033–1036**  
 Black Racial Identity Attitudes Scale (RIAS-B) and,  
**3:1287, 3:1292**  
 Black Racial Identity Scale and, **3:1035**  
*Black* terminology and, **3:1036**  
 Kenneth Bancroft Clark and, **3:1050–1052**  
 complexity of, **3:1038**  
 Cross Racial Identity Scale (CRIS) and, **3:1035, 3:1078,**  
**3:1079, 3:1080, 3:1287–1288**  
 William E. Cross's work in, **3:1078–1080, 3:1296–1297**  
 cultural paranoia and, **3:1093–1094**  
 W. E. B. Du Bois's work in, **3:1036**  
 future directions regarding, **3:1038**  
 gender, class, sexual orientation factors and, **3:1038**  
 healthy paranoia and, **3:1153**  
 Janet E. Helms's work and, **3:1154–1156, 3:1229,**  
**3:1296–1297**  
 Jackson's four-stage model of, **3:1036**  
 Kwanzaa and, **3:1189–1190**  
 lifespan changes in, **3:1038**  
 mainstream *vs.* underground theories and, **3:1037**  
 models of, **3:1036–1037**  
 Multidimensional Inventory of Black Identity (MIBI)  
 and, **3:1288**  
 multiracial families and, **3:1234**  
 Nigrescence theory and, **3:1036, 3:1078–1079, 3:1287,**  
**3:1364, 3:1380, 3:1381**  
 oppression role in, **3:1038**  
 race importance in self-concept and, **3:1036**  
 racial/cultural development theory and, **3:1036**  
 racial discrimination and oppression and, **3:1036**  
 training and counseling applications of, **3:1037–1038**  
 Western *vs.* non-Western cultural contexts of, **3:1038**  
*See also African Americans; Ethnic identity; Racial*  
*identity*
- Black Racial Identity Scale, **3:1035**  
*Black Rage* (Grier and Cobbs), **3:1092, 3:1093**  
 Blauner, R., **3:1347**  
 Bleuler, J. C., **4:1516**  
 Bleuler, Eugen, **2:845**  
 Bloch, Sidney, **2:658**  
 Block, Jack, **2:770–771**  
 Blood quantum  
 Certificate of Degree of Indian Blood and, **3:1045–1046**  
 Native American tribal enrollment and, **3:973, 3:1183**  
 Bloomfield, Meyer, **4:1446**  
 Blustein, Dave, **1:263, 2:925, 4:1475, 4:1635**  
 B/MEI. *See* Bicultural/Multicultural Experience  
 Inventory (B/MEI)  
 B'nai B'rith Vocational Service Bureau, **4:1446**  
 Boas, F., **3:1082**  
 Bohart, Arthur, **2:486, 2:487**  
 Bohr, Yvonne, **2:580**  
 Bolden, Mark, **3:1296**  
 Bolles, Richard, **4:1422**  
 Bond, Julian, **3:1239**  
 Bonilla-Silva, Eduardo, **3:1064**  
 Bonny method of guided imagery and music, **1:307–308**  
 Borderline personality disorder (BPD)  
 characteristics of, **2:730**  
 comorbidity of, **2:732**  
 dialectical behavior therapy (DBT), **1:300**  
 invalidating environments and, **2:758**  
 treatment of, **2:733–734**  
 Bordin, Edward S., **2:513, 2:532, 2:922, 2:923**  
 Borgen, Fred, **4:1408–1409**  
 Borman, W. C., **4:1596**  
 Boston Diagnostic Aphasia Examination, **2:671**  
 Bowen, Murray, **1:124**  
 Bowlby, John  
 attachment types and, **1:321, 2:762**  
 grief process and, **1:51**  
 Bowman, S. L., **4:1576**  
 BPD. *See* Borderline personality disorder (BPD)  
 Bradford, David, **3:1024**  
 Brain drain, **3:986**  
 Bransome, E. D., Jr., **1:112**  
 Bratton, Sue, **1:333**  
 Brechesisen, Briana, **4:1486**  
 Brewer, John M., **4:1446**  
 Brewer, Marilyn B., **3:1228–1229**  
 BRID. *See* **Black racial identity development (BRID)**  
 BRIEF. *See* Behavior Rating Scale of Executive Function  
 (BRIEF)  
**Brief therapy, 2:479–483**  
 affect phobia and, **2:482**  
 behavior therapy and, **2:479**  
 cognitive-behavioral brief therapy, techniques of,  
**2:480, 2:482**



- cognitive-behavioral brief therapy, theory of, 2:480  
critical incident stress debriefing and, 2:548–550, 2:628  
defense, anxiety, feelings poles and, 2:482  
family therapy and, 2:479  
future directions in, 2:483  
Gestalt brief therapy, techniques of, 2:482–483  
Gestalt brief therapy, theory of, 2:482  
history of, 2:479–480  
managed care cost-consciousness and, 2:480, 2:483  
popularity of, 2:479–480  
schemas and, 2:480  
short-term dynamic psychotherapy, techniques of, 2:482  
short-term dynamic psychotherapy, theory of, 2:482  
single-session therapy, techniques of, 2:480  
single-session therapy, theory of, 2:480  
solution-focused brief therapy (SFBT) and,  
2:524, 2:876–879  
triangle of conflict, triangle of person and, 2:482  
types of, summary, 2:481 (table)  
*See also* **Solution-focused brief therapy** (SFBT)
- Broderick, C. D., 1:137  
Brody, Viola, 1:332  
Bronfenbrenner, Uri  
bioecological adult development theory of, 1:10  
ecological theory, crisis counseling and, 2:546  
Bronstein, Phyllis, 3:1093  
Brooks, L., 4:1577  
Brooks-Harris, Jeff, 2:649  
Brossart, D. F., 2:904  
Broverman, I. K., 3:1317  
Brown, John, 3:1375  
Brown, Laura, 3:1316  
Brown, Murray, 1:204  
Brown, Ryan P., 2:606  
Brown, Steven, 3:1006, 4:1627  
Brown Berets, 3:1048  
Brownmiller, Susan, 3:1317  
**Brown's values-based career theory, 4:1415–1416**  
assumptions of, 4:1416  
career counseling stages and, 4:1416  
counseling implications of, 4:1416  
cultural values categories and, 4:1415–1416  
goal attainment behavior and, 4:1415  
life-career counseling and, 4:1415–1416  
life values and, 4:1416  
values definition and, 4:1415  
work values and, 4:1416  
*Brown v. Board of Education of Topeka, Kansas*, 3:952  
African American civil rights and, 3:1047  
Black psychology and, 3:1034  
Kenneth Bancroft Clark and, 3:1050, 3:1051, 3:1148,  
3:1238  
Mamie Phipps Clark and, 3:1052, 3:1148  
cross-cultural psychology, training and, 3:1087  
importance of, 3:1221  
multicultural psychology and, 3:1228  
NAACP and, 3:1238  
BRP-2. *See* Behavior Rating Profile (BRP-2)  
behavior rating scale  
Bruner, Jerome, 2:593  
Bruscia, K. E., 1:306  
*Buck v. Bell*, 1:193  
Bulimia Test-Revised (BULIT-R), 2:580  
BULIT-R. *See* Bulimia Test-Revised (BULIT-R)  
**Bullying, 1:55–57**  
anger management and, 2:703  
boy vs. girl bullying and, 1:55–56  
bully outcomes from, 1:56  
definition of, 1:55  
direct vs. indirect forms of, 1:55  
gender differences and, 1:55–56  
intent to harm component of, 1:55  
Olweus Bully Program and, 1:56–57  
power imbalance component of, 1:55  
prevalence of, 1:56  
repetition of behavior component of, 1:55  
school shootings and, 1:55  
social or relational bullying and, 1:55  
Steps to Respect Program and, 1:57  
types of, 1:55  
victim outcomes and, 1:56  
**Bureau of Indian Affairs (BIA), 3:1038–1041**  
assimilation policies and, 3:1039–1040  
boarding school system and, 3:1039–1040  
Carlisle Indian Industrial School and, 3:1039–1040  
Certificate of Degree of Indian Blood and, 3:1046  
General Allotment Act (Dawes Act) of 1887  
and, 3:1039  
Indian Child Welfare Act (1978) and, 3:1040  
Indian Civil Rights Act (1968) and, 3:1040  
Indian Religious Freedom Act (1978) and, 3:1040  
Indian Removal Act (1830) and, 3:1039  
Indian Territory and, 3:1039  
Native Nations' governments and, 3:1040–1041  
removal, reservations and, 3:1039  
role transformations of, 3:1039  
self-determination policies and, 3:1040  
self-governance policies and, 3:1040–1041  
termination policies and, 3:1039  
Trail of Tears and, 3:1039



- treaty violations and, **3:1039**  
water and land rights protection and, **3:1040–1041**  
**Bureau of Labor Statistics, 4:1416–1417,**  
    **4:1446, 4:1448**  
career counseling pertinent reports of, **4:1416–1417**  
Department of Labor and, **4:1416, 4:1417**  
early annual reports of, **4:1417**  
history of, **4:1417**  
information available from, **4:1416–1417**  
Web site, **4:1417**  
*Burgus v. Braun*, **2:604**  
Buriel, Raymond, **3:1016**  
Burkhard, Alan, **3:1382**  
Burk's Behavior Rating Scales, **1:48**  
Burrow, J., **1:406**  
Burt, Cyril, **3:1109**  
Bush, George H. W.  
    Americans with Disabilities Act and, **1:23**  
    career development policies of, **4:1448, 4:1450**  
Bush, George W.  
    IDEA reauthorized by, **1:250**  
    President's New Freedom Commission on  
        Mental Health and, **1:155, 1:288, 1:289, 1:293,**  
        **2:849, 3:994**  
Butcher, James N., **3:1084**  
Byran, W. L., **1:254**
- CACCM. *See* Culturally Appropriate Career Counseling Model (CACCM)  
CACG. *See* **Computer-assisted career counseling**  
CACREP. *See* **Accreditation by the Council for Accreditation of Counseling and Related Educational Programs (CACREP)**  
CADI. *See* Career Adjustment and Development Inventory (CADI)  
CAGE screening test, **2:896**  
C-AHEAD. *See* Counseling Association of Humanistic Education and Development (C-AHEAD)  
CAI (computer-assisted instruction).  
    *See* **Computer-assisted testing**  
California Achievement Test, Sixth Edition (CAT/6), **2:451**  
California Achievement Test (CAT), **2:451**  
California Proposition 209 (1996), **3:957**  
California Psychological Inventory (CPI), **2:725–726, 2:813**  
    personality assessment and career and, **4:1599**  
California Q-set, **2:728**  
California Verbal Learning Test, 2nd Edition (CVLT-II),  
    **2:698, 2:700**  
Cambridge Behaviour Prospective Memory Test (CBPMT), **2:688**
- Campbell, David, **4:1407, 4:1419, 4:1641**  
    Edward G. Williamson and, **4:1678**  
    *See also* **Campbell Interest and Skill Survey (CISS)**  
Campbell, J., **4:1596**  
**Campbell Interest and Skill Survey (CISS),**  
    **4:1419–1421**  
    administration of, **4:1420**  
    basic scales of, **4:1420**  
    career planning and decision making tool of, **4:1419**  
    CISS Career Planner and, **4:1421**  
    history of development, **4:1407, 4:1419**  
    Holland's RIASEC model and, **4:1420, 4:1538**  
    interpretation of, **4:1421**  
    item content, **4:1419–1420**  
    occupational scales of, **4:1420**  
    occupation definitions contained in, **4:1419**  
    orientation scales of, **4:1420**  
    report format of, **4:1421**  
    self-assessed skills measured by, **4:1419**  
    self-confidence measured by, **4:1419, 4:1420**  
    special scales of, **4:1420**  
    Strong-Campbell Interest Inventory (SCII) and, **4:1419**  
    Strong Vocational Interest Blank (SVIB) revision  
        and, **4:1419**  
    Web site, **4:1421**  
Campbell's Interest and Skill Survey, **4:1407**  
CAMS. *See* Collaborative Assessment and Management of Suicidality (CAMS)  
Canady, Herman, **3:1033**  
**Cancer management, 1:59–63**  
    Elizabeth Altmaier's work in, **1:21–22**  
    approach *vs.* avoidance strategy of, **1:59**  
    benefit-finding and, **1:60–61**  
    in childhood and adolescence, **1:61–62, 1:75–76**  
    coping definition and, **1:59**  
    coping strategies in, **1:59–60**  
    focusing on and venting of emotions strategy of, **1:59**  
    individual differences in coping process and, **1:60**  
    internal and external demands of, **1:59**  
    positive emotional coping and, **1:60–61**  
    positive reinterpretation and growth strategy of, **1:59**  
    problem-focused *vs.* emotion-focused strategy of,  
        **1:59–60**  
    quality of life issue focus in, **1:59**  
    repressive coping style and, **1:62**  
    social support role and, **1:60**  
Cannon, Walter B., **2:673, 2:883**  
Cantril, Hadley, **2:674**  
CAPA Interest Inventory, **4:1408–1409**  
Caplan, Gerald, **2:525, 2:545**



- CAPM. *See* Comprehensive Assessment of Prospective Memory (CAPM)
- Capobianco, Joseph, **2:489**
- CAPTA. *See* Child Abuse Prevention and Treatment Act (CAPTA)
- Card sorts, 4:1421–1423**  
 career counseling intervention of, **4:1483–1484**  
 client self-awareness and, **4:1421–1422**  
 counseling advantages of, **4:1422–1423**  
 Missouri Occupational Card Sort and, **4:1422**  
 nonstandardized, subjective assessment tool of, **4:1421**  
 overview of, **4:1421–1422**  
 research on, **4:1422**  
 therapeutic relationship and, **4:1423**  
 Leona Tyler's work in, **4:1422**
- Career Adjustment and Development Inventory (CADI), **4:1488–1490**
- Career advancement, 4:1423–1424**  
 how-to books on, **4:1423–1424**  
*The Seven Habits of Highly Effective People* (Covey) and, **4:1424**  
 stereotype worker profile and, **4:1421**  
*What Color Is Your Parachute* (Bolles) and, **4:1424**
- Career Attitudes and Strategies Inventory (CASI), 4:1424–1425**  
 career or work aspects measured by, **4:1425**  
 John Holland and, **4:1544, 4:1545**  
 Holland's RIASEC model and, **4:1424**  
 information measured by, **4:1424**  
 interest and ability measures supplement of, **4:1424**  
 items of, **4:1424–1425**  
 normative group of, **4:1425**  
 reliability and validity of, **4:1425**  
 screener or discussion facilitator use of, **4:1424**  
 self-report assessment of, **4:1424**
- Career Barriers Inventory (CBI), 4:1425–1426**  
 CBI-R and, **4:1425**  
 gender differences in results of, **4:1426**  
 intercorrelations of scales variability and, **4:1426**  
 internal consistency of, **4:1425–1426**  
 items on, **4:1425**  
 scales of, **4:1425**  
 self-report instrument format of, **4:1425**
- Career Beliefs Inventory (CBI), 4:1426–1427**  
 beliefs that block career progress and, **4:1426**  
*CBI Applications and Technical Guide* manual of, **4:1426**  
 computer scored version of, **4:1426**  
 contact information for, **4:1426**  
*Exploring Your Career Beliefs* client workbook of, **4:1426**
- John Krumboltz and, **4:1565**  
 scales categories of, **4:1426**  
 self-scorable version of, **4:1426**
- Career construction theory, 4:1427–1429, 4:1429**  
 action theory and, **4:1397–1400**  
 adults in transition and, **4:1401–1404**  
 attitudes, beliefs, competencies (ABCs) of career construction, **4:1428**  
 career adaptability and, **4:1428**  
 Career Style Interview and, **4:1429**  
 counseling implications of, **4:1403, 4:1428–1429**  
 Holland's RIASEC framework and, **4:1427**  
 life themes and, **4:1427, 4:1428–1429**  
 meaning imposed on vocational behavior and, **4:1427**  
 narrative paradigm to organize biographical thinking and, **4:1428–1429**  
 psychosocial adaptability and, **4:1428**  
 social constructionist epistemology of, **4:1427**  
 vocational personality and, **4:1427**
- Career Convergence* web-based magazine (NCDA), **4:1582**
- Career counseling, 4:1429–1438**  
 action theory and, **4:1397–1400**  
 ACT's Interest Inventory (UNIACT) and, **4:1431**  
 Adult Career Concerns Inventory (ACCI) and, **4:1400–1401, 4:1650**  
 adults in transition clients and, **4:1434**  
 African American clients and, **4:1435, 4:1438–1440, 4:1576**  
 aging American workforce issues and, **4:1430**  
 Asian American clients and, **4:1435, 4:1487**  
 assessment procedures importance in, **4:1437**  
 attachment theory and, **4:1410–1412**  
 baby boom generation and, **4:1430**  
 Binet and Simon and, **4:1430**  
 Rosie Phillips Bingham's work in, **1:53–55**  
 Campbell Interest and Skill Survey (CISS) and, **4:1419–1421**  
 career advancement and, **4:1423–1424**  
 career choice and, **4:1483**  
 career education interventions and, **4:1432**  
 Career Planning System and, **4:1431, 4:1511**  
 career satisfaction counseling and, **4:1483**  
 colleges and universities settings and, **4:1433**  
 computer-assisted career counseling and, **4:1510–1514**  
 conclusion regarding, **4:1437**  
 constructivist career counseling and, **4:1514–1516**  
 John G. Darley and, **4:1430**  
 development of, **4:1429–1430**  
 disabled clients and, **4:1434–1435**  
 DISCOVER and, **4:1431–1432**



electronic media interventions and, **4:1431–1432**  
 Eurocentric focus and, **4:1435, 4:1487**  
 gay/lesbian clients and, **4:1436–1437**  
 group counseling interventions and, **4:1431**  
 immigrant clients and, **4:1436**  
 individual counseling interventions and, **4:1431**  
 issues in, **4:1437, 4:1482–1483**  
 job finding counseling and, **4:1483**  
 Kuder Interest Inventory and, **4:1431**  
 Latino clients and, **4:1435–1436**  
 listening skills importance in, **4:1437**  
 Minnesota Employment Stabilization Research Institute (MESRI) and, **4:1430**  
 Native American clients and, **4:1436**  
 Occupational Information Network (O\*NET) and, **4:1431**  
 online career counseling services and, **4:1432**  
 organizations settings and, **4:1433**  
 Frank Parson's work and, **4:1429**  
 Donald G. Paterson's trait-and-factor work and, **4:1430**  
 private practice settings and, **4:1433–1434**  
 process of, **4:1437, 4:1483**  
 religion and, **3:1302**  
 school settings and, **4:1432–1433**  
 Self-Directed Search and, **4:1431**  
 stages of, **4:1416**  
 Strong Interest Inventory and, **4:1431**  
 System of Interactive Guidance Information (SIGI) and, **4:1431–1432**  
 therapeutic relationship and, **4:1437, 4:1482**  
 White client reversed racism and, **3:1304–1305**  
 work-bound youth clients and, **4:1434**  
 work-family balance and, **4:1680–1684**  
 World Wars I, II and Great Depression and, **4:1429–1430**  
*See also specific instrument*

#### **Career counseling, African Americans, 4:1438–1440**

annual earnings statistics and, **4:1438**  
 Association of Black Psychologists and, **3:1004–1005**  
 biological factors and, **4:1439**  
 career development factors and, **4:1435, 4:1439**  
 Client Career Counseling Checklist and, **4:1439–1440**  
 cultural assessments and, **4:1439–1440**  
 dominant group impact on, **4:1439**  
 family factors and, **4:1439**  
 genetic factors and, **4:1439**  
 jobs meeting human needs vs. career and, **4:1439**  
 multicultural career assessment and, **4:1440**  
 Multicultural Career Counseling Checklist and, **4:1439–1440, 4:1576**  
 racial identity development factors and, **4:1439**

social cognitive career counseling and, **4:1439**  
 Bruce Walsh's work and, **4:1675**

#### **Career counseling, Asian Americans, 4:1440–1443**

acculturation levels and, **3:997**  
 annual earnings statistics and, **4:1438**  
 assessment instruments and, **4:1442**  
 career behaviors of, **4:1441–1442**  
 career choices of, **4:1441**  
 career interests of, **4:1441**  
 collectivist influences in, **4:1435, 4:1441, 4:1492**  
 Confucianism and, **3:1067–1068**  
 dependent decision-making styles and, **4:1441**  
 discrimination experienced by, **4:1442**  
 family focus and, **3:996, 4:1441, 4:1442, 4:1487**  
 family influences and, **4:1442**  
 group and societal analysis level and, **4:1444**  
 individual level of analysis of, **4:1441–1442**  
 limited information regarding, **4:1435–1436**  
 "loss of face" concept and, **4:1435, 4:1442**  
 model minority myth and, **4:1435, 4:1442**  
 occupational discrimination and, **4:1442**  
 occupational segregation and, **4:1442**  
 occupational stereotyping and, **4:1442**  
 occupational values of, **4:1441**  
 personality traits associated with, **4:1441–1442**  
 within-group diversity and, **4:1442**

#### **Career counseling, gay and lesbian, 4:1443–1445**

acting, passing, covering, implicitly and explicitly out coping strategies and, **4:1444**  
 assessment bias potential and, **4:1444**  
 career choice stereotypes regarding, **4:1437, 4:1443**  
 coping strategies of, **4:1444**  
 counseling implications and, **4:1444–1445**  
 counselor personal values and, **4:1437, 4:1444, 4:1445**  
 discrimination management and, **4:1444**  
 formal vs. informal discrimination and, **4:1443**  
 GLB therapy and, **2:613–615**  
 identity management coping strategy and, **4:1444**  
 issues in, **4:1444–1445**  
 legal and institutionalized discrimination and, **4:1436–1437**  
 potential vs. encountered discrimination and, **4:1443**  
 real vs. perceived discrimination and, **4:1443**  
 sexual identity factor and, **4:1444**  
 sexual orientation, career effects and, **4:1624–1626**

#### **Career counseling, history of, 4:1445–1446, 4:1445–1450**

first stage: job placement services, **4:1445–1446**  
 second stage: educational guidance in the schools, **4:1446**



- third stage: colleges and universities and the training of counselors, **4:1446–1447**
- fourth stage: meaningful work and organizational career development, **4:1447–1448**
- fifth stage: independent practice career counseling and outplacement counseling, **4:1448–1449**
- sixth stage: new directions, **4:1449–1450**
- American Association for Counseling and Development and, **4:1447**
- American Counseling Association and, **4:1447**
- American Personnel and Guidance Association and, **4:1447**
- American School Counselor Association (ASCA) and, **1:5, 1:108, 1:123, 1:382, 4:1450, 4:1635**
- Americans with Disabilities Act (1990) and, **4:1450**
- American Vocational Association (AVA) and, **4:1450**
- Area Redevelopment Act (1961) and, **4:1447**
- Association for Career and Technical Education and, **4:1450**
- B'nai B'rith Vocational Service Bureau and, **4:1446**
- Bureau of Labor Statistics and, **4:1446, 4:1448**
- child labor laws and, **4:1446**
- Civilian Conservation Corps (CCC) and, **4:1446**
- Counseling and Guidance Training Institutes and, **4:1447**
- Jesse B. Davis and, **4:1446**
- Dictionary of Occupational Titles* and, **4:1446**
- disabled veterans and, **4:1447**
- economic issues regarding, **4:1445**
- Economic Opportunity Act (1964) and, **4:1447**
- Education Commission and, **4:1448**
- Employment and Training Agency and, **4:1448**
- Fair Labor Standards Act (1938) and, **4:1446**
- George-Deen Act (1936) and, **4:1446**
- George-Ellzey Act (1934) and, **4:1446**
- George-Reed Act (1929) and, **4:1446**
- GI Bill of Rights and, **4:1447**
- Greater Avenues to Independence and, **4:1449**
- Job Training Partnership Act and, **4:1449**
- Lyndon Johnson's Great Society and, **4:1447**
- John F. Kennedy and, **4:1447**
- Juliet Lester and, **4:1448**
- Manpower Development and Training Act (1962) and, **4:1447**
- National Board for Certified Counselors (NBCC) and, **4:1449**
- National Career Counselor Examination and, **4:1448**
- National Career Development Association (NCDA) and, **4:1446, 4:1449, 4:1450**
- National Center for Education Statistics and, **4:1448**
- National Certified Career Counselor credential and, **4:1449**
- National Council for Credentialing Career Counselors and, **4:1448**
- National Defense Education Act (NDEA, 1957) and, **4:1447**
- National Occupational Information Coordinating Committee (NOICC) and, **4:1448, 4:1450**
- National Vocational Guidance Association (NVGA) and, **4:1446, 4:1448**
- Omnibus Trade and Competitiveness Act (1988) and, **4:1449**
- One-Stop Career Centers Act (1994) and, **4:1450**
- outplacement counseling and, **4:1449**
- Frank Parsons and, **4:1445**
- Carl D. Perkins Vocational and Applied Technology Education Act Amendments (1998) and, **4:1450**
- Carl D. Perkins Vocational Education Act (1984) and, **4:1449**
- Progressive social reform movement and, **4:1445, 4:1446**
- psychological testing and, **4:1445–1446**
- School-to-Work Opportunities Act (1994) and, **4:1450**
- Smith-Hughes Act (1917) and, **4:1446**
- Social Security Act (1967) and, **4:1447**
- Sputnik* launch and, **4:1446–1447**
- State Occupational Information Coordinating Committees (OICCs) and, **4:1448, 4:1450**
- Donald Super's developmental theory and, **4:1449**
- technology advancements and, **4:1450**
- underserved populations and, **4:1449**
- Vocational/Career Counseling Competencies and, **4:1448**
- Vocational Education Act Amendments (1967) and, **4:1448**
- Vocational Education Act (1963) and, **4:1447, 4:1449**
- vocational education and, **4:1446**
- Eli Weaver and, **4:1446**
- Welfare to Work (1997) and, **4:1449**
- Workforce 2000* and, **4:1448**
- workforce demographic changes and, **4:1450**
- Workforce Initiative Act (1998) and, **4:1449**
- Works Progress Administration and, **4:1446**
- World War I veterans and, **4:1445**
- World War II and, **4:1446–1447**
- Career counseling, immigrants, 4:1451–1453**
- ACA Code of Ethics and, **4:1452**
- administrative barriers and, **4:1436**
- Center for Immigration Studies and, **4:1451**
- counseling implications of, **4:1451–1452**
- cultural adjustments and, **4:1452**



employment barriers experienced by, **4:1451**  
ethical issues and, **4:1452**  
Eurocentric focus factor and, **4:1436**  
family role in, **4:1452**  
gender issues and, **4:1452**  
green cards and, **4:1451**  
Holland's RIASEC model and, **4:1452**  
illegal immigration and, **4:1451**  
immigrant children and, **4:1451**  
immigration processes and, **4:1451**  
immigration statistics and, **4:1451**  
individualistic vs. collectivistic cultural factors and, **4:1452**  
information importance and, **4:1451**  
interpersonal styles factor and, **4:1436, 4:1451**  
language barrier and, **4:1436, 4:1451**  
multicultural counseling application to, **4:1452**  
personal issues factor and, **4:1436**  
professional credentials and, **4:1451**  
Strong Interest Inventory and, **4:1452**  
translation methods and, **3:1350–1353**  
Web site, **4:1453**

**Career counseling, Latinos, 4:1453–1456**

annual earnings statistics and, **4:1438**  
Blustein's psychology of working and, **4:1455**  
career assessment with Latinos and, **4:1455**  
career-related self-beliefs and, **4:1435–1436, 4:1453**  
counseling considerations and, **4:1453, 4:1455**  
culture and, **4:1454, 4:1455**  
education factors and, **4:1436**  
empirical information limitations and, **4:1454**  
environment and, **4:1454**  
family core value and, **4:1435–1436, 4:1454**  
general theories and, **4:1455**  
Latino-specific theories and, **4:1455**  
mentors and, **4:1454**  
Mexican American women career model and, **4:1455**  
multicultural theories, **4:1455**  
nonlinear career path process and, **4:1454**  
social class influences and, **4:1454**  
theories and models for, **4:1454–1455**  
within-group diversity and, **4:1453**

**Career counseling, Native Americans, 4:1456–1458**

academic achievement deficit of, **4:1456**  
biculturalism element of, **4:1457, 4:1458**  
collectivist values and, **4:1436, 4:1458**  
counseling implications of, **4:1457–1458**  
culture and context focus of, **4:1457**  
family and tribe factors in, **4:1436**  
First Nations people of Canada and, **4:1457**

Holland's RIASEC model and, **4:1457**  
modern perspectives on, **4:1456–1457**  
physical place emphasis and, **4:1436, 4:1458**  
positivistic, universalistic assumptions and, **4:1456–1457**  
postmodern perspectives on, **4:1457**  
social connections importance and, **4:1457–1458**  
social unit advancement factor and, **4:1436**  
traditional culture commitment and, **4:1436**  
unemployment, poverty statistics and, **4:1456**  
within-group differences and, **4:1458**

**Career counseling in colleges and universities, 4:1458–1460**

adults returning to college and, **4:1459**  
assessment devices and, **4:1459**  
attachment theory and, **4:1411**  
campus career centers and, **4:1460**  
career classes and, **4:1485**  
career decision making and, **4:1458–1459**  
career services availability and, **4:1433**  
career workshops and, **4:1485**  
client demand and, **4:1517**  
cooperative education and internship programs and, **4:1460**  
developmental theory and, **4:1458–1459**  
disabled students and, **4:1459**  
exploratory stage in, **4:1433**  
group career counseling and, **4:1484**  
individual vs. group counseling and, **4:1459**  
informational interviewing and, **4:1459**  
information resources and, **4:1459, 4:1460**  
insufficient staff and, **4:1517**  
life stage progressions and, **4:1459**  
minority student services and, **4:1460**  
older adult student needs and, **4:1433**  
people of color career development and, **4:1459**  
personality traits with job characteristics match and, **4:1459**  
professionals providing career services and, **4:1460**  
self-directed career planning and, **4:1459**  
self-knowledge need and, **4:1433, 4:1459, 4:1460**  
services offered and, **4:1459–1460**  
time constraints in, **4:1516–1517**  
university counseling centers and, **1:431–437**  
women's career development and, **4:1459**  
world of work knowledge and, **4:1459–1460**

*See also specific instrument*

**Career counseling in organizations, 4:1461–1463**

American Counseling Association (ACA) and, **4:1461**  
American Psychological Association (APA), Division 17 and, **4:1461**



- business life cycle factor and, **4:1462**
- career management term and, **4:1461**
- computer-assisted guidance systems and, **4:1462**
- contemporary perspective on, **4:1461–1462**
- correctional facilities and, **4:1433, 4:1461**
- employee selection and, **4:1433**
- future prospects regarding, **4:1462–1463**
- government agencies and, **4:1433**
- group guidance and counseling and, **4:1462**
- history of, **4:1447–1448**
- individual career advancement and, **4:1433**
- industrial era and, **4:1461**
- information-service era and, **4:1461**
- internal vs. external career professionals and, **4:1462**
- interventions used in, **4:1462**
- military to civilian occupation transition and, **4:1461**
- organizational settings and, **4:1461**
- paraprofessional titles of, **4:1461–1462**
- professional identity, **4:1461–1462**
- rehabilitation agencies and, **4:1433**
- role and function of, **4:1462**
- training in organizations and, **4:1661–1663**
- 20th-century foundation of, **4:1461**
- U.S. Employment Service and, **4:1461**
- Career counseling in schools, 4:1463–1466**
  - academic achievement and, **2:448–455, 4:1391–1392**
  - assessment and, **4:1463**
  - attachment theory and, **4:1411**
  - B'nai B'rith Vocational Service Bureau and, **4:1446**
  - career choice process and, **4:1464**
  - career days, speakers and, **4:1432**
  - Career Decision Scale and, **4:1464**
  - career fantasies to realistic career planning transition and, **4:1432**
  - Career Maturity Inventory and, **4:1464**
  - Career Planning Survey and, **4:1495–1496**
  - Civilian Conservation Corps (CCC) and, **4:1446**
  - client demand and, **4:1517**
  - constructivist and hermeneutic approaches to, **4:1465**
  - contextual considerations of, **4:1464–1465**
  - counselor knowledge, roles and competencies in, **4:1465**
  - Jesse B. Davis and, **4:1446**
  - defining characteristics of, **4:1463**
  - developmental pace changes and, **4:1432**
  - developmental stages focus of, **4:1463–1464**
  - Dictionary of Occupational Titles* and, **4:1446**
  - elementary through high school years and, **4:1432**
  - exploration stage of, **4:1464**
  - in high school, **4:1432–1433**
  - history of, **4:1446**
  - identity development statuses and, **4:1464**
  - information and its application to, **4:1464**
  - insufficient staff and, **4:1517**
  - job, career, world of work changes and, **4:1464–1465**
  - in middle school, **4:1432**
  - My System of Career Influences and, **4:1465**
  - National Career Development Association (NCDA) and, **4:1465**
  - parental careers and, **4:1463–1464**
  - personal counseling and, **4:1463**
  - Progressive reform and, **4:1446**
  - theoretical developments in, **4:1465–1466**
  - time constraints and, **4:1465–1466**
  - Eli Weaver and, **4:1446**
  - Web site, **4:1466**
  - work-bound youth and, **4:1678–1680**
  - Works Progress Administration and, **4:1446**
  - See also specific instrument*
- Career counseling process, 4:1466–1468**
  - assessment interpretation and, **4:1467–1468**
  - career/life paradigm and, **4:1488–1490**
  - dose effect, number of sessions and, **4:1467**
  - face-to-face interaction and, **4:1466**
  - factors worthy of additional investigation in, **4:1467–1468**
  - helping skills importance in, **4:1466–1467**
  - minority intervention selection and, **4:1467**
  - negative outcomes process factors and, **4:1467**
  - personal counseling vs., **4:1466–1467**
  - positive outcomes process factors and, **4:1467**
  - working alliance importance and, **4:1467**
- Career Decision-Making Difficulties Questionnaire (CDDQ), 4:1468–1469**
  - Adult Career Concerns Inventory (ACCI) and, **4:1400–1401**
  - career decision-making measure of, **4:1481, 4:1590**
  - categories of difficulties of, **4:1468**
  - description of, **4:1468–1469**
  - reliability, consistency of, **4:1469**
  - research finding regarding, **4:1469**
  - taxonomy of, **4:1468**
  - Web site regarding, **4:1469**
- Career Decision Scale (CDS), 4:1469–1470**
  - career counseling in schools and, **4:1464**
  - career decision making tool of, **4:1590**
  - career indecision and, **4:1481**
  - CDDQ and, **4:1469**
  - factor structure of, **4:1470**
  - Holland's Vocational Identity Scale and, **4:1673**
  - Samuel H. Osipow and, **4:1590**



reliability and validity of, **4:1469–1470**  
 score interpretation of, **4:1470**  
 structure of, **4:1469**  
 undergraduates clinical experience and, **4:1469**

**Career Decision Self-Efficacy Scale (CDSE),  
 4:1470–1471**

attachment theory and, **4:1411**  
 Bandura's self-efficacy theory and, **4:1470**  
 career choice competencies and sample items on, **4:1470**  
 CDDQ and, **4:1469**  
 empirical research regarding, **4:1470–1471**  
 five-level response continuum of, **4:1470**  
 self-efficacy definition and, **4:1470**  
 short form of, **4:1470**  
 theory of career maturity and, **4:1470**  
 use in evaluating career development  
 interventions, **4:1471**

*Career Development: Choice and Adjustment* (Tiedeman  
 and O'Hara), **4:1658**

**Career Development Inventory (CDI), 4:1471–1472**

Career Pattern Study and, **4:1471, 4:1646, 4:1648**  
 composite score scales of, **4:1472**  
 decision-making readiness and, **4:1471, 4:1472**  
 research on, **4:1472**  
 scales of, **4:1471**  
 Donald Super's career development theory and,  
**4:1471, 4:1646–1647**  
 uses of, **4:1472**

**Career Development Quarterly (CDQ), 4:1472–1473**

APA style manual and, **4:1473**  
 Editorial Board of, **4:1473**  
 name change history of, **4:1473**  
 National Career Development Association (NCDA)  
 and, **4:1472**  
 professional literature reviewed in, **4:1472–1473**  
*Social Sciences Citation Index* and, **4:1472**  
 subjects covered in, **4:1472**  
 Web site, **4:1473**

**Career education, 4:1473–1474**

career knowledge and decision making skills  
 importance and, **4:1474**  
 career planning and, **4:1494–1495**  
 Career Planning Survey and, **4:1495–1496**  
 career support term and, **4:1473**  
 challenges faced by, **4:1473–1474**  
 components of, **4:1473**  
 curricular aspects of, **4:1474**  
 curricular school-to-work programs meaning of, **4:1473**  
 decision making skills and, **4:1474**  
 exploration stage importance and, **4:1474**

external agencies contracted to provide, **4:1473**  
 global economic forces and, **4:1474**  
 holistically planned programs and, **4:1473**  
 knowledge of world of work and, **4:1474**  
 life skills-based syllabi meaning of, **4:1473**  
 life transition coping skills and, **4:1474**  
 mainstream education provision of, **4:1473**  
 self-awareness development and, **4:1474**  
 technology changes and, **4:1474**  
 work-bound youth and, **4:1678–1680**

**Career Exploration**

career planning and, **4:1494–1495**

**Career exploration, 4:1474–1477**

Adult Career Concerns Inventory (ACCI) and,  
**4:1400–1401, 4:1650**  
 attachment theory and, **4:1410–1411**  
 Career Exploration Program (CEP) and, **4:1405**  
 Career Planning Survey and, **4:1495–1496**  
 children's vocational development and, **4:1475**  
 conceptual and propositional model of, **4:1475**  
 conclusions regarding, **4:1476**  
 conscious and unconscious activities of, **4:1475**  
 definition of, **4:1474–1475**  
 diversive exploratory behavior and, **4:1475–1476**  
 exploration definitions and, **4:1475–1476**  
 exploratory competence and, **4:1475**  
 history of the concept and, **4:1475**  
 importance of, **4:1474**  
 integrating broader literature with, **4:1476**  
 literature review regarding, **4:1475–1476**  
 specific exploratory behavior and, **4:1476**  
 Donald Super's career development theory and,  
**4:1475, 4:1649**  
 vocational exploration and, **4:1475**

Career Exploration Program (CEP), **4:1405**

**Career Factors Inventory (CFI), 4:1477–1480**

accuracy of self-scoring instruments and, **4:1479**  
 administration of, **4:1477–1478**  
 ambiguous wording of, **4:1479**  
 Career Choice Anxiety scale of, **4:1477, 4:1478**  
 career indecision and, **4:1481**  
 career indecision focus of, **4:1477**  
 convergent and discriminate validity of, **4:1479**  
 criterion-related validity of, **4:1479**  
 decision needs measured by, **4:1477**  
 description of, **4:1477**  
 evaluation of, **4:1479**  
 factorial validity of, **4:1478–1479**  
 Generalized Indecisiveness scale of, **4:1477**  
 informational needs measured by, **4:1477**



- interpretation of, **4:1478**  
 Need for Career Information scale of, **4:1477, 4:1478**  
 Need for Self-Knowledge scale of, **4:1477, 4:1478**  
 reliability of, **4:1478**  
 stability of scores on, **4:1479**  
 Career Horizons program, **4:1679**  
**Career indecision, 4:1480–1482, 4:1482**  
   America's Career InfoNet and, **4:1481**  
   anxiety management and, **4:1482**  
   assessment of, **4:1481**  
   Career Decision Difficulties Questionnaire (CDDQ)  
     assessment of, **4:1481**  
   Career Decision Scale (CDS) assessment of, **4:1481**  
   Career Factors Inventory (CFI) assessment of, **4:1481**  
   career planning and, **4:1494–1495**  
   Career Thoughts Inventory (CTI) assessment of,  
     **4:1481, 4:1482**  
   choice anxiety and, **4:1480–1481**  
   chronic indecisiveness and, **4:1481**  
   cohesive identity need and, **4:1482**  
   definition of, **4:1480**  
   developmental indecision and, **4:1481**  
   disagreement with others and, **4:1481**  
   DISCOVER and, **4:1481**  
   identity diffusion and, **4:1480**  
   interventions for, **4:1481–1482**  
   lack of/need for information and, **4:1480**  
   Making Better Career Decisions systems and, **4:1481**  
   negative affect stabilization and, **4:1482**  
   Occupational Information Network (O\*NET)  
     and, **4:1481**  
   trait indecision and, **4:1480, 4:1481–1482**  
   Web sites regarding, **4:1482**  
**Career interventions, 4:1482–1488**  
   card sorts and, **4:1483–1484**  
   career advancement and, **4:1423–1424**  
   career assessment interpretation and, **4:1483–1484**  
   career choice and, **4:1483**  
   career classes and, **4:1485**  
   career counseling and, **4:1482–1483**  
   career/life paradigm and, **4:1488–1490**  
   career satisfaction counseling and, **4:1483**  
   career workshops and, **4:1485**  
   CHOICES and, **4:1485–1486**  
   client contextual factors and, **4:1487**  
   cognitive variables assessment and, **4:1484**  
   computer assisted career guidance systems (CACGS)  
     and, **4:1485–1486, 4:1487**  
   counselor-directed intervention outcomes and, **4:1487**  
   counselor-free interventions and, **4:1486**  
   cultural and contextual factors importance and, **4:1483**  
   definition of, **4:1482**  
   DISCOVER and, **4:1485–1486**  
   effectiveness of, **4:1486–1487**  
   elements of effective interventions and, **4:1487**  
   future implications regarding, **4:1487**  
   General Aptitude Test Battery and, **4:1484**  
   group assessment interpretations, **4:1484–1485**  
   group career counseling and, **4:1484**  
   job finding counseling and, **4:1483**  
   multicultural focus needed by, **4:1487**  
   outcomes meta-analysis and, **4:1486**  
   Frank Parsons' vocational guidance work and, **4:1482**  
   process variables assessment and, **4:1484**  
   SIGI PLUS and, **4:1485–1486**  
   Strong Interest Inventory and, **4:1483, 4:1484**  
   therapeutic relationship components and, **4:1483**  
**Career/life, 4:1488–1490**  
   Adult Career Concerns Inventory (ACCI) and,  
     **4:1400–1401, 4:1650**  
   Brown's values-based career theory and, **4:1415–1416**  
   career advancement and, **4:1423–1424**  
   career development needs of poor people and, **4:1490**  
   economic globalization and, **4:1490**  
   emergence of, **4:1488**  
   future challenges and directions regarding, **4:1490**  
   holistic paradigm of, **4:1488**  
   intertwined issues of, **4:1488–1489**  
   life-role balance and, **4:1571–1573**  
   National Career Development Association and, **4:1489**  
   National Vocational Guidance Association and, **4:1489**  
   Frank Parsons' vocational guidance work of, **4:1489**  
   person-environment matching and, **4:1489**  
   society changes and, **4:1490**  
   Super's life/career rainbow concept and, **4:1488**  
   technology advancements and, **4:1490**  
   vocational guidance roots of, **4:1489**  
   work-family balance and, **4:1680–1684**  
**Career Mastery Inventory (CMAS), 4:1490–1491**  
   adjustive coping response and, **4:1491**  
   Career Adjustment and Development Inventory (CADI)  
     and, **4:1488–1490**  
   coping with work place problems portion of, **4:1491**  
   establishment stage of career development and,  
     **4:1490–1491, 4:1649**  
   hand vs. machine scoring of, **4:1491**  
   integrative coping response and, **4:1491**  
   mastery of developmental tasks portion of, **4:1490–1491**  
   nonadjustive coping response and, **4:1491**  
   *User's Guide* of, **4:1491**



**Career maturity, 4:1491–1492**

career adaptability term and, 4:1493  
 career decision-making elements and, 4:1491  
 career decision vs., 4:1491  
 career planning and, 4:1494–1495  
 career programs goal of, 4:1491  
 definition of, 4:1491  
 flexibility or adaptability importance and, 4:1492  
 Frank Parsons and, 4:1491  
 positive attitude and, 4:1492  
 self-knowledge and, 4:1491  
 Donald E. Super's life-span vocational development model and, 4:1402, 4:1491  
 vocational identity and, 4:1672–1673  
 world of work knowledge and, 4:1491–1492  
*See also Career Maturity Inventory (CMI)*

**Career Maturity Inventory (CMI), 4:1492–1493**

career adaptability term and, 4:1493  
 career counseling in schools and, 4:1464  
*Career Developer* guide and, 4:1492  
 competencies measured by, 4:1492  
 John Crites and, 4:1492–1493, 4:1520  
 cross-cultural considerations of, 4:1492  
 cultural bias revision of, 4:1493  
 potential uses of, 4:1492  
 readiness attitudes of students and, 4:1492  
 revision of, 4:1493  
 self-knowledge measured by, 4:1492  
 Donald Super's career development theory and, 4:1492  
 Web site, 4:1493  
 world-of-work knowledge measured by, 4:1492

**Career Occupational Preference System (COPSystem), 4:1493–1494**

Career Ability Placement Survey (CAPS) component of, 4:1493–1494  
 Career Orientation Placement and Evaluation Survey (COPES) component of, 4:1493, 4:1494  
 COPSystem Interest Inventory (COPS) component of, 4:1493  
 employment clusters of, 4:1493

Career Pattern Study, 4:1471, 4:1646, 4:1648

**Career planning, 4:1494–1495**

career plan implementation stage of, 4:1495  
 Career Planning Survey and, 4:1495–1496, 4:1667  
 computer-assisted career guidance systems (CACGS) and, 4:1494  
 definition of, 4:1494  
 in-depth evaluation and goal setting stage of, 4:1494–1495  
 knowledge of academic-career options stage of, 4:1494

Occupational Information Network (O\*NET) resource of, 4:1494

*Occupational Outlook Handbook of*, 4:1494

problem-solving appraisal and, 2:789–790

self-assessment stage of, 4:1494

vocational identity and, 4:1672–1673

**Career Planning Survey, 4:1495–1496**

ACT World-of-Work Map and, 4:1495

assessments feature of, 4:1495

*Career Planning Survey Technical Manual* and, 4:1495, 4:1496

John Holland's theory of careers and, 4:1495

Inventory of Work-Relevant Abilities (IWRA) and, 4:1495

Japanese Edition of, 4:1496

score report, student materials features of, 4:1495–1496

Unisex Edition of the ACT Interest Inventory (UNIACT) and, 4:1495, 4:1667

*Career Planning Survey Technical Manual*, 4:1495, 4:1496

Career Planning System, 4:1431, 4:1511

**Career Resource Centers (CRC), 4:1496–1498**

assessment instruments and, 4:1497

budget of, 4:1497

career centers and, 4:1496

career counseling availability at, 4:1497

definitions of, 4:1496

development of, 4:1496–1497

educational settings and, 4:1496

information resources and, 4:1497

instructional resources and, 4:1497

Internet, virtual CRCs and, 4:1498

location and facilities of, 4:1497–1498

marketing and public relations of, 4:1498

materials acquisition, management and, 4:1498

Frank Parsons Vocation Bureau and, 4:1496

resources found at, 4:1497

services provided by, 4:1496

staffing and operations of, 4:1497

vocational guidance movement and, 4:1496

**Career Services Model, 4:1498–1499**

active environment negotiation concept and, 4:1499

assessment and, 4:1499

career adjustment issues and, 4:1499

career choice problem and, 4:1499

career development issues and, 4:1499

career education issues and, 4:1499

career/life development and, 4:1499

career life span issues and, 4:1499

career placement issues and, 4:1499

career problem assessment and, 4:1499



- career service areas of, **4:1498**
- client self-concept and job matches and, **4:1499**
- developmental levels of, **4:1498**
- interpersonal and intrapersonal domains of, **4:1498–1499**
- theory and practice connection theory and, **4:1498**
- Career Style Interview (CSI), 4:1499–1502**
  - Adlerian and constructivism influences on, **4:1500**
  - career adaptability and, **4:1501**
  - career construction theory and, **4:1429**
  - career style definition and, **4:1500**
  - early recollections, memories and, **4:1501**
  - early role models identification and, **4:1501**
  - history of, **4:1500**
  - John Holland's RIASEC model and, **4:1500–1501**
  - life themes and, **4:1500, 4:1501–1502**
  - narratives or self-stories used by, **4:1500**
  - process of, **4:1500–1502**
  - Super's life-span life-space career approach and, **4:1500**
  - theory of career construction and, **4:1500**
  - vocational personality and, **4:1500–1501**
- Career Thoughts Inventory (CTI), 4:1502–1503**
  - administration and scoring of, **4:1503**
  - career indecision and, **4:1481, 4:1482**
  - CDDQ and, **4:1469**
  - cognitive information processing theory and, **4:1502**
  - construct scales of, **4:1502–1503**
  - CTI Workbook* and, **4:1502**
  - dysfunctional career thoughts measured by, **4:1502**
  - knowledge domains and, **4:1502**
  - problem solving and decision making skills assessment and, **4:1507**
  - problem solving thinking and
    - decision-making and, **4:1502**
  - self-administered, objectively scored and, **4:1502**
- Career Transitions Inventory (CTI), 4:1503–1504**
  - career change examples and, **4:1503**
  - career transitions definition and, **4:1503**
  - internal process career transition variables and, **4:1503**
  - personality traits and, **4:1504**
  - transition factors measured by, **4:1503**
- Caregiver burden, 1:63–66**
  - caregiver, care receiver demographics and, **1:63**
  - Caregiver Strain Index measure of, **1:65**
  - caregiver well-being vs., **1:65**
  - contextual variables and, **1:64**
  - definition of, **1:63**
  - elder abuse and, **2:447–448**
  - group vs. individual support or therapy for, **1:65–66**
  - informal caregivers and, **1:63**
  - instrumental vs. personal activities of daily living and, **1:63**
  - interventions to reduce, **1:65–66**
  - measurement of, **1:64–65**
  - mediator variables in, **1:64**
  - mental retardation, developmental disabilities and, **1:296**
  - National Alliance for Caregiving and, **1:63**
  - objective vs. subjective burden and, **1:64**
  - as predictor vs. outcome, **1:63–64**
  - receiver illness variables and, **1:63–64**
  - respite care and, **1:65**
  - Zarit Burden Interview measure of, **1:64–65**
  - See also Caregiving*
- Caregiver Strain Index (CSI) measure, **1:65**
- Caregiver-Teacher Report For (C-TRF)/1½-5 Achenbach behavior rating scale, **1:46**
- Caregiving, 1:66–69**
  - adverse outcomes of, **1:67**
  - approach-related coping strategies and, **1:67–68**
  - caregiver burden contextual factors and, **1:67**
  - caregiver experience elements and, **1:67**
  - coping with, **1:67–68**
  - cultural differences in, **1:67**
  - definition of, **1:66–67**
  - elder abuse and, **2:447–448**
  - emotion-focused coping strategies and, **1:67**
  - "Graying of America" concept and, **1:66**
  - hospice care and, **1:243–245**
  - informal caregiving and, **1:66–67**
  - mental retardation, developmental disabilities and, **1:296**
  - negative and positive outcomes of, **1:67**
  - "positive aging" approach skills and, **1:68**
  - Positive Aspects of Caregiving Scale and, **1:68**
  - positive counseling approach to, **1:68**
  - See also Caregiver burden*
- Carkhuff, Robert R., **2:919**
- Carkoff, R., **1:406**
- Carlisle Indian Industrial School, **3:1039–1040**
- Carlson, Caryn, **1:157**
- Carney, C., **4:1469**
- Carr, Leslie, **3:1064–1065**
- Carroll, John, **2:924**
- Carter, Jean, **1:132**
- Carter, Jimmy, **3:994**
- Carter, R. T., **3:1281–1282, 3:1385**
- Carter, Robert L., **3:1238**
- Carter, Robert T., **3:1285**
- Cartwright, Samuel Adolphus, **3:1124**
- Carver, Charles S., **2:707**



CAS. *See* Cognitive Assessment System (CAS) of cognitive intelligence

**Casas, Jesús Manuel, 3:1043–1045**

advocacy, consultation work of, **3:1044**

Donald Ray Atkinson and, **3:1006**

Chicano/a psychology focus of, **3:1043–1044**

childhood of, **3:1043**

discrimination experiences of, **3:1043**

honors and awards received by, **3:1043**

multicultural counseling work of, **3:1043–1044**

professional associations and leadership of, **3:1043–1044**

publications of, **3:1044**

racial/ethnic heritage of, **3:1043**

teaching, mentoring accomplishments of, **3:1044**

Case study qualitative method

case within case study design and, **1:361**

collective case studies and, **1:361**

holistic case study and, **1:360**

intense description of one bonded unit and, **1:360**

intrinsic vs. instrumental cases and, **1:360–361**

Casey, Patricia R., **2:732**

CASI. *See* **Career Attitudes and Strategies Inventory (CASI)**

Cass, Vivian, **2:614**

Castellazzo, Grace, **3:1328**

Castonguay, Louis, **1:175, 2:649**

CASVE Cycle. *See* **Cognitive Information Processing Model (CIP)**

CAT. *See* California Achievement Test (CAT)

CAT/6. *See* California Achievement Test, Sixth Edition (CAT/6)

Cattell, James M.

Cattell-Horn-Carroll (CHC) theory of cognitive abilities and, **2:497, 2:498**

group intelligence tests, large samples and, **1:133, 1:364**

Frederic Kuder and, **4:1568**

psychological testing, career counseling and, **4:1445**

three-stratum hierarchy of intelligence and, **2:498**

David Wechsler and, **2:938**

Cattell, Raymond B., **2:736**

hierarchical theory of intelligence and, **2:924**

personality theory of, **2:752, 2:770, 2:813**

Caukins, Mary, **1:370**

C-BAR. *See* **Community-based action research (C-BAR)**

CBASP. *See* Cognitive-behavioral analysis system of psychotherapy (CBASP)

CBCL. *See* Child Behavior Checklist (CBCL)/6-18 Achenbach behavior rating scale

CBI. *See* **Career Barriers Inventory (CBI); Career Beliefs Inventory (CBI)**

CBPMT. *See* Cambridge Behaviour Prospective Memory Test (CBPMT)

CBT. *See* **Cognitive-behavioral therapy and techniques (CBT)**

CCC. *See* Civilian Conservation Corps (CCC)

CCMHC. *See* Certified Clinical Mental Health Counselor (CCMHC)

CCPTP. *See* Council of Counseling Psychology Training Programs (CCPTP)

CCSC. *See* Children's Coping Strategies Checklist (CCSC)

CDDQ. *See* **Career Decision-Making Difficulties Questionnaire (CDDQ)**

CDI. *See* **Career Development Inventory (CDI)**

CDIB. *See* **Certificate of Degree of Indian Blood (CDIB)**

CDQ. *See* **Career Development Quarterly (CDQ)**

CDS. *See* **Career Decision Scale (CDS)**

CDSE. *See* **Career Decision Self-Efficacy Scale (CDSE)**

Cellular aging theory, **1:16**

Center for Epidemiological Studies' Depression Scale, **2:558**

Center for Immigration Studies, **4:1451**

CEP. *See* Career Exploration Program (CEP)

**Certificate of Degree of Indian Blood (CDIB), 3:1045–1046**

blood quantum and, **3:1045, 3:1183**

colonization and, **3:1045**

controversy regarding, **3:1045–1046**

Freedmen discrimination by, **3:1046**

Quarter Blood Amendment Act (1985) and, **3:1045**

tribal rolls and, **3:1045**

Certificate of Professional Qualification in Psychology (CPQ), **1:144–145**

Certificate of Proficiency, of APA, **1:145**

Certified Clinical Mental Health Counselor (CCMHC), **1:142, 1:143**

Certified Family Therapist (CFT), **1:143**

Certified Group therapist (CGP), **2:621**

Certified Rehabilitation Counselor (CRC), **1:143, 2:831**

CFI. *See* **Career Factors Inventory (CFI)**

CFT. *See* Certified Family Therapist (CFT)

Chang, Alice, **2:994, 3:995**

**Change agent, 3:1046–1047**

change induction groups, T-groups and, **3:1046**

client self-regulation and, **3:1046**

definition of, **3:1046**

ethics codes and, **3:1046–1047**

multicultural personality and, **3:1226–1227**



- psychological and behavior functioning alterations and, **3:1046**
- Self-System psychotherapy awareness movement, **3:1046**
- social justice and, **3:1322**
- tokenism and, **3:1349–1350**
- World War II group dynamics research and, **3:1046**
- Change Through Interaction* (Strong and Claiborn), **2:892**
- Chartrand, Judy M., **4:1477**
- Chase, Christopher, **1:158**
- Chávez, César, **3:1048**, **3:1127**
- Chavis, Benjamin, **3:1239**
- Chavous, Tabbye, **3:1038**
- CHEA. *See* Council for Higher Education Accreditation (CHEA)
- Chee, W., **1:247**
- Chesler, Phyllis, **3:1316**, **3:1318**
- Chickering, A. W., **1:166**
- Child Abuse Prevention and Treatment Act (CAPTA), **1:71**
- Child Behavior Checklist (CBCL)
- AD/HD diagnosis and, **1:29**
  - conduct disorder and, **1:100**
  - oppositional defiant disorder and, **1:100**
- Child Behavior Checklist (CBCL)/6-18 Achenbach behavior rating scale, **1:45–46**
- Childhood disintegrative disorder. *See* **Autism/Asperger's syndrome**
- Child maltreatment, 1:69–75**
- abuse and, **1:70**
  - American Humane Association and, **1:71**
  - brain development and, **1:72**
  - causes of, **1:71–72**
  - Child Abuse Prevention and Treatment Act and, **1:71**
  - child factors in, **1:71**
  - child labor laws and, **1:70**, **1:71**
  - child welfare agencies and, **1:71**
  - consequences of, **1:72–73**
  - counseling interventions and, **1:73–74**
  - cultural variables in, **1:73**
  - definitions of, **1:69–70**
  - environmental factors in, **1:72**
  - families and society affected by, **1:72–73**
  - family interventions and, **1:73**
  - forensic counseling application and, **1:215–216**
  - historical perspective on, **1:70–71**
  - incidence, demographic statistics of, **1:69**
  - Indian Child Welfare Act and, **1:71**
  - individual interventions and, **1:73**
  - internalizing disorders and, **1:72**
  - legal issues in parenting and, **1:278–281**
  - Making an Issue of Child Abuse* (American Humane Association) and, **1:71**
  - neglect and, **1:69**
  - parental factors in, **1:71**
  - Prevent Child Abuse America report and, **1:72**
  - prevention programs for, **1:74**
  - psychological maltreatment vs. emotional abuse and, **1:70**
  - sexual exploitation and, **1:70**
  - signs and symptoms of, **1:70**
  - systems framework regarding, **1:73**
  - treatment phases and, **1:73–74**
  - UN resolution on the Rights of Children and, **1:71**
  - willful neglect vs. poverty effects and, **1:69–70**
- Children's Coping Strategies Checklist (CCSC), **2:528**
- Children with chronic illness, 1:75–78**
- approach coping and, **1:77**
  - asthma and, **1:75**, **1:79**
  - cancer and, **1:75**, **1:79**
  - cognitive-behavioral therapy and, **1:77**
  - diabetes and, **1:75**, **1:79**
  - educational, systems approach interventions for, **1:77**
  - educational implications of, **1:76–77**
  - family-based interventions for, **1:77**, **1:79**
  - family implications of, **1:76**
  - Individualized Education Plan and, **1:77**
  - integrative, reintegration interventions for, **1:77–78**
  - juvenile rheumatoid arthritis and, **1:75**
  - low-incidence conditions and, **1:76**
  - pediatric cancer and, **1:60–61**
  - psychosocial and educational implications of, **1:76–77**
  - social, behavioral interventions for, **1:76–77**, **1:77**
  - social implications of, **1:76**
  - stress management and, **1:77**
- See also* **Chronic illness**
- Childress, James, **1:270**
- Child Welfare League of America, **3:1354**
- Chin, Robert, **3:994**
- "Chinatown," **3:1048**
- Chinese Americans
- bicultural conflict, depression and, **3:944**
  - Chinese Exclusion Act (1882) and, **3:1170**
- Chinese Exclusion Act (1882), **3:1048**, **3:1170**, **3:1373**
- Chi Sigma Iota (CSI) international honorary society, **1:354**
- CHOICES, **4:1485–1486**, **4:1512**
- Chomsky, N., **3:1348**
- Choney, Sandra, **3:1288**
- Choosing a Vocation* (Parsons), **1:121**, **4:1496**, **4:1537**, **4:1597**
- Chowdrow, N. J., **1:210**



Christal, Raymond E., 2:736, 2:752

**Chronic illness, 1:78–83**

- adjustments to living with, 1:78–79
- adults and, 1:78–79
- cancer management and, 1:59–63
- children or adolescents and, 1:75–78, 1:79
- Chronic Disease Self-Management Course and, 1:82
- chronic pain and, 1:83–87
- components of, 1:78–79
- counseling interventions and, 1:81–82
- counselor roles and, 1:82–83
- cultural diversity considerations and, 1:80
- denial and, 1:78
- diagnosis of, 1:78
- emotional changes and, 1:81
- family issues and, 1:79–80, 1:81
- formal measures assessment and, 1:81
- future directions in, 1:83
- genetic testing and, 1:83
- individual assessment and, 1:80–81
- interviews assessment and, 1:80–81
- meaning-making and, 1:80–81
- personal meaning of illness and, 1:80–81
- quality of life issues and, 1:81
- roles of the counselor and, 1:82–83
- self-efficacy enhancement intervention and, 1:82
- stress management intervention and, 1:82
- support group intervention and, 1:82

*See also* **Children with chronic illness; Chronic pain**

**Chronic pain, 1:83–87**

- alexithymia construct of, 1:84
- Elizabeth Altmaier's work in, 1:21–22
- antidepressant medication and, 1:86
- assessment of, 1:85–86
- Battery for Health Improvement assessment of, 1:85–86
- biopsychosocial phenomenon of, 1:83–84
- cancer management and, 1:59–63
- catastrophizing of, 1:86
- complex nature of, 1:84
- definitions of, 1:83–84
- development perspective on, 1:84
- endocrine system and, 1:85
- family affected by, 1:87
- hypnosis and, 1:248
- insomnia and, 1:86
- lifestyle changes and, 1:86
- limbically augmented pain syndrome and, 1:85
- low back pain, headaches prevalence and, 1:85
- management of, 1:86–87
- medical setting and, 1:85

- Melzack's gate control theory of, 1:84–85
- neuromatrix theory of, 1:85
- nociception sensory system and, 1:84
- physical vs. social pain and, 1:84
- psychosocial treatment of, 1:86
- self-limiting behavior and, 1:86
- sleep hygiene training and, 1:86
- somatic preoccupation with, 1:86
- stress management of, 1:86
- subjective nature of, 1:85
- theories of, 1:84–85
- visual analog vs. numerical rating scale of, 1:85
- See also* **Children with chronic illness; Chronic illness**

Chu, Serena, 2:909

*Church of Lukumi Babalu Aye v. City of Hialeah*, 3:1308

CIDI-CORE. *See* Composite International Diagnostic Interviews: Authorized Core Version 1.0 (CIDI-CORE)

**Cigarette smoking, 1:87–90**

- African Americans and, 1:93
- assessment of tobacco use and, 1:88
- brief clinical interventions and, 1:89
- clinical practice guidelines and, 1:88
- community-based health promotion and, 1:93–94
- counseling psychology role in cessation of, 1:88–89, 1:94
- dose-response relationship in, 1:89
- hazards of, 1:87–88
- intensive clinical interventions and, 1:89
- multicomponent treatment and, 1:94
- nicotine replacement therapy and, 1:94
- non-smoker health risks and, 1:87–88
- pharmacotherapies for, 1:89, 1:94
- psychiatric patients and, 1:88
- PTSD and, 1:88–89
- relapse prevention and, 1:89–90, 1:93, 1:94
- self-medication of emotional symptoms by, 1:88
- smoking cessation and, 1:88
- statistics and, 1:87
- tobacco dependence etiology and, 1:88
- willingness to quit and, 1:89

CIP. *See* **Cognitive Information Processing Model (CIP)**

CISD. *See* **Critical incident stress debriefing (CISD)**

CISS. *See* **Campbell Interest and Skill Survey (CISS)**

Civilian Conservation Corps (CCC), 4:1446

Civil Liberties Act (1988), 3:1048

**Civil rights, 3:1047–1050**

- affirmative action and, 3:957–958
- of African Americans, 3:1047–1048



- American Indian Civil Rights Act (1968) and, **3:1048**  
 American Indian Movement (AIM) and, **3:1048**  
 Asian American movement and, **3:1048**  
 of Asian Americans, **3:1048**  
 Asian American studies and, **3:1048**  
 Brown Berets and, **3:1048**  
*Brown v. Board of Education of Topeka, Kansas*  
   and, **3:1047**  
 César Chávez and, **3:1048**  
 “Chinatowns” and, **3:1048**  
 Chinese Exclusion Act (1882) and, **3:1048**  
 Civil Liberties Act (1988) and, **3:1048**  
 Kenneth Bancroft Clark and, **3:1050–1052**  
 definition of, **3:1047**  
 14th Amendment and, **3:1047**  
 Immigration Act (1924) and, **3:1048**  
 Indian Reorganization Act (1934) and, **3:1048**  
 Japanese internment camps and, **3:1048**  
 Jim Crow laws and, **3:1047**  
 Martin Luther King, Jr. and, **3:1047**  
 of Latino/a Americans, **3:1048–1049**  
 LGBT civil rights legislation and, **3:1049**  
 Malcolm X and, **3:1048**  
 mental health and, **3:1049**  
 National Association for the Advancement of Colored  
   People (NAACP) and, **3:1047**  
 of Native Americans/American Indians, **3:1048**  
 19th Amendment and, **3:1047**  
 of other marginalized groups, **3:1049**  
 Rosa Parks and, **3:1048**  
*Plessy v. Ferguson*, “separate but equal” and, **3:1047**  
 Poor People’s Campaign and, **3:1049**  
 Puerto Rican voting rights and, **3:1048–1049**  
 same-sex marriages and unions and,  
   **2:614, 3:1049, 3:1302**  
 Society for Human Rights and, **3:1049**  
 state civil union clauses and, **3:1049**  
 13th Amendment and, **3:1047**  
 Trail of Tears and, **3:1048**  
 United Farm Workers and, **3:1048**  
 of women, **3:1049**  
 written or implied law of, **3:1047**  
 Yellow Power movement and, **3:1048**  
*See also National Association for the Advancement of*  
   **Colored People** (NAACP); *specific legislation,*  
   *Supreme Court case*  
 Civil Rights Act of 1964, **3:957**  
   affirmative action and, **3:1123**  
   Americans with Disabilities Act and, **1:23**  
   importance of, **3:1221**  
   multicultural psychology and, **3:1228**  
   NAACP and, **3:1238**  
   pay equity and, **4:1595**  
 Civil Rights Act of 1991, **3:957, 3:1239**  
 Claiborn, Chuck, **2:892**  
 Clandinin, Jean, **1:361**  
**Clark, Kenneth Bancroft, 3:1050–1052**  
   academic years of, **3:1050**  
   *Brown v. Board of Education of Topeka, Kansas* and,  
     **3:1050, 3:1051, 3:1148, 3:1238**  
   childhood of, **3:1050**  
   Mamie Phipps Clark and, **3:1050**  
   cultural prejudice and, **3:1050**  
   deficits approach of ethnic identity study and, **3:1050**  
   doll study of, **3:1050, 3:1135, 3:1291, 3:1296**  
   Harlem Youth Opportunities Unlimited and, **3:1051**  
   Metropolitan Applied Research Center and, **3:1051**  
   NAACP work of, **3:1051**  
   Northside Center for Child Development  
     founded by, **3:1051**  
   racial identity development in children work of, **3:1050**  
   research and activism of, **3:1051**  
   segregated schools work of, **3:1050–1051**  
   social justice work of, **3:1050–1051**  
 Clark, Kenneth E., **4:1641**  
**Clark, Mamie Phipps, 3:1052–1054**  
   activism in the community by, **3:1053–1054**  
   *Brown v. Board of Education of Topeka, Kansas* and,  
     **3:1052, 3:1148**  
   Kenneth Bancroft Clark and, **3:1050–1052**  
   doll study of, **3:1050, 3:1135, 3:1291, 3:1296**  
   early life of, **3:1052**  
   Harlem Youth Opportunities Unlimited and,  
     **3:1053–1054**  
   Northside Center for Child Development and,  
     **3:1052, 3:1053**  
   racial self-identification work of, **3:1052–1053**  
   racism, discrimination experienced by, **3:1052**  
   training in psychology of, **3:1052–1053**  
   treatment philosophy of, **3:1053**  
 Clark, R., **3:1295**  
 Clarke, Russell, **2:793**  
 Classical conditioning  
   behavior therapy and, **2:470–471**  
   Ivan Pavlov’s work in, **2:736**  
   PTSD and, **2:787**  
**Classism, 3:1054–1059**  
   achievement gap and, **3:1056**  
   bias and, **3:1014–1016**  
   Class Action resource center and, **3:1054**



“cognitive and behavioral distancing from the poor”  
and, **3:1055–1056**

college education costs and, **3:1056**

conceptual framework regarding, **3:1055**

counseling psychology and, **3:1329**

definition of, **2:573–574, 3:1054**

depreciation of working-class people organizations  
example of, **3:1058**

educational inequities example of, **3:1056**

education as social equalizer and, **3:1056**

environmental injustice example of, **3:1057**

healthcare inequities example of, **3:1056–1057**

individual classism and, **2:574**

institutional classism and, **2:574**

invisibility of poor and working class example of,  
**3:1055–1056**

judicial system disparities example of, **3:1057**

labor unions and, **3:1058**

language use in, **3:1054**

living wage and, **3:1058**

middle class and, **3:1054**

minimum wage example of, **3:1057–1058**

negative attitudes and beliefs example of, **3:1056**

oppression vs. prejudice and, **3:1055**

owning class and, **3:1055**

political correctness and, **3:1263–1264**

poverty class and, **3:1054**

*The Shame of the Nation* (Kozol) and, **3:1056**

social class and, **4:1626–1627**

social power and powerlessness language of, **3:1054**

socioeconomic status and, **3:1329**

stereotype and, **3:1333–1339**

unconscious classism and, **3:1055**

White Americans and, **3:1371–1375**

working class and, **3:1054**

#### **Client attitudes and behaviors, 2:485–490**

action stage of therapeutic change and, **2:489**

APA Division 29, Task force on Empirically Supported  
Therapy Relationships and, **2:485**

client as “self-healer” and, **2:487**

client self-observation as precursor to  
change and, **2:489**

clinical presenting issues and, **2:491–494**

contemplation stage of therapeutic change and, **2:487**

deference and, **2:487**

empathy and, **2:486–487, 3:1066**

expectations about therapy and, **2:593–599, 3:1364**

first impression importance and, **2:485**

maintenance stage of therapeutic change and, **2:489**

meaning-making, attribution and, **2:485–486**

positive expectation, hope of, **2:513**

precontemplation stage of therapeutic change and, **2:487**

preparation stage of therapeutic change and, **2:487**

projection and, **2:485–486**

psychoeducation and, **2:799–803**

self-disclosure and, **2:488–489**

stages of change and, **2:487–488**

termination stage of therapeutic change and, **2:489**

therapeutic relationship and, **2:486, 2:513–514**

therapist self-disclosure and, **2:489**

therapist self-regulation and, **2:486**

transtheoretical model of therapeutic change  
and, **2:487–488**

*See also* Empathy of therapist; **Self-disclosure**

Client Career Counseling Checklist, **4:1439–1440**

Client Reactions System (CRS), **2:532–533**

Clinical Evaluation of Language Fundamentals, **2:670**

*Clinical Handbook of Marital Therapy*

(Jacobson and Gurman), **1:138**

#### **Clinical interview as an assessment**

##### **technique, 2:490–491**

Composite International Diagnostic Interviews:

Authorized Core Version 1.0 (CIDI-CORE)

and, **2:490**

Diagnostic Interview Schedule (DIS), **2:490, 2:810**

“ecological validity” concept and, **2:809**

information gathered during, **2:490, 2:809**

interviewing techniques and, **2:490–491**

multicultural counseling competence and, **3:961**

Psychiatric Research Interview for Substance and  
Mental Disorders (PRISM), **2:490**

Research Diagnostic Criteria (RDC), **2:809**

Schedule for Affective Disorders and Schizophrenia  
(SADS), **2:809**

Socratic Method and, **2:875–876**

structured, unstructured, semistructured

interview and, **2:490**

Structured Clinical Interview for Axis I DSM-IV  
Disorders (SCID-I), **2:490**

Structured Clinical Interview for the *DSM* (SCID), **2:810**

structured interviews, “objective” ratings from, **2:809**

therapist interpretation and, **2:910–911**

underdiagnosis/overdiagnosis and, **2:935–936**

unstructured interview, advantages of, **2:809**

unstructured interview, disadvantages of, **2:809**

#### **Clinical presenting issues, 2:491–494**

of adults, **2:493**

of children, adolescents, **2:492–493**

definition of, **2:491**

helping professional and, **2:491–492**



- of mandated clients, 2:493
- multicultural competency and, 2:492
- Policy Leadership Cadre for Mental Health in Schools (2001) report and, 2:492–493
- schizophrenia and, 2:845–849
- self-disclosure and, 2:851–852
- setting and, 2:492
- therapist sensitivity, competence in crisis management and, 2:491–492
- of young adults, 2:493
- Clinical Versus Statistical Prediction* (Meehl), 2:684
- Clinician-Administered PTSD Scale for the DSM-IV, 2:786
- Clinton, Bill
  - career development policies of, 4:1448, 4:1450
  - Race Advisory Board of, 3:994
- Cloninger's Temperament and Character Inventory (TCI), 2:725
- CMAS. *See* **Career Mastery Inventory** (CMAS)
- CMI. *See* **Career Maturity Inventory** (CMI); Cultural Mistrust Inventory (CMI)
- CNPAAEMI. *See* Council of National Psychological Associations for the Advancement of Ethnic Minority Interests (CNPAAEMI)
- Cobbs, Price, 3:1092, 3:1093, 3:1153
- CoBRAS. *See* Color-Blind Racial Attitudes Scale (CoBRAS)
- Code of ethics and standards of practice, 2:494–497**
  - confidentiality and, 2:495
  - confidentiality and legal privilege and, 2:519–522
  - current controversies and future directions regarding, 2:496
  - duty to warn and protect and, 2:575–578
  - ethics codes, need for, 2:495
  - false memories and, 2:604–605
  - as hallmark of a profession, 2:495
  - impairment and, 1:249–250
  - informed consent and, 2:495, 2:645–647
  - managed care, financial resources and, 2:496
  - moral principles of, 2:495
  - relationships with clients and, 2:832–837
  - responsibilities to clients and, 2:495
  - responsibilities to other professionals, 2:496
  - responsibility to human society, 2:496
  - social justice concern and, 2:496
  - therapist–client relationship and, 2:494
  - welfare of client primary importance and, 2:495, 2:496
- See also* American Counseling Association (ACA): code of ethics; **Standards and competencies**
- Code of Professional Ethics for Rehabilitation Counselors, 2:831
- Coercive restraint therapies, 2:629
- Cognition/intelligence, assessment of, 2:497–502**
  - adaptive behavior testing and, 2:455–457
  - classic assessment instruments and, 2:497–498
  - Cognitive Assessment System (CAS), 2:499
  - Comprehensive Test of Nonverbal Intelligence (CTONI), 2:500
  - Consensual Assessment Technique, 2:501
  - contemporary approaches to, 2:499–500
  - creativity and, 2:501
  - Differential Ability Scales (DAS), 2:499
  - Flynn effect and, 2:500–501, 2:656–657
  - giftedness and, 2:501
  - intelligence tests and, 3:1179–1182
  - Kauffman Adolescent and Adult Intelligence Test (KAIT), 2:498
  - Kaufman Assessment Battery for Children, Second Edition (KABC-II), 2:498
  - Kaufman Test of Educational Achievement, Second Edition (K-TEA II), 2:452
  - key issues in, 2:500–501
  - major developments regarding, 2:501
  - Naglieri Nonverbal Ability Test and, 2:500
  - neuropsychological functioning and, 2:695–702
  - nonverbal tests and, 2:499–500
  - norm- vs. criterion-referenced tests and, 2:451
  - planning-attention-simultaneous-successive model of human intelligence and, 2:498
  - Raven's Progressive Matrices, 2:499, 2:500, 2:656–657
  - Stanford-Binet Intelligence Scale (SB5), 2:497–498
  - Torrance Tests of Creative Thinking (TTCT), 2:501
  - Universal Nonverbal Intelligence Test (UNIT), 2:500
  - Wechsler scales, 2:498
  - Woodcock-Johnson Test of Cognitive Abilities, 2:498
- See also* **Intelligence**
- Cognitive-affective personality system, 2:746
- Cognitive Assessment System (CAS) of cognitive intelligence, 2:499
- Cognitive-behavioral analysis system of psychotherapy (CBASP), 2:514
- Cognitive-behavioral therapy and techniques (CBT), 2:502–508**
  - ABC model and, 2:504
  - action oriented feature of, 2:504
  - Adlerian therapy and, 2:458–459
  - anger management and, 1:214–215
  - applications of, 2:503



- Albert Bandura's social cognitive theory and, **2:505**  
Aaron T. Beck's work and, **2:469–470, 2:503, 2:504–505, 2:542, 2:701, 2:746**  
behavior rehearsal technique in, **2:506–507**  
behavior therapy and, **2:470–476**  
bipolar disorder and, **2:479**  
brief therapy and, **2:479–483**  
children with chronic illness and, **1:77**  
cognitive-behavioral analysis system of psychotherapy (CBASP) and, **2:514**  
Cognitive Behavioral Intervention for Trauma in Schools and, **1:165**  
cognitive restructuring technique, **2:506**  
cognitive theory of depression and, **2:505**  
cognitive therapy and, **2:504–505**  
cognitive triad concept of, **2:505**  
collaborative feature of, **2:503–504**  
conduct disorder and, **1:102**  
counselor self-disclosure and, **2:852**  
couple and marital counseling and, **1:138**  
dialectical behavior therapy and, **2:571–572**  
directive role of therapist and, **2:504**  
disasters, impact on children and, **1:165**  
eating disorder treatment and, **2:583**  
ecosystemic play therapy and, **1:332**  
emphasis on the present feature of, **2:504**  
empirical grounding of, **2:503**  
eye movement desensitization, reprocessing (EMDR) and, **1:198–202**  
flooding technique and, **2:507, 2:917–918**  
historical and theoretical background of, **2:502–503**  
imagery rehearsal technique in, **2:507**  
neurotic anxiety response habits and, **2:508**  
oppositional defiant disorder and, **1:318**  
overview of therapies, **2:504–506**  
for panic disorder, **2:718–719**  
pathological gambling and, **1:229**  
personality disorders and, **2:733**  
problem focused and goal oriented features of, **2:503**  
problem-solving therapy, decision-making counseling and, **2:505–506**  
psychoeducation and, **2:506**  
PTSD and, **2:787**  
rational emotive behavior therapy (REBT) and, **2:504, 2:823–826**  
rational-emotive therapy and, **2:504, 2:746**  
rehabilitative counseling and, **2:830**  
relaxation technique in, **2:507**  
sleep disorders and, **1:394**  
social and communication skills training in, **2:506**  
social learning theory and, **2:505**  
social problem-solving skills training and, **1:102**  
strategies and techniques for, **2:506–508**  
stress inoculation training and, **2:505**  
structured homework assignments in, **2:504**  
substance abuse and, **2:897, 2:898**  
systematic desensitization technique and, **2:507–508, 2:889**  
therapy, basic features of, **2:503–504**  
time limited aspect of therapy, **2:503**  
Trauma-Focused Cognitive-Behavioral Therapy and, **1:165**  
traumatic brain injury rehabilitation and, **1:423**  
*See also* **Cognitive therapy; Rational emotive behavior therapy (REBT)**  
Cognitive evaluation theory, **2:662**  
**Cognitive Information Processing Model (CIP), 4:1504–1509**  
apex of, **4:1506**  
best practices implications of, **4:1509**  
career decision making definition and, **4:1505**  
career development definition and, **4:1505**  
career problem definition and, **4:1504**  
career problem solving and decision-making skills acquisition and, **4:1508**  
career problem solving and decision-making skills and, **4:1504, 4:1507**  
career problem solving definition and, **4:1505**  
career problem solving skills assessment and, **4:1507**  
Career Thoughts Inventory (CTI) and, **4:1502, 4:1507**  
CASVE Cycle heuristic and, **4:1505–1506, 4:1506 (figure)**  
decision-making skills assessment and, **4:1507**  
executive processing domain skills acquisition and, **4:1508**  
eye movement desensitization, reprocessing (EMDR) and, **1:198–202**  
Puncky Paul Heppner and, **2:631**  
implementation process and, **4:1508–1509**  
interventions and, **4:1507–1508**  
knowledge bases of, **4:1502, 4:1505**  
occupational knowledge acquisition and, **4:1508**  
occupational knowledge assessment and, **4:1507**  
problem space definition and, **4:1504–1505**  
Pyramid of Information Processing domains of, **4:1502, 4:1505–1506, 4:1505 (figure)**  
self-knowledge acquisition and, **4:1508**  
self-knowledge assessment and, **4:1507**



Cognitive Linguistic Quick Test, 2:671

**Cognitive therapy, 2:508–511**

Aaron T. Beck's cognitive therapy and, 2:469–470,

2:508, 2:509–510, 2:542, 2:701

bibliotherapy, 2:914

bipolar disorder and, 2:479

catastrophizing, 2:914

cognitive-behavioral therapy (CBT and, 2:508–509

cognitive distortions, irrational beliefs and, 2:508

cognitive restructuring, 2:914

collaborative empiricism and, 2:510

consciousness raising, 2:914

counselor self-disclosure and, 2:852

depression and, 2:869

Albert Ellis's rational emotive behavior therapy and,

2:504, 2:508, 2:509, 2:542, 2:588–589, 2:746

evidence-based treatment of, 2:510

future directions in, 2:510–511

gender role analysis, 2:914

mindfulness-based cognitive therapy (MBCT)

and, 2:511

miracle question, 2:877–878, 2:914

for panic disorder, 2:718–719

positive imagery technique of, 2:510

positive self-talk technique of, 2:510, 2:921

push-button technique, 2:914

rededication, 2:914

research support of, 2:510

schema therapy and, 2:510

stress inoculation training (SIT) and, 2:505, 2:510–511

techniques of, 2:508

thought scheduling technique, 2:913–914

thought stopping technique of, 2:510, 2:913

*See also* Beck, Aaron T.; Cognitive-behavioral therapy and techniques (CBT); Ellis, Albert; Rational emotive behavior therapy (REBT)

Cohen, Susan, 1:257

Collaborative Assessment and Management of Suicidality (CAMS), 2:901

Collaborative language systems, 1:204

Collaborative language systems theory family counseling and, 1:204

**Collectivism, 3:1059–1061**

allocentrism and, 3:971–972

Asian cultural values of, 3:1100

career development and, 4:1531

collectivism vs. individualism elements and, 3:1168–1169

Confucianism and, 3:1067–1068

counseling implications of, 3:1060–1061

cross-cultural psychology and, 3:1083

cross-cultural studies of, 3:1060

cultural value of, 3:1096

decision making styles and, 4:1524–1525

definition of, 3:1059

economic factors affecting, 3:1177

empirical research regarding, 3:1178–1179

equality and, 3:1059

fatalism and, 3:1150

filial piety and, 3:1151

group harmony, cooperation, collective goals and, 3:1059

horizontal and vertical patterns of, 3:1178

identity and, 3:1161

individualism vs., 1:261, 3:1059–1060, 3:1177

ingroup and outgroup definition and, 3:1059

locus of control and, 3:1203–1204

loss of face and, 3:1205

measurement of, 3:1060

Native American cultural value of, 3:1101

personal traits facilitative of, 3:1059

psychological functioning and, 3:1059

relatedness element of, 3:1059

relationship preservation vs. justice and, 3:1059

self-concept and, 3:1059

College Board, 4:1511

College Student Expectations Questionnaire (CSXQ), 4:1510

**College Student Experiences Questionnaire (CSEQ), 4:1509–1510**

college activities questions of, 4:1509–1510

college environment questions and, 4:1510

College Student Expectations Questionnaire (CSXQ) and, 4:1510

CSEQ Research Program and, 4:1510

data uses of, 4:1510

estimate of gains items and, 4:1510

quality of effort measured by, 4:1509

Collins, Chuck, 3:1326

Collison, Brooke, 4:1639

**Colonialism, 3:1061–1063**

pre-European colonialism and, 3:1061

first wave of European colonialism and, 3:1061–1062

independence in the Americas and, 3:1062

western expansion and, 3:1062

New imperialism and, 3:1062

Scrabble for Africa and, 3:1062

American Empire vs. Benevolent Empire concepts and, 3:1063

controversy regarding, 3:1063

counseling implications of, 3:1062–1063



decolonialism and, **3:1062**  
 definition of, **3:1061**  
 Hannibal and, **3:1063**  
 Genghis Khan and, **3:1063**  
 Mongol Empire and, **3:1063**  
 neocolonialism and, **3:1062–1063**  
 Portuguese and Spanish exploration  
     and, **3:1063–1064**  
 postcolonialism and, **3:1063**  
 racism, ethnocentrism, imperialism values and, **3:1061**  
 racist pseudoscientific theories, religion and, **3:1039**  
 types of, **3:1061**  
 Color-Blind Racial Attitudes Scale (CoBRAS), **3:1065**  
**Color-blind racial ideology, 3:1063–1065**  
     abstract liberalism and, **3:1064**  
     affirmative action and, **3:1064–1065**  
     APA and, **3:1063–1064**  
     Color-Blind Racial Attitudes Scale (CoBRAS)  
         and, **3:1065**  
     color-evasion and, **3:1064**  
     counseling and, **3:1065**  
     critical race theory and, **3:1071–1078**  
     cultural color-blindness and, **3:1064**  
     definition of, **3:1063–1064**  
     existing racial inequalities supported by, **3:1064, 3:1379**  
     housing, health, employment and, **3:1064**  
     impact of, **3:1063–1065**  
     institutional racism and, **3:1064**  
     interracial comfort and, **3:1182–1183**  
     measurement of, **3:1064–1065**  
     minimization of racism and, **3:1064, 3:1379**  
     naturalism and, **3:1064**  
     political correctness and, **3:1263–1264**  
     power-evasion and, **3:1064, 3:1379**  
     White privilege and, **3:1379**  
 Colorism  
     definition of, **2:574**  
     hierarchical system of, **2:574**  
     slavery foundation of, **2:574**  
*Color of Wealth* (Lui), **3:1372**  
 Colozzi, E. A., **4:1488, 4:1516, 4:1517**  
 Comas-Diaz, L., **3:1348**  
 Combs, Dennis, **3:1094**  
 Commission of Recognition of Specialties  
     and Proficiencies in Professional Psychology  
     (CRSPP), **1:105**  
     Web site of, **1:106**  
 Commission on Rehabilitation Counselor Certification  
     (CRCC), **2:827**  
 Commission on Rehabilitation Education (CORE), **1:8**

### **Common factors model, 2:511–515**

    bonds, tasks, goals of therapeutic relationship and,  
         **2:513–514, 2:892**  
     change processes and, **2:514**  
     client factors and, **2:513**  
     cognitive-behavioral analysis system of psychotherapy  
         (CBASP) and, **2:514**  
     components of, **2:512**  
     the Dodo Bird conjecture and, **1:175, 2:512, 2:714–715**  
     explanation of, **2:511–512**  
     master therapists and, **2:513**  
     positive descriptors therapist trait and, **2:513**  
     psychotherapy effectiveness meta-analysis  
         findings and, **2:512**  
     relationship factors and, **2:513–514**  
     tear and repair hypothesis of therapeutic relationship  
         and, **2:514**  
     therapist empathy and, **2:513, 3:1066**  
     therapist factors and, **2:512–513**  
     treatment adherence and, **2:513**  
     treatment structures and, **2:514**  
     Bruce Wampold's work in, **2:937**

### **Communication, 3:1065–1067**

    biculturalism and, **3:1310**  
     client self-understanding and, **3:1067**  
     cooperation promoted through, **3:1065**  
     definition of, **3:1065–1066**  
     future directions regarding, **3:1067**  
     high-context communication and, **3:1158–1159**  
     information sharing and, **3:1065–1066**  
     language difficulties, clinical  
         assessment of, **2:669–671**  
     linear model of, **3:1066**  
     listening skills and, **3:1066**  
     low-context communication and, **3:1206**  
     metaphor use and, **2:690–691**  
     models of, **3:1066**  
     multicultural issues and, **3:1066**  
     multicultural model of in counseling, **3:1067**  
     personal space and, **3:1261**  
     Socratic Method and, **2:875–876**  
     stress management through, **2:887**  
     transactional model of, **3:1066**  
     translation methods and, **3:1350–1353**  
     *See also* **High-context communication (HC);**  
         **Low-context communication (LC)**

### **Community-based action research (C-BAR), 1:90–93**

    action, participatory research and, **1:90–91**  
     action research spiral in, **1:91**  
     Kenneth Bancroft Clark and, **3:1050–1052**



- collaborative partnership cornerstone of, 1:90, 1:91, 1:92
- community defined and, 1:90
- counseling psychology and, 1:92
- empowerment focus of, 1:90, 1:91, 1:92
- examples of, 1:92
- health belief model and, 1:235–237
- historical roots of, 1:91
- Indian Health Service and, 3:1174–1176
- Kurt Lewin and, 1:91
- methodological approach of, 1:91
- Pedagogy of the Oppressed* (Freire) and, 1:9
- philosophical roots of, 1:90–91
- self-help groups and, 2:866–869
- self-reflective loops of systemic inquiry and, 1:91
- social justice advocacy of, 1:90, 1:92, 2:496
- social support and, 2:872–875
- Tavistock Institute of Human Relations and, 1:91
- Community-based health promotion, 1:93–96**
- community-based action research and, 1:90–93
- diseases as threats to, 1:93
- health definitions and, 1:93
- obesity and, 1:94–95
- personal, community, cultural, contextual factors and, 1:93
- psychoeducation and, 2:799–803
- quality of life and, 1:93
- sedentary lifestyle and, 1:95–96
- smoking cessation and, 1:93–94
- Community Mental Health Act (1963), 1:124, 2:799, 3:1157
- Composite International Diagnostic Interviews: Authorized Core Version 1.0 (CIDI-CORE), 2:490
- Comprehensive Assessment of Prospective Memory (CAPM), 2:688
- Comprehensive Test of Basic Skills (CTBS), 2:451
- Comprehensive Test of Nonverbal Intelligence (CTONI), 2:500
- Compulsive sexual behavior (CSB), 1:96–99**
- abusive childhood experiences and, 1:97
- antidepressant treatment of, 1:98
- causes of, 1:97–98
- characteristics of, 1:97
- cognitive-behavioral therapy and, 1:96
- developmental progression of, 1:97
- diagnosis of, 1:98
- gender differences in, 1:97
- group therapy and, 1:98
- individual psychotherapy and, 1:96
- learning theory and, 1:97
- neurotransmitters linked to, 1:96, 1:97–98
- prevalence of, 1:97
- psychiatric comorbidity of, 1:97
- social contextual factors of, 1:98
- SSRIs treatment of, 1:98
- terminology of, 1:97
- testosterone-reducing agents and, 1:96–97, 1:98
- treatment of, 1:98
- 12-step programs and, 1:96, 1:98
- Computer-aided counseling. *See* **Ethics in computer-aided counseling**
- Computer-assisted career counseling, 4:1510–1514**
- ACT, Inc. and, 4:1511
- Association of Computer-Based Systems for Career Information and, 4:1512
- asynchronous vs. synchronous communication and, 4:1513
- Career Planning System and, 4:1511
- CHOICES and, 4:1512
- College Board and, 4:1511
- computer adaptive testing (CAT) and, 4:1511
- Computer-Assisted Career Guidance Systems (CACG) and, 4:1485–1486, 4:1487, 4:1494, 4:1511, 4:1512
- computerized career assessment and, 4:1511
- considerations for counseling professionals and, 4:1513
- DISCOVER and, 4:1512
- Internet career information guidelines and, 4:1512
- Internet ethical concerns and, 4:1513
- Internet formats and, 4:1513
- Internet technology and, 4:1510, 4:1511–1512
- Kuder Interest Inventory and, 4:1511
- Occupational Information Network (O\*NET) Interest Profiler and, 4:1511
- Occupational Outlook Handbook* (Dept. of Labor) and, 4:1511
- online career counseling and, 4:1512–1513
- online information sources and, 4:1511–1512
- Self-Directed Search and, 4:1511
- SIGI Plus and, 4:1512
- Strong Interest Inventory and, 4:1511
- Tiedeman's decision-making theory and, 4:1658
- UNIACT and, 4:1511
- Web sites, 4:1514
- See also* **System of Interactive Guidance Information (SIGI)**
- Computer Assisted Career Guidance systems (CACG), 4:1485–1486, 4:1487, 4:1494, 4:1511, 4:1512
- Computer-assisted testing, 2:515–518**
- Armed Services Vocational Aptitude Battery and, 2:939
- branched or response-contingent testing and, 2:516



computer-assisted instruction and, **2:515**  
computerized adaptive test (CAT) and, **2:517**, **4:1511**  
conventional testing and, **2:516**  
current issues and future directions  
    regarding, **2:517–518**  
fully adaptive testing and, **2:517**  
Graduate Record Examination and, **2:939**  
history of, **2:515–516**  
Internet delivered tests, validity issues and, **2:517–518**  
item response theory (IRT) and, **2:517**  
minicomputer, personal computer development  
    and, **2:515–516**  
partially adaptive testing and, **2:516–517**  
score interpretation, analysis and, **2:515**  
sequential testing and, **2:517**  
Web site regarding, **2:518**  
David J. Weiss's work in, **2:939**  
Computerized Vocational Information System (CVIS),  
    **4:1526–1527**

Comte, Auguste, **2:785**

### **Conduct disorder, 1:99–103**

AD/HD comorbidity with, **1:31**, **1:49**  
APD and, **1:100**  
assessment of, **1:100**  
behavior rating scales assessment of, **1:100**  
child-focused interventions and, **1:102**  
childhood- vs. adolescent-onset types of, **1:100–101**  
cognitive behavioral therapy and, **1:102**  
community-based interventions and, **1:102**  
community factors and, **1:101**  
developmental progression of, **1:100**  
*DSM-IV-R* classification of, **1:100**, **1:197**  
externalizing problems of childhood and, **1:197**  
external risk factors of, **1:101**  
family based interventions and, **1:101–102**  
family structure dysfunction and, **1:101**  
functional family therapy and, **1:101**  
functional family therapy (FFT) parent training  
    program and, **1:327**  
genetic heritability of, **1:101**  
incredible years parent training program and, **1:327**  
individual-based interventions and, **1:102**  
internal risk factors of, **1:101**  
learning disorder comorbidity with, **1:157**  
multimodal interventions and, **1:102**  
multisystemic therapy and, **1:102**  
nature of, **1:99–100**, **1:197**  
ODD and, **1:100**, **1:317**, **1:319**  
oppositional defiant disorder and, **1:100**  
parental psychopathology and, **1:101**

parent management training and, **1:101**  
physical and sexual abuse and, **1:101**  
prevalence and comorbidity of, **1:100**  
single domain behavior rating scales and, **1:45**  
social cognitive characteristics and, **1:101**, **1:197**  
social problem-solving skills training and, **1:102**

### **Conferences, counseling psychology, 1:103–106**

Ann Arbor conference and, **1:103**  
APA and, **1:103**, **1:104**  
Association of Counseling Center Training  
    Agents and, **1:106**  
Atlanta Conference (1987) and, **1:104–105**, **1:127**  
Commission of Recognition of Specialties and  
    Proficiencies in Professional Psychology  
    (CRSPP), **1:105**  
Council of Counseling Psychology Training Programs  
    annual conference and, **1:103**  
counseling psychology definition and, **1:105**  
counseling vs. clinical psychology (Ann Arbor)  
    and, **1:103**  
Greyston Conference (1964) and, **1:104**, **1:129**  
Houston Conference (2001) and, **1:105–106**  
hygiology, preservation of health theme (Northwestern)  
    and, **1:103**  
identity issue (Greyston) and, **1:104**, **1:389**  
identity issue (Houston) and, **1:105**  
identity issues (Atlanta) and, **1:104–105**  
Northwestern Conference (1951) and,  
    **1:103–104**, **1:127**, **1:128–129**  
social, political advocacy theme (Atlanta) and, **1:105**  
social, political advocacy theme (Greyston) and, **1:104**  
social, political advocacy theme (Houston)  
    and, **1:105–106**  
social, political advocacy theme (Northwestern)  
    and, **1:103–104**  
Society of Counseling Psychology (SCP) and, **1:103**  
training issues (Atlanta) and, **1:105**  
training issues (Greyston) and, **1:104**  
training issues (Houston) and, **1:105**  
training issues (Northwestern) and, **1:103**  
2008 International Counseling Conference and, **1:106**  
Vail conference (1973) and, **1:337**, **3:1087**,  
    **3:1222**, **3:1228**

### **Conferences in counseling, 1:107–109**

American Counseling Association (ACA) and, **1:107**  
conferences in context and, **1:107**  
educational, mentoring, networking, socializing  
    contacts and, **1:108–109**  
financial management function of, **1:108**  
learning and, **1:107**



- as learning opportunities, 1:107
- personal functions and, 1:108–109
- policies and procedures review function of, 1:108
- professional functions and, 1:108
- professional identity articulation of, 1:108
- professional societies, associations and, 1:107
- Confidentiality**
  - code of ethics and, 1:178, 2:495, 2:645
  - in computer-aided counseling, 1:189
  - e-counseling and, 1:171
  - ethics in research and, 1:191
  - online counseling and, 1:413
  - online research and, 1:247
  - therapeutic structure and, 2:798
  - See also Confidentiality and legal privilege*
- Confidentiality and legal privilege, 2:519–522**
  - APA, ACA ethics codes and, 2:519, 2:520
  - confidentiality and, 2:519–520
  - contact breaches and, 2:519
  - contact confidentiality and, 2:519
  - content breaches and, 2:519
  - content confidentiality and, 2:519
  - defamation, libel, slander and, 2:521
  - duty to warn and protect and, 2:575–578
  - Fifth Amendment, right to avoid self-incrimination and, 2:520
  - informed consent and, 2:519, 2:645–647
  - Jaffee v. Redmond* and, 2:519
  - limits and exceptions to, 2:521–522
  - privileged communication laws and, 2:520–521
  - privileged communication laws and, exceptions to, 2:520–521
  - psychologist vs. counselor privileged communication and, 2:520
  - qualified privilege and, 2:521
  - right to privacy, personal autonomy and, 2:519
  - “self-determination” and, 2:519
  - trust in counseling relationship and, 2:519–520
  - See also Confidentiality*
- Conformatory Factor Analysis, 2:528**
- Confucianism, 3:1067–1068**
  - Analects* and, 3:1067
  - counseling implications of, 3:1068
  - education, family importance in, 3:1067
  - filial piety and, 3:1151
  - Five Relations of, 3:1068
  - Neo-Confucianism and, 3:1068
  - proposals for socioethical ways of life and, 3:1067
  - sincerity, honesty, interpersonal harmony focuses of, 3:1067
  - socialization through codes of conduct and, 3:1068
  - social reform begins with individual reform and, 3:1068
  - Taoism, Buddhism and, 3:1068
  - Western individualism and, 3:1068
- Congress on Racial Equality, 3:1238
- Connelly, Michael, 1:361
- Conners’ Rating Scales-Revised (CRS-R), 1:109–110**
  - AD/HD diagnosis and, 1:29, 1:48, 1:109
  - Adolescent Self Report long form of, 1:48
  - Conners’ Adult ADHD Rating Scales of, 1:48
  - DSM-IV* and, 1:48
  - multimodal evaluation using, 1:48
  - self-report and observer forms of, 1:48
  - standard error of measurement of, 1:109
  - ten scales of, 1:48
  - test-retest reliability of, 1:109
  - validity of, 1:109–110
- Connors’ Continuous Performance Test II (CPT II), 2:698
- Consciousness raising of feminist therapy, 1:210
- Consensual Assessment Technique, of cognition/intelligence, 2:501
- Conservation of resources (COR) theory, 2:873–874
- Conservative Jews, 3:978
- Constanino, Guiseppe, 2:524
- Constantine, Madonna G., 3:1068–1071, 3:1232**
  - achievements in relational context by, 3:1070
  - career path of, 3:1068–1069
  - editorial work of, 3:1069
  - education and training for psychologists work of, 3:1070, 3:1232
  - honors and awards received by, 3:1069–1070
  - multicultural counseling competence work of, 3:1067, 3:1070
  - national leadership and service of, 3:1069
  - racial microaggressions work of, 3:1070, 3:1382
  - racism in psychology and education work of, 3:1067, 3:1070, 3:1382
  - scholarship by, 3:1070
  - scientist-practitioner model of, 3:1067
  - social justice focus of, 3:1067, 3:1070
  - Teaching to Transgress* (hooks) and, 3:1070
- Constantinople, Anne, 3:1164
- Constructivist career counseling, 4:1514–1516**
  - action, meaning, and life themes focus of, 4:1515
  - career counseling in schools and, 4:1465
  - Career Style Interview (CSI) and, 4:1500
  - counselor expertise and client self-expertise and, 4:1515
  - diverse client populations and, 4:1515
  - explanation of, 4:1514
  - implications of, 4:1514–1515



individuals create their own reality and, **4:1514–1515**  
 language and dialogue use and, **4:1515**  
 meaning from present actions and past experiences  
 and, **4:1515**  
 modernist to postmodernist ideology shift and, **4:1514**  
 paradigm shift for career theory and, **4:1514**  
 practice of, **4:1515**  
 relational nature of career construction and, **4:1515**  
 Tiedeman's decision-making theory and, **4:1658**

### **Constructivist theory, 2:522–524**

action theory and, **4:1397–1400**  
 Adlerian therapy and, **2:459**  
 Arab American therapy and, **3:890**  
 community-based action research and, **1:90**  
 constructive alternativism and, **2:523**  
 definition of, **2:522**  
 Albert Ellis and, **2:509**  
 meaning, creation of, **2:683–684**  
 meaning making and, **2:523**  
 narrative therapy and, **2:524**  
 personal construct theory and, **2:523**  
 Jean Piaget, adult development and, **1:10**  
 postmodernist "objectivist" position and, **2:522**  
 qualitative methodologies and, **1:301**  
 radical constructivism and, **2:522–523**  
 radical constructivism work of, **2:523**  
 research support of, **2:524**  
 Carl Rogers influence on, **2:542**  
 social constructivism and, **1:184, 2:523**  
 solution-focused brief therapy (SFBT) and,  
**2:523–524, 2:876–879**  
 Stanley B. Strong and, **2:892**  
 therapeutic approaches based on, **2:523–524**  
 Lev Vygotsky and, **2:523**

*See also Constructivist career counseling*

### **Consultation, 2:524–526**

agency consultation and, **2:525**  
 collegial consultation and, **2:525**  
 competency standards and, **2:526**  
 definition of, **2:525**  
 stages of consulting and, **2:525–526**  
*The Theory and Practice of Mental Health Consultation*  
 (Caplan) and, **2:525**

Contact hypothesis, of prejudice, **3:1228**

*Contemporary Psychology* journal, **4:1677**

Contingency management, in behavior therapy, **2:742**

### **Continuing education, 1:110–112**

content of, **1:111**  
 distance education/dispersed learning and, **1:165–167**  
 format of, **1:111**

frequency and amount of, **1:111–112**  
 licensure, certification maintenance and, **1:110**  
 mandatory continuing education, lifelong learning  
 and, **1:110–111**  
 purpose of, **1:110–111**  
 sustained knowledge, continued skill acquisition  
 and, **1:110–111**  
 trends and directions of, **1:112**

### **Continuous performance tests (CPT), 1:112–114**

AD/HD diagnosis and, **1:29, 1:114**  
 basic paradigm of, **1:112–113**  
 consistency, variability of performance  
 over time and, **1:113**  
 correct hits, omission errors and, **1:113**  
 reaction time variable and, **1:113**  
 response inhibition measured by, **1:112**  
 signal detection theory and, **1:113**  
 sustained attention measured by, **1:112**  
 technical adequacy of, **1:113**  
 use and interpretation of, **1:113–114**  
 variables of interest and, **1:113**

### **Contract work, 4:1516–1519**

business person vs. counselor roles and, **4:1518**  
 catalyst for inspiration and, **4:1517**  
 client demand and, **4:1517**  
 establishing the office and, **4:1518**  
 factors in choosing contract work and, **4:1516–1517**  
 future directions regarding, **4:1518–1519**  
 insufficient staff and, **4:1517**  
 National Career Development Association (NCDA) and,  
**4:1518–1519**  
 one-on-one relationship benefit of, **4:1516**  
 opportunities and, **4:1518**  
 preferred interest factor and, **4:1516**  
 private practice career counseling and, **4:1609**  
 success strategies and, **4:1518**  
 targeting the market and, **4:1518**  
 technology innovations and, **4:1518**  
 therapeutic alliance focus in, **4:1516**  
 time constraints and, **4:1516–1517**  
 Web sites regarding, **4:1519**

Controlled Oral Word Association Test (COWA), **2:700**

### **Conversion therapy, 1:114–116**

cessation, changing of same-sex attraction, sexual  
 behavior and, **1:114**  
 "ex-gays" designation and, **1:115**  
 medical, moral, religious traditions and, **1:114**  
 sexual identity development research and, **1:115**  
 success or failure of, **1:115–116**  
 summary of, **1:116**



- techniques and approaches of, 1:115  
 transformational ministries and, 1:115
- Cook, Donelda A., 3:1229, 3:1363
- Cooke, K, 4:1455
- Cooley, Charles, 2:858
- Coon, Heather M., 3:1169
- Cooper, Stewart E., 2:526
- Cooper, Zafra, 2:580
- Coopersmith Self-Esteem Inventory (SEI),  
 2:861, 2:863, 2:864
- COPE measure of, 2:528
- Coping, 2:526–530**  
 active vs. avoidant vs. proactive coping  
   behavior and, 2:527  
 acute vs. chronic stressors and, 2:529  
 adjustment and, 2:528  
 Adolescent Coping Orientation for Problem  
   Experiences Scale (A-COPES), 2:528  
 Elizabeth Altmaier's work in, 1:21–22  
 appraisal, behavior, reappraisal stages of, 2:527  
 bereavement and, 1:50–53  
 cancer management and, 1:59–63  
 Children's Coping Strategies Checklist (CCSC), 2:528  
 competence, relatedness, autonomy needs and, 2:527  
 Conformatory Factor Analysis, 2:528  
 COPE measure of, 2:528  
 coping questions and, 2:878  
 Coping Response Inventory, 2:528  
 cultural paranoia and, 3:1093–1094  
 culture-specific coping and, 3:1297–1298  
 definition of, 1:59, 2:527  
 ego strength and, 2:585–587  
 emotion- vs. problem-focused coping and, 2:527  
 environmental influences on, 2:529  
 familial, cultural, social factors and, 2:529  
 features of, 2:527  
 Five Factor model of personality theory and, 2:754  
 functions of, 2:527  
 future directions in, 2:529  
 gender differences in, 2:528  
 HIV/AIDS and, 1:239–240  
 hospice care and, 1:243–245  
 individual influences on, 2:528  
 job loss and, 4:1556  
 measurement of, 2:527–528  
 personality factors in, 2:528  
 problem-solving appraisal and, 2:789  
 psychological defenses and, 2:554–556, 2:795  
 religious coping and, 2:881  
 Responses to Stress Questionnaire (RSQ), 2:528  
 situational influences on, 2:529  
 spirituality, religion and, 2:879–882, 3:1331–1333  
 stress and adversity and, 2:526–527, 2:884–885  
 structure of, 2:527  
 Ways of Coping Checklist and, 2:528  
 work stress and, 4:1685–1686
- Coping Response Inventory, 2:528
- COPSystem. *See* **Career Occupational Preference System (COPSystem)**
- COR. *See* Conservation of resources (COR) theory
- Corbett, Maureen M., 2:919
- CORE. *See* Commission on Rehabilitation Education (CORE)
- Core self theories of aging, 1:15
- Corrections applications, 1:116–119**  
 corrections population, growth of, 1:117  
 counseling needs of population and, 1:117  
 deinstitutionalization of mental patients and, 1:117  
*Estelle v. Gamble* and, 1:117  
 health issues and, 1:117–118  
 HIV/AIDS and, 1:118  
 mental illness rates in population and, 1:117  
 release and reintegration and, 1:118  
 sexually transmitted diseases, chronic  
   diseases and, 1:118  
 substance abuse and, 1:117, 1:118  
 vocational and academic counseling and, 1:118
- Corsi Block Test, 2:687
- Corsini, Raymond J., 2:658, 2:903
- COSE. *See* Counseling Self-Estimate Inventory (COSE)
- Costa, Paul T. and McCrae, Robert R., 2:530–531**  
 Basic Tendencies concept of, 2:753  
 Characteristic Adaptations concept of, 2:753  
 Hans Eysenck influence on, 2:530  
 Five Factor Inventory (NEO-FFI) and, 2:530, 4:1598  
 NEO (neuroticism, extraversion, openness) personality  
   inventory and, 2:530, 2:752  
 NEO-PI-R and, 2:530, 2:752, 2:753, 2:755, 2:906  
 Objective Biography concept of, 2:753  
 personality trait work of, 2:530, 2:736  
 professional affiliations of, 2:530
- Cottone, R. R., 1:185
- Council for Accreditation for Counseling and Related  
 Educational Programs (CACREP), 1:354  
 formation of, 1:125  
*See also* **Accreditation by the Council for  
 Accreditation of Counseling and Related  
 Educational Programs (CACREP)**
- Council for Higher Education Accreditation  
 (CHEA), 1:1, 1:5



Council of Counseling Psychology Training Programs (CCPTP), **1:105, 1:128, 1:132**  
annual conference of, **1:103**  
Bruce Fretz and, **1:217**  
statistics on women in counseling psychology and, **1:211**

Council of National Psychological Associations for the Advancement of Ethnic Minority Interests (CNPAAEMI), **2:994, 3:1242, 3:1324**

Council on Accreditation in Counseling and Related Educational Professions (CACRE), **4:1639**

Council on Adoptable Children, **3:1354**

Council on Rehabilitation Education (CORE), **2:831**

**Counseling, definition of, 1:119–120**

lay counseling vs., **1:119**

psychotherapy vs., **1:119–120**

Sputnik, Cold War and, **1:123**

types of, **1:119**

*See also* **Conferences, counseling**

**psychology; Conferences in counseling;**

**Counseling, history of**

**Counseling, history of, 1:120–126**

early 20th century and, **1:120–122**

early 20th century and, professional organizations, publications of, **1:122**

1920s and, **1:122**

1930s and, **1:122–123**

1940s and, **1:123**

1950s and, **1:123–124**

1950s and, professional organizations of, **1:123**

1960s and, **1:124–125**

1970s and, **1:125**

1980s and, **1:125**

1990s and, **1:125–126**

American Association for Counseling and Development and, **1:125**

Alfred Binet, intelligence scales work of, **1:121**

certification and, **1:125**

community counselor field and, **1:125**

Community Mental Health Centers Act (1963) and, **1:124**

compulsory education focus and, **1:121**

Council for Accreditation of Counseling and Related Educational Programs (CACREP) and, **1:125**

Jesse B. Davis, guidance and vocational work of, **1:121**

John Dewey, progressive education and, **1:121**

*Dictionary of Occupational Titles* and, **1:124**

Education Resources Information Clearinghouse and, **1:124**

Erik Erikson, life span development work of, **1:125**

ethics, professionalism in, **1:124**

George Barden Act (1946) and, **1:123**

George-Deen Act (1936) and, **1:122**

Great Depression and, **1:122**

guidance movement and, **1:120**

humanistic reform period and, **1:120**

Industrial Revolution, urban

migration and, **1:120–121**

managed care, accountability issues and, **1:126**

Horace Mann, free universal education and, **1:121**

marriage and family therapy development and, **1:124**

Abraham Maslow's humanistic counseling theory, behavioral counseling work and, **1:124**

National Board for Certified Counselors (NBCC) and, **1:125**

National Defense Education Act and, **1:123**

Frank Parsons, vocational guidance work and, **1:121**

professional identity focus and, **1:125**

psychology field influence on, **1:120**

psychotherapy influence on, **1:123**

Carl Rogers, relationship dynamics work and, **1:123**

Smith Hughes Act (1917) and, **1:122**

society changes and, **1:120**

state, national licensure and, **1:125**

Strong Vocational Interest Blank and, **1:122**

technology impact and, **1:126**

U.S. Department of Veterans Affairs

grants and, **1:123**

vocational guidance focus of, **1:121, 1:122**

E. G. Williamson, trait-factor counseling work of, **1:122, 4:1663–1665, 4:1677–1678**

women in the work force and, **1:123**

World War I and, **1:122**

World War II and, **1:123**

Gilbert Wrenn, school counselor function work of, **1:124**

*See also* **Conferences in counseling; Counseling, definition of**

Counseling and Guidance Training Institutes, **4:1447**

*Counseling and Psychotherapy* (Rogers, C.), **1:123**

Counseling Association of Humanistic Education and Development (C-AHEAD), **1:353**

Counseling bisexual clients. *See* **Career counseling, gay and lesbian; Gay, lesbian, and bisexual therapy** (GLB); Gay, lesbian, bisexual, and transgender (GLBT) community

Counseling lesbian clients. *See* **Career counseling, gay and lesbian; Gay, lesbian, and bisexual therapy** (GLB); Gay, lesbian, bisexual, and transgender (GLBT) community



*Counseling Negroes* (Vontress), 3:1365

Counseling outcomes. *See* **Outcomes of counseling and psychotherapy**

Counseling process. *See* **Therapy process, individual**

**Counseling process/outcome, 2:531–536**

Barrett-Lennard Relationship Inventory, 2:533

Beck Depression Inventory, 2:534

Client Reactions System, 2:532–533

clinical interview and, 2:490–491

Counseling Self-Estimate Inventory, 2:533

Counselor Effectiveness Rating Scale, 2:533

Counselor Effectiveness Scale, 2:533

Counselor Evaluation Inventory, 2:533

Counselor Rating Scale, 2:533

creation of meaning and, 2:683–684

empirically based professional practice and, 1:172–175

Expectation about Counseling Scale, 2:533

Expectations About Counseling-Brief Form, 2:532

expectations about therapy and, 2:593–599, 3:1364

facilitative conditions and, 2:601–603

factor analysis and, 2:532

future directions in, 2:535

Global Assessment of Functioning, 2:535

Clara E. Hill's work in, 2:632

internal consistency and, 2:531

interrater reliability and, 2:531

outcome measures and, 2:533–535

Outcome Questionnaire, 2:535

paradoxical interventions and, 2:719–721

Personal Attributes Inventory, 2:533

process measures of, 2:532–533

process vs. outcome and, 2:531

relationships with clients and, 2:832–837

reliability and, 2:531

Session Evaluation Questionnaire measure, 2:532

social desirability and, 2:531

solution-focused brief therapy (SFBT) and, 2:876–879

State-Trait Anxiety Inventory, 2:534–535

Structural Analysis of Social Behavior, 2:533

test-retest reliability and, 2:531

units of measurement issue and, 2:531

validity and, 2:531–532

Bruce Wampold's work in, 2:937

Working Alliance Inventory measure, 2:532

*See also* **Outcomes of counseling and psychotherapy;**

**Process and outcome research**

*The Counseling Psychologist* journal of Society of

Counseling Psychology, 1:103–104, 1:124, 1:127,

1:128–29, 1:130–131, 1:263, 1:264, 4:1677

**Counseling psychology, definition of, 1:126–128**

*Archival Description of Counseling Psychology* (APA) and, 1:127

Atlanta Conference (1987) and, 1:104–105, 1:127

counseling psychologists description and, 1:127

current definition and parameters of, 1:127

Division 17, Division of Counseling and Guidance of APA and, 1:126

Division 17, Division of Counseling Psychology of APA and, 1:127, 1:129

holistic counseling emphasis and, 1:126

life adjustments focus of, 1:127

multicultural counseling standards, competencies and, 1:126

Northwestern Conference (1951) on the Standards for Training Counseling Psychologists and, 1:103–104, 1:127, 1:128–129

“valued characteristics” of, 1:127

World War II veterans and, 1:128

*See also* **Conferences, counseling psychology;**

**Counseling psychology, history of; International developments, counseling**

**Counseling psychology, history of, 1:128–133**

*Annual Review of Psychology* and, 1:128, 1:129, 1:131

APA Division 17, Division of Counseling and Guidance and, 1:128

APA Division 17, Division of Counseling Psychology and, 1:129

Book Series in Counseling Psychology and, 1:131

clinical psychology vs., 1:129

Council of Counseling Psychology Training Programs (CCPTP) and, 1:105, 1:128, 1:132, 1:217

*The Counseling Psychologist* journal of Society of Counseling Psychology and, 1:103–104, 1:124, 1:127, 1:128–29, 1:130–131, 1:263, 1:264

*Counseling Psychology as a Specialty* Division 17 report and, 1:129

cultural themes in, 1:130

diversity emphasis and, 1:131

Division 17 reorganizations and, 1:128–129, 1:132

doctoral training standards and, 1:129

formal definition of, 1:129–130

Greyston Conference (1964) and, 1:104, 1:129, 1:389

*Guidelines for Psychological Practice with Girls and Women* and, 1:131, 1:145

*Handbooks* of, 1:131

identity crisis and, 1:129

identity issues and, 1:130–131

independent practice and, 1:131–132

*Journal of Counseling Psychology* and, 1:129



- legal issues and, **1:132**  
 Model Training Program and, **1:132**  
 1960s, early 1970s and, **1:130**  
 race, ethnicity, gender, sexual orientation  
   focus of, **1:131**  
 Carl Rogers person-centered therapy work and, **1:128**  
 science and practice integration, science-practitioner  
   model and, **1:133**  
 Society of Counseling Psychology (SCP) and,  
   **1:103, 1:128, 1:132**  
 supervisions contributions and, **1:132**  
 Task force on the Status of Women (APA) and, **1:131**  
*See also* **Conferences, counseling psychology;**  
**International developments, counseling**  
 Counseling Self-Estimate Inventory (COSE), **2:533**  
**Counseling skills training, 2:536–539**  
   attending behavior and, **2:536**  
   barriers to cross-cultural counseling and, **3:1009–1010**  
   Madonna G. Constantine and, **3:1068–1071**  
   feedback in counseling training, immediate and,  
     **1:207–209**  
   Clara E. Hill's work in, **2:632**  
   interview stages and, **2:537–539**  
   Allen E. Ivey's work in, **1:266–268, 2:536–537, 2:538**  
     (figure), **3:1185–1187**  
   mentoring and, **1:296–299**  
   microcounseling approach to teaching counseling skills  
     and, **2:536–537**  
   Microskills Hierarchy and, **2:537, 2:538** (figure)  
   microskills model adaptations and, **2:539**  
   multicultural sensitivity and, **2:539**  
   origins and development of skills and, **2:536–537**  
   predicting results from interviewing skills and, **2:537**  
   reflection of feeling and, **2:536, 2:537**  
   Helen J. Roehlke and, **1:375–377**  
   social skills training and, **2:537**  
 Counseling techniques. *See* **Therapist**  
**techniques/behaviors**  
*Counseling the Culturally Diverse* (D. W. Sue and D.  
 Sue), **1:402, 3:1229, 3:1342**  
**Counseling the elderly, 1:133–137**  
   adaptations to the process and, **1:135–136**  
   adjustment disorder and, **1:134**  
   aging and, **1:14–17, 1:133–134**  
   anxiety and, **1:134**  
   caregiver factors and, **1:136**  
   chronic mental illness, personality disorders and,  
     **1:134–135**  
   client death and, **1:136**  
   cognitive impairment and, **1:134**  
   conclusions regarding, **1:136–137**  
   delirium and, **1:134**  
   dementias and, **1:134**  
   depression and, **1:134**  
   elder abuse and, **2:447–448**  
   gerontology and, **1:231–234**  
   grief, loss experiences of, **1:134**  
   hearing, vision deficits and, **1:135**  
   individual, group counseling and, **1:135**  
   insomnia and, **1:134**  
   language, terminology use and, **1:135**  
   living environment factors and, **1:136**  
   pace of therapy factors and, **1:135–136**  
   presenting issues in, **1:134**  
   psychological disorders and, **1:134–135**  
   reducing barriers to, **1:136**  
   respect, empathy, support central to, **1:134**  
   social context and, **1:135**  
   substance abuse and, **1:134**  
   suicide potential and, **1:134, 1:151, 1:234, 1:245**  
   transference, countertransference and, **1:136**  
   types of counseling and, **1:135**  
   universality of, **1:133–134**  
**Counseling theories and therapies, 2:539–542**  
   barriers to cross-cultural counseling and, **3:1009–1010**  
   behavior therapy and, **2:470–476**  
   brief therapy and, **2:479–483**  
   common characteristics of, **2:540**  
   community-based action research and, **1:90–93**  
   developmental counseling and therapy and, **2:561–568**  
   emphasizing background, **2:540–541**  
   emphasizing behavior, **2:541**  
   emphasizing emotion, **2:541–542**  
   emphasizing thought, **2:542**  
   Sigmund Freud's psychoanalysis influence on, **2:541**  
   humanistic approaches to, **2:637–641**  
   individual therapy and, **2:643–645**  
   integrative/eclectic therapy and, **2:542, 2:647–651**  
   John C. Norcross and, **1:309–311**  
   person-centered counseling and, **2:541**  
   psychoeducation and, **2:799–803**  
   psychological defenses and, **2:554–556, 2:795**  
   purposes of, **2:540**  
   Carl Rogers's work in, **2:541–542**  
   solution-focused brief therapy (SFBT) and, **2:876–879**  
   *See also* **Rogers, Carl R.**  
 Counselor Effectiveness Rating Scale, **2:533**  
 Counselor Effectiveness Scale, **2:533**  
 Counselor Evaluation Inventory, **2:533**  
 Counselor Rating Scale, **2:533**



**Counselors and therapists, 2:542–544**

- barriers to cross-cultural counseling and, 3:1009–1010
- counseling, humanistic function of, 2:543
- counseling, optimal functioning and decision making and, 2:543
- Sigmund Freud's psychoanalysis and, 2:543
- future directions regarding, 2:544
- group therapy and, 2:618–622
- mentoring and, 1:296–299
- perspectives emphasizing the differences between, 2:543–544
- perspectives emphasizing the similarity between, 2:544
- Carl Rogers person-centered helping and, 2:543
- similarities and differences between, 2:543
- therapists, psychopathology remediation and, 2:543
- Countertransference. *See* **Transference and countertransference**
- Couple and marital counseling, 1:137–140**
  - “active listening model” of communication and, 2:705
  - Adlerian therapy and, 2:458
  - American Association of Marriage and Family Counselors and, 1:138
  - American Association of Marriage and Family Therapists and, 1:138
  - American Association of Marriage Counselors and, 1:137
  - attachment theory, emotionally focused counseling and, 1:138
  - attachment theory and, 1:138
  - behavioral couple counseling and, 1:138
  - challenges of, 1:140
  - Clinical Handbook of Marital Therapy* (Jacobson and Gurman) and, 1:138
  - cognitive-behavioral couple counseling and, 1:138
  - common issues of, 1:139–140
  - criticism, defensiveness, contempt, stonewalling negative interactions and, 2:705
  - family counseling and, 1:203–207
  - forgiveness and, 2:605–607
  - Myrna L. Friedlander's work and, 1:218–220
  - history of, 1:137–138
  - individual vs. couple sessions and, 1:139
  - listening skills in, 3:1066
  - positive vs. negative sentiment override and, 2:705
  - psychoanalytic couple counseling and, 1:138
  - religion issues and, 3:1302
  - secret in, 1:139
  - solution-focused brief therapy (SFBT) and, 2:876–879

- substance abuse problems and, 2:895–896
- systems theory, systemic counseling and, 1:139
- unique process of, 1:139
- violent relationships and, 1:140
- work-family balance and, 4:1680–1684

**Courtois, Christine A., 1:140–142**

- Abuse and Dissociative Disorders Recovery Unit and, 1:141
- academic career of, 1:140–141
- books, publications of, 1:141
- The Center: Posttraumatic Disorders Program and, 1:141
- faculty appointments of, 1:141
- Healing the Incest Wound* written by, 1:141
- honors and awards received by, 1:141
- professional associations of, 1:141
- PTSD, sexual abuse, incest work of, 1:140
- Covey, Stephen, 4:1424
- COWA. *See* Controlled Oral Word Association Test (COWA)
- Cowherd, D. M., 4:1595
- CPI. *See* California Psychological Inventory (CPI)
- CPQ. *See* Certificate of Professional Qualification in Psychology (CPQ)
- CPT. *See* **Continuous performance tests (CPT); Current procedural terminology (CPT)**
- CPT II. *See* Connors' Continuous Performance Test II (CPT II)
- CRC. *See* **Career Resource Centers (CRC); Certified Rehabilitation Counselor (CRC)**
- CRCC. *See* Commission on Rehabilitation Counselor Certification (CRCC)
- Credentialing individuals, 1:142–146**
  - American Board of Professional Psychology and, 1:143–144
  - Certificate of Professional Qualification in Psychology and, 1:144–145
  - Certificate of Proficiency, 1:145
  - Certified Clinical Mental Health Counselor, 1:143
  - Certified Family Therapist, 1:143
  - Certified Rehabilitation Counselor, 1:143
  - doctoral level credentials and, 1:143–146
  - Master Addictions Counselor, 1:142–143
  - master's level credentials and, 1:142–143
  - National Board for Certified Counselors and, 1:142
  - National Certified Counselor, 1:142
  - National Certified School Counselor, 1:142
  - National Register of Health Service Providers and, 1:145–146
  - online counseling, technology and, 1:413



Crenshaw, Kimberle, **3:1074**

**Crisis counseling, 2:544–548**

adaptational theory and, **2:546**  
 antipsychotic medication and, **2:545–546**  
 basic crisis intervention and, **2:547**  
 bereavement and, **1:50–53**  
 crisis counseling skills and, **2:547**  
 crisis intervention models and, **2:547**  
 crisis lines and, **2:545**  
 critical incident stress debriefing, **2:548–550**  
 definition of, **2:544–545**  
 developmental crises, **2:546**  
 dialectical behavior therapy and, **2:571**  
 dual diagnosis clients and, **2:545–546**  
 ecological theory and, **2:546**  
 equilibrium/disequilibrium crisis intervention model, **2:547**  
 existential crises, **2:546–547**  
 eye movement desensitization, reprocessing (EMDR) and, **1:198–202**  
 history of, **2:545–546**  
 interpersonal theory and, **2:546**  
 interpersonal violence and, **2:545**  
 PTSD and, **2:545**  
 situational crises, **2:546**  
 six-step crisis intervention model and, **2:547**  
 substance abuse and, **2:545**  
 suicide postvention and, **1:403–404**  
 suicide potential and, **2:545, 2:899–901**  
 systemic crises, **2:547**  
 systems crisis theory and, **2:546**  
 theories of crisis intervention and, **2:546**  
 time limited nature of, **2:545**  
 transcrisis state and, **2:545**  
 typologies of crises and, **2:546–547**  
 Vietnam War and, **2:545**  
 women's movement, domestic violence and, **2:545**

Criterion-referenced achievement tests, **2:451**

**Crites, John O., 4:1519–1520**

academic career of, **4:1519**  
 Career Adjustment and Development Inventory (CADI) and, **4:1488**  
 Career Maturity Inventory (CMI) and, **4:1464, 4:1492–1493, 4:1520**  
 career maturity theory of, **4:1470**  
 Decision-Making Competency Scales of, **4:1519–1520**  
 honors and awards received by, **4:1519**  
 publications of, **4:1519**  
 Vocational Development Attitude Scale of, **4:1519–1520**  
 vocational psychology work of, **4:1519–1520**

**Critical incident stress debriefing (CISD),**

**2:548–550, 2:628**

conditions relating to, **2:549**  
 crisis intervention technique of, **2:548**  
 critical incident stress management and, **2:548**  
 definition of, **2:548**  
 follow-up to, **2:550**  
 historical synopsis of, **2:548–549**  
 intervention team and, **2:549**  
 Jeffrey T. Mitchell's work in, **2:548–549**  
 objectives of, **2:549**  
 perspective of, **2:548**  
 phase 1 - introduction, **2:549**  
 phase 2 - fact overview, **2:549–550**  
 phase 3 - thought collection, **2:550**  
 phase 4 - reaction focus, **2:550**  
 phase 5 - symptom association, **2:550**  
 phase 6 - teaching, **2:550**  
 phase 7 - reentry, **2:550**  
 potential harm from, **2:549**  
 process of, **2:549–550**  
 small group "psychological first aid" and, **2:548**  
 timing of, **2:549**

**Critical race theory (CRT), 3:1071–1078**

anti-essentialism, intersectionality and, **3:1073**  
 assigned racial group categorizations and, **3:1072**  
 assimilation, racial integration not in best interests and, **3:1073**  
 basic tenets and dominant themes of, **3:1071–1074, 3:1077 (table)**  
 Derrick Bell and, **3:1074**  
 color-blindness, meritocracy challenged by, **3:1072–1073, 3:1074**  
 color-blind racial ideology vs., **3:1071**  
 conclusion regarding, **3:1076, 3:1078**  
 counseling and psychotherapy applications of, **3:1076, 3:1077 (table)**  
 critical White studies and, **3:1075**  
 ecological issues and, **3:1075**  
 education issues and, **3:1075**  
 future applications of, **3:1078**  
 globalization and immigration issues and, **3:1075**  
 integration's negative effects and, **3:1073**  
 "interest convergence" concept, **3:1072**  
 internalized negative stereotypes and, **3:1073**  
 legal system and, **3:1075**  
 lived experience of racial/ethnic minorities importance and, **3:1074**  
 material determinism concept and, **3:1072**  
 mental health issues and, **3:1076**



- origin and interdisciplinary applications of, 3:1074–1075
- political science field and, 3:1075
- poverty and race intersection and, 3:1073
- psychological critical race theory and, 3:1075–1076
- psychology, multicultural counseling and, 3:1075–1076, 3:1077 (table)
- race as a social construct *vs.* biological phenomenon and, 3:1072
- racial identity is influenced by racial stratification and, 3:1073
- racial stratification in everyday life and, 3:1071
- racism benefits privileged, serves interests of power and, 3:1072
- racism is endemic to American life and, 3:1072
- social construction thesis of, 3:1072
- social justice, racial oppression elimination goals of, 3:1074
- social justice implications of, 3:1075, 3:1076
- sociopolitical context of race and racism and, 3:1074
- subdivisions of, 3:1074–1075
- “unmasking color-blindness” focus of, 3:1074
- Whiteness idealization and, 3:1073
- within-group heterogeneity significance and, 3:1073
- Crocker, Peter, 2:923
- Cronbach, Lee J., 1:364, 1:367, 2:684
- Cross, William E., Jr., 3:1078–1080**
- Black movement influence on, 3:1079
- childhood of, 3:1078
- Cross Racial Identity Scale (CRIS) and, 3:1035, 3:1078, 3:1079, 3:1080, 3:1287–1288
- empirical research on work of, 3:1080
- Janet E. Helms influenced by, 3:1154
- identity change process and, 3:1078–1079
- identity clusters and, 3:1036
- identity status and, 3:1229
- internalized identities and, 3:1079
- Martin Luther King’s assassination and, 3:1079
- legacy of, 3:1079–1080
- negative identity dynamics and, 3:1079
- Nigrescence Model expansion, 3:1079
- Nigrescence Model origins, 3:1078–1079, 3:1285, 3:1287, 3:1364, 3:1380
- Nigrescence Model revision, 3:1036
- Nigrescence Model stages, 3:1036–1037, 3:1079, 3:1229, 3:1287
- Racial Identity Attitude Scale-Black and, 3:1037
- stage model of racial identity and, 3:1028, 3:1035, 3:1079, 3:1080, 3:1166, 3:1229, 3:1246, 3:1296–1297
- Cross-cultural adoption. *See* **Transracial adoption**
- Cross cultural counseling. *See* **Barriers to cross-cultural counseling; Cross-cultural psychology; Cross-cultural training**
- Cross-cultural psychology, 3:1080–1086**
- absolutism *vs.* relativism *vs.* universalism and, 3:1082–1083
- Association of Black Psychologists and, 3:1081
- barriers to cross-cultural counseling and, 3:1009–1010
- collectivism and, 3:1059–1061
- Confucianism and, 3:1067–1068
- counseling research and, 3:1085
- critical race theory and, 3:1071–1078
- cultural equivalence and, 3:1091–1092
- cultural relativism and, 3:1082–1083, 3:1094–1095, 3:1359
- cultural values and, 3:1095–1097
- culture-bound syndromes and, 3:1102–1104
- definition of, 3:1078–1079
- development research and, 3:1084–1085
- dichotomous *vs.* integrative and, 3:1082
- ethnic minority psychology *vs.*, 3:1081
- etic–emic distinction and, 3:1082, 3:1144–1147
- Eurocentrism and, 3:1147–1148
- existentialism and, 3:1366
- fatalism and, 3:1150
- filial piety and, 3:1151
- gender issues research and, 3:1084
- goals of, 3:1081–1082
- handbook publications and, 3:1081
- Hispanic Journal of Behavioral Sciences* and, 3:1081
- historical background regarding, 3:1081–1082
- individualism *vs.* collectivism and, 3:1083
- integration of psychological research and, 3:1082
- International Association for Cross-Cultural Psychology and, 3:1081
- International Association of Applied Psychology and, 3:1081
- International Union of Psychological Sciences and, 3:1081
- Journal of Black Psychology* and, 3:1081
- Journal of Cross-Cultural Psychology* and, 3:1081
- journal publications and, 3:1081
- loss of face and, 3:1205
- mental illness and well-being research and, 3:1085
- multicultural psychology *vs.*, 3:1227
- Paul Pedersen and, 1:263
- personality research and, 3:1084
- professional organizations of, 3:1081
- Derald Wing Sue and, 1:401–403, 3:1088, 3:1341–1343



- translation, adaptation of psychological tests and, **1:418–421**
- universalism and, **3:1359–1361**
- values research and, **3:1083–1084**
- Clemmont Eyvind Vontress's work in, **3:1364–1365**
- Joseph L. White's work and, **3:1369–1371**
- World War II, Cold War and, **3:1081**
- Cross-cultural training, 3:1086–1089**
- academy demographics and, **3:1086–1087**
- APA focus on, **3:1086, 3:1087, 3:1088**
- Patricia Arredondo's work in, **3:1088**
- Asian American Psychological Association and, **3:1087**
- Asociación Por La Raza and, **3:1087, 3:1222**
- Association of Black Psychologists and, **3:1087**
- barriers to cross-cultural counseling and, **3:1009–1010**
- Brown v. Board of Education of Topeka, Kansas* and, **3:1087**
- Jesús Manuel Casas and, **3:1043–1045**
- counselor self-awareness importance and, **3:1087**
- definition of, **3:1086**
- espiritismo and, **3:1131–1132**
- existentialism and, **3:1366**
- final note regarding, **3:1088**
- Guidelines for Providers of Psycho-Diverse Populations* and, **3:1087**
- Guidelines on Multicultural Education, Training, Research, Practice, and Organizational Change for Psychologists* and, **1:435, 3:991–993, 3:1064, 3:1087, 3:1088, 3:1222, 3:1231, 3:1351, 4:1639**
- historical context of, **3:1087**
- importance of, need for, **3:1086**
- Allen E. Ivey's work in, **1:266–268, 3:1185–1187**
- key components of, **3:1088**
- machismo and, **3:1196–1197, 3:1207–1208**
- marianismo and, **3:1208–1209**
- meta-analysis of effectiveness of, **3:1088**
- population demographics and, **3:1086**
- race, ethnicity focus of, **3:1086**
- reference group identities and, **3:1086**
- Society of Indian Psychologists and, **3:1087**
- Derald Wing Sue's multicultural training model and, **1:401–403, 3:1088, 3:1341–1343**
- translation methods and, **3:1350–1353**
- universalism and, **3:1359–1361**
- universalist approach legacy to, **3:1086**
- Vail Conference and, **1:337, 3:1087, 3:1222, 3:1228**
- Clemmont Eyvind Vontress's work in, **3:1364–1365**
- Joseph L. White's work and, **3:1369–1371**
- Cross Racial Identity Scale (CRIS), **3:1035, 3:1078, 3:1079, 3:1080, 3:1287–1288**
- Crouch, Eric C., **2:658**
- Crozier, William J., **2:870**
- CRS. *See* Client Reactions System (CRS)
- CRSPP. *See* Commission of Recognition of Specialties and Proficiencies in Professional Psychology (CRSPP)
- CRS-R. *See* **Conners' Rating Scales-Revised (CRS-R)**
- CSB. *See* **Compulsive sexual behavior (CSB)**
- CSEQ. *See* **College Student Experiences Questionnaire (CSEQ)**
- CSI. *See* **Career Style Interview (CSI)**; Caregiver Strain Index (CSI) measure; Chi Sigma Iota (CSI) international honorary society
- Csikszentmihalyi, Mihaly, 2:550–551**
- desire for meaningful life and, **2:551**
- "flow" theory of, **2:551, 2:662, 2:672, 2:774**
- happiness theories of, **2:551**
- positive psychology and, **2:551, 2:781**
- professional associations of, **2:551**
- psychology of optimal experience and, **2:551**
- CSXQ. *See* College Student Expectations Questionnaire (CSXQ)
- CTBS. *See* Comprehensive Test of Basic Skills (CTBS)
- CTI. *See* **Career Thoughts Inventory (CTI)**; **Career Transitions Inventory (CTI)**
- CTONI. *See* Comprehensive Test of Basic Skills (CTBS)
- C-TRF. *See* Caregiver-Teacher Report For (C-TRF)/1½-5 Achenbach behavior rating scale
- Cuban Adjustment Program, **3:1170**
- Cuban Americans, **3:1197**
- Cuéllar, Israel, **3:943**
- Cultural accommodation and negotiation, 3:1089–1090**
- accommodation definition and, **3:1089**
- accommodation theory and, **3:1089**
- acculturation and, **3:941–946, 3:1089**
- acculturation levels, cultural biases and, **3:1089**
- bicultural conflict and, **3:1089–1090**
- culture-specific constructs and, **3:1089**
- enculturation and, **3:1129–1131**
- Frederick T. L. Leong's work in, **3:1089**
- multicultural personality and, **3:1226–1227**
- negotiation definition and, **3:1089**
- orthogonal cultural identification theory and, **3:1250–1252**
- Cultural anthropology, psychology worldview and, **3:1384–1385**
- Cultural encapsulation, 3:1090–1091**
- assumptions regarding, **3:1090–1091**
- cultural values and, **3:1096**
- definition of, **3:1090**



- global change protection and, **3:1090**  
 intervention strategy against, **3:1091**  
 Christopher G. Wrenn's work in, **3:1090**
- Cultural equivalence, 3:1091–1092**  
 achievement gap and, **3:952–955**  
 assessment tool cultural bias and, **3:1091**  
 conceptual equivalency and, **3:1091**  
 content equivalency and, **3:1091**  
 culture-free testing and, **3:1104–1106**  
 definition of, **3:1091**  
 intelligence tests and, **3:1179–1182**  
 linguistic equivalency and, **3:1091**  
 normative equivalency and, **3:1091–1092**  
 technical equivalency and, **3:1091**  
 translation, adaptation of psychological tests and, **1:418–421**
- Culturally Appropriate Career Counseling Model (CACCM), **4:1577**
- Cultural mistrust, 3:1092–1093**  
 adaptive attitudinal stance of, **3:1092**  
 Black mental health services use and, **3:1092**  
*Black Rage* (Grier and Cobbs) and, **3:1092, 3:1093**  
 client self-disclosure limited by, **3:1092**  
 counseling and, **3:1092–1093**  
 Cultural Mistrust Inventory (CMI) and, **3:1093**  
 cultural paranoia and, **3:1092, 3:1093–1094, 3:1297**  
 definition of, **3:1092**  
 healthy paranoia and, **3:1153**  
 perceived racism and, **3:1297**  
 research regarding, **3:1092**  
 Whaley's meta-analysis of, **3:1092, 3:1093–1094**  
 White privilege and, **3:1375–1380**  
 xenophobia and, **3:1380**
- Cultural Mistrust Inventory (CMI), **3:1093**
- Cultural paranoia, 3:1093–1094**  
 antisemitism and, **3:983–985**  
*Black Rage* (Grier and Cobbs) and, **3:1092, 3:1093**  
 client self-disclosure limited by, **3:1093**  
 clinical paranoia vs., **3:1093**  
 cultural mistrust and, **3:1092–1093, 3:1093, 3:1297**  
 Cultural Mistrust Inventory (CMI) and, **3:1093**  
 definition of, **3:1093**  
 healthy coping behavior of, **3:1093, 3:1094**  
 healthy paranoia and, **3:1153**  
 model minority myth and, **3:1211–1214**  
 multicultural counseling implications of, **3:1094**  
 paranoia continuum concept and, **3:1093**  
 Whaley's meta-analysis of, **3:1092, 3:1093–1094**  
 xenophobia and, **3:1380**  
*See also Antisemitism; Healthy paranoia*
- Cultural racism, **2:573, 3:1376, 3:1378–1379**
- Cultural relativism, 3:1094–1095**  
 biracialism and, **3:1027–1032**  
 cultural encapsulation and, **3:1090–1091**  
 culture definition and, **3:1094**  
 deficit model of behavior and, **3:1094–1095**  
 definition of, **3:1094**  
 etic and emic contexts and, **3:1095, 3:1359**  
 mental health in normative cultural context and, **3:1095**  
 universalism vs., **3:1359**  
 Western European psychology ideology and, **3:1094–1095, 3:1359**
- Cultural values, 3:1095–1097**  
 acculturation and, **3:941–946**  
 acculturative stress and, **3:946–952, 3:1096**  
 of African Americans, **3:1099**  
 allocentrism and, **3:971–972**  
 of Asians, **3:1099**  
 Brown's values-based career theory and, **4:1415–1416**  
 categories of, **3:1096–1097**  
 collectivism and, **3:1059–1061**  
 Confucianism and, **3:1067–1068**  
 cultural accommodation and negotiation and, **3:1089–1090**  
 cultural artifacts definition and, **3:1095**  
 cultural contingency and, **3:1097**  
 cultural encapsulation and, **3:1095–1096**  
 cultural norms definition and, **3:1095**  
 cultural relativism and, **3:1094–1095**  
 cultural universalism and, **3:1095**  
 culture definition and, **3:1095**  
 definition of, **3:1095**  
 dominant culture conflict over, **3:1096**  
 enculturation and, **3:1129–1131**  
 equifinality and, **3:1096**  
 ethnocentrism and, **3:1097**  
 of European Americans, **3:1099–1100**  
 expectations about therapy and, **2:597–598**  
 fatalism and, **3:1150**  
 filial piety and, **3:1151**  
 formation of, **3:1096**  
 human capacity to create culture and, **3:1095**  
 Allen Ivey's work in, **1:266–268**  
 Kwanzaa and, **3:1189–1190**  
 of Latinos/as, **3:1100**  
 loss of face and, **3:1205**  
 machismo and, **3:1196–1197, 3:1207–1208**  
 marianismo and, **3:1196–1197, 3:1208–1209**  
 of Native Americans, **3:1100**  
 parochialism and, **3:1096**



personal space and, **3:1261**  
psychologists' role and, **3:1097**  
role of, **3:1095–1096**  
within-group variation of, **3:1096**

**Culture, 3:1097–1102**

acculturation and, **3:941–946**  
affective/emotional systems theory of, **3:1099**  
affective primacy concept and, **3:1099**  
African American cultural values and, **3:1100**  
Asian cultural values and, **3:1100**  
biological foundations theory of, **3:1098**  
career development and, **4:1531**  
coevolution of psychological and cultural phenomena and, **3:1098**  
cognitive/communication systems theory of, **3:1099**  
cultural relativism and, **3:1094–1095**  
cultural values and, **3:1095–1097, 3:1099–1100**  
definitions of, **3:1097–1098**  
dynamic social impact theory (DSIT) and, **3:1099**  
enculturation and, **3:1129–1131**  
ethnicity vs., **3:1137–1138**  
European American cultural values and, **3:1100**  
evolutionary biological theory of, **3:1098**  
expectations about therapy and, **2:597–598**  
historical perspective regarding, **3:1097**  
implicit and explicit behavior patterns and, **3:1097**  
Latinos/as cultural values and, **3:1101**  
linguistic theory of, **3:1099**  
meaning of life importance in, **3:1098–1099**  
motivational systems theory of, **3:1098–1099**  
Native Americans cultural values and, **3:1101**  
neurological biological theory of, **3:1098**  
personal space and, **3:1261**  
plasticity of culture concept and, **3:1098**  
psychological processes and, **3:1098–1099**  
strength, immediacy, and number factors of social influence and, **3:1099**  
Derald Wing Sue and, **1:401–403, 3:1341–1343**  
terror management theory and, **3:1098–1099**

**Culture-bound syndromes, 3:1102–1104**

controversy regarding, **3:1103**  
counseling implications of, **3:1103–1104**  
definitional iterations of, **3:1102–1103**  
*DSM* diagnostic criteria for, **3:1102**  
rootwork example of, **3:1103**  
*shenjing shaijo* (“weakened nerves”) example of, **3:1103**

**Culture-free testing, 3:1104–1106**

classic test theory and, **3:1105**  
cultural equivalence and, **3:1091–1092**  
culture-fair testing concept and, **3:1105**

explanation of, **3:1104–1105**  
Leo Goldman's work in, **2:617–618**  
historical backdrop regarding, **3:1105**  
modern test theory implications and, **3:1105**  
translation, adaptation of psychological tests and, **1:418–421**  
two test paradigms or models and, **3:1105**

**Culture shock, 3:1106–1107**

acculturative stress and, **3:946–952**  
anxiety, sadness, loss and, **3:1106**  
cognitive reaction of, **3:1106**  
contemporary views on, **3:1106–1107**  
counseling implications of, **3:1106, 3:1107**  
definitions of, **3:1106**  
historical perspective regarding, **3:1106**  
panic attacks and, **3:1107**  
somatic reactions to, **3:1106–1107**  
symptoms and manifestations of, **3:1106**

Cummins, Jim, **3:1023**

Cunningham's Community Parent Education, **1:32**

**Current procedural terminology (CPT), 2:551–552**

AMA descriptive terms, codes and, **2:551**  
Category III codes and, **2:552**  
Healthcare Common Procedure Coding System (HCPCS) and, **2:552**  
Health Insurance Portability and Accountability Act (HIPAA) and, **2:551, 2:646, 3:1351**  
Level I, II, III codes and, **2:552**  
Medicare physician, hospital reimbursement and, **2:551**  
purpose of, **2:551**  
Web sites regarding, **2:552**

**Custody evaluations, 1:146–148**

best-interest doctrine and, **1:146–147**  
British common law influence on, **1:146**  
collateral contacts and, **1:147**  
decision-making responsibilities issue and, **1:147**  
forensic counseling applications of, **1:214**  
grandparent custody and, **1:147**  
joint custody statute, North Carolina (1957) and, **1:147**  
legal issues in parenting and, **1:279**  
Millon Clinical Multiaxial Inventory-III and, **1:147**  
Minnesota Multiphasic Personality Inventory-2 assessment tool and, **1:147**  
*Painter v. Bannister* and, **1:147**  
parental responsibility evaluation and, **1:146**  
parenting time issue and, **1:147**  
paternal entitlement and, **1:146**  
primary residential parent issue and, **1:147**  
tender-years doctrine and, **1:146**  
Uniform Marriage and Divorce Act (1974) and, **1:146–147**



- CVIS. *See* Computerized Vocational Information System (CVIS)
- CVLT-II. *See* California Verbal Learning Test, 2nd Edition (CVLT-II)
- Daiger, Denise, **4:1579**
- Daily Record of Dysfunctional Thoughts cognitive assessment, **2:747**
- D'Andrea, Michael, **1:131, 1:268**
- Darley, John G., **2:773, 4:1430, 4:1569, 4:1641, 4:1643, 4:1655**
- DAS. *See* Differential Ability Scales (DAS)
- Das, J. P., **2:498**
- Dasen, Pierre R., **3:1081**
- DAST. *See* Drug Abuse Screening Test (DAST)
- DAT. *See* Differential Aptitude Test (DAT)
- Davies, Paul, **3:1339**
- Davis, Angela, **3:1246, 3:1314**
- Davis, Jesse B., **1:121, 4:1446**
- Davis, Peggy C., **3:1290**
- Davis, T., **1:8**
- Dawes Act (1887), **3:1039**
- Dawis, René Villanueva, 2:773, 2:904, 2:939, 4:1397, 4:1521–1522**
- academic career of, **4:1521**
- consulting work of, **4:1521–1522**
- honors and awards received by, **4:1521**
- Lloyd Henry Lofquist and, **4:1573**
- Minnesota Importance Questionnaire and, **4:1521**
- Minnesota Satisfaction Questionnaire and, **4:1521**
- Occupational Reinforcer Patterns and, **4:1521**
- psychology of individual differences and, **4:1521**
- publications and books of, **4:1521**
- Howard Tinsley and, **4:1659**
- trait-and-factor matching model and, **4:1655**
- Vocational Psychology Research Web site and, **4:1522**
- Edward G. Williamson and, **4:1678**
- Work Adjustment Project and, **4:1521, 4:1522, 4:1573, 4:1655–1657, 4:1659**
- Day, Jeannie, **1:441**
- DBT. *See* Dialectical behavior therapy (DBT)
- DCT. *See* **Developmental counseling and therapy (DCT)**
- Death and dying, 1:149–152**
- accidental death and, **1:150**
- acknowledgment stage of, **1:150–151**
- advance directives and, **1:151–152**
- anticipated death and, **1:150**
- anticipatory mourning and, **1:150**
- bereavement and, **1:50–53**
- bioethics field and, **1:151**
- cancer management and, **1:59–63**
- contradictions in, **1:149**
- death-denying society and, **1:149**
- death out of time and, **1:150**
- denial, rage, bargaining, depression, acceptances stages and, **1:151**
- dying well transition and, **2:681**
- euthanasia and, **1:151**
- Forum for Death Education and Counseling and, **1:150**
- gerontology and, **1:231–234**
- Harvard Criteria of brain death and, **1:151**
- health care proxy and, **1:152**
- HIV/AIDS and, **1:237–240**
- hospice, palliative care and, **1:149, 1:151, 1:243–245**
- International Work Group on Death, Dying and Bereavement and, **1:149**
- lack of closure and, **1:150**
- life-prolonging technology and, **1:151**
- living will and, **1:152, 1:245**
- nearing death awareness and, **1:152**
- Patient Self-Determination Act (1990) and, **1:152**
- professional developments in, **1:149–150**
- societal perceptions of, **1:149**
- suicide and, **1:134, 1:150, 1:245**
- suicide postvention and, **1:403–404**
- unexpected death and, **1:150**
- vegetative state, brain dead and, **1:151**
- violent, wrongful death and, **1:150**
- Deci, Edward L. and Ryan, Richard M., 2:553–554**
- autonomy need and, **2:553**
- autonomy-supported classroom teaching and, **2:553–554**
- intrinsic motivation and, **2:553**
- motivation affected by social context and, **2:553**
- SDT applications and, **2:553**
- self-determination theory (SDT) of, **2:553–554, 4:1679**
- skills for work-bound youth and, **4:1679**
- social cognitive processes underlying motivation and, **2:553**
- Decision making, 4:1522–1525**
- attachment theory and, **4:1410–1412**
- cultural contextual factors and, **4:1524–1525**
- decision-making styles and, **4:1523–1524**
- definition of, **4:1522**
- descriptive models of, **4:1522–1523**
- dissonance reduction model of, **4:1522–1523**
- future directions regarding, **4:1525**
- Vincent A. Harren's four phases of awareness model of, **4:1522**
- P. P. Heppner's problem solving model of, **4:1523**
- individual variation models of, **4:1523–1525**
- judgments in relation to the world of work and, **4:1522**



- mathematical models of, **4:1523**
- Frank Parson's person-environment interaction model of, **4:1523**
- PIC model of career decision-making and, **4:1605–1608**
- prescriptive models of, **4:1523, 4:1606**
- as a process and, **4:1522–1523**
- rational style of, **4:1524**
- reliance on expert judges and, **4:1524**
- sequential elimination model of, **4:1523**
- Tiedeman's decision-making theory and, **4:1657–1658**
- David V. Tiedeman's stage process model of, **4:1522**
- trait-like categories of deciders and, **4:1523–1524**
- utility approaches to, **4:1523**
- variations from the context of, **4:1524–1525**
- Decision-Making Competency Scales, **4:1519–1520**
- Defense mechanisms. *See* **Defenses, psychological**
- Defense Mechanisms Manual, for Thematic Apperception Test, **2:793**
- Defenses, psychological, 2:554–556**
  - basic formulation of, **2:554**
  - coping and, **2:526–530**
  - as coping mechanism, **2:555**
  - cultural mistrust and, **3:1092–1093**
  - cultural paranoia and, **3:1093–1094**
  - defense mechanisms and, **2:554, 2:555**
  - ego strength and, **2:585–587**
  - evidence-based research regarding, **2:556**
  - Sigmund Freud psychoanalysis theory and, **2:554, 2:555**
  - Anna Freud's ego defense concept and, **2:554–555**
  - future directions in, **2:556**
  - healthy sense of self expressed through, **2:556**
  - Otto Kernberg's work regarding, **2:555**
  - Heinz Kohut's self-psychology work and, **2:555**
  - manifestation of resistance and, **2:555**
  - post-Freudian development of the construct and, **2:554–556**
  - projection mechanism and, **2:555**
  - resistance and, **2:555**
  - sublimation mechanism and, **2:555**
  - therapeutic process and, **2:555**
  - unconscious feature of defenses and, **2:554**
  - working with the defense and, **2:555–556**
- Deficit hypothesis, 3:1109–1111**
  - alternative premises and, **3:1111**
  - The Bell Curve* (Hernstein and Murray) and, **3:1109–1110**
  - cultural deprivation premise and, **3:1110**
  - cultural diversity vs., **3:1111**
  - The Culturally Deprived Child* (Riessman) and, **3:1110**
  - drapetomania and, **3:1124–1125**
  - explanation of, **3:1109**
  - gender differences in moral development example of, **3:1110–1111**
  - genetic inferiority premise of, **3:1109–1110**
  - historic examples of, **3:1109**
  - The Mark of Oppression* (Kardiner and Ovesey) and, **3:1110**
  - monocultural term and, **3:1214–1215**
  - nondominant groups and, **3:1110–1111**
  - optimal human functioning premise vs., **3:1111**
  - skull size criteria and, **3:1109**
  - social class and, **4:1626–1627**
  - visible racial/ethnic groups and, **3:1364**
- DeGeronimo, T. F., **1:432**
- Deiplmate in Group Psychology, **2:621**
- Delgado, Richard, **3:1074**
- Delis-Kaplan Executive Function System (D-KEFS), **2:698, 2:699, 2:700**
- Dell, Don, **2:892**
- Delworth, Ursula, 1:132, 1:152–153**
  - advocate for change and, **1:153**
  - early academic years of, **1:152–153**
  - honors and awards received by, **1:153**
  - integrated developmental model of supervision and, **1:407**
  - outreach work of, **1:153**
- Dementia, 2:556–557**
  - aging and, **1:17**
  - Alzheimer's disease and, **1:232, 2:557**
  - American Psychiatric Association diagnostic criteria of, **2:557**
  - Behavior Rating Scale of Executive Function (BRIEF) and, **1:49**
  - caregiver burden and, **1:63, 1:64, 1:68**
  - inclusivity of term and, **2:556**
  - reversible vs. irreversible dementia and, **2:556**
  - statistics regarding, **2:556**
- Demographics, United States, 3:1111–1113**
  - age changes and, **3:1111–1112**
  - Bureau of Labor Statistics and, **4:1416–1417**
  - client-counselor ethnic match and, **3:1113**
  - of counseling psychologists, **3:1112–1113**
  - households/family structure changes and, **3:1111–1112**
  - McArthur Foundation National Survey of Midlife Development and, **3:1112**
  - mental health care needs and use and, **3:1112**
  - National Comorbidity Survey Replication and, **3:1112**
  - race/ethnicity changes and, **3:1111**



Denver Developmental Screening Test, **2:670, 2:838**

**Department of Veterans Affairs (VA), 1:153–156**

clinical training by, **1:155**

community-based mental health care, support services of, **1:154**

continuum of care by, **1:154**

counseling services available through, **1:154**

electronic medical record system of, **1:154**

geriatric research, education, clinical centers (GRECCs) of, **1:155**

inpatient counseling services of, **1:154**

interdisciplinary care of, **1:154**

Mental Health Intensive Case Management program of, **1:154**

mental health needs of returning veterans focus of, **1:156**

mental health residential treatment services of, **1:154**

mental health strategic plan of, **1:155**

mental illness research, education, clinical centers (MIRECCs) of, **1:154–155**

National Center for Posttraumatic Stress Disorder (NCPTSD) of, **1:155**

outpatient counseling services of, **1:154**

practice guidelines of, empirically based professional practice and, **1:173, 1:175**

President's New Freedom Commission on Mental Health and, **1:155**

readjustment counseling, outreach services of, **1:154**

recovery-based model of care and, **1:155**

research and training by, **1:154–155**

transformation of care in, **1:155–156**

underserved populations of, **1:155–156**

VA medical centers, community-based outpatient clinics of, **1:154**

Veterans Health Administration and, **1:153–154**

Dependent personality disorder (DPD), **2:731**

**Depression, 2:557–561**

AD/HD comorbidity with, **1:31, 1:49**

Alaska Natives and, **3:968–969**

Anxiety Disorders Interview Schedule, **2:558**

Beck Depression Inventory (BDI), **1:420, 2:463, 2:534, 2:558**

Beck Depression Inventory-H and, **2:470**

Aaron T. Beck's work and, **2:469–470**

bipolar disorder and, **2:477**

bullying victims and, **1:56**

Center for Epidemiological Studies' Depression Scale, **2:558**

childhood depressive disorder and, **1:259–260**

cognitive-behavioral therapy for, **2:560, 2:869**

collaborative care management programs and, **2:560**

conduct disorder and, **1:100**

cross-cultural research on, **3:1085**

CT, REBT interventions for, **2:510**

*DSM-IV-TR* diagnostic criteria for, **2:557, 3:1085**

electroconvulsive shock therapy for, **2:560**

exercise intervention and, **1:196**

functional analysis assessment method and, **2:559**

gender differences in, **2:557–558**

Hamilton Depression Inventory, **2:558**

Hamilton Rating Scale for Depression, **2:558**

Harvard Department of Psychiatry/National Depression Screening Day Scale, **2:558–559**

learned helplessness and, **2:869**

learning disorder comorbidity with, **1:157**

major depressive disorder (MDD) and, **2:557**

Minnesota Multiphasic Personality Inventory 2 Depression Scale (MMPI-2), **2:559**

multimodal therapy for, **2:560**

National Institute of Mental Health Treatment of Depression Collaborative Research Project and, **1:174**

observational assessment methods and, **2:559**

Personality Assessment Inventory, **2:559**

pharmacological treatment of, **2:559–561, 2:816**

physical health and, **2:780**

prevalence and impact of, **2:557–558**

primary care medical treatment settings and, **2:560**

problem solving appraisal and, **2:789**

psychosocial interventions for, **2:560**

psychotherapy for, **2:560–561**

Reynolds Depression Screening Inventory, **2:559**

risk factors of, **2:558**

Schedule for Affective Disorders and Schizophrenia, **2:558**

self-efficacy, coping efficacy and, **2:855–856**

self-report assessment measures and, **2:558–559**

socioeconomic factors and, **3:1329**

Structured Clinical Interview for DSM-IV-Patient Version, **2:558**

suicide potential and, **1:134, 2:899–901**

treatment strategies of, **2:559–561**

unstructured and structured interview assessment of, **2:558**

Derogatis, Leonard, **2:814**

Descartes, René, **2:779, 2:785**

**Developmental counseling and therapy (DCT), 2:561–568**

aging and, **1:14–17**

application and research regarding, **2:567**



- cognitive-emotional-development (CED)  
     styles and, 2:563  
 concrete CED style and, 2:563  
 concrete CED style and, assessment of, 2:565–566  
 concrete interventions and, 2:567  
 cross-cultural psychology and, 3:1084–1085  
 developmental challenges and, 2:562  
 dialectic systemic CED style and, 2:564  
 dialectic systemic CED style and, assessment of, 2:566  
 dialectic systemic interventions and, 2:567  
 empowerment to change using, 2:567  
 formal CED style and, 2:563–564  
 formal CED style and, assessment of, 2:566  
 formal interventions and, 2:567  
 human development nature and, 2:561–562  
 integrative counseling models advantages and, 2:567  
 Allen Ivey's work in, 1:266–268, 2:542, 2:561  
 Allen E. Ivey's work in, 3:1185–1187  
 normal development and, 2:562  
 Piaget and, 2:562  
 Plato and, 2:562  
 sensorimotor CED style and, 2:563  
 sensorimotor CED style and, assessment of, 2:565  
 sensorimotor interventions and, 2:567  
 Standard Cognitive Developmental Interview (SCDI)  
     and, 2:564–565  
 trauma responses and, 2:562  
 treatment planning using, 2:566–567  
 wellness holistic perspective and, 2:562, 2:567
- Developmental Disabilities Act (1978), 1:157
- Developmental disorders, 1:156–161, 1:158**  
 ability/achievement discrepancy definition  
     criteria of, 1:158  
 autism/Asperger's syndrome and, 1:34–36  
 causes of, 1:158–159  
 comorbidity issue and, 1:157  
 concluding comments and, 1:160–161  
 definition of, 1:156–157  
 definition of, issues in, 1:157–158  
 Developmental Disabilities Act (1978) and, 1:157  
 disorder of written expression and, 1:160  
*DSM-IV*, learning disorder definition and, 1:157  
*DSM-IV-TR*, learning disability types and, 1:158  
 family studies of, 1:158  
 impairment term and, 1:157  
 Individuals with Disabilities Education Act  
     (IDEA) and, 1:158  
 intelligence level assessment and, 1:159  
 Kennedy's panel on mental retardation  
     and, 1:156–157  
 learning disorders and, 1:157–158, 1:159  
 learning disorders not otherwise specified and, 1:160  
 low-incidence disabilities and, 1:281–283  
 mathematics disorder and, 1:159–160  
 mental retardation, developmental disabilities  
     and, 1:294–296  
 neuropsychological assessment and, 1:158  
 other learning disability subtypes and, 1:160  
 reading disorder and, 1:159  
 support-based definition orientation and, 1:157
- Developmental psychology. *See* **Adult development**
- Dewey, John  
     *How We Think* written by, 2:787  
     progressive education and, 1:121
- Diagnostic and Statistical Manual of Mental Disorders (DSM), 2:568–571***  
 American Psychiatric Association  
     publication of, 2:568  
 atheoretical diagnosis approach in later versions  
     of, 2:568–569  
 axis I: clinical disorders and “V” codes  
     and, 2:569–570  
 axis II: personality disorders and mental retardation  
     and, 2:570  
 axis III: general medical conditions and, 2:570  
 axis IV: psychosocial and environmental  
     problems and, 2:570  
 axis V: the global assessment of functioning  
     scale and, 2:570  
 benefits to, 2:570  
 cultural awareness in, 2:569  
 diagnostic biases and, 3:1015  
 DSM assessment and, 2:570  
 epistemological assumptions in, 2:569  
 Eurocentric standards of, 2:568  
*International Classification of Diseases, Injuries, and Causes of Death (ICD)* and, 2:569  
 medical model and categorical approach of, 2:569  
*mental disorder* definition in, 2:569  
 multiaxial system of diagnosis in, 2:569–570  
 PTSD diagnostic symptoms in, 3:1133  
 schizophrenia diagnostic criteria in, 2:845  
 valid and reliable diagnostic system of, 2:568
- Diagnostic and Statistical Manual of Mental Disorders-IV (DSM-IV)***  
 alcohol withdrawal and, 1:19  
 cigarette smoking classification in, 1:88  
 Conners' Rating Scales and, 1:48  
 homosexuality as a mental disorder and, 1:370–371  
 learning disorder definition in, 1:158



- ODD diagnostic criteria in, **1:317**  
 pathological gambling diagnostic criteria and, **1:227**  
 Sexual Disorder Not Otherwise Specified  
     category in, **1:370–371**  
*Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR)*  
 adaptive behavior testing and, **2:456**  
 AD/HD diagnostic criteria in, **1:28–29**  
 anorexia, bulimia diagnostic criteria in, **2:579**  
 antisocial personality disorder in, **2:730**  
 anxiety disorders in, **2:703**  
 autism, Asperger's syndrome diagnostic  
     category in, **1:34**  
 avoidant personality disorder in, **2:731**  
 borderline personality disorder in, **2:730, 2:732**  
 childhood anxiety disorders and, **1:260**  
 childhood depressive disorders and, **1:259–260**  
 conduct disorder diagnostic criteria in, **1:100**  
 dependent personality disorder in, **2:731**  
 depression diagnostic criteria in, **2:557, 3:1085**  
 Diagnostic Interview for Children and  
     Adolescents-Revised, **1:29**  
 Diagnostic Interview Schedule (DIS) and, **2:490, 2:810**  
 Diagnostic Interview Schedule for  
     Children-Version IV, **1:29**  
 disorder of written expression classification in,  
     **1:158–159**  
 eating disorder not otherwise specified diagnostic  
     criteria in, **2:579**  
 externalizing problems of childhood and, **1:197–198**  
*Glossary of Culture-Bound Syndromes* in, **3:1002**  
 histrionic personality disorder in, **2:730**  
 homosexuality as a mental disorder and, **1:370–371**  
 IDEA disability categories and, **1:251, 1:252**  
 intelligence level assessment and, **1:159**  
 learning disability types in, **1:158**  
 learning disorder classification in, **1:158**  
 learning disorders not otherwise specified  
     classification in, **1:159**  
 mathematics disorder classification in, **1:158–159**  
 mental retardation, developmental disabilities diagnostic  
     criteria, **1:294–295**  
 narcissistic personality disorder in, **2:730–731, 2:732**  
 obsessive-compulsive personality disorder in, **2:731**  
 ODD diagnostic criteria in, **1:197**  
 other learning disability subtypes classification in, **1:159**  
 panic disorder diagnostic criteria in, **2:717**  
 paranoid personality disorder in, **2:729**  
 personality disorder not otherwise specified  
     (PD-NOS) in, **2:729**  
 PTSD in, **2:786**  
 reading disorder classification in, **1:158**  
 schizoid personality disorder in, **2:729**  
 schizotypal personality disorder in, **2:729–730, 2:732**  
 Sexual Disorder Not Otherwise Specified  
     category in, **1:370–371**  
 sleep disorders and, **1:393–394**  
 spirituality, religious issues in, **2:882**  
 Structured clinical Interview for DSM (SCID)  
     and, **2:810**  
 substance abuse diagnostic criteria in, **2:817, 2:893–894**  
 Diagnostic Interview for Children and  
     Adolescents-Revised, **1:29**  
 Diagnostic Interview Schedule (DIS), **2:490, 2:810**  
 Diagnostic Interview Schedule for  
     Children-Version IV, **1:29**  
**Dialectical behavior therapy (DBT),**  
     **1:300, 2:571–572**  
     behavior therapy and, **2:470–476**  
     distress tolerance skills of, **2:571**  
     emotion regulation skills of, **2:571**  
     functions and modes of, **2:571**  
     interpersonal effectiveness skills of, **2:571**  
     mindfulness skills of, **2:571**  
     quality of life improvement and, **2:571**  
     Socratic Method and, **2:875–876**  
     suicide prevention and, **2:571**  
     targets of, **2:571**  
 DiClemente, Carlos, **2:648**  
*Dictionary of Holland Occupational Titles* (Holland),  
     **4:1544–1545, 4:1549**  
*Dictionary of Occupational Titles (DOT), 1:124,*  
     **4:1525–1526**  
     career counseling in schools and, **4:1446**  
     classification system of, **4:1526**  
     disability benefits use of, **4:1526**  
     Employment and Training  
         Administration and, **4:1417**  
     first publication of, **4:1446**  
     Holland's revision of, **4:1544, 4:1545, 4:1549**  
     Holland's RIASEC Model and, **4:1587, 4:1599**  
     Occupational Information Network (O\*NET)  
         replacement of, **4:1526, 4:1588**  
*Dictionary of Psychology* (APA), **2:522**  
 Diener, Ed, **2:781**  
 Differential Ability Scales (DAS), **2:499**  
 Differential Aptitude Test (DAT),  
     **4:1393, 4:1395, 4:1396**  
 Differential Aptitude Tests, **4:1541**  
 Differentiation of self, **1:204**



Digman, John M., **2:736**  
 DiMatteo, M. Robin, **1:424**  
 Dinkmeyer, Don, **1:327**  
 Dinkmeyer, Don, Jr., **2:458**  
 Dinkmeyer, Don, Sr., **2:458**  
 Diop, Cheikh Anta, **3:964**  
 DIS. *See* Diagnostic Interview Schedule (DIS)  
 Disabilities. *See* **Americans with Disabilities Act (ADA); Individuals with Disabilities Education Act (IDEA); Low-incidence disabilities; Mental retardation and developmental disabilities; Persons with disabilities**  
**Disasters, impact on children, 1:161–165**  
   AD/HD and, **1:162**  
   adolescents and, **1:163**  
   aggression, withdrawal behaviors and, **1:163**  
   behavioral effects of, **1:163**  
   children's responses to, **1:162–163**  
   child's developmental level factor in, **1:164**  
   Cognitive Behavioral Intervention for Trauma in Schools and, **1:165**  
   cognitive behavioral treatment of, **1:165**  
   cognitive reactions of, **1:162**  
   cultural factors in, **1:164**  
   emotional reactions of, **1:162**  
   exposure extent factor and, **1:163**  
   family stressors factor in, **1:164**  
   Healing After Trauma Skills and, **1:165**  
   helplessness, guilt, grief and, **1:162**  
   high-risk behavior and, **1:163**  
   interventions and, **1:165**  
   intrusive thoughts and, **1:162**  
   Listen, Protect, and Connect intervention model and, **1:165**  
   loss factor in, **1:163**  
   mediating factors in, **1:163–164**  
   physiological effects of, **1:162–163**  
   preexisting risk factors and, **1:163–164**  
   Psychological First Aid models and, **1:165**  
   PsySTART mental health triage assessment and, **1:165**  
   PTSD and, **1:164**  
   resilience factor in, **1:164**  
   routine disruption factor in, **1:163**  
   separation anxiety and, **1:163**  
   social relationship changes and, **1:163**  
   time separation factor in, **1:163**  
   Trauma-Focused Cognitive-Behavioral Therapy and, **1:165**  
   Web sites regarding, **1:165**  
   worries, anxieties, fears and, **1:162**

**DISCOVER, 4:1526–1529**

  ACT Career Planning Program and, **4:1526**  
   ACT's Interest Inventory (UNIACT) and, **4:1528**  
   assessments provided, **4:1528**  
   career counseling interventions and, **4:1431–1432, 4:1485–1486**  
   Career Decision Self-Efficacy Scale and, **4:1471**  
   career indecision and, **4:1481**  
   career portfolio component of, **4:1528**  
   computer-assisted career counseling and, **4:1512**  
   Computerized Vocational Information System (CVIS), **4:1526–1527**  
   counselor features of, **4:1529**  
   data, ideas, people, and things work dimensions of, **4:1527–1528**  
   description of, **4:1526**  
   educational institution information in, **4:1528**  
   history of, **4:1526–1527**  
   John L. Holland's career types and, **4:1528**  
   information components used and, **4:1528**  
   majors information in, **4:1528**  
   navigation within, **4:1528**  
   occupational descriptions in, **4:1528, 4:1588**  
   professional support with, **4:1529**  
   resume, course plan components of, **4:1528**  
   target populations and, **4:1529**  
   theoretical model of, **4:1527–1528**  
   UNIACT and, **4:1667**  
   Web site of, **4:1482**  
   World-of-Work Map of, **4:1527, 4:1527 (figure), 4:1528, 4:1668**

**Discrimination, 3:1113–1119**

  ability and motivation to, **3:1114**  
   acculturation, assimilation and, **3:942**  
   acculturative stress and, **3:950**  
   affirmative action and, **3:957–958, 3:1117**  
   “amity” and “enmity” group behavior coding and, **3:1115**  
   bias and, **3:1014–1016**  
   biracial experiences of, **3:1029**  
   Kenneth Bancroft Clark and, **3:1050–1052**  
   classism and, **3:1054–1059**  
   cultural discrimination and, **4:1631**  
   deficit hypothesis and, **3:1109–1111**  
   definition of, **3:1113–1114**  
   drapetomania and, **3:1124–1125**  
   ethnic identity and, **3:1136**  
   ethnocentrism and, **3:1115**  
   Eurocentrism and, **3:1147–1148**  
   forms and level of, **3:1114–1115**  
   gender discrimination, **3:1117**



- individual level discrimination and, **3:1115**  
 ingroup–outgroup bias theory and, **3:1115–1116**  
 institutional discrimination and, **3:1115**  
 other types of, **3:1118**  
 political correctness and, **3:1263–1264**  
 power factor in, **3:1114**  
 prejudice *vs.*, **3:1114, 3:1274**  
 psychological distress and, **3:1276**  
 race or ethnicity discrimination and, **3:1116–1117**  
 race-related stress, **3:1377**  
*Regents of the University of California v. Bakke* and, **3:957, 3:1224**  
 reverse discrimination and, **2:572, 3:957, 3:1117, 3:1224, 3:1303**  
 self-categorization theory and, **3:1115**  
 sexual orientation, ability, or mental illness  
   discrimination and, **3:1117–1118**  
 social discrimination and, **3:1113–1114, 4:1630–1634**  
 social dominance theory and, **3:1116**  
 social identity theory and, **3:1115, 3:1319**  
 stereotypes and prejudice *vs.*, **3:1114**  
 stereotype threat and, **3:1340**  
 straight-line discrimination and, **3:1114–1115**  
 subtle discrimination and, **3:1115**  
 tokenism and, **3:1349–1350**  
 types of, **3:1114, 4:1631**  
 White privilege and, **3:1375–1380**  
 xenophobia and, **3:1116–1117, 3:1380**  
*See also Antisemitism; Discrimination;*  
   **Discrimination and oppression; Prejudice;**  
   **Racism; Social discrimination; Stereotype;**  
   **Stereotype threat**
- Discrimination and oppression, 2:572–575**  
 ableism and, **2:574**  
 affirmative action, positive discrimination and, **2:572**  
 ageism and, **2:574**  
 antisemitism and, **3:983–985**  
 classism and, **2:573–574, 3:1054–1059**  
 colonialism and, **3:1061–1063**  
 colorism and, **2:574**  
 critical race theory and, **3:1071–1078**  
 direct *vs.* indirect discrimination and, **2:572**  
 discrimination, definition of, **2:572**  
 distinctions between people based on  
   differences and, **2:572**  
 drapetomania and, **3:1124–1125**  
 Eurocentrism and, **3:1147–1148**  
 healthy paranoia and, **3:1153**  
 heterosexism and, **2:573**  
 individual oppression and, **2:574–575**  
 institutional oppression and, **2:575**  
 internalized oppression and, **2:575**  
 lookism and, **2:574**  
 multiculturalism definition and, **2:572**  
 power abuse and, **2:572**  
 racism and, **2:572–573**  
 reverse discrimination and, **2:572, 3:957, 3:1117, 3:1224, 3:1303**  
 sexism and, **2:573**  
 stereotypes and, **3:1333–1339**  
 Derald Wing Sue and, **1:401–403, 3:1341–1343**  
*See also Antisemitism; Discrimination; Prejudice;*  
   **Racism; Social discrimination; Stereotype;**  
   **Stereotype threat**
- Disorder of written expression, 1:160**  
**Displaced Persons Act (1948), 3:1170**  
**Dissociative identity disorder-oriented treatment, 2:630**  
**Distance education/dispersed learning, 1:165–167**  
 best teaching practices and, **1:166**  
 Blackboard Web-based systems and, **1:166**  
 cognitive theory, instructional design  
   theory and, **1:168**  
 designing web-based materials for, **1:167**  
 development and delivery of, **1:166–167**  
 eCollege and, **1:166**  
 flexible education opportunities and, **1:167–168**  
 instructional design process of, **1:168**  
 multiple means of presentation, expression and  
   engagement and, **1:166**  
 universal design for learning and, **1:166**  
 WebCT and, **1:166**
- Diversity, 3:1119–1124**  
 affirmative action and, **3:1122, 3:1123–1124**  
 counseling practice and research  
   implications of, **3:1120**  
 definition of, **3:1119–1120**  
 ethnicity, race, and gender focus of, **3:1119**  
*Gratz v. Bollinger* and, **3:1122**  
*Grutter v. Bollinger* and, **3:1122**  
 in higher education, **3:1122–1123**  
 inclusivity and broad perspective focus of, **3:1120**  
 interracial comfort and, **3:1182–1183**  
 melting pot concept and, **3:1120**  
 multiculturalism and, **3:1120–1121**  
 power distribution inequities and, **3:1119**  
 sexual orientation, age, and religion and, **3:1119–1120**  
 student enriched learning environment and,  
   **3:1122–1123**  
 student intellectual growth and development and,  
   **3:1122–1123**



- tokenism and, **3:1349–1350**  
 in the workplace, **3:1121–1122**  
*See also* **Affirmative action; Multicultural counseling; Multicultural counseling competence; Multiculturalism; Multicultural psychology; Recruitment: history and recent trends in diversity**
- Diversity issues in career development, 4:1529–1533**  
 career counseling models and, **4:1532–1533**  
 counseling implications of, **4:1533**  
 culturally appropriate career counseling model and, **4:1533**  
 culture and, **4:1531**  
 education/academic preparation and, **4:1532**  
 gender socialization factors and, **4:1530**  
 immigrant issues and, **4:1531**  
 individual diversity factors and, **4:1530–1532**  
 labor force changes and, **4:1533**  
 other relevant considerations-constructs and, **4:1531**  
 physical or learning disabilities and, **4:1531**  
 race or ethnicity and, **4:1530–1531**  
 real or perceived barriers and, **4:1532**  
 sexual orientation and, **4:1531**  
 social or economic factors and, **4:1531–1532**  
 society demographic changes and, **4:1532–1533**  
 socioeconomic status and, **4:1532**  
 tokenism and, **3:1349–1350**  
*See also* **Career counseling, specific group**
- Division 17. *See* American Psychological Association (APA)
- Divorce  
 custody evaluations and, **1:146–147**  
 family counseling and, **1:205**  
 forensic counseling, divorce adjustment therapy and, **1:214**  
 Uniform Marriage and Divorce Act (1974) and, **1:146–147**  
*See also* **Custody evaluations**
- Dixon, A. E., **1:139**  
 Dixon, Dave, **2:892**  
 D-KEFS. *See* Delis-Kaplan Executive Function System (D-KEFS)
- Dobbins, James E., **3:1295**  
 Dodo Bird conjecture, **1:175, 2:512, 2:714–715**  
 Dohrenwend, Bruce P., **3:1150**  
 Dollard, John, **2:541, 2:735**  
 behavioral personality theory of, **2:739**  
 behaviorism, psychoanalysis reconciliation and, **2:737**  
 conflict of response hierarchies and, **2:739–740**  
 critical training periods concept of, **2:740**  
 environmental cues and, **2:739**  
 external vs. internal drives and, **2:739**  
 Sigmund Freud's influence on, **2:739–740**  
 frustration-aggression hypothesis of, **2:740**  
 Dollard and Miller's theory. *See* Dollard, John; Miller, Neal E.
- Dosmas-Díaz, Lillian, **3:1246**  
*DOT. See* **Dictionary of Occupational Titles (DOT)**
- Douce, Louise, 1:167–169**  
 American Psychological Association work of, **1:168–169, 1:264**  
 Association of Counseling Center Training Agencies and, **1:168**  
 early years of, **1:168**  
 empowerment, advocacy, equality focuses of, **1:167**  
 feminism and, **1:167**  
 international counseling psychology work of, **1:264**  
 LGB counseling psychology and, **1:168–169**  
 mentoring importance to, **1:168**  
 multiculturalism focus of, **1:168**  
 Ohio State career of, **1:168**  
 professional associations of, **1:168**  
 scholarly publications of, **1:168–169**
- Doucet, Joanne, **3:1329**  
 Dovidio, John F., **3:1228, 3:1281, 3:1294**  
 Dowding, Keith, **3:1271**  
 DPD. *See* Dependent personality disorder (DPD)
- Drapetomania, 3:1124–1125**  
 contemporary views on, **3:1124–1125**  
 description of, **3:1124**  
 fleeing from slavery symptom of, **3:1124**  
 racist pseudoscience of, **3:1124–1125**
- Dreikurs, Rudolf, **1:327, 2:457**  
 Driscoll, Jeanine, **2:780**  
 Drotar, Dennis, **1:426**  
 Drug Abuse. *See* **Substance abuse and dependence**  
 Drug Abuse Screening Test (DAST), **2:896**  
 DSIT. *See* Dynamic social impact theory (DSIT)
- DSM. See** **Diagnostic and Statistical Manual of Mental Disorders (DSM)**  
*DSM-IV. See* **Diagnostic and Statistical Manual of Mental Disorders-IV (DSM-IV)**  
*DSM-IV-TR. See* **Diagnostic and Statistical Manual of Mental Disorders-IV-TR (DSM-IV-TR)**
- D'Souza, Dinesh, **3:1264**  
 Du Bois, W. E. B.  
 “double consciousness” concept of, **3:964**  
 NAACP and, **3:1238**  
 racial identity theory work of, **3:1036**  
*The Souls of Black Folk* written by, **3:964**  
 White privilege and, **3:1374**



- Dudley, Gordon, **4**:1658
- Duncan, Otis Dudley, **3**:1328
- Duncan's Socioeconomic Index, **3**:1328
- Dunlap, Knight, **2**:720
- Duration recording behavioral observation method, **1**:40
- Durham, C. C., **1**:257
- Durkheim, Émile
- fatalism and, **3**:1150
  - sociogenic adult development theory of, **1**:9
- Duty to warn and protect, 2:575–578**
- client autonomy and, **2**:577
  - client well-being and, **2**:577
  - confidentiality and legal privilege and, **2**:519–522, **2**:575, **2**:577, **2**:645
  - e-counseling and, **1**:171
  - ethical codes and, **1**:183, **2**:575–576
  - guidelines for, **2**:576–577
  - HIV/AIDS confidentiality, ethical codes and, **2**:496, **2**:576
  - incorrect diagnosis issue and, **2**:576
  - informed consent and, **2**:645–647
  - interpretations, inconsistencies in, **2**:576
  - other therapeutic issues and, **2**:576
  - privileged communication and, **2**:575
  - steps to follow relating to, **2**:577
  - Tarasoff v. Regents of the University of California* and, **2**:576
  - therapeutic considerations and, **2**:577
  - warn vs. protect definition and, **2**:575
- Dweck, Carol, **2**:747
- Dye, D., **4**:1535
- Dynamic social impact theory (DSIT), **3**:1099
- The Dynamics of Vocational Adjustment* (D. E. Super), **4**:1645
- Dynamic theories of aging, **1**:15
- Dyslexia reading disorder, **1**:159
- D'Zurilla, Thomas, **2**:505
- EACB. *See* Expectations About Counseling–Brief Form (EACB)
- EAPs. *See* Employee Assistance Programs (EAPs)
- EAS. *See* **Employee Aptitude Survey** (EAS)
- EAT. *See* **Environmental Assessment Technique** (EAT)
- EAT-26. *See* Eating Attitudes Test-26 (EAT-26)
- Eating Attitudes Test-26 (EAT-26), **2**:580
- Eating Disorder Diagnostic Scale (EDDS), **2**:580
- Eating Disorder Inventory-3 (EDI-3), **2**:580
- Eating disorders (EDs), 2:579–585**
- adaptive eating and, **2**:580
  - anorexia nervosa *DSM-IV-TR* diagnostic criteria and, **2**:579
  - assessment of eating behavior and, **2**:580–581
  - body dysmorphic disorder and, **2**:584
  - bulimia *DSM-IV-TR* diagnostic criteria and, **2**:579
  - Bulimia Test-Revised (BULIT-R) and, **2**:580
  - cognitive-behavioral therapy and, **2**:583
  - counterattitudinal exercises and, **2**:582
  - dual pathway model of, **2**:582
  - Eating Attitudes Test-26 (EAT-26) and, **2**:580
  - Eating Disorder Diagnostic Scale (EDDS) and, **2**:580
  - Eating Disorder Examination and, **2**:580
  - Eating Disorder Inventory-3 (EDI-3) and, **2**:580
  - eating disorder not otherwise specified *DSM-IV-TR* diagnostic criteria and, **2**:580
  - family therapy for, **2**:583
  - feminist therapy for, **2**:583
  - future directions regarding, **2**:583–584
  - health risks of, **2**:579–580
  - interaction models of, **2**:582
  - interpersonal therapy for, **2**:583
  - intuitive eating and, **2**:580
  - Intuitive Eating Scale (IES) and, **2**:581
  - less severe eating disturbances and, **2**:580
  - of men, **2**:584
  - objectification theory and, **2**:581
  - personality disorders comorbidity with, **2**:732
  - personal variables and, **2**:581
  - physical health and, **2**:780
  - prediction of eating disorder symptomatology and, **2**:581–582
  - prevention of, **2**:582
  - Questionnaire for Eating Disorder Diagnoses (Q-EDD) and, **2**:580
  - relational variables and, **2**:581
  - risk factors of, **2**:581
  - sociocultural variables and, **2**:581
  - systematic desensitization and, **2**:582
  - thin-ideal societal standard and, **2**:581, **2**:582, **2**:584
  - treatment of, **2**:582–583
  - women of color and, **2**:584
- Eberhardt, Jennifer L., **3**:1114
- Ebonics, **3**:1032
- EBPP. *See* **Empirically based professional practice** (EBPP)
- Eckstein, R., **1**:405
- Eclectic therapy. *See* **Integrative/eclectic therapy**
- Ecological theory
- crisis counseling and, **2**:546
  - ecological congruence, social support and, **2**:873
- Economic Apartheid in America* (Yeskel), **3**:1326



Economic Opportunity Act (1964), **4**:1447

**E-counseling, 1:171–172**

confidentiality issues and, **1**:171, **1**:413

duty to warn issue and, **1**:171

empathy in text environment difficulties and, **1**:172

ethical and legal issues of, **1**:171–172, **1**:414–415

informed consent and, **1**:171

Internet accessibility and, **1**:171

Internet delivery of mental health services and, **1**:171

online counseling, technology and, **1**:413

protection of tests, assessments and, **1**:171–172

state licensure legalities and, **1**:172

training issues of, **1**:172

EDDS. *See* Eating Disorder Diagnostic Scale (EDDS)

EDI-3. *See* Eating Disorder Inventory-3 (EDI-3)

EDs. *See* **Eating disorders** (EDs)

*Educational and Psychological Measurement*  
journal, **4**:1569

Education Commission, **4**:1448

Education Resources Information Clearinghouse  
(ERIC), **1**:124

The Education Trust, **4**:1392

Edwards Personal Preference Schedule (EPPS), **2**:726

*The Ego and the Mechanisms of Defense*  
(A. Freud), **2**:795

**Ego strength, 2:585–588**

assessment of, **2**:587

ego deficits and, **2**:585

ego function assessment and, **2**:587

ego functions and, **2**:585, **2**:586 (table)

ego psychology and, **2**:587

Sigmund Freud's ego concept and, **2**:585–586

Anna Freud's work in, psychological defense and,  
**2**:554–555, **2**:795

historical perspective of, **2**:585–587

indicators of, **2**:585

intrapsychic and interpersonal dimensions of, **2**:585  
of therapist, **2**:585

transactional analysis and, **2**:926–928

utility and relevance of, **2**:585

Ehrenreich, Barbara, **3**:1056

Ekman, Paul, **2**:883

**Elder abuse**

Amendments to the Older Americans Act  
(1987) and, **2**:447

domestic, institutional abuse and, **2**:447

emotional, psychological abuse and, **2**:447

family, caregiver stress and, **2**:448

human dignity and, **2**:448

intergenerational violence and, **2**:448

material, financial exploitation and, **2**:447

personal, familial privacy issue and, **2**:448

physical abuse and, **2**:447

self-neglect and, **2**:447

societal attitudes toward elders and, **2**:448

*See also* **Counseling the elderly**

Electrical and Electronics Test, **4**:1393

Elementary and Secondary Education Act  
(1974), **3**:1221

Elliott, Robert, **2**:486, **2**:903

**Ellis, Albert, 2:588–589**

ABC therapy model and, **2**:504, **2**:509, **2**:823–824

childhood of, **2**:588–589

cognitive-behavioral therapy and,

**2**:503, **2**:541, **2**:588, **2**:823

cognitive processing errors, irrational beliefs and,

**2**:504, **2**:509, **2**:542, **2**:588, **2**:823, **2**:824, **2**:889

*How to Live With a Neurotic* written by, **2**:588

irrational belief forms and, **2**:824

logical positivism to constructivist, postmodern  
transition and, **2**:509

philosophy of happiness and, **2**:509, **2**:823

psychoanalysis work of, **2**:588

rational emotive behavior therapy (REBT) and, **2**:504,

**2**:509, **2**:542, **2**:588–589, **2**:746, **2**:823–826, **2**:879

rational-emotive therapy work of,

**2**:504, **2**:509, **2**:588, **2**:823

religion and, **2**:879, **2**:880

transference and, **2**:930

*See also* **Rational emotive behavior therapy** (REBT)

Embedded design, of mixed methodology

research, **1**:303

EMDR. *See* **Eye movement desensitization and  
reprocessing** (EMDR)

Empathy of therapist

client active self-healing efforts and, **2**:487

definition of, **2**:486

exploration and creation of meaning and, **2**:486

increased feelings of safety and, **2**:486

listening, communication skills and, **3**:1066

multicultural counseling competence and, **3**:1216

positive bonding function of,

**2**:486, **2**:513, **2**:514, **2**:602

relational-cultural theory and, **3**:1317

Carl Rogers and, **2**:514, **2**:541–542, **2**:601, **2**:638–639,

**2**:704, **2**:736, **2**:803, **3**:1066

secondary trauma and, **2**:850

therapist compassion fatigue and, **2**:850

trait forgiveness and, **2**:606

validation of client feelings and, **2**:486



**Empirically based professional practice (EBPP),**  
**1:172–176**

- action theory and, **4:1399**
- common factors vs. treatment factors and, **1:174–175**
- Dodo Bird conjecture and,  
**1:175, 2:512, 2:714–715**
- effectiveness real-world clinical psychotherapy research  
 and, **1:173–174**
- efficacy time-limited psychotherapy outcome research  
 and, **1:173–174**
- efficacy vs. effectiveness model issue of, **1:173–174**
- evidence of efficacy in professional  
 psychology and, **1:173**
- Paul E. Meehl and, **2:684–686**
- National Institute of Mental Health Treatment  
 of Depression Collaborative Research  
 Project and, **1:174**
- National Institute on Alcohol Abuse and Alcoholism's  
 Project MATCH and, **1:174**
- practice guidelines prevalence and, **1:173**
- present situation and, **1:175**
- "science" over "art" concept and, **1:173**
- therapeutic process variables and, **1:174–175**
- therapist variables and, **1:174**
- value of intuition issue and, **1:173**

**Empirically validated treatments. See Evidence-based  
 treatments**

**Employee Aptitude Survey (EAS), 4:1535–1536**

- Examiner's Manual* of, **4:1535**
- individual and group administration of, **4:1535**
- other ability batteries compared to, **4:1535–1536**
- paper and pencil or online versions of, **4:1535**
- reliability data of, **4:1535**
- Supplemental Norms Report* of, **4:1535**
- Technical Manual* of, **4:1535**
- validity studies of, **4:1535**
- Web site regarding, **4:1535**

**Employee Assistance Programs (EAPs), 4:1685**

**Employment and Training Agency, 4:1448**

**Empowerment, 3:1127–1129**

- adaptation and, **3:956**
- adventure therapy and, **1:12–14**
- Patricia Arredondo's work in, **3:991**
- civil rights movement and, **3:1127**
- community-based action research and, **1:90–92**
- conceptualization of, **3:1128**
- counseling implications of, **3:1128**
- critical consciousness and, **3:1128, 3:1245–1246**
- cultural adaptation and, **3:956**
- definition of, **3:1127**

developmental counseling and therapy and, **2:567**

- Louise Douce and, **1:167–169**
- ethnic pride and, **3:1142**
- feminist therapy and, **1:210–211**
- group consciousness and, **3:1128**
- group identification and, **3:1128**
- history of, **3:1127**
- individual, social, and political  
 empowerment and, **3:1127**
- of interpersonal violence survivors, **2:445–446**
- intrapersonal, interaction, and behavioral  
 empowerment and, **3:1128**
- multicultural issues and, **3:1127–1128**
- from narrative career counseling, **4:1581**
- rehabilitation counseling and, **2:829**
- self-efficacy and, **3:1128**
- self-empowerment and, **3:1127**
- self-help groups and, **2:866–869**
- vocational settings of, **3:1127**

**Enculturation, 3:1129–1131**

- acculturation and, **3:941–946, 3:1129, 3:1138–1139**
- adaptation and, **3:956**
- behavioral, affective, and cognitive functioning  
 levels of, **3:1129–1130**
- colonialism and, **3:1061–1063**
- culture shock and, **3:1106–1107**
- definition and clarification of, **3:1129**
- dimensions of, **3:1129–1130**
- ethnicity and, **3:1138–1139**
- future directions regarding, **3:1130**
- marginalization vs., **3:1130**
- psychological implications of, **3:1130**
- resocializing into, maintaining indigenous  
 culture and, **3:1129**
- values and knowledge functioning levels of, **3:1130**

*See also* **Ethnic identity**

**Endicott, Jean, 2:811**

**Engel, George, 2:779–780**

**Engels, Dennis W., 2:881**

**England, George W., 4:1573**

*Enjoy Old Age* (Skinner), **2:871**

**Enright, Robert D., 2:606**

**Entity theory of personality, 2:747**

**Environmental Assessment Technique (EAT),  
 4:1536–1537**

**Holland Occupational Codes and, 4:1536–1537**

**Holland's RIASEC Model and,**

**4:1536, 4:1544, 4:1545, 4:1549**

**person-environment fit and, 4:1601**

**scales of, 4:1536**



- scoring and interpretation of, **4:1536–1537**  
 theoretical background of, **4:1536**  
 utility of, **4:1536**
- Epel, Elissa S., **3:1328**
- EPPP. *See* Examination for the Professional Practice of Psychology (EPPP)
- EPPS. *See* Edwards Personal Preference Schedule (EPPS)
- EPQ. *See* Eysenck Personality Questionnaire Revised (EPQ)
- Epson, David, **1:204**
- Equal Pay Act (1963), **3:1314, 4:1595**
- Equity theory, **4:1595**
- ERIC. *See* Education Resources Information Clearinghouse (ERIC)
- Erickson, Milton, **1:204**
- Erikson, Erik  
 adult development and, **1:9**  
 children's autonomy development and, **2:761**  
 core self theories and, **1:17**  
 counseling expectations and, **2:598**  
 ego development and, **2:587, 2:735, 2:761, 4:1658**  
 ego integrity of older adults and, **1:232**  
 identity commitment and, **3:1164**  
 identity development and, **3:1161, 3:1163–1164, 4:1464**  
 identity vs. identity confusion and, **3:1164**  
 life span development work of, **1:125, 2:761, 3:1164**
- Eskimos (Inuit), **3:966**
- Espiritismo, 3:1131–1132**  
 Arab jinn belief similar to, **3:1131**  
 counseling implications of, **3:1131–1132**  
 espiritista interventions and, **3:1131**  
*Le Livre des Esprits* (The Spirits' Book) (Kardec) and, **3:1131**  
 Santería and, **3:1131, 3:1307–1309**  
 spirits of dead persons and, **3:1131**  
 spirituality, religion and, **2:879–882**
- Essandoh, Pius K., **3:1227**
- Estelle v. Gamble*, **1:117**
- Ethical codes, 1:176–182**  
 ACA code of ethics, **1:176, 1:177–182, 3:1046**  
 autonomy and, **1:176, 1:183, 1:186, 1:191–192, 1:247, 1:441, 2:495**  
 beneficence and, **1:176–177, 1:183, 1:186, 1:192, 1:441, 2:495, 3:1046**  
 code of ethics and standards of practice and, **2:494–497**  
 confidentiality and legal privilege and, **2:519–522**  
 counseling profession and, **1:176**  
 definition of, **1:176**  
 duty to warn and protect and, **2:575–578**  
 e-counseling and, **1:171–172**  
 fidelity and, **1:177, 1:183, 1:186, 1:192, 1:441**  
 hypnosis and, **1:248**  
 impairment and, **1:249–250**  
 informed consent and, **2:645–647**  
 international counseling psychology and, **1:262**  
 justice and, **1:177, 1:183, 1:186, 1:192, 1:441, 2:495**  
 law vs., **1:176**  
 moral principles in ethical decisions and, **1:176–177**  
 nonmaleficence and, **1:176, 1:183, 1:186, 1:192, 1:441, 2:495, 3:1046**  
 relationships with clients and, **2:832–837**  
 sexual relationships with clients and, **2:835–836**  
 veracity and, **1:177, 1:183, 1:186, 1:192, 1:441**  
 virtue ethics and, **1:441–442**  
*See also* American Counseling Association (ACA): code of ethics; **Code of ethics and standards of practice; Ethical decision making; Ethical dilemmas; Ethics in computer-aided counseling; Ethics in research**
- Ethical decision making, 1:182–185**  
 aspirational ethics and, **1:182–183**  
 autonomy and, **1:176, 1:183, 1:186, 1:191, 1:247, 1:441, 2:495**  
 beneficence and, **1:176–177, 1:183, 1:186, 1:192, 1:441, 2:495, 3:1046**  
 code of ethics and standards of practice and, **2:494–497**  
 ethical dilemmas and, **1:183, 1:185–187, 1:191**  
 ethics, ethical codes defined and, **1:182**  
 feminist decision making model and, **1:184**  
 fidelity and, **1:177, 1:183, 1:186, 1:192, 1:441**  
 foundations of, **1:183–184**  
 justice and, **1:177, 1:183, 1:186, 1:192, 1:441, 2:495**  
 Kitchener's principle or rational model of, **1:184**  
 Karen Strohm Kitchener's work in, **1:269–271**  
 mandatory ethics and, **1:183**  
 models of, **1:184**  
 morals defined and, **1:182**  
 multiple relationships with clients and, **2:836**  
 nonmaleficence and, **1:176, 1:183, 1:186, 1:192, 1:441, 2:495, 3:1046**  
 philosophical ethics and, **1:182**  
 philosophy discipline and, **1:182, 1:186**  
 prelicensure supervision and, **1:335**  
 process of, steps in, **1:187**  
 professional ethics and, **1:182**  
 professional self-regulation and, **1:183**  
 public and counselor protection and, **1:183**  
 purpose of ethical codes and, **1:183**  
 relationships with clients and, **2:832–837**  
 Rest's four-component model of, **1:184**



- skills of, **1:184–185**  
 social constructivism and, **1:184**  
 social justice advocates and, **1:184, 2:496**  
 veracity and, **1:177, 1:183, 1:186, 1:192, 1:441**  
 virtue ethics and, **1:183, 1:441–442**  
*See also* American Counseling Association (ACA): code of ethics; **Code of ethics and standards of practice; Ethical codes; Ethical dilemmas; Ethics in computer-aided counseling; Ethics in research**
- Ethical dilemmas, 1:185–187**  
 code of ethics and standards of practice and, **2:494–497**  
 confidentiality and legal privilege and, **2:519–522**  
 contextual elements of, **1:186**  
 cultural context and, **1:186–187**  
 definition of, **1:183, 1:186**  
 duty to warn and protect and, **2:575–578**  
 ethical decision-making process and, **1:187**  
 ethical decisions to resolve, **1:187**  
 ethical violations vs., **1:186**  
 ethics, ethical codes defined and, **1:185–186**  
 identification of, **1:186–187**  
 Karen Strohm Kitchener's work in, **1:269–271**  
 moral principles and, **1:176–177, 1:183, 1:186, 1:191–192**  
 philosophy discipline and, **1:186**  
 relationships with clients and, **2:832–837**  
 supervision, peer consultation to resolve, **1:185**  
 virtue ethics and, **1:441–442**  
*See also* American Counseling Association (ACA): code of ethics; **Code of ethics and standards of practice; Ethical codes; Ethical decision making; Ethics in computer-aided counseling; Ethics in research**
- Ethics. See** American Counseling Association (ACA): code of ethics; **Code of ethics and standards of practice; Ethical codes; Ethical decision making; Ethics in computer-aided counseling; Ethics in research**
- Ethics in computer-aided counseling, 1:187–190**  
 assessment issues and, **1:188–189**  
 competence in use of, **1:188–189**  
 computerized psychological tests benefits and, **1:188**  
 diagnosis enhanced by, not limited to, **1:188**  
 disposal of electronic files and, **1:189**  
*Guidelines for Computer-Based Tests and Interpretations* of APA and, **1:188**  
 implications for development and sales of, **1:188**  
 improper use, unrealistic expectations and, **1:189–190**  
 informed consent issue in, **1:189**  
 online counseling and, **1:413–415**  
 storage of electronic records and, **1:189**  
 technology advantages and, **1:187–188**  
 test materials, test security issue in, **1:189**  
*See also* American Counseling Association (ACA): code of ethics; **Code of ethics and standards of practice; Ethical codes; Ethical decision making; Ethical dilemmas**
- Ethics in HIV-Related Psychotherapy* (Kitchener, co-author), **1:270**
- Ethics in research, 1:190–192**  
 code of ethics and standards of practice and, **2:494–497**  
 confidentiality requirement and, **1:191**  
 ethical decision making and, **1:182–185, 1:191–192**  
 ethical dilemmas and, **1:191**  
 informed consent requirement and, **1:191**  
 Institutional Review Boards and, **1:191**  
 Stanley Milgram authority-obedience studies and, **1:190–191**  
 Nazi medical experiments and, **1:190**  
 principles of, **1:176–177, 1:183, 1:191–192**  
 Tuskegee syphilis experiment and, **1:190**  
 virtue ethics and, **1:441–442**  
 voluntary consent requirement and, **1:191**  
 Phillip Zimbardo "prison" experiment and, **1:191**  
*See also* American Counseling Association (ACA): code of ethics; **Code of ethics and standards of practice; Ethical codes; Ethical decision making; Ethical dilemmas**
- Ethnic cleansing, 3:1132–1135**  
*The Convention on the Prevention and Punishment of the Crime of Genocide* (UN) and, **3:1132**  
 counseling implications of, **3:1133–1134**  
 Dafur, Western Sudan atrocities and, **3:1133**  
 definition of, **3:1133**  
 experiences and needs of survivors of, **3:1133–1134**  
 fear of dissimilarity and, **3:1132**  
 genocide and, **3:1132**  
 Holocaust example of, **2:573, 3:1132, 3:1240**  
 Native American forced displacement example of, **3:1132**  
 political regional struggles and, **3:1132–1133**  
 PTSD and, **3:1133**  
 Rwandan genocide example of, **3:1133**  
 survivor guilt and, **3:1134**
- Ethnic identity, 3:1135–1137**  
 acculturation factor in, **3:941–946, 3:1136**  
 Arab Americans and, **3:989, 3:990**  
 Martha Bernal's work in, **3:1012–1014**  
 biculturalism, acculturation and, **3:1018**



biculturalism and, **3:1017–1018**  
 biracialism and, **3:1027–1032**  
 Black English and, **3:1032–1033**  
 Black racial identity development and, **3:1036–1038**,  
     **3:1296–1297**  
 cognitive, behavioral, affective components of, **3:1136**  
 components of, **3:1135**  
 context dependency of, **3:1136**  
 critical race theory and, **3:1071–1078**  
 cultural values and, **3:1095–1097**  
 definition of, **3:1017–1018**, **3:1135**  
 discrimination factor in, **3:1136**  
 doll study of, **3:1050**, **3:1135**, **3:1291**, **3:1296**  
 eating disorders, women of color and, **2:584**  
 enculturation and, **3:1129–1131**  
 ethnic belongingness and, **3:1018**  
 ethnicity *vs.*, **3:1138**  
 ethnic minority and, **3:1139–1141**  
 ethnic pride and, **3:1141–1142**  
 external *vs.* internal ethnic identity and, **3:1018**  
 future directions regarding, **3:1136–1137**  
 historical perspectives on, **3:1135–1136**  
 influences on, **3:1136**  
 Kwanzaa and, **3:1189–1190**  
 multicultural personality and, **3:1226–1227**  
 multidimensional perspective on, **3:1136**  
 parent socialization factor in, **3:1136**  
 racial identity *vs.*, **3:1135**, **3:1285**  
 social identity theory and, **3:1135**  
 stage models of, **3:1135–1136**, **3:1229**  
 stereotype threat and, **3:1340**  
 transracial adoption and, **3:1355**  
*See also* **Ethnic pride**

### **Ethnicity, 3:1137–1139**

biracialism and, **3:1027–1032**  
 career development and, **4:1530–1531**  
 counseling implications of, **3:1139**  
 cultural values and, **3:1095–1097**  
 culture *vs.*, **3:1137–1138**  
 definition of, **3:1137**, **3:1140**  
 enculturation, acculturation and, **3:1138–1139**  
 ethnic belongingness and, **3:1018**  
 ethnic identity and, **3:1138**  
 phenotypic qualities and, **3:942**, **3:958**, **3:974**, **3:981**,  
     **3:1042**, **3:1043**, **3:1072**, **3:1076**, **3:1135**, **3:1229**,  
     **3:1279**, **3:1280**, **3:1353**  
 psychological well-being and, **3:1137**, **3:1139**  
 race *vs.*, **3:1137–1138**, **3:1279**  
 self-esteem and, **2:866**, **3:1138**  
*See also* **Ethnic identity**

### **Ethnic minority, 3:1139–1141**

Martha Bernal's work in, **3:1012–1014**  
 counseling implications of, **3:1141**  
 definition of, **3:1139**  
 ethnic group definition and, **3:1139**  
 ethnic injustices *vs.* racial injustices and, **3:1140**  
 ethnicity definition and, **3:1140**  
 minority definition and, **3:1140**  
 people of color *vs.* colored people and, **3:1141**  
 positive *vs.* negative connotations of, **3:1140**  
 racial/ethnic minority term and, **3:1141**  
 racial minority and, **3:1140–1141**  
 religious minorities and, **3:1140**  
 U.S. ethnic minority groups and, **3:1139**  
 Ethnic Minority Psychological Association, **3:1242**

### **Ethnic pride, 3:1141–1142**

acculturation and assimilation and, **3:1142**  
 definition of, **3:1141–1142**  
 ethnic identity and, **3:1141–1142**  
 ethnocentrism and racism *vs.*, **3:1142**  
 health and academic outcomes of, **3:1142**  
 increase of, **3:1142**  
 Kwanzaa and, **3:1189–1190**  
*See also* **Ethnic identity**

### **Ethnocentrism, 3:1142–1144**

antisemitism and, **3:983–985**  
 bias and, **3:1014–1016**  
 colonialism and, **3:1061–1063**  
 counseling relationship affected by, **3:1144**  
 counselors' ethnocentrism and, **3:1143**  
 cultural encapsulation and, **3:1090–1091**  
 cultural relativism and, **3:1094–1095**  
 deficit hypothesis and, **3:1109–1111**  
 ethnic belongingness and, **3:1018**  
 Eurocentrism and, **3:1147–1148**  
 explanation of, **3:1142–1143**  
 monocultural term and, **3:1214–1215**  
 multicultural counseling and, **3:1144**  
 positive *vs.* negative effects of, **3:1143**  
 presenting concerns of the ethnocentric  
     client and, **3:1143–1144**  
 social identity theory and, **3:1143**  
 of White American culture, **3:1373**  
 xenophobia and, **3:1380**

### *See also* **Antisemitism**

### **Ethnography qualitative method**

hallmark of qualitative research and, **1:360**  
 in-depth study of naturally occurring  
     behavior and, **1:360**  
 participant observer collection of data and, **1:360**



**Etic–emic distinction, 3:1144–1147**

contemporary perspectives of, 3:1146  
 cross-cultural psychology and, 3:1082  
 cultural relativism and, 3:1082  
 derived etics and, 3:1146  
 dichotomous perspective on, 3:1145  
 emic, qualitative research methods and, 3:1083  
 etic, quantitative research methods and, 3:1083  
 identity development process and, 3:1162  
 imposed etics and, 3:1146  
 integrated-symbiotic perspective on, 3:1145–1146  
 multicultural counseling competence and, 3:1225  
 parallel emics and, 3:1146  
 Paul Bodholdt Pedersen's criticism of, 3:1082  
 psudoetics and, 3:1146  
 universalism and, 3:1359–1360

**Eugenics, 1:192–194**

American Eugenics Society and, 1:193  
 assessing genetic abilities and, 1:193  
*Buck v. Bell* and, 1:193  
 critics, supporters of, 1:192  
 definition of, 1:192  
 euthanasia and, 1:193  
 fertility practices and, 1:194  
 Francis Galton, Sir and, 1:192–193  
 genetic screening and, 1:194  
 Human Genome Project and, 1:194  
 intelligence tests role in, 1:193  
 Law for the Prevention of Genetically Diseased  
 Offspring (Nazi Germany) and, 1:193  
 marriage restrictive laws and, 1:193  
 mental illness and, 1:194  
 Nazi medical experimentation and, 1:193  
 reproduction regulation, manipulation and, 1:192  
 Social Darwinism and, 3:1573  
 sterilization of mentally ill and, 1:193  
 20th century and, 1:193  
 21st century and, 1:193–194

**Eurocentrism, 3:1147–1148**

career counseling and, 4:1435  
 deficit hypothesis and, 3:1109–1111, 3:1147  
 definition of, 3:1147  
*DSM* diagnostic categories vulnerability to, 3:1147  
 everyday life and, 3:1147  
 group-based oppression and, 3:1147  
 identity and, 3:1161  
 immigrant assimilation assumption and, 3:1147  
 individual, cultural, and institutional  
 levels of, 3:1147  
 locus of control and, 3:1203, 3:1204

of mental health professionals, 3:1147–1148, 3:1218,  
 3:1225, 3:1276, 3:1277  
 monocultural term and, 3:1214–1215  
 multicultural education challenge of, 3:1222–1223  
 nationalism and, 3:1239–1240  
 prejudice based on, 3:1147, 3:1276  
 Western counseling tradition and,  
 3:1262–1263, 3:1276, 3:1277, 3:1341,  
 3:1369, 3:1383–1384  
 Western values and characteristics of, 3:1147  
 White culture and, 3:1373–1374

**Euthanasia**

assisted suicide and, 1:151, 1:245  
 eugenics movement and, 1:193  
 morphine drip, “terminal sedation” and, 1:151  
 physician aid-in-dying and, 1:151  
 physician-assisted suicide (PAS) and, 1:151  
 voluntary active euthanasia (VAE) and, 1:151

Evans, Sara, 3:1049

Everly, George, Jr., 2:886, 2:887, 2:888 (figure)

Evers-Williams, Myrlie, 3:1239

Everyday Memory Questionnaire, 2:688

**Evidence-based treatments, 2:589–592**

APA Division 17, task force on empirically validated  
 treatments (1993–1995) and, 2:589  
 APA Division 29, task force on empirically supported  
 relationships and, 2:589  
 APA 2005 Presidential Task Force on Evidence-Based  
 Practice and, 2:590–591, 2:626  
 cognitive therapy and, 2:510  
 “effective treatment” debate and, 2:589  
 empirically based professional  
 practice and, 1:172–175  
 empirically supported relationships and, 2:590–592  
 empirically supported treatments and, 2:589  
 future directions in, 2:592  
 integrative/eclectic therapy and, 2:647–651  
 Joint Task Force on Empirically Supported Principles of  
 Therapeutic Change and, 2:591–592  
 Paul E. Meehl and, 2:684–686  
 John C. Norcross and, 1:309–311  
 psychological defenses and, 2:556, 2:795  
 rational emotive behavior therapy  
 (REBT) and, 2:510  
 Response to Intervention school psychology service  
 delivery and, 1:172–175  
 schizophrenia and, 2:848  
 scientist-practitioner model of training and, 1:391  
 Examination for the Professional Practice of  
 Psychology (EPPP), 1:395



**Exercise and sport psychology, 1:194–197**

- active collaboration requirement and, 1:195
- Association for Applied Sport Psychology (AASP) and, 1:197–198
- attending practice, competitions and, 1:195
- “client” vs. “patient” athlete self-concept and, 1:195
- confidentiality, privacy issues and, 1:196
- consultation relationship and, 1:195–196
- definition of, 1:195
- exercise, mental health intervention and, 1:196
- Exercise and Sport Psychology Division of APA and, 1:195
- future directions in, 1:196
- history of, 1:194–195
- journals of, 1:195
- physical activity counseling and, 2:777–779
- positive youth development promotion and, 1:196
- psychotherapy intervention and, 1:196
- sedentary lifestyle, community-based health promotion and, 1:95–96
- sport knowledge importance and, 1:195
- working with athletes and, 1:195–196

**Existentialism, 2:757**

- counselor self-disclosure and, 2:852
- cultural anthropology, psychology worldview and, 3:1384–1385
- existential cross-cultural counseling and, 3:1365, 3:1366–1367
- positive psychology and, 2:782

**Expectancy-value theory of personality,**

1:235, 2:707, 2:854

locus of control and, 3:1204

**Expectations about counseling. See Expectations about therapy****Expectations about Counseling-Brief Form (EACB), 2:532, 2:594–595, 4:1660****Expectations about Counseling Scale, 2:533****Expectations about therapy, 2:593–599**

- Asian expectations and, 2:597
- construct of expectations, 2:593
- construct of expectations, counseling and psychotherapy expectations and, 2:593
- construct of expectations, development of, 2:593
- correlates of expectations and, 2:597–598
- counseling process and outcomes affected by, 2:598
- cultural factors in, 2:597–598
- “determining tendency” concept and, 2:593
- developmental level factors in, 2:598
- EAC-B reliability and validity and, 2:595
- early research on, 2:593–594

**Euro-American expectations and, 2:597**

- expectancy manipulation and, 2:595–596
- expectancy manipulation research, overview of, 2:596
- expectancy manipulation strategies, effectiveness of, 2:596
- Expectations about Counseling-Brief Form (EACB), 2:532, 2:594–595, 4:1660
- Expectations about Counseling Scale and, 2:533
- expectations vs. preferences vs. perceptions and, 2:594
- gender differences in, 2:593
- Hispanic expectations and, 2:597–598
- importance of expectations and, 2:595
- measuring expectations and, 2:594–595
- nurturant therapist and, 2:593
- placebo effect and, 2:593–594
- relationships with clients and, 2:832–837
- research directions in, 2:598
- therapist behavior and, 2:594
- unrealistic expectations, consequences of, 2:595
- unrealistic expectations, prevalence of, 2:595
- visible racial/ethnic groups and, 3:1364

**Experiential techniques**

- assuming responsibility, 2:917
- dream work, 2:917
- empty chair, 2:640, 2:916–917
- exaggerating movement, 2:917
- flooding, 2:507, 2:917–918
- hot seat, 2:917
- may I feed you a sentence, 2:917
- playing the projection, 2:917
- reversals, 2:917
- top dog/underdog, 2:916

**Explanatory design, of mixed methodology research, 1:303****Exploratory design, of mixed methodology research, 1:303****Exploring Your Career Beliefs workbook, 4:1565****Expressed, manifest, tested, and inventoried interests, 4:1537–1539**

- checklists and rating scales and, 4:1538
- cost considerations and, 4:1538–1539
- criterion keying scale construction method and, 4:1538
- expressed interests and, 4:1537
- Holland’s RIASEC model and, 4:1538
- interests definitions and, 4:1537
- inventoried interests and, 4:1538
- manifest interests and, 4:1537
- memory or knowledge examination and, 4:1538
- operational definitions of interest and, 4:1538



- Frank Parsons' interest questionnaire and, 4:1537  
 rational scale construction method and, 4:1538  
 self-reported activities and, 4:1537  
 Donald Super's interest categories and, 4:1537  
 tested interests and, 4:1538  
 try out activities concept and, 4:1537–1538  
 UNIACT and, 4:1667
- Expressive Vocabulary Test, 2:670
- Externalizing problems of childhood, 1:197–198**  
 AD/HD and, 1:197  
 conduct disorder and, 1:197  
 definition of, 1:197  
 diagnosis of, 1:197–198  
*DSM-IV-TR diagnostic criteria of*, 1:197  
 oppositional defiant disorder and, 1:197, 1:317–320  
 parenting and, 1:324–328  
 play therapy and, 1:331–334
- Extrinsic motivation, 2:660, 2:663, 4:1558
- Eybert, Sheila, 1:326–327
- Eye movement desensitization and reprocessing (EMDR), 1:198–202**  
 adaptive information processing model  
   and, 1:199–200  
 explanation of, 1:198  
 eye movements affecting memory and, 1:199  
 history of, 1:198–199  
 negative life experiences application of, 1:198  
 neurobiological mechanisms of, 1:199  
 neurochemical release in, 1:199  
 phase 1 - client history, treatment planning and, 1:200  
 phase 2 - client preparation and, 1:200  
 phase 3 - assessment of the target memory  
   and, 1:200–201  
 phase 4 - desensitization and, 1:201  
 phase 5 - cognitive installation and, 1:201  
 phase 6 - body scan and, 1:201  
 phase 7 - closure and, 1:201–202  
 phase 8 - reevaluation, 1:202  
 process summary and, 1:198  
 PTSD application of, 1:198, 1:199  
 stress management using, 2:889
- Eysenck, Hans J.  
 biosocial theory of, 2:736  
 effectiveness of therapy and, 2:512, 2:713–714  
 neuroticism, extraversion, psychoticism personality  
   dimensions and, 2:530, 2:723, 2:770  
 personality assessment and, 2:724, 2:770  
 Leona E. Tyler and, 1:429
- Eysenck Personality Questionnaire Revised (EPQ), 2:725
- Facilitated communication, 2:629
- Facilitative conditions, 2:601–603**  
 congruence, realness, transparency terms and, 2:602  
 definition of, 2:601  
 empathy and, 2:602  
 genuineness and, 2:602  
 humanistic counseling approaches and, 2:637–641  
 Carl Rogers's person-centered counseling  
   approach and, 2:601  
 self-disclosure and, 2:851–852  
 therapeutic relationship and, 2:601, 2:602  
 unconditional positive regard and, 2:601–602,  
   2:638–639, 2:704
- Fairbairn, W. R. D., 2:762
- Fairburn, Christopher, 2:580
- Fair Housing Act, 1:26
- Fair Labor Standards Act (1938), 4:1446
- False memories, 2:603–605**  
 avoidance of, 2:604–605  
*Burgis v. Braun* and, 2:604  
 definition of, 2:603  
 distortion in memory and, 2:603–604  
 flashbulb memories and, 2:603  
 how to create false memories and, 2:604  
 infantile amnesia and, 2:603  
 legal implications of, 2:604  
 misinformation effect and, 2:604  
 not all memories are created equal and, 2:603  
 reconstructive process of memory and, 2:603  
 recovered memory techniques and, 2:629–630  
 repressed memories and, 2:604  
 schemas misleading memory and, 2:603  
 source monitoring errors and, 2:603  
 therapeutic techniques and, 2:604  
 time factor in recall and, 2:603  
 wrongful conviction interrogation practices and, 2:604
- Familismo, 3:1149–1150**  
 compadrazgos (godparents) and, 3:1196  
 counseling implications of, 3:1149–1150  
 cultural value of, 3:1096  
 definition of, 3:1149  
 filial piety and, 3:1151  
 Latino/a adolescent well-being supported by, 3:1149  
 Latinos/as well-being and, 3:1149  
 misinterpretation of, 3:1149  
 nuclear and extended family and, 3:1149  
 structural, behavioral, attitudinal dimensions of,  
   3:1149, 3:1195–1196  
 treatment adherence promoted by,  
   3:1149, 3:1195–1196



Family and Medical Leave Act (FMLA), **1:26**

**Family counseling, 1:203–207**

A. A. and, **1:14–18**

Nathan Ackerman and, **1:203**

Adlerian therapy and, **2:458**

adolescent substance abuse and, **2:898**

alternative families and, **1:204–205**

American Organization for Marriage and Family Therapy (AAMFT) and, **1:138, 1:206**

applications of, **1:203**

blended families and, **1:205**

Brief Therapy and, **1:204**

Murray Brown, family systems theory and, **1:204**

chronic illness and, **1:79–81**

code of ethics and, **1:206**

cybernetics and, **1:203**

different approaches of, **1:204**

differentiation of self concept and, **1:204**

divorced families and, **1:205**

eating disorder therapy and, **2:583**

equilibrium concept in, **1:203**

*Families and Family Therapy* (Minuchin) and, **1:204**

family developmental life cycles and, **1:204–205**

feminist theory and, **1:204**

filial piety and, **3:1151**

forensic counseling application and, **1:214–216**

forgiveness and, **2:607**

Myrna L. Friedlander's work and, **1:218–220**

gay, lesbian families and, **1:205**

GLB therapy and, **2:613–615**

group therapy and, **2:618–622**

historical overview of, **1:203–204**

International Association of Marriage and Family Counselors (IAMFC) and, **1:206**

*The Journal of Marital and Family Therapy* and, **1:206**

legal issues in parenting and, **1:278–281**

licensure, certification and, **1:206**

listening skills in, **3:1066**

narrative therapy and, **1:204**

online counseling, technology and, **1:413**

parenting and, **1:324–328**

postmodernism and, **1:204**

privileged communication concept and, **1:206**

professional organizations of, **1:206**

repetitive patterns of interaction and, **1:203**

runaways, homeless youth and, **1:241, 1:242**

same-sex marriages and unions and, **2:614, 3:1049, 3:1302**

single parent families and, **1:205**

social constructionism and, **1:204**

solution-focused brief therapy (SFBT) and,

**1:204, 2:876–879**

structural family therapy and, **1:204**

substance abuse problems and,

**1:206, 2:895–896, 2:898**

suicide postvention and, **1:403–404**

symbolic experimental family therapy and, **1:204**

systems theory and, **1:203–204**

teenage parents and, **1:415–418**

theory of collaborative language systems and, **1:204**

transracial adoption and, **3:1355**

violence, physical and sexual abuse and, **1:205–206**

Fanon, Frantz, **3:1246, 3:1296**

Farber, Barry, **2:489**

Farmer, Janet, **2:580**

Fassinger, R. E., **4:1455**

**Fatalism, 3:1150–1151**

Asian culture and, **3:1150**

collectivistic cultures and, **3:1150**

generalized expectancies framework and, **3:1150**

internal-external locus of control and, **3:1150**

Latino fatalismo vs., **3:1150**

mental disorder, suicide and, **3:1150**

spirituality and, **3:1150**

*Fat is a Feminist Issue* (Orbach), **3:1317**

Faust, David, **2:814**

FBA. *See* **Functional behavioral assessment (FBA)**

Fechner, Gustav, **1:364**

**Feedback in counseling, immediate, 1:207–209**

bug-in-the-ear supervisory instructional

practices and, **1:207**

counselors-in-training and, **1:207**

feedback and, **1:207**

field-based or community settings and, **1:207**

Sigmund Freud and, **1:207**

hands-on, real-world experiences in, **1:207**

in-room, supervisory instructional practices and, **1:207**

instruction and, **1:207**

interpersonal learning, interpersonal feedback and, **2:658–660**

interpersonal process recall and, **1:209**

live observation and, **1:208**

peer feedback and, **1:207**

positive balanced with corrective feedback and, **1:207**

practicum and, **1:207**

role-playing sessions and, **1:207**

supervision and, **1:207–208**

Feighner, John P., **2:811**

Feliciano, C., **3:1312**



Feltham, Colin, **2:543**

**Feminist therapy, 1:209–211**

- community-based action research and, **1:90, 1:91**
- consciousness raising and, **1:210**
- counselor self-disclosure and, **2:852**
- developmental issues and, **1:210**
- Louise Douce and, **1:167–169**
- eating disorder treatment and, **2:583**
- ethical decision-making models and, **1:184**
- family counseling and, **1:204**
- feminist and equal rights movements and, **1:209**
- feminist counseling approaches and, **3:1317**
- feminist views on psychopathology and, **1:210**
- feminization of psychology and, **1:211–213**
- multicultural career assessment models and, **4:1576–1577**
- multiple diversities, oppressions and, **1:209**
- personal esteem, empowerment and, **1:210–211**
- personal validation and, **1:210–211**
- philosophy of psychotherapeutic interventions and, **1:209**
- Carl Rogers influence on, **2:542**
- self-disclosure by therapist and, **1:210**
- social change and, **1:210**
- society gender roles and, **1:210**
- tenets of, **1:209**
- “the personal is political” concept and, **1:209**
- therapeutic relationship, power dynamics of, **1:210**

**Feminization of psychology, 1:211–213**

- APA Division 17, Advancement of Women group and, **1:212–213**
- counseling psychology and, **1:211–212**
- Louise Douce and, **1:167–169**
- female gender impact and, **1:211**
- feminist therapy and, **1:209–211**
- future directions in, **1:213**
- gender prejudice vs., **1:211–212**
- gender related change focus and, **1:211**
- impact on psychotherapy and, **1:212–213**
- impact on research and, **1:212**
- impact on status, prestige and, **1:212**
- relational-cultural therapy and, **3:1317**
- research-practitioner activities imbalance and, **1:212**
- scientist-practitioner model and, **1:212**
- sex ratio in psychology and, **1:211**
- The Shoulders of Women* (Philipson) and, **1:212**
- understanding the term and, **1:211**
- women’s emotional health and, **3:1316–1317**
- work structure changes in psychology and, **1:213**

Festinger, Leon, **2:593**

FFM. *See* **Personality theories, five-factor model (FFM)**

FFT. *See* Functional family therapy (FFT) parent training program

Fidelity

- ethical codes and, **1:177, 1:183, 1:186, 1:192**
- virtue ethics and, **1:441**

15th Amendment, **3:1237**

Fight or flight response

- occupational stress and, **1:313**
- panic disorders and, **2:718–719**
- stress-related disorders and, **1:399, 1:400, 2:703, 2:883, 2:886–887**

**Filial piety, 3:1151**

- Asian cultural value of, **3:1100, 3:1151**
- Asian Indian dharma and, **3:1151**
- collectivism and, **3:1059–1061, 3:1151**
- Confucianism and, **3:1151**
- definitions regarding, **3:1151**
- Filipino utang ng loob and, **3:1151**
- gender differences in, **3:1151**
- Latino/a familismo and, **3:1151, 3:1195–1196**
- The Twenty-Four Examples of Filial Piety* (Guo Jujing) and, **3:1151**

First International Congress of Psychology (1889), **1:107**

First Nations People

- career counseling of, **4:1457**
- multicultural counseling and, **2:539**

First Voice homeless youth program, **1:243**

Fisher, Ronald A., **1:364**

Fiske, Donald, **2:736**

Fiske, Susan T., **3:1114**

Fitzgerald, Louise, **3:1006, 4:1590**

Five Factor model of personality traits. *See* **Personality theories, five-factor model (FFM)**

Fleming, J., **1:406**

Fleming, K., **1:112**

Fletcher, Jack, **1:158**

Flooding technique, of cognitive-behavioral therapy, **2:507**

Flores, L. Y., **4:1577**

Flow theory, **2:551, 2:662, 2:672, 2:774**

- well-being and, **2:783–784**

Flum, Hanoch, **4:1475**

Flynn, James

- Flynn Effect and, **2:500–501, 2:656–657**

FMLA. *See* Family and Medical Leave Act (FMLA)

Folkman, Susan

- acculturative stress and, **3:946–947**
- cognitive changes during stress process and, **2:883**
- coping process and, **1:59, 1:399, 2:527, 3:946–947**



Fonagy, Peter, **2:734**

Fontes, Lisa Aronson, **1:73**

Fordyce, Michael, **2:784**

Forehand, Rex, **1:326**

**Forensic applications, 1:213–216**

anger management and, **1:214–215**

assessment instruments, personalized  
treatment plan, **1:213**

assessment instruments, personalized treatment  
plan and, **1:213**

child maltreatment and, **1:215–216**

counseling adolescents and, **1:215**

counseling adults and, **1:215**

counseling intervention and, **1:213**

counseling victims and, **1:215**

custody evaluations and, **1:214**

definition of, **1:213–214**

deterrence issues, **1:213**

divorce counseling and, **1:214**

forensic psychologist doctoral degree and, **1:356**

intellectual comprehension of criminal  
behavior and, **1:213**

**Forgiveness, 2:605–607**

conflict management skills and, **2:606**

couples therapy and, **2:607**

definition of, **2:605**

effects on forgiven and, **2:607**

exclusion and, **2:605**

false forgiveness and, **2:607**

families and, **2:607**

Forgiving Personality Inventory and, **2:606**

future research regarding, **2:607**

gender differences in, **2:606**

intentional harm response of, **2:605**

interpersonal context of, **2:605**

interventions to help clients forgive and, **2:606–607**

letting go of negative thoughts and, **2:605**

personality trait forgiveness and, **2:606**

physical well-being and, **2:606**

psychological well-being and, **2:606**

self-forgiveness and, **2:607**

spirituality, religion and, **2:879–882**

state forgiveness and, **2:605–606**

Tendency to Forgive measure and, **2:606**

transformation of oneself and, **2:605**

types of, **2:605–606**

*The Forgotten Half* (W. T. Grant Foundation),  
**4:1617–1618**

Forrest, Linda, **1:106, 4:1577**

Forum for Death Education and Counseling, **1:150**

Fouad, Nadya, **1:103, 1:105, 1:131, 3:1219,**  
**4:1533, 4:1577, 4:1635**

Foucault, Michael, **3:1271**

*The Foundations of Ethical Practice, Research, and*  
*Teaching in Psychology* (Kitchener), **1:270**

14th Amendment, **3:1047, 3:1237**

Frame switching, **3:1020**

Francis, David, **1:158**

Frank, Jerome B., **2:512, 2:647**

Frank, Johann Peter, **1:70**

Frank, Julia D., **2:512, 2:647**

Frankenberg, Ruth, **3:1064, 3:1373**

Frankl, Viktor

counseling, psychotherapy influence of, **1:121, 2:782**  
paradoxical intention, logotherapy of, **2:720**

Fredrickson, Barbara, **2:581**

**Free association, 2:607–608**

basic rule of psychoanalysis of, **2:796**

dream interpretation and, **2:798**

Sigmund Freud and, **2:607–608**

Carl Jung and, **2:667**

reliability, validity issues of, **2:608**

therapist interpretation and, **2:910–911**

therapist interpretation issue and, **2:608**

therapist suggestion factor in, **2:608**

Freeman, Alan, **3:1074**

Freeman, Duey, **2:482**

Freire, Paulo, **1:91, 3:1245**

French, David, **3:1083, 3:1145**

**Fretz, Bruce, 1:216–218**

academic career of, **1:216–217**

APA leadership positions of, **1:217**

*Counseling Psychology* (Gelso and Fretz)

co-written by, **1:217**

education, training and, **1:216**

international counseling psychology efforts of, **1:263**

leadership in field of counseling psychology and,  
**1:130, 1:216, 1:217**

legacy of, **1:217**

nonverbal communication in counseling

focus of, **1:217**

teaching philosophy of, **1:217**

writing, research of, **1:217**

Freud, Anna

*The Ego and the Mechanisms of Defense*

written by, **2:795**

ego defense mechanisms and, **2:554–555, 2:761**

ego strength work of, **2:585–588, 2:735**

Sigmund Freud's theories and, **2:609, 2:610**

play therapy and, **1:332**



- psychoanalysis focus of, **2:610, 2:735**  
 psychological defenses in emotional  
   functioning and, **2:795**  
 therapeutic working alliance and, **2:797**
- Freud, Sigmund, 2:608–612**  
 bilingual patient treatment and, **3:1022**  
 Josef Breuer and, **2:609–610**  
 case reports illustrations and, **2:611**  
 client self-disclosure and, **2:851**  
 compromise formations of personality and, **2:610**  
 conclusions regarding, **2:612**  
 countertransference and, **2:797, 2:929**  
 displaced aggression concept of, **2:739**  
 Dollard and Miller's behavioral personality  
   theory and, **2:739–740**  
 dynamic unconscious concept of, **2:607, 2:795**  
 early developmental influences on, **2:609**  
 education of, **2:609–610**  
 ego, id, superego concepts of, **2:585–587,**  
   **2:611, 2:735, 2:759–761**  
 free association and, **2:607–608**  
 Anna Freud and, **2:610**  
 grief process and, **1:51**  
 International Psychoanalytic  
   Association and, **2:611**  
*The Interpretation of Dreams* written by, **2:610, 2:611**  
*Introductory Lectures on Psycho-Analysis* written by,  
   **2:610–611**  
 Carl Jung and, **2:667**  
 nuclear wish of preschool years and, **2:610, 2:611**  
 Oedipus complex and, **2:610**  
 personal psychoanalysis of students and, **1:207**  
 play therapy and, **1:332**  
 psychoanalysis and, **2:541, 2:611**  
 psychoanalytic theory of, **1:121, 2:543, 2:554, 2:611**  
 psychosexual development stages and, **2:740, 3:1163**  
 psychotherapy of hysteria work of, **2:610**  
 religion and, **2:879**  
 repression as determinant of consciousness  
   and, **2:611**  
 role of sexuality in human development and, **1:9**  
 seduction theory and, **2:929**  
*Studies in Hysteria* (Freud and Breuer) and, **2:610**  
 therapeutic relationship importance and,  
   **2:513, 2:797, 2:919**  
 topographic model of, **2:610–611**  
 transference work of, **2:611, 2:797,**  
   **2:922, 2:928–929**  
 Vienna Psychoanalytic Society and, **2:611**  
*See also* Freud, Sigmund: psychoanalytic theory of
- Freud, Sigmund: psychoanalytic theory of,  
   **1:121, 2:543, 2:554, 2:611**  
 aggressive (self-preservation) drive and, **2:759**  
 anal psychosexual development stage and,  
   **2:760, 2:796, 2:929**  
 castration anxiety and, **2:760**  
 conscious superego component and, **2:760**  
 dream interpretation and, **2:798**  
 drive theory and, **2:759**  
 ego defense mechanisms and, **2:759–760**  
 ego ideal superego component and, **2:760**  
 ego psychic structure and, **2:759–760**  
 ego psychology and, **2:760**  
 Anna Freud and, **2:761**  
 genital psychosexual development stage and,  
   **2:761, 2:929**  
 id psychic structure and, **2:759**  
 latency psychosexual development stage and, **2:761**  
 libido and, **2:759**  
 life and death drives and, **2:759**  
 Oedipus complex and, **2:760, 2:796**  
 oral psychosexual development stage and,  
   **2:759, 2:796, 2:929**  
 penis envy and, **2:760**  
 phallic psychosexual development stage and, **2:760**  
 Carl Rogers and, **2:761**  
 seduction theory and, **2:929**  
 sexual (species-preservation) drive and, **2:759**  
 structural theory and, **2:759**  
 superego psychic structure and, **2:760**  
 unconscious focus of, **2:759**
- Friedan, Betty, **3:1049**
- Friedlander, Myrna L., 1:218–220**  
 academic career of, **1:218–219**  
 career of, **1:218–219**  
 collaborations and publications of, **1:219**  
*Critical Events in Psychotherapy Supervision*  
   co-written by, **1:219**  
 ethnic identity, international adoption work of, **1:219**  
 Laurie Heatherington and, **1:219**  
 honors and awards received by, **1:219–220**  
 psychotherapy as a social system and, **1:218**  
 psychotherapy “science” vs. “art” and, **1:218**  
 Stanley Strong's work and, **1:218**  
 System for Observing Family Therapy  
   Alliances and, **1:219**  
*Therapeutic Alliances in Couple and Family Therapy*  
   co-written by, **1:218, 1:219**
- Fromm, Erich, **2:782, 3:1163**
- Fry, William, **1:203**



Fulton, Robert, 1:245

**Functional behavioral assessment (FBA), 1:220–225**

- adaptive behavior testing and, 2:455–457
  - antecedent-behavior-consequence (ABC)
    - observations and, 1:223
  - antecedents preceding behavior and, 1:222
  - behavioral observation and, 1:37–42, 1:223
  - behavior modification and, 1:222
  - definition of, 1:220
  - developing interventions based on, 1:224
  - duration recording and, 1:223
  - event sampling and, 1:223
  - experimental operant paradigm and, 1:222
  - functional analysis and, 1:223–224
  - functions of behavior and, 1:221–222
  - historical progression of, 1:222
  - indirect assessment, interviews and, 1:222–223
  - interval recording and, 1:223
  - law of effect and, 1:221
  - learned problem behaviors focus of, 1:221
  - learning theory foundation of, 1:220
  - operant conditioning principles and, 1:221, 1:222
  - purposes of, 1:220
  - rating scales, behavior checklists and, 1:223
  - reinforcer vs. punisher consequences and, 1:221
  - setting events and, 1:222
  - situational cues and, 1:221
  - theoretical principles of, 1:221–222
- Functional family therapy (FFT) parent training program, 1:327

Gabbard, Glenn O., 2:763

Gaertner, S., 3:1294

GAF. *See* Global Assessment of Functioning (GAF)

Galton, Francis, Sir, 2:497

- eugenics and, 1:192–193
- heritability of intellectual traits work of, 1:192
- psychological testing and, 4:1445

**Gambling, 1:227–229**

- chasing behavior, losing streak and, 1:228
- classification controversy regarding, 1:227
- comorbid disorders with, 1:227
- criminal activity and, 1:228
- DSM-IV* diagnostic criteria and, 1:227
- escape vs. sensation seekers and, 1:228
- family history data and, 1:228
- gender factors of, 1:227
- pathological gambling and, 1:227
- personality disorders and, 1:227
- phases of, 1:228

- psychosocial costs of, 1:227
- statistics regarding, 1:227
- substance dependency features and, 1:227
- suicidal behavior and, 1:228
- telescoping symptom of, 1:227
- tolerance and withdrawal features of, 1:227
- treatment interventions and, 1:228–229
- twin studies of, 1:228
- youth and, 1:227

Gamson, Z. F., 1:166

Gandhi, Mahatma, 3:1127

García, Eugene, 3:1224

Gardner, Howard, 3:1180

Garfinkel, Paul, 2:580

Garnezy, Norman, 2:838

Garner, David, 2:580

Garnier, Jeanne, 1:243

Garrison, Andrew, 3:956

Garrison, William Lloyd, 3:1375

Garvey, Marcus, 3:1240

GATB. *See* **General Aptitude Test Battery (GATB)**

Gati, Itamar, 4:1468, 4:1523, 4:1590, 4:1605–1606

*See also* **Prescreening, in-depth exploration, and choice model (PIC)**

**Gay, lesbian, and bisexual therapy (GLB), 2:613–615**

- anti-GLB, heterosexist attitudes and, 2:614–615
- civil rights of, 3:1049
- clinical presenting issues and, 2:493
- coming out process and, 2:613
- conversion therapy and, 1:114–116
- Louise Douce and, 1:167–169
- family counseling and, 1:205
- grief and loss of heterosexual privilege and, 2:614
- internalized homophobia and, 2:447, 2:615
- “in the closet” meaning and, 2:613
- prejudice, discrimination and, 2:614–615
- relationship and parenting issues and, 2:615
- same-sex marriage issue and, 2:614, 3:1049, 3:1302
- sexual assault, sexual identity and, 2:447
- sexual identity development phases and, 2:613–614
- sexual orientation, career effects and, 4:1624–1626
- social support and, 2:615
- violent hate crimes and, 2:614, 3:1118

Gay, lesbian, bisexual, and transgender (GLBT)

community

- career counseling for, 4:1443–1445
- career development and, 4:1531
- hate crimes and, 3:1049, 3:1118
- heterosexual privilege and, 3:1380
- household, family structure demographics and, 3:1112



- internalized homophobia and, **3:1246**  
 LGBT civil rights legislation and, **3:1049**  
 mental health care need statistics of, **3:1112**  
 queer critical interest group and, **3:1074–1075**  
 same-sex marriages and unions and,  
     **2:614, 3:1049, 3:1302**  
 sexual orientation, career effects and, **4:1624–1626**  
 Society for Human Rights and, **3:1049**  
 state civil union clauses and, **3:1049**  
 women of color and queer women, multiple oppressions  
     and, **3:1318**  
*See also Career counseling, gay and lesbian*
- Gelfand, Michele, **3:1178**
- Gelso, Charles J., 2:616**  
 bubble hypothesis and, **2:616**  
 high external vs. internal validity of field  
     research and, **2:616**  
 honors and awards received by, **2:616**  
 professional affiliations of, **2:616**  
 psychotherapy relationship work of, **2:616**  
 research methodology work of, **2:616**  
 scholarship of, **2:616**  
 transference, countertransference and, **2:616**
- Gender differences  
 in AD/HD, **1:28**  
 in bipolar disorder, **2:477**  
 in bullying, **1:55–56**  
 in career development, **4:1530**  
 in chronic ill child care, **1:76**  
 in coping, **2:528**  
 cross-cultural research on, **3:1084**  
 in depression, **2:557–558**  
 in filial piety, **3:1151**  
 in forgiveness, **2:606**  
 in help-seeking behavior, **3:1158**  
 in intrinsic motivation, **2:664–665**
- Latino machismo vs. marianismo and,  
     **3:1196–1197, 3:1207–1208**  
 in occupational stress, **2:886**  
 in pathological gambling, **1:227**  
 personal space and, **3:1261**  
 in power, **3:1271–1272**  
 in PTSD, **2:786**  
 in puberty transition, **2:678**  
 in racial pride socialization, **3:1292**  
 in school-to-work programs, **4:1618**  
 in self-esteem, **2:866**  
 sex-role socialization and, **3:1084**  
 in therapy expectations, **2:593**  
 in wages paid for work, **3:1314, 3:1325, 4:1595**
- Gender discrimination, **3:1117**  
*The Gender Knot* (A. Johnson), **3:1313**
- General adaptation syndrome (GAS), stress-related  
 disorders and, **1:399**
- General Allotment Act (1887), **3:1039**
- General Aptitude Test Battery (GATB), 4:1541–1542**  
 achievement, aptitude, and ability tests  
     and, **4:1393, 4:1396**  
 administration of, **4:1541**  
 career counseling interventions and, **4:1484**  
 cognitive, perceptual, psychomotor abilities  
     measured by, **4:1541**  
 Differential Aptitude Tests vs., **4:1541**  
 employee abilities to jobs match by, **4:1541**  
 group differences issue of, **4:1542**  
 job classifications outdated on, **4:1542**  
 meaningfulness of tests of, **4:1541**  
 revisions of, **4:1541**  
 subtests of, **4:1541**  
 Theory of Work Adjustment (TWA) and, **4:1656**  
 U.S. Employment Service development of, **4:1541**  
 verbal, quantitative reasoning, performance  
     measures of, **4:1541**
- Genetic aging theory, **1:15**
- Genetic counseling, 1:229–231**  
 American Board of Genetic Counseling certification  
     and, **1:230, 1:231**  
 birth defect statistics and, **1:229**  
 definition of, **1:229**  
 genetic defect risk factors and, **1:229–230**  
 genetic disorders and, **1:229**  
 genetic testing for chronic illness and, **1:83**  
 historical perspective of, **1:230–231**  
 National Society of Genetic Counselors and,  
     **1:230, 1:231**  
 preparing for career in, **1:230**  
 recent innovations in, **1:231**  
 Web sites regarding, **1:231**
- George Barden Act (1946), **1:123**  
 George-Deen Act (1936), **1:122, 4:1446**  
 George-Ellzey Act (1934), **4:1446**  
 George-Reed Act (1929), **4:1446**
- Gergen, Kenneth J., **2:523**
- Gerlardin, S., **4:1517**
- Gernat, Carol, **3:1382**
- Gerontology, 1:231–234**  
 ageism, prejudice, discrimination and, **1:232**  
 aging and, **1:14–17**  
 aging stereotypes and, **1:232**  
 chronic degenerative diseases and, **1:232**



- cognitive abilities and, **1:232**  
definition of, **1:231–232**  
ego integrity of older adults and, **1:232**  
living arrangement options and, **1:233**  
mental health disorder statistics and, **1:232**  
multidisciplinary field of, **1:232**  
physical aspects of aging and, **1:232**  
professional organizations and, **1:233**  
psychological aspects of aging and, **1:233**  
retirement and, **1:232**  
sexuality importance and, **1:232**  
social aspects of aging and, **1:232–233**  
social security and, **1:232–233**  
stroma vs. parenchyma tissue and, **1:232**  
suicidal behavior and, **1:232**
- Gerontology Society of America (GSA), **1:232**
- Gerstein, Lawrence H., **1:264**
- Gestalt therapy (GT), **2:639–640**  
awareness facilitated through, **2:640**  
empty chair dialogue technique and, **2:640, 2:916–917**  
exploring experience focus of, **2:640**  
individual choice and responsibility focus of, **2:639, 2:640**  
introjection, projection, deflection, retroflection, confluence defense mechanisms and, **2:640**  
meaning created from perceptual stimuli concept in, **2:639**  
need satisfaction, contact cycle and, **2:639–640**  
Fritz Perls's work and, **2:639, 2:761**  
process-experiential psychotherapy and, **2:640–641**  
Carl Rogers and, **2:541–542**  
techniques of, **2:482–483**  
theory of, **2:482**  
top dog/underdog dialogue technique of, **2:640, 2:916**  
transactional analysis and, **2:928**  
universalist focus of, **3:1359**
- GI Bill of Rights, **4:1447**
- Gilbreth, Lillian Mollen, **1:254**
- Gilliagan, Carol, **3:1110–1111**
- Gilliland, Burl E., **2:544–545, 2:547**
- Gilmer, D., **1:10**
- Ginsberg, Sol, **4:1648**
- Ginzberg, Eli, **4:1646, 4:1648**
- Girando, D. A., **2:887**
- Glass, Gene V., **2:512, 2:627, 2:714**
- Glass ceiling, **3:1314–1315, 3:1350**
- Glass Ceiling Commission, **3:1315**
- Glasser, William, **2:541**
- GLB. *See* Gay, lesbian, and bisexual therapy (GLB)
- GLBT. *See* Gay, lesbian, bisexual, and transgender (GLBT) community
- Global Assessment of Functioning (GAF), **2:535**
- Gloria, A. M., **4:1455**
- Gold, J. M., **1:112**  
relational psychoanalytic therapy work of, **2:649**
- Goldberg, Lewis R., 2:616–617**  
academic career of, **2:617**  
“Big Five” adjectives rating self and others and, **2:617, 2:736**  
cultural lexical hypothesis of, **2:616–617**  
early years of, **2:617**  
International Personality Item Pool and, **2:617**  
professional affiliations of, **2:617**
- Goldberg Big Five Markers, **2:724**
- Goldbert, T. W., **1:112**
- Goldfried, Marvin, **2:505**
- Goldman, Leo, 2:617–618**  
cultural validity in standardized tests issue and, **2:618**  
psychological testing work of, **2:617–618**  
qualitative methods, testing recommended by, **2:618**  
standardized testing limitations and, **2:618**
- Goldstein, Arnold P., **2:593**
- Gomez, M. J., **4:1455**
- Good, Catherine, **3:1339**
- Good, Glenn, **2:649, 3:1006**
- Goodman, Paul, **2:639**
- Goolishian, Harry, **1:204**
- Gordon, Bruce S., **3:1239**
- Gordon, Kristina Coop, **2:607**
- Gordon, Milton, **3:1001, 3:1003**
- Gordon Diagnostic System, **2:698**
- Gore, Paul, **4:1635**
- Gottfredson, Gary D., **4:1424, 4:1544–1545, 4:1549**
- Gottfredson, L. S., **2:652** (figure)
- Gottlieb, Michael C., **2:836**
- Gottman, John M., **2:705**
- Gough, Harrison, **2:813**
- Gould, Stephen Jay, **3:1109**
- Graduate Records Examination (GRE), **2:450, 2:939, 4:1393**
- Graham, John, **3:989**
- Gramsci, Antonio, **3:1374**
- William T. Grant Foundation, **4:1617**
- Gratz v. Bollinger*, **3:1122**
- Graumann, Carl Friedrich, **3:1113**
- Graves, J. L., **3:1280**
- GRE. *See* Graduate Records Examination (GRE)
- Greater Avenues to Independence, **4:1449**
- Greenberg, Jack, **3:1238**



- Greenberg, Jay R., 2:763  
 Greenberg, Leslie S., 2:486, 2:919, 2:940  
 Greene, Beverly, 3:1246  
 Greene, David, 2:673  
 Greenfield, Patricia, 3:1145  
 Greyston Conference of counseling psychology (1964), 1:104, 1:129, 1:389  
 Grey-Wheelwright Jungian Type Survey, 2:727  
 Grier, William, 3:1092, 3:1093, 3:1153  
 Grobstein, Paul, 2:763  
 Grounded theory qualitative method  
   axial coding in, 1:360  
   constant comparative method of, 1:359  
   interactive data collection and analysis in, 1:359–360  
   open coding in, 1:360  
   saturation concept in, 1:360  
   selective coding in, 1:360  
   social theory result of, 1:360  
 Group Counseling Helpful Impacts Scale, 2:904  
**Group therapy, 2:618–622**  
   A. A. and, 1:14–18  
   adventure therapy and, 1:12–14  
   Adlerian therapy and, 2:458  
   benefits of, 2:621  
   career counseling and, 4:1431, 4:1484  
   chronic illness and, 1:82  
   counseling group focus and goals and, 2:619  
   critical incident stress debriefing and, 2:548–550  
   effectiveness of, 2:621–622  
   emotional interactions of group as tool of, 2:618  
   group counseling vs. group psychotherapy and, 2:619  
   group member selection and, 2:620–621  
   group therapist qualifications and, 2:621–622  
   heterogeneous vs. homogeneous groups and, 2:620  
   interpersonal learning, interpersonal  
     feedback and, 2:658–660  
   as laboratory for practicing new behavior, 2:621  
   numbers, timing, duration of, 2:618–619  
   open vs. closed groups and, 2:620  
   outpatient therapy group process and, 2:620–621  
   pathological gambling and, 1:229  
   psychotherapy group focus and goals and, 2:619–620  
   psychotherapy groups varieties and, 2:620  
   self-help groups and, 2:866–869  
   setting varieties of, 2:620  
   transactional analysis and, 2:926–928  
   types of groups and, 2:619  
 Grutter v. Bollinger, 3:1122  
 GSA. *See* Gerontology Society of America (GSA)  
 GT. *See* Gestalt therapy (GT)  
 Guerney, Bernard, 1:332  
*Guidelines and Principles for Accreditation of Programs in Professional Psychology* (APA), 1:2, 1:4, 3:1087  
*Guidelines for Computer-Based Tests and Interpretations* (APA), 1:188  
*Guidelines for Providers of Psycho-Diverse Populations* (APA), 3:1087  
*Guidelines for Psychological Practice with Girls and Women* (APA), 1:131, 1:435  
*Guidelines for Psychotherapy with Lesbian, Gay, and Bisexual Clients* (APA), 1:435, 4:1624  
*Guidelines on Multicultural Education, Training, Research, Practice, and Organizational Change for Psychologists* (APA), 1:435, 3:991–993, 3:1064, 3:1087, 3:1088, 3:1231, 3:1351, 4:1639  
 Guilford Zimmerman Temperament Survey (GZTS), 2:460–461  
 Guindon, Mary, 3:1245  
 Guinness, J. P., 1:432  
 Gurman, A. S., 1:138  
 Guthrie, Robert, 3:1109  
 GZTS. *See* Guilford Zimmerman Temperament Survey (GZTS)  
 Hackett, Gail, 2:767, 3:1006, 3:1165, 4:1406, 4:1627  
 Hadley, Suzanne W., 2:712  
 Haehnen, F. P., 4:1488  
 Hagenah, Theda, 4:1641  
 Hahn, Kurt, 1:12  
 Hahn, Milton E., 1:129  
 Hakuta, Kenji, 3:1224  
 Haley, Jay  
   marriage, family therapy work of, 1:124  
   schizophrenic communication  
     dynamics work of, 1:203  
 Hall, Christine Iijima, 2:994, 3:1228  
 Hall, Edward T., 3:1158, 3:1206  
 Hall, G. Stanley, 3:1109  
 Hallahan, Daniel, 1:158  
**Hall Occupational Orientation Inventory (HOOI), 4:1543–1544**  
   age-appropriate forms of, 4:1544  
   *Choosing: Your Way* manual of, 4:1544  
   limitations of, 4:1544–1545  
   normative data absence of, 4:1544–1545  
   Scholastic Testing Service and, 4:1544  
   Scholastic Testing Service Web site, 4:1545  
   scoring of, 4:1544  
   self-assessment format of, 4:1544  
   structure of, 4:1544



- Halloran, Sean, **2:580**
- Halstead-Reitan Neuropsychological Battery (HRB), **2:696**
- Hambleton, Ronald, **1:266**
- Hambridge, Gove, **1:332**
- Hamilton Depression Inventory, **2:558**
- Hamilton Rating Scale for Depression, **2:463, 2:558**
- Hammond, Marie, **4:1470**
- Handbook of Career Counseling for Women* (Heppner and Bruce), **4:1676**
- Handbook of Multicultural Competencies in Counseling and Psychology* (Pope-Davis, ed.), **4:1639**
- Handbook of Religion and Health* (Koenig, McCullough, and Larson), **2:880**
- Handbook of Vocational Psychology* (Osipow and Bruce), **4:1590**
- Handbook of Vocational Psychology* (Osipow and Walsh), **4:1676**
- Handelsman, Mitchell, **2:646**
- Hanf, Constance, **1:326, 1:332**
- Hanjorgiris, W. F., **3:1216**
- Hanna, Fred, **3:1245**
- Hansen, Sunny, **1:263**
- Hanson, Jo-Ida, **4:1678**
- Halloway, Elizabeth, **3:1006**
- Happiness/hardiness, 2:623–626**
- approach vs. avoidance coping, hardiness and, **2:625**
  - autonomy and, **2:553–554**
  - bottom-up vs. top-down theories of happiness and, **2:623–624**
  - control, commitment, challenge hardiness attitudes and, **2:624–625**
  - Mihaly Csikszentmihalyi's work in, **2:551**
  - eudaemonic view of happiness and, **2:623**
  - forgiveness and, **2:605–607**
  - happiness, definition of, **2:623**
  - happiness, factors leading to, **2:624**
  - happiness, measurement and constituents of, **2:623–624**
  - happiness, overview of, **2:623**
  - hardiness, buffering and mediational hypothesis of, **2:625, 2:626**
  - hardiness, counseling and, **2:625**
  - hardiness, definition of, **2:623, 2:624**
  - hardiness, measurement and limitations of, **2:624–625**
  - hardiness, stress coping strategy and, **2:885**
  - hedonic view of happiness and, **2:623**
  - hope and, **2:634–637**
  - intrinsic motivation and, **2:553–554**
  - job satisfaction, well-being and, **4:1557–1559**
  - life-role balance and, **4:1571–1573**
  - neuroticism, extraversion personality dimensions and, **2:624, 2:626**
  - optimism, pessimism and, **2:707–710**
  - Personal Viewers Survey of hardiness and, **2:624**
  - positive psychology and, **2:781–784**
  - psychological well-being and, **2:803**
  - relationship between, **2:625–626**
  - short- vs. long-term happiness and, **2:623**
  - trait happiness and, **2:623**
- Hardiman, Rita, **3:1285**
- Hardiness. *See* **Happiness/hardiness**
- Hardy, Emily, **1:132, 1:407**
- Hare Psychopathy Checklist-Revised, **1:420**
- Haritatos, Veronica, **3:1020**
- Harkness, Sara, **3:1084**
- Harlem Youth Opportunities Unlimited, **3:1051, 3:1053–1054**
- Harmful psychological**
- critical incident stress debriefing and, **2:628**
- Harmful psychological treatments, 2:626–631**
- coercive restraint therapies, **2:629**
  - deterioration following vs. resulting from and, **2:627**
  - dissociative identity disorder-oriented treatment, **2:630**
  - facilitated communication and, **2:629**
  - “First, do no harm” credo and, **2:626**
  - future directions in, **2:630**
  - harm as multifaceted phenomenon and, **2:627–628**
  - holding, rebirthing therapy, **2:629**
  - negative effects sizes from meta-analysis and, **2:627**
  - opportunity cost side effect and, **2:627**
  - psychotherapy deterioration and, **2:626–627**
  - to qualify as, **2:628**
  - randomized controlled trials and, **2:627**
  - recovered memory techniques, **2:629–630**
  - scared straight programs, **2:628–629**
  - statistics regarding, **2:626–627**
- Harmon, Lenore W., **4:1563**
- Harper, Dennis, **1:156**
- Harrell, S., **3:1295**
- Harren, Vincent A., **4:1522, 4:1523–1524, 4:1657, 4:1658**
- Harris, Thomas, **2:927**
- Harris-Bowlsbey, JoAnn, **4:1526–1527**
- Harter Self-Perception Profiles, **2:861, 2:864**
- Hartigan, J. A., **4:1542**
- Hartigan, John, **3:1374**
- Hartmann, Heinz, **2:587, 2:761**
- Hartung, P., **4:1577**
- Harvard Department of Psychiatry/National Depression Screening Day Scale, **2:558–559**



- Harvard Immigration Study, **3:950**
- Harvath, Theresa, **1:245**
- Hasidic Jews, **3:978**
- Hatacher, R., **1:408**
- Havighurst, Robert, **1:10**
- Hawthorne effect, workplace psychology and, **1:254**
- HBM. *See* **Health Belief Model (HBM)**
- HC. *See* **High-context communication (HC)**
- HCPCS. *See* Healthcare Common Procedure Coding System (HCPCS)
- Healing the Incest Wound* (Courtois), **1:141**
- Health. *See* **Health Belief Model (HBM)**; **Indigenous healing; Physical health**
- Health Belief Model (HBM), 1:235–237**
- application of, **1:236**
  - Albert Bandura's self-efficacy theory and, **1:235**
  - beliefs and values impact on health-related decision making and, **1:235**
  - explanation of, **1:235**
  - health-related motivation focus of, **1:235**
  - implications for future research and, **1:236**
  - medication adherence and, **1:287**
  - perceived benefits, barriers and, **1:235**
  - perceived susceptibility and severity, **1:235**
  - perceived threat and, **1:235**
  - physical activity counseling and, **2:777–779**
  - public policy and, **1:236**
  - treatment compliance and, **1:425–426**
  - understanding ineffective treatment regimens and, **1:236**
  - as value-expectancy theory, **1:235**
- Healthcare Common Procedure Coding System (HCPCS), **2:552**
- Health Insurance Portability and Accountability Act (HIPAA), **2:551, 2:646, 3:1351**
- Healthy paranoia, 3:1153–1154**
- counseling implications for, **3:1153**
  - cultural mistrust and, **3:1092–1093**
  - cultural paranoia and, **3:1093–1094**
  - definition of, **3:1153**
  - misdiagnosis of, **3:1153**
  - racism perceived by Black Americans and, **3:1153**
- Healthy People 2010*, **1:96, 2:780**
- Healthy Personality Inventory, **4:1408–1409**
- Healy's career appraisal model, **4:1576**
- Heatherington, Laurie, **1:219**
- Heesacker, Marty, **2:892**
- Heider, Fritz
- attribution theory and, **2:744**
  - dissonance theory of, **2:892**
  - naïve psychology and, **2:744**
  - phenomenal causality concept of, **2:744**
- Helminiak, Daniel, **2:881**
- Helms, Janet E., 3:1154–1156**
- APA work of, **3:1156**
  - Black Racial Identity Attitudes Scale and, **3:1287, 3:1292**
  - counseling relationships work of, **3:1037–1038, 3:1304**
  - W. E. Cross's influence on, **3:1154**
  - direct assessment recommended by, **3:1154**
  - ego status and, **3:1286**
  - identity development models for Blacks, Whites and people of color and, **3:1154, 3:1229, 3:1246, 3:1285–1286**
  - identity statuses and, **3:1229**
  - impact of race and racism and, **3:1155**
  - information processing strategies and, **3:1154**
  - international influence of, **3:1154**
  - People of Color Racial Identity Attitudes Scale (POCRIAS) and, **3:1289**
  - published works of, **3:1156**
  - racial appraisals and, **3:1154**
  - Racial Identity Attitude Scale-Black developed by, **3:1037**
  - racial identity theory and, **3:1035, 3:1036–1037, 3:1154–1155, 3:1162, 3:1216, 3:1229, 3:1246, 3:1280–1281, 3:1296–1297**
  - racial interaction model of, **3:1154**
  - test bias work of, **3:1154**
  - visible racial/ethnic groups term and, **3:1363**
  - White Racial Identity Attitude Scale (WRIAS) and, **3:1288, 3:1381**
  - White racial identity development model of, **3:1381**
- Helpful impacts. *See* **Taxonomy of helpful impacts**
- Helping the Noncompliant Child parent training program, **1:326**
- Help-seeking behavior, 3:1156–1158**
- clinical presenting issues and, **2:491–494**
  - Community Mental Health Act (1963) and, **3:1157**
  - coping and, **2:526–530**
  - couple and family counseling and, **3:1157**
  - deinstitutionalization of mental health patients and, **3:1157**
  - extended family decline and, **3:1156**
  - feminist movement and, **3:1157**
  - gender factor in, **3:1158**
  - health belief model and, **1:235–237**
  - historical background of, **3:1156–1157**
  - immigration pattern changes and, **3:1157**
  - immigration status factor in, **3:1157–1158**



- mandated referrals and, **3:1157**
- provider-client relationship and, **3:1158**
- psychoeducation and, **2:799–803**
- race and ethnicity factors in, **3:1157**
- religious affiliation factor in, **3:1157**
- self-help groups and, **2:866–869**
- social class factor in, **3:1158**
- Helson, Harry, **2:593**
- Heppner, Puncky Paul, 1:132, 1:133, 2:631–632, 2:892**
  - The Counseling Psychologist* and, **1:263–264**
  - cross-cultural training importance and, **3:1088**
  - information processing focus of, **2:631**
  - problem-solving behavior work of, **2:631, 4:1523**
  - Problem Solving Inventory of, **2:631**
  - professional associations of, **2:631**
  - Research Design in Counseling* written by, **2:631**
  - social influence in the counseling process and, **2:631**
- Herek, Gregory, **2:614**
- Herma, John, **4:1648**
- Hernstein, Richard, **3:1109–1110**
- Herskovits, Melville J., **3:947, 3:1082, 3:1129**
- Heterosexism
  - Abrahamic religions and, **2:573**
  - education, government contributions to, **2:573**
  - GLB therapy and, **2:613–615**
  - homosexuality discrimination and, **2:573**
- Hewlett, Sylvia, **4:1683**
- Higgins, E. Tory, **2:747**
- High-context communication (HC), 3:1158–1159**
  - contexting process and, **3:1159**
  - contextual factors focus in, **3:1158–1159**
  - cultural factors in, **3:1159**
  - cultures adept at, **3:1159**
  - Edward T. Hall's work in, **3:1158**
  - low-context communication and, **3:1206**
  - symbolic representation patterns and, **3:1159**
- Hill, Clara E., 2:632–633**
  - Client Reactions System counseling process measure and, **2:533**
  - consensual qualitative research (CQR) and, **2:632**
  - counseling process and outcome research work of, **2:632**
  - Helping Skills* written by, **2:632**
  - qualitative research paradigm work of, **2:632**
  - teaching helping skills model of, **2:632, 2:649**
  - therapy process work of, **2:486, 2:919, 2:920, 2:921**
  - working with dreams work of, **2:632**
- Hill, Robert, **1:68**
- Hill, William F., **2:658**
- Hillard, Asa, **3:964**
- Hinduism, **3:1302**
- HIPAA. *See* Health Insurance Portability and Accountability Act (HIPAA)
- Hiroto, Donald, **3:1199**
- Hispanic Journal of Behavioral Sciences*, **3:1081**
- Histrionic personality disorder (HPD)
  - characteristics of, **2:730**
  - comorbidity of, **2:733**
- Hitchcock, Jeff, **3:1375**
- Hitler, Adolf, **3:1240**
- HIV/AIDS, 1:237–240**
  - AIDS-related death bereavement, grief and, **1:50**
  - Alaska Natives and, **3:969**
  - alcohol consumption risk factor and, **1:238**
  - behavioral risk-education interventions and, **1:238**
  - Black women and, **3:1316**
  - cognitive-behavioral stress management treatment and, **1:240**
  - diagnosis of, **1:238**
  - duty to warn and protect and, **2:496, 2:576**
  - epidemiological shift in, **1:237**
  - Ethics in HIV-Related Psychotherapy* (Kitchener, co-author) and, **1:270**
  - geographic prevalences of, **1:237**
  - healthcare worker education and, **1:237**
  - highly aggressive antiretroviral therapy and, **1:238–239**
  - history of, **1:237**
  - immune defense mechanisms compromise and, **1:237**
  - increased longevity and, **1:237**
  - Latinos and, **3:1194**
  - long-term survivors of, **1:239–240**
  - medication adherence importance and, **1:287**
  - middle-aged, older persons infected with, **1:239–240**
  - prison population and, **1:118**
  - progress in treatment of, **1:238–239**
  - psychological coping and, **1:239**
  - psychosocial implications of testing for, **1:238**
  - quality of life interventions and, **1:240**
  - quality of life psychological interventions and, **1:239**
  - risk and risk factors of, **1:237–238**
  - social support and, **1:239**
  - stress management treatment and, **1:238, 1:240**
  - therapist ethical concerns and, **2:496**
  - treatment compliance and, **1:425**
- Hobsbawm, E., **3:1347, 3:1348**
- Hoffman, Irwin Z., **2:763**
- Hoffman, Mary Ann, **2:780**
- Hofstede, Geert, **3:1169, 3:1178**
- Hogan, R., **1:406**
- Hogan Personality Inventory (HPI), **2:724**



Holistic models of adult development, 1:10–11

**Holland, John L., 4:1544–1546**

Career Attitudes and Strategies Inventory of, 4:1544, 4:1545

career exploration concept and, 4:1475

content-based concepts of, 4:1550

*Dictionary of Holland Occupational Titles* and, 4:1544–1545, 4:1549

*Dictionary of Occupational Titles* revised by, 4:1544, 4:1545, 4:1549

empirical and theoretical research themes by, 4:1544–1545

Environmental Assessment Technique (EAT) and, 4:1536–1537

Environmental Assessment Technique of, 4:1544, 4:1545

hexagonal congruence model of, 2:773–774

honors and awards received by, 4:1545–1546

important research findings by, 4:1545

instrumentation development research of, 4:1545

inventory assessments developed by, 4:1544

*Making Vocational Choices* written by, 4:1536, 4:1545, 4:1546

My Vocational Situation of, 4:1544, 4:1545, 4:1579–1580, 4:1673

person-environment fit research of, 2:773–774, 4:1544–1545, 4:1563, 4:1646

Position Classification Inventory of, 4:1544, 4:1545

*Psychology of Vocational Choice* written by, 4:1546

Self-Directed Search of, 4:1544, 4:1545

self-directed techniques focus of, 4:1545

significant and enduring influences of, 4:1545

Strong Interest Inventory and, 4:1544

Vocational Identity Scale of, 4:1544, 4:1545, 4:1673

vocational interest types and, 2:755, 2:925, 4:1407, 4:1528, 4:1544

Vocational Preference Inventory of, 4:1544, 4:1545

vocational psychology and personality combined by, 4:1544

Bruce Walsh and, 4:1675

Edward G. Williamson and, 4:1678

work satisfaction research of, 4:1545

*See also* **Holland's theory of vocational personalities and work environments**

**Holland's theory of vocational personalities and work environments, 4:1546–1550, 4:1550**

career construction theory and, 4:1427

Career Planning Survey and, 4:1495

Career Style Interview (CSI) and, 4:1500–1501

congruence concept and, 4:1602

Environmental Assessment Technique and, 4:1549

immigrant career counseling and, 4:1452

*Journal of Vocational Behavior* special issue on, 4:1563

My Vocational Situation and, 4:1673

Native American career counseling and, 4:1457

personality assessment and careers and, 4:1598–1599

person-environment fit research of, 2:773–774, 4:1544–1545, 4:1549, 4:1563, 4:1600–1602

power differentials and, 4:1548

practical applications of, 4:1550

research evidence regarding, 4:1549

RIASEC (Realistic, Investigative, Artistic, Social, Enterprising, and Conventional) Model, applications of, 2:925, 4:1420, 4:1424, 4:1452, 4:1457, 4:1500–1501, 4:1528, 4:1536, 4:1538, 4:1546–1550, 4:1547 (figure), 4:1587–1588, 4:1589, 4:1598–1599, 4:1643, 4:1644, 4:1660, 4:1664, 4:1665, 4:1668, 4:1669

types of people and, 4:1547

types of people and, assessment of, 4:1548–1549

types of people and, relationships between, 4:1547–1548

user friendliness of, 4:1550

Vocational Identity Scale and, 4:1544, 4:1545, 4:1673

work environment and, 4:1548

work environment and, assessment of, 4:1549

work environment size and, 4:1548

*See also* **Environmental Assessment Technique (EAT)**

Hollingshead Index of Social Position, 3:1327, 3:1328

Hollingshead Two-Factor Index, 3:1327

Holmes, Stacey E., 2:660

Holocaust, 2:573, 3:1132, 3:1240

prejudice research and, 3:1275

**Homeless youth, 1:240–243**

causes of, 1:241

community agencies support of, 1:240–241

definition of, 1:241

deinstitutionalization and, 2:848

dysfunctional home experiences of, 1:241

female homelessness, abuse and, 2:444

First Voice program and, 1:243

GLBT adolescents and, 1:241

interventions for, 1:240, 1:242–243

living environments of, 1:241

mental health problems of, 1:241, 1:242

multidimensional family therapy and, 1:241

preventive interventions and, 1:242

reintegration programs and, 1:242–243

risks of, 1:241–242

runaway, chronic and acute designation and, 1:241

statistics regarding, 1:240



- survival mechanisms, street skills of, **1:241–242**  
 throwaway designation and, **1:241**  
 trust issues of, **1:241, 1:242**  
 unfavorable outcomes of, **1:240**
- Homework assignments, 2:633–634**  
 Beutler's model of systematic treatment  
   selection and, **2:648**  
 cognitive-behavioral therapy and, **2:504**  
 history and research regarding, **2:633**  
 managed care and, **2:633**  
 for panic disorder, **2:718**  
 purpose and benefits of, **2:633**  
 rational emotive behavior therapy and, **2:648, 2:825**  
 relevance of, **2:633**
- Homophobia: A Weapon of Sexism* (Pharr), **3:1318**
- HOOI. See Hall Occupational Orientation Inventory (HOOI)**
- Hooker, Evelyn, **1:114**
- hooks, bell, **3:1049**  
 "feminism is for everybody" and, **3:1318**  
 internalized oppression and, **3:1318**  
 multiple oppressions work of, **3:1246, 3:1314**  
*Teaching to Transgress* (hooks), **3:1070**
- Hope, 2:634–637**  
 academic success and, **2:634–635**  
 agency component of, **2:634**  
 aspects of well-being and, **2:634–636, 2:783–874**  
 happiness/hardiness and, **2:623–626, 2:783**  
 hope theory defined, **2:634**  
 meaning in life and, **2:636, 2:784**  
 pathways component of, **2:634**  
 physical health and, **2:635**  
 positive expectations for goal attainment and, **2:634**  
 positive psychology and, **2:634, 2:781–784**  
 psychological adjustment and, **2:635–636**  
 psychological well-being and, **2:803**  
 C. R. Snyder's work and, **2:783**
- Hopkins, R., **3:1386**
- Horn, John, **2:924**
- Horney, Karen, **1:9, 2:735**
- Horvath, A. O., **2:940**
- Hospice, 1:243–246**  
 admission to, **1:243–244**  
 affirmation of life philosophy of, **1:244**  
 anticipatory grief and, **1:245**  
 assisted suicide and, **1:245**  
 caregiver stress and, **1:245**  
 community outreach and, **1:245**  
 ethical aspects of, **1:245**  
 funding of, **1:244**  
 grief stages and, **1:245**  
 history of, **1:243**  
 Hospice Medicare benefit and, **1:244**  
 living will and, **1:245**  
 medical social worker and, **1:244–245**  
 psychological aspects of, **1:244**  
 psychosocial services after patient's death and, **1:245**  
 psychosocial services during patient's  
   life and, **1:244–245**  
 self-determination philosophy of, **1:244**  
 types of, **1:243**
- Houston, Charles Hamilton, **3:1238**
- Houston Conference (2001) of counseling psychology,  
   **1:105–106**
- Hovath, Adam, **2:486**
- Howard, K. A. S., **4:1679, 4:1680**
- Howard, Kenneth, **1:174, 2:919, 2:920**
- Hoyt, Ken, **4:1450**
- HPD. *See* Histrionic personality disorder (HPD)
- HPI. *See* Hogan Personality Inventory (HPI)
- HRB. *See* Halstead-Reitan Neuropsychological Battery  
   (HRB)
- Hug-Hellmuth, Hermine, **1:332**
- Hughes, Diane, **3:1279**
- Hull, Clark, **2:593, 2:739**
- Human figure drawing projective techniques, **2:793, 2:811**
- Human Genome Project  
   developmental, learning disorders and, **1:159**  
   genetic testing, chronic illness and, **1:83**  
   genetic testing, fertility practices and, **1:194**
- Humanistic approaches, 2:637–641**  
 assumptions of, **2:637–638**  
 counselor self-disclosure and, **2:852**  
 freedom and responsibility of the  
   individual focus of, **2:637**  
 Gestalt therapy and, **2:639–640**  
 ideal self and, **2:638**  
 individual agency, holistic functioning focus of, **2:637**  
 individual experiencing importance in, **2:637**  
 individual therapy and, **2:643–645**  
 person-centered therapy and, **2:638–639**  
 phenomenological personality theories and, **2:756–757**  
 positive psychology and, **2:782**  
 process-experiential psychotherapy and, **2:640–641**  
 self-actualizing tendency of humans and, **2:638**  
 self-awareness emphasis in, **2:637**  
 self-concept in, **2:638**  
 therapeutic environment importance in, **2:637–638**  
*See also* Gestalt therapy (GT); Process-experiential  
   psychotherapy (PE); **Rogers, Carl R.**



Human multipotentiality. *See* **Tyler, Leona E.: human multipotentiality**

**Human subjects review in an online world, 1:246–248**

- autonomy issues of, 1:247
- beneficence issues of, 1:247
- confidentiality and, 1:247
- data security and, 1:247
- delivery, evaluation of therapeutic interventions and, 1:246
- general ethical guidelines and, 1:246–247
- International Review Board criteria for, 1:246–247
- justice issues of, 1:247
- National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research and, 1:246–247
- observational research and, 1:246
- online data collection and, 1:246
- online surveys and, 1:246
- privacy expectations and, 1:247
- technology and treatment and, 1:411–415

Hume, David, 2:785

Hungarian Refugee Act (1956), 3:1170

Huntington's disease, 1:17

Hurst, J. C., 1:432

Hyde, Shibley, 4:1682

Hynd, George, 1:158

Hyperkinesis. *See* **Attention deficit/hyperactivity disorder (AD/HD)**

Hyperkinetic reaction of childhood. *See* **Attention deficit/hyperactivity disorder (AD/HD)**

**Hypnosis, 1:248**

- altered state of consciousness of, 1:248
- coping skills treatment and, 1:248
- focused awareness in, 1:248
- relaxation state and, 1:248
- trust and, 1:248

Hypodescent concept, 3:1027, 3:1280

IAAP. *See* International Association of Applied Psychology (IAAP)

IACS. *See* International Association of Counseling Services (IACS)

IAEVG. *See* **International Association for Educational and Vocational Guidance (IAEVG)**

IAMFC. *See* International Association of Marriage and Family Counselors (IAMFC)

IAPT. *See* International Association for Play Therapy (IAPT)

Ibrahim, F. A., 3:1386

ICD. *See* **International Classification of Diseases, Injuries, and Causes of Death (ICD)**

ICF. *See* International Classification of Functioning, Disability and Health (ICF)

Ickovics, Jeannette R., 3:1328

ICWA. *See* Indian Child Welfare Act (ICWA, 1978)

IDEA. *See* **Individuals with Disabilities Education Act (IDEA)**

IDEIA. *See* Individuals with Disabilities Education Improvement Act of 2004 (IDEIA)

**Identity, 3:1161–1163**

- Black racial identity development and, 3:1036–1038
- cognitive, emotion, and social factors of, 3:1161–1163
- in collectivistic cultures, 3:1161
- definition of, 3:1161
- developmental process of, 3:1161
- ethnic minority and, 3:1139–1141
- Eurocentric concept limitations and, 3:1161
- GLB therapy and, 2:613–615
- group and social identity formation and, 3:1161
- Janet E. Helms's work in, 3:1154–1156, 3:1162, 3:1229
- identity development models and, 3:1162–1163
- multiracial families and, 3:1234
- personal self and social would integration and, 3:1161
- sense of "belonging" and, 3:1162
- single vs. multiple group memberships and, 3:1162–1163
- social and group identity and, 3:1162–1163
- transracial adoption and, 3:1355
- White racial identity development and, 3:1380–1383
- See also* **Black racial identity development (BRID); Ethnic identity; Identity development; Racial identity; Social identity theory; Vocational identity; White racial identity development (WRID)**

**Identity development, 3:1163–1168**

- biracialism and, 3:1027–1032
- Black racial identity development and, 3:1036–1038
- counseling implications of, 3:1167
- ego identity status paradigm and, 3:1164–1165
- Erik Erikson's developmental stage work and, 3:1161, 3:1163–1164
- ethnic identity development theory and, 3:1166
- filial piety and, 3:1151
- foreclosure stage of, 3:1165
- Freud's psychosexual development stages and, 2:740, 3:1163
- future directions regarding, 3:1167
- Janet E. Helms's work and, 3:1154–1156, 3:1162, 3:1229



- identity achievement stage of, **3:1165**  
 identity confusion, identity commitment and, **3:1164**  
 identity diffusion stage of, **3:1164–1165**  
 identity vs. identity confusion and, **3:1164**  
 informational, normative, and diffuse/avoidance identity orientations and, **3:1165**  
 internalized oppression and, **3:1246**  
 James E. Marcia's work in, **3:1164–1165**  
 moratorium stage of, **3:1165**  
 multicultural personality and, **3:1226–1227**  
 multidimensional racial identity model and, **3:1166**  
 multiracial families and, **3:1234**  
 narrative view, life story model of, **3:1166–1167**  
 new advances in, **3:1166–1167**  
 Nigrescence racial identity development theory and, **3:1078–1079, 3:1166, 3:1287, 3:1364, 3:1380, 3:1381**  
 nonlinear models of, **3:1165–1166**  
 sexual identity development and, **3:1167**  
 social, personal, and collective identification elements of, **3:1165–1166**  
 social class status and, **3:1166**  
 social cognitive model of, **3:1165–1166**  
 social identity theory and, **3:1166**  
 stage models of, **3:1163–1165, 3:1229**  
 status regression and, **3:1164**  
 transracial adoption and, **3:1355**  
 White racial identity development and, **3:1380–1383**  
*See also* **Black racial identity development (BRID); Ethnic identity; Identity; Racial identity; Social identity theory; Vocational identity; White racial identity development (WRID)**
- Ideological racism, **3:1293**
- Idiocentrism, 3:1168–1170**  
 allocentrism and, **3:971–972, 3:1168**  
 characteristics of, **3:1168–1169**  
 cultural mistrust and, **3:1092–1093**  
 definition of, **3:1168**  
 empirical findings and, **3:1169**  
 individualism and, **3:1168**  
 individualism vs. collectivism elements and, **3:1168–1169**  
 ingroups of, **3:1169**  
 personality traits associated with, **3:1168, 3:1169**
- IEP. *See* **Individuals with Disabilities Education Act (IDEA)**
- IES. *See* Intuitive Eating Scale (IES)
- IFSP. *See* **Individuals with Disabilities Education Act (IDEA)**
- IHCIA. *See* Indian Health Care Improvement Act (IHCIA)
- IHS. *See* **Indian Health Service (IHS)**
- Illiberal Education* (D'Souza), **3:1264**
- Illinois Test of Psychological Abilities, **2:670**
- Im, E., **1:247**
- Image rehearsal therapy, **2:507**
- Immigrants, 3:1170–1173**  
 abuse victims and, **2:443, 2:446**  
 acculturation and, **3:941–946**  
 acculturative stress and, **3:946–952**  
 brief history of immigration and, **3:1170–1171**  
 career counseling for, **4:1451–1453**  
 career development and, **4:1531**  
 Chinese Exclusion Act (1882) and, **3:1170**  
 counseling implications and, **3:1173**  
 Cuban Adjustment Program and, **3:1170**  
 cultural psychoeducation concerns and, **2:801–802**  
 demographics of, **3:1111–1113**  
 Displaced Persons Act (1948) and, **3:1170**  
 ethnic-specific mental health services and, **3:999**  
 eugenics and, **3:1170**  
 family difficulties and, **3:1172**  
 federal and state benefits eligibility and, **3:1171–1172**  
 financial stress challenge of, **3:1171**  
 help-seeking behavior of, **3:1157–1158**  
 help-seeking behaviors of, **3:1172–1173**  
 Hungarian Refugee Act (1956) and, **3:1170**  
 illegal immigrant issue and, **3:1171**  
 Immigration and Naturalization service and, **3:1170**  
 Immigration Reform and Control Act (1986) and, **3:1171**  
 immigration restricting legislation and, **3:1170**  
 Johnson-Reed Act (1924) and, **3:1170**  
 language "brokering" by children of, **3:949, 3:1172, 3:1193**  
 melting pot concept and, **3:942, 3:1001, 3:1019, 3:1120, 3:1251**  
 Mexican immigration history and, **3:1170**  
 national origins quota system and, **3:1170–1171**  
 nonparallel mental health services and, **3:999**  
 prejudice challenge and, **3:1171–1172**  
 psychological distress challenge and, **3:1172**  
 Refugee-Escapee Act (1957) and, **3:1170**  
 Refugee Relief Act (1953) and, **3:1170**  
 refugee relief legislation and, **3:1170**  
 somatization complaints of, **3:1172**  
 statistics regarding, **3:1170**  
 translation methods and, **3:1350–1353**  
 unification of families and, **3:1170–1171**  
 U.S. border patrol and, **3:1170**  
*See also specific immigrant group; specific immigration legislation*



- Immigration Act (1924), **3:1048**  
 Immigration and Naturalization Service, **3:1170**  
 Immigration Reform and Control Act (1986), **3:1171**  
**Impairment, 1:249–250**  
   definition of, **1:249**  
   depression, substance abuse, relationship problems,  
     physical illnesses and, **1:249**  
   detection during training and, **1:249–250**  
   distress vs., **1:249**  
   ethical codes and, **1:249**  
   impairment rating scales, AD/HD  
     diagnosis and, **1:29**  
   intervention after the fact and, **1:249**  
   traumatic childhood experiences and, **1:249**  
 Implicit Association Test (IAT), **2:863, 2:864**  
 Impulse control disorder, **1:227**  
 Incredible years parent program, **1:327**  
 Indian Adoption Project, **3:1353**  
 Indian Child Welfare Act (ICWA, 1978),  
   **1:71, 3:974, 3:975, 3:1040, 3:1353**  
 Indian Civil Rights Act (1968), **3:1040**  
 Indian Health Care Improvement Act (IHCIA), **3:1174**  
**Indian Health Service (IHS), 3:1174–1176**  
   activities of, **3:1174**  
   administration of, **3:1174**  
   alcoholism, substance abuse and, **3:1175**  
   *Broken Promises: Evaluating the Native American*  
     *Health Care System* report, **3:1175**  
   chronic underfunding of, **3:1175**  
   cultural, social, structural barriers within, **3:1175**  
   free health care in exchange for tribal land, **3:1174**  
   health care services of, **3:975–976**  
   Indian Health Care Improvement Act  
     (IHCIA) and, **3:1174**  
   mental and physical health disparities  
     and, **3:1174–1175**  
   mission of, **3:1174**  
   principal healthcare provider, health advocate  
     services of, **3:1174**  
   staff and clinical staff of, **3:1174**  
   Urban Indian Health Programs and, **3:1174, 3:1175**  
   U.S. Commission on Civil Rights and, **3:1175**  
 Indian Religious Freedom Act (1978), **3:1040**  
 Indian Removal Act (1830), **3:1039**  
 Indian Reorganization Act (1934), **3:1048**  
 Indian Territory, **3:1039, 3:1048**  
**Indigenous healing, 3:1176–1177**  
   African American healing practices and, **3:1176**  
   Asian healing practices and, **3:1176–1177**  
   characteristics of, **3:1176**  
   counseling implications of, **3:1177**  
   emotional, spiritual, and physical healing  
     practices and, **3:1176**  
   espiritismo and, **3:1131–1132**  
   Indian Health Service and, **3:1174–1176**  
   indigenous definition and, **3:1176**  
   indigenous implied deficiency and, **3:1176**  
   Latino/a healing practices and, **3:1176**  
   Native American healing practices and, **3:1176**  
   Santería and, **3:1176, 3:1307–1309**  
   “universal shamanic tradition” concept and, **3:1176**  
**Individualism, 3:1177–1179**  
   allocentrism and, **3:971–972**  
   American and French Revolutions and, **3:1177**  
   career development and, **4:1531**  
   characteristics of, **3:1178**  
   collectivism vs., **1:261, 3:1059–1060,**  
     **3:1083, 3:1177**  
   counseling implications of, **3:1179**  
   cross-cultural psychology and, **3:1083**  
   definition of, **3:1177**  
   economic factors affecting, **3:1177**  
   empirical research regarding, **3:1178–1179**  
   Eurocentric White culture and, **3:1373–1374**  
   European American cultural value of, **3:1100, 3:1177**  
   European political philosophers and, **3:1177**  
   historical foundations of, **3:1177–1178**  
   horizontal and vertical patterns of, **3:1178**  
   human multipotentiality and, **2:931–933**  
   idiocentrism and, **3:1168–1170, 3:1178**  
   individual variation decision making models  
     and, **4:1523–1525**  
   locus of control and, **3:1203–1204**  
   mental health, illness and treatment of, **3:1179**  
   methodological individualism and, **2:785**  
   self, goals, relationships, and social behaviors  
     of, **3:1178**  
   Leona E. Tyler and, **1:428–430, 2:931–933**  
   variations and types of, **3:1178**  
 Individual racism, **2:573, 3:1293, 3:1376–1377**  
**Individuals with Disabilities Education Act (IDEA),**  
   **1:250–254**  
   adaptive behavior testing and, **2:456**  
   All Handicapped Children Act (1975) and, **1:250**  
   assessment and eligibility issues of, **1:251–252**  
   credentialing issues and, **1:253–254**  
   disability categories of, **1:251**  
   disciplinary decisions and, **1:251**  
   *DSM-IV-TR* diagnostic criteria and, **1:251, 1:252**  
   eligibility determination procedures and, **1:252**



- emotional disturbance definition
  - controversy and, **1:252**
- funding and, **1:250–251**
- Individualized Education Program (IEP), for children with chronic illness and, **1:77**
- Individualized Education Program (IEP), for special education services and, **1:252**
- individualized family service plan (IFSP) and, **1:253**
- Individuals with Disabilities Education Improvement Act of 2004 (IDEIA) and, **1:26**
- learning disability defined in, **1:158**
- least restrictive environment placement decisions and, **1:252–253**
- marginalized groups of children focus of, **1:250**
- mental health providers, “related services” and, **1:251**
- mental retardation definition controversy and, **1:252**
- NCLB and, **1:250, 1:253**
- nondisability privilege and, **3:1380**
- parental written consent and, **1:253**
- Part C, infants and toddlers and, **1:253**
- Parts A, B, C, D coverages and, **1:250**
- procedural issues and, **1:252–253**
- professional issues and, **1:253–254**
- reauthorizations of, **1:250**
- response-to-intervention provision of, **1:251**
- safe school environment and, **1:251**
- special education services qualifications and, **1:251**
- See also* **Low-incidence disabilities; Persons with disabilities**
- Individuals with Disabilities Education Improvement Act of 2004 (IDEIA), **1:26**
- Individual therapy, 2:643–645**
  - attitudes toward, **2:644**
  - career counseling and, **4:1431**
  - change producing mechanisms of, **2:644**
  - collaborative feature of, **2:644**
  - Freud, psychoanalysis foundation of, **2:643–644**
  - goals of, **2:644**
  - humanistic counseling approaches to, **2:637–641**
  - integrative/eclectic therapy and, **2:647–651**
  - interpersonal learning, interpersonal feedback and, **2:658–660**
  - logistics of, **2:643–644**
  - other therapy vs., **2:644**
  - primary dyads for, **2:643**
  - self-help groups and, **2:866–869**
  - social relationships foundation of, **2:643, 2:644**
  - Socratic Method and, **2:875–876**
  - therapeutic working alliance relationship and, **2:643, 2:644**
- Individual Variables of Attention, **1:29**
- Industrial/organizational psychology (I/O psychology), 1:254–259**
  - affective, continuance, normative commitment and, **1:257**
  - Armed Services Vocational Aptitude Battery and, **1:255**
  - Army Alpha/Beta tests and, **1:254**
  - Army General Classification Test (AGCT) and, **1:255**
  - biodata measures and, **4:1413–1415**
  - career counseling in organizations and, **4:1461–1463**
  - Civil Rights Act and, **1:255**
  - counseling and, **1:255–256, 1:258**
  - counseling and consultation overlap and, **1:258**
  - doctoral degree in, **1:357**
  - dysfunctional vs. functional conflict and, **1:257**
  - early pioneers in, **1:254**
  - employee satisfaction, commitment and, **1:257**
  - employee selection and, **1:255**
  - ergonomics and, **1:255**
  - executive coaching, consultation and, **1:257–258**
  - group behavior, teams, group conflict and, **1:256–257**
  - group conflict resolution and, **1:257**
  - Hawthorne studies, effect and, **1:254**
  - history of, **1:254–255**
  - human resource management duties of, **1:255–256**
  - interpersonal communication and, **1:256**
  - Abraham Maslow’s hierarchy of needs and, **1:256**
  - motivation and, **1:256**
  - organizational communication and, **1:256**
  - performance appraisal services and, **1:255**
  - performance modeling and, **4:1596**
  - scientist-practitioner model and, **1:254**
  - Frederick W. Taylor and, **1:254**
  - training and development services and, **1:255**
  - training in organizations and, **4:1661–1663**
  - upward, downward, business, informal communication and, **1:256**
  - work, parallel, project, management teams and, **1:257**
  - workforce demographic changes and, **1:255**
  - workplace psychology and, **1:254**
  - World War I and, **1:254**
- Infante, Dominic, **3:1065, 3:1066**
- Information System for Vocational Decisions (ISVD), **4:1658**
- Informed consent, 2:645–647**
  - in computer-aided counseling, **1:189**
  - confidentiality and legal privilege and, **2:519–522, 2:645**
  - content of procedures and, **2:645**



- definition of, 2:645  
 duty to warn and protect and, 2:575–578, 2:645  
 in e-counseling, 1:171  
 effects of, 2:646–647  
 ethical codes regulation of, 1:177–180, 2:495, 2:645  
 ethics in research and, 1:191  
 Health Insurance Portability and Accountability Act (HIPAA) and, 2:551, 2:646, 3:1351  
 managed care and, 2:645  
 online research and, 1:247  
 in rehabilitation counseling, 2:829  
 timing of, 2:646  
 written and oral methods of, 2:646
- Inman, Arpana G., 3:1231
- Institutional racism, 2:573, 3:959, 3:1064, 3:1199, 3:1293, 3:1376, 3:1377–1378
- Integral psychology adult development model, 1:11
- Integrative/eclectic therapy, 2:647–651**  
 assimilative integration and, 2:648–649  
 client's frame of reference importance and, 2:647  
 cognitive analytic therapy and, 2:648  
 common factors of, 2:647  
 cross-cultural healing approaches and, 2:647  
 cyclical psychodynamics and, 2:648  
 emerging models of, 2:649  
 future directions in, 2:650  
 helping skills model and, 2:648  
 individual therapy and, 2:643–645  
 interpersonal focus of, 2:648  
 multimodal therapy and, 2:648  
 John C. Norcross and, 1:309–311  
 relational psychoanalytic therapy and, 2:648  
 systematic treatment selection and, 2:648  
 technical eclecticism and, 2:648  
 theoretical integration and, 2:648  
 therapy relationships, personal integration and, 2:647, 2:649–650  
 transtheoretical therapy approach and, 2:648
- Integrity self-pertaining virtue, 1:442
- Intelligence, 2:651–658**  
 adopted children studies of, 2:656  
 assessment, development disorders and, 1:159  
 benefits of assessing, 2:657  
 career interests, career choices differing in areas of relative strength, 2:654 (figure)  
 cognition/intelligence assessment and, 1:497–502  
 cognitive abilities, general intelligence *g* and, 2:651–653, 2:651 (figure)  
 cognitive abilities, hierarchical structure of, 2:651 (figure)  
 comparison of two mathematically talented groups on four criteria, 2:655 (figure)  
 dynamics and, 2:655–657  
 environmental factor and, 2:655, 2:656  
 first law of individual differences and, 2:656  
 Flynn effect and, 2:500–501, 2:656–657  
 Gardner's theory of multiple intelligences and, 2:652–653  
 genetic heritability factors and, 2:655–656  
 intelligence tests and, 3:1179–1182  
 likelihood of life events and, 2:652 (figure)  
 mental retardation measurement and, 1:294–295  
 neuropsychological functioning and, 2:695–702  
 norm- vs. criterion-referenced tests and, 2:451  
 phenotypic growth and, 2:656  
 planning-attention-simultaneous-successive (PASS) model of, 2:498  
 specific cognitive abilities and, 2:653–655, 2:654 (figure), 2:655 (figure)  
 Sternberg's triarchic model of, 2:653  
 twin studies of, 2:656  
 David Wechsler's work in, 2:938  
*See also Cognition/intelligence, assessment of; Intelligence tests; Wechsler Scales; specific measure, test*
- Intelligence tests, 3:1179–1182**  
 abilities measured by, 3:1179  
 ability profiles by racial and ethnic group and, 3:1180  
 Binet intelligence scales and, 1:121  
 contextual and cultural considerations and, 3:1180–1181  
 cultural equivalence and, 3:1181  
 cultural factors in, 3:1179–1180, 3:1181–1182  
 cultural loading and, 3:1181  
 culture and alternative forms of intelligence and, 3:1180  
 deficit hypothesis and, 3:1180  
 developmental disorders and, 1:159  
 differential item function and, 3:1181  
 emotional intelligence and, 3:1180  
 eugenics and, 1:193  
 home environment factor and, 3:1181  
 multiple intelligences concept and, 3:1180  
 racial and ethnic groups and, 3:1180  
 scores by racial and ethnic group and, 3:1180  
 social intelligence and, 3:1180  
 socioeconomic status and, 3:1181  
 standardization definition and, 3:1179  
 Stanford-Binet tests and, 3:1179  
 stereotype threat and, 3:1181, 3:1340  
 test bias and, 3:1181



Universal Nonverbal Intelligence Test and, **3:1180**

verbal vs. nonverbal scales and, **3:1180**

Wechsler Scales and, **3:1179**

David Wechsler's work in, **2:938**

*See also* **Intelligence**; Wechsler Scales

*Intentional Interviewing and Counseling*

(Ivey and Ivey), **3:1186**

Interethnic Placement Act (1996), **3:1354–1355**

Internalized racism, **3:1246, 3:1296, 3:1320**

**Internalizing problems of childhood, 1:259–260**

anxiety disorders and, **1:260**

comorbidities of, **1:260**

depressive disorders and, **1:259–260**

*DSM-IV-TR* diagnostic criteria of, **1:259**

externalizing disorders vs., **1:259**

parenting and, **1:324–328**

play therapy and, **1:331–334**

International Accreditation Forum, **4:1638**

**International approaches** (to career

counseling/guidance), **4:1551–1553**

Australia example of, **4:1551–1552**

Canada example of, **4:1551–1552, 4:1552–1553**

career guidance term and, **4:1551**

Denmark example of, **4:1552**

future outlook of, **4:1552–1553**

Japan example of, **4:1552**

South Africa example of, **4:1552**

variation factors in, **4:1551**

worldwide process of career counseling and, **4:1551**

International Association for Cross-Cultural

Psychology, **3:1081**

International Association for Educational and Vocational

Guidance, **4:1635**

**International Association for Educational and Vocational Guidance (IAEVG), 4:1553–1554**

executive board of, **4:1553**

history and governance of, **4:1553**

international cooperation of, **4:1554**

*International Journal for Educational and Vocation*

*Guidance* published by, **4:1554**

objectives of, **4:1553**

professional services of, **4:1554**

research focus of, **4:1554**

Web site of, **4:1554**

International Association for Play

Therapy (IAPT), **1:333**

International Association of Applied Psychology (IAAP),

**1:265, 3:1081**

International Association of Counseling Services

(IACS), **1:435**

International Association of Marriage and Family Counselors (IAMFC)

Certified Family Therapist credential and, **1:143**

family counseling code of ethics and, **1:206**

*The Family Journal: Counseling and Therapy for*

*Couples and Families* journal of, **1:206**

National Credentialing Academy for Marriage and

Family Therapists and, **1:206**

*International Classification of Diseases, Injuries, and*

*Causes of Death (ICD)*, **2:569, 2:729**

International Classification of Functioning, Disability and

Health (ICF), **4:1603**

**International developments, counseling,**

**1:260–263, 1:262**

alternative methodologies and, **1:261**

APA international special interest groups and, **1:260**

consensual validation for standards of “normal”

behavior and, **1:262–263**

cross-cultural differences and, **1:261**

ethical practice and, **1:262**

First International Congress of Psychology and, **1:260**

generalization of Western diagnostic systems and, **1:261**

globalization and, **1:261**

individualist vs. collectivistic view of

identity and, **1:261**

necessity of growth and, **1:262–263**

opportunities and risks in, **1:261**

professional collaboration and, **1:261–262**

social policy, special interests and, **1:262**

*See also* **International developments, counseling**

**psychology**

**International developments, counseling**

**psychology, 1:263–265**

APA Division 17, international issues and, **1:264**

around the globe and, **1:264–265**

conclusion regarding, **1:265**

counseling psychology by geographic location,

**1:264–265**

Louise Douce and, **1:264**

Bruce Fretz and, **1:263**

Paul Heppner's work in, **1:263–264**

International Association of Applied Psychology

(IAAP) and, **1:265**

*International Journal for the Advancement of*

*Counseling* and, **1:263**

Minnesota International Counseling

Institute and, **1:263**

Paul Pedersen, cross-cultural counseling

work and, **1:263**

role of culture importance and, **1:264**



- in the United States and, 1:263–264
- Web sites of, 1:265
- See also **International developments, counseling**
- International Interviewing and Counseling* (Ivey), 1:267
- International Journal for Educational and Vocation Guidance* (IAEVG), 4:1554
- International Journal for the Advancement of Counseling*, 1:263
- International Organization for Standardization (ISO), 4:1638
- International Test Commission (ITC), 1:419
- International Test Commission (ITC), 1:265–266**
- best practice in psychological and educational testing goal of, 1:266
  - developing international guidelines and, 1:266, 1:419
  - Ronald Hambleton and, 1:266
  - international conferences of, 1:266
  - International Journal of Testing* and, 1:266
  - Internet-delivered computer-based testing and, 1:266
  - test adaptations and, 1:266
  - Testing International* journal of, 1:266
  - translation and adaptation of psychological tests and, 1:419
- International Transactional Analysis Association (ITAA), 2:928
- International Union of Psychological Sciences, 3:1081
- International Work Group on Death, Dying and Bereavement, 1:149
- Internet
- Internet-delivered computer-based testing and, 1:266
  - online counseling and, 1:413
- See also **E-counseling; Human subjects review in an online world**
- Inter-Organizational Council for the Accreditation of Postdoctoral Training Programs (IOC), 1:337, 1:396
- Interpersonal Adjective Scales-Revised, 2:724
- Interpersonal feedback. See **Interpersonal learning and interpersonal feedback**
- Interpersonal learning and interpersonal feedback, 2:658–660**
- definitions regarding, 2:658
  - future directions regarding, 2:660
  - group therapy and, 2:618–622
  - input, output dimensions of, 2:659
  - interpersonal feedback, effective exchange in groups and, 2:660
  - interpersonal feedback, interpersonal learning element of, 2:659–660
  - interpersonal feedback, positive and corrective feedback and, 2:659–660
  - interpersonal learning, historical perspective on, 2:658
  - interpersonal learning, in group counseling, 2:658–659
  - interpersonal learning, process of, 2:659
  - interpersonal learning, therapeutic factors and, 2:658–659
  - social support and, 2:872–875
  - transactional analysis and, 2:926–928
- Interpersonal process recall (IPR) feedback in counseling training, 1:209
- Interpersonal theory, 2:546
- Interpersonal therapy, 2:583
- Interpretation. See **Test interpretation; Therapist interpretation**
- Interracial adoption. See **Transracial adoption**
- Interracial comfort, 3:1182–1183**
- dating, romance, and marriage context of, 3:1182
  - explanation of, 3:1182
  - school environment factor in, 3:1182
  - social norms and, 3:1182–1183
- Interracial marriage, 3:1183–1185**
- counseling implications of, 3:1184, 3:1185
  - culture definition and, 3:1183
  - current trends regarding, 3:1183–1184
  - definition of, 3:1183
  - family of origin, social support and, 3:1184
  - interracial comfort and, 3:1182
  - legislative influences on, 3:1183
  - Loving v. Virginia* and, 3:1183, 3:1184, 3:1233
  - multiracial families and, 3:1233–1235
  - race definition and, 3:1183
  - racial designation and, 3:1183
  - racial identity and, 3:1184
  - statistics regarding, 3:1182
  - U.S. Census data regarding, 3:1184, 3:1234
- Interview inquiry qualitative data collection method, 1:361
- Intrinsic motivation, 2:660–666**
- amotivation vs., 2:660
  - applications of, 2:664–665
  - autonomy and, 2:553–554
  - autotelic activities and, 2:661–662
  - behavioral measure of, 2:661
  - cognitive evaluation theory and, 2:662
  - definition of, 2:660, 2:661
  - extrinsic motivation vs., 2:660, 2:663, 2:673
  - extrinsic rewards and, 2:665, 2:673
  - flow theory and, 2:551, 2:662, 2:672, 2:774
  - future work in, 2:665–666



- gender differences in, **2:664–665**
- high-stakes testing and, **2:665**
- history of, **2:661–662**
- job satisfaction and general well-being and, **4:1558**
- leisure and, **2:673**
- mastery goals and, **2:664**
- ongoing debate regarding, **2:665**
- operant conditioning theory and, **2:661**
- performance-approach, -avoidance goals and, **2:664**
- performance-contingent rewards and, **2:665**
- performance goals and, **2:664**
- physical activity counseling and, **2:777–779**
- psychological needs and, **2:661–662**
- self-determination theory and, **2:553–554**, **2:662–663**
- self-regulation of motivation theory and, **2:663**
- self-report measure of, **2:661**
- situational and individual factors and, **2:661**, **2:663–664**
- sport psychology and, **2:665**
- vocational, career choices and, **2:664–665**
- Intuitive Eating Scale (IES), **2:581**
- Inventory of Memory Experiences, **2:688**
- Inventory of Work-Relevant Abilities (IWRA), **4:1495**
- IOC. *See* Inter-Organizational Council for the Accreditation of Postdoctoral Training Programs (IOC)
- I/O psychology. *See* **Industrial/organizational psychology** (I/O psychology)
- Iowa Test of Basic Skills, **2:452**
- IPR. *See* Interpersonal process recall (IPR) feedback in counseling training
- Ishiyama, F. Ishu, **3:1066–1067**
- ISI-R. *See* Occupational Stress Inventory-Revised Edition (ISI-R)
- Islam
  - Arab Americans and, **3:987**
  - beliefs of, **3:987**
  - children and parent relationship in, **3:1302**
  - collectivism and, **3:987**
  - extended family importance in, **3:987**
  - Five Pillars of, **3:987**
  - foundational principles of, **3:1302**
  - Hajj and, **3:987**
  - Salat and, **3:987**
  - Sawm and, **3:987**
  - Shahadah and, **3:987**
  - Zakah and, **3:987**
- Israel, Tania, **3:1006**, **4:1640**
- ISVD. *See* Information System for Vocational Decisions (ISVD)
- ITC. *See* **International Test Commission** (ITC)
- Ivey, Allen E., 1:131, 1:266–268**
  - APA work of, **1:267**
  - childhood years of, **1:266–267**
  - contextual approach to counseling and, **1:267**
  - culture-centered skills focus of, **1:267**
  - developmental counseling and therapy contributions of, **1:267–268**, **2:542**
  - education and professional career of, **1:267**
  - International Interviewing and Counseling* written by, **1:267**
  - microcounseling contributions of, **1:267**, **2:536–537**, **2:538** (figure)
  - multicultural counseling and, **1:268**, **2:539**
  - multicultural development and, **1:268**
  - skills laboratory training model of, **1:406**
  - See also* **Ivey, Allen E.: counseling theory and skills training**
- Ivey, Allen E.: counseling theory and skills training, 3:1185–1187**
  - awareness and knowledge focus of, **3:1186**
  - counseling theory and, **3:1186–1187**
  - culture-centered counseling and, **3:1186**
  - developmental counseling and, **3:1186**
  - developmental counseling and therapy and, **2:561–568**
  - evolution of consciousness and, **3:1186**
  - Intentional Interviewing and Counseling* written by, **3:1186**
  - legacy of, **3:1187**
  - liberation of consciousness and, **3:1186**
  - microskills training method of, **3:1185–1186**
  - multicultural counseling and, **3:1185**
  - scholarly work of, **3:1185**
  - Joseph L. White and, **3:1370**
  - White racial identity development work of, **3:1381**
  - See also* **Developmental counseling and therapy (DCT); Ivey, Allen E.**
- Ivey, Mary Bradford, **1:268**, **3:1186**
- Jackson, Bailey, **3:1036**
- Jackson, Don, **1:203**
- Jackson, Douglas, **4:1555**
- Jackson Personality Inventory (JPI), **2:725**
- Jackson Vocational Interest Inventory (JVIS), 4:1555–1556**
  - career development uses of, **4:1556**
  - JVIS Report produced by, **4:1556**
  - JVIS Technical Manual* of, **4:1556**
  - reliability of, **4:1556**



- scales of, **4:1556**  
 Sigma Assessment Systems publication of, **4:1556**  
 structure of, **4:1556**  
 vocational roles and styles basis of, **4:1556**  
 Web sites regarding, **4:1556**  
 Web version of, **4:1556**
- Jacobs, James, **3:1028**  
 Jacobson, Edith, **2:762**  
 Jacobson, Edmund, **2:890**  
 Jacobson, N., **1:138**  
 Jacobson, Neil S., **2:711**  
 Jadhav, Sushrut, **3:1085**  
*Jaffee v. Redmond*, **2:519**  
 Jahoda, Gustav, **3:1084**  
 Jahoda, M., **4:1556**  
 James, G. G., **3:964**  
 James, Richard, **2:547**  
 James, Richard K., **2:544–545**  
 James, William, **1:11**, **2:744**  
   “I” vs. “me” distinction and, **2:756**, **2:858**  
   *The Principles of Psychology* written by, **2:858**  
   self-esteem and, **2:858**, **2:863**  
 James-Myers, L., **3:1385**, **3:1386**  
 Janz, N. K., **1:287**  
 Japanese Americans internment camps, **3:1048**  
 JA (Junior Achievement) Worldwide, **4:1519**  
 JCA. *See* **Journal of Career Assessment (JCA)**  
 Jennings, Len L., **2:513**  
 Jensen, Robert, **3:1375**  
 Jernberg, Ann, **1:332**  
 Jerrigan, M., **3:1280**  
 Jews. *See* **American Jews; Antisemitism**  
 Jim Crow laws, **3:1047**  
 Jobes, David A., **2:900**  
**Job loss, 4:1556–1557**  
   coping with, **4:1556**  
   detrimental impact of, **4:1556**  
   future directions regarding, **4:1556**  
   physical well-being affected by, **4:1556**  
   psychological well-being affected by, **4:1556**  
   sociopsychological functions of work and, **4:1556**  
**Job satisfaction and general well-being, 4:1557–1559**  
   Mihaly Csikszentmihalyi’s work in, **2:551**  
   extrinsic vs. intrinsic motivation and, **4:1558**  
   goal attainment and, **4:1557**  
   hedonic and eudemonic perspectives on, **4:1557–1558**  
   life domains concept and, **4:1558**  
   life-role balance and, **4:1571–1573**  
   meaning and self-realization eudemonic perspective of, **4:1557**  
   Moos’s social ecological approach to, **4:1558**  
   occupational stress and, **1:313–316**  
   person-environment fit importance and, **4:1557**  
   pleasure attainment vs. pain avoidance hedonic perspective of, **4:1557**  
   psychological well-being and, **2:803**  
   Social Climate Scales and, **4:1558**  
   social ecological approach to, **4:1558**  
   theory of work adjustment (TWA) and, **2:773**, **4:1557–1558**, **4:1655–1657**  
   value contrasts and, **4:1558**  
   work stress and, **4:1684–1686**  
**Job sharing, 4:1559–1561**  
   applications of, **4:1559**  
   clear expectations requirement of, **4:1560**  
   communication requirements of, **4:1560**  
   definition of, **4:1559**  
   disabled workers and, **4:1560**  
   flexibility benefit of, **4:1560**  
   full-time employment desirability and, **4:1559**  
   future directions regarding, **4:1560–1561**  
   infrequency of, **4:1559**  
   layoffs alternative of, **4:1560**  
   opportunities and challenges of, **4:1560**  
   restricted work schedules accommodation and, **4:1559–1560**  
   retirement phasing and, **4:1560**  
   work-family balance and, **4:1559**  
 Job Training Partnership Act, **4:1449**  
 Johnson, B., **1:139**  
 Johnson, James Weldon, **3:1238**  
 Johnson, Lyndon B.  
   affirmative action policies of, **3:1224**  
   Executive Order 11246 and, **3:957**, **3:1123**  
   Great Society and, **4:1447**  
 Johnson-Reed Act (1924), **3:1170**  
 Jones, James, **3:1075–1076**, **3:1297**, **3:1376**  
 Jones, Richard L., **3:1034**  
 Jones, Warren H., **2:606**  
 Jordaán, Jean Pierre, **4:1475**  
 Jourard, Sidney, **2:851**  
*Journal of Black Psychology*, **3:1005**, **3:1034**, **3:1081**  
*Journal of Career Assessment (JCA)*, **4:1561–1562**  
   assessment term and, **4:1561**  
   career assessment term and, **4:1561**  
   journal ranking of, **4:1561**  
   Sage Publications and, **4:1561**  
   special issues topics of, **4:1561**



- theory, research, and practice focuses of, **4:1561**  
 W. Bruce Walsh and, **4:1561, 4:1677**  
 Web site of, **4:1562**
- Journal of Career Development, 4:1562**  
*Journal of Career Education* precursor of, **4:1562**  
 life-span focus of, **4:1562**  
 Sage Publications and, **4:1562**  
 statement of purpose of, **4:1562**
- Journal of College Student Personnel, 4:1677*  
*Journal of Counseling and Development, 1:122*  
*Journal of Counseling Psychology, 1:22, 1:54, 1:129, 1:220, 1:376, 2:536, 2:616, 2:784, 2:925, 2:932, 2:939, 3:1006, 4:1677*
- Journal of Individual Psychology, 2:459*  
*Journal of Multicultural Counseling and Development, 3:1006*  
*Journal of Occupational Health Psychology, 4:1586*  
*Journal of the American Medical Association, 1:173*
- Journal of Vocational Behavior (JVB), 4:1563**  
 career interventions, career theory in, **4:1563**  
 Holland's theory of vocational personalities and work environments and, **4:1563**  
 individual vocational behavior focus of, **4:1563**  
 meta-analyses presented in, **4:1563**  
 Samuel Osipow and, **4:1563**  
 psychometric research in, **4:1563**  
 special issues of, **4:1563**  
 Howard Tinsley and, **4:1659, 4:1660**  
 vocational choice subjects in, **4:1563**  
 Web site, **4:1563**  
 work adjustment subjects in, **4:1563**
- Journal of Vocational Psychology, 4:1677*  
 JPI. *See* Jackson Personality Inventory (JPI)  
 JRA. *See* Juvenile rheumatoid arthritis (JRA)  
 Judge, Timothy, **1:257**  
 June, L., **1:432**
- Jung, Carl, 2:667–668**  
 archetypes and, **2:667**  
 autonomous, unconscious concept of, **2:667**  
 collective unconscious and, **2:667, 2:735**  
 compensation, synchronicity, individuation concepts and, **2:668, 2:735**  
 extraversion, introversion concepts of, **2:667, 2:723**  
 free association technique of, **2:667**  
 Freud's psychoanalytic theory and, **2:667, 2:761**  
 mid-life crisis concept of, **1:9**  
 occult experiences and, **2:667, 2:668**  
 shadow, anima, animus, Self archetypes and, **2:667**  
 superficial personal unconscious and, **2:667**  
 unconscious motivation and, **2:667**
- Juntunen, Cindy, **4:1457**
- Justice  
 ethical decision making and, **1:177, 1:183, 1:186, 1:192, 2:495**  
 online research and, **1:247**  
 virtue ethics and, **1:441**  
*See also* **Social justice**
- Juvenile rheumatoid arthritis (JRA), **1:75**
- JVB. *See* **Journal of Vocational Behavior (JVB)**
- JVIS. *See* **Jackson Vocational Interest Inventory (JVIS)**
- Kabat-Zinn, Jon, **2:511, 2:890**
- KABC-II. *See* Kaufman Assessment Battery for Children, Second Edition (KABC-II)
- Kadison, R., **1:432**
- Kagan, Norman, **1:130, 1:209, 1:406**
- Kahn, H., **3:1385, 3:1386**
- Kambon, Kobi K. K., **3:964, 3:1033, 3:1385**
- Kandel, Eric, **2:763**
- Kanner, Leo, **1:34**
- Kanter, Rosabeth Moss, **4:1681**
- Kaplan, Mordecai, **3:979**
- Karasek, Robert, **4:1586**
- Kardiner, Abram, **3:1110, 3:1296**
- Karenga, Maulana, **3:964, 3:1189**
- Kastenbaum, R. J., **1:150**
- Katz, Judith, **3:1373, 3:1375, 3:1380–1381**
- Kauffman, James, **1:158**
- Kauffman Adolescent and Adult Intelligence Test (KAIT), **2:498**
- Kaufman, Alan, **2:497, 2:498**
- Kaufman, Nadeen, **2:498**
- Kaufman Assessment Battery for Children, Second Edition (KABC-II)  
 CHC theory of cognitive abilities and, **2:498**  
 A. R. Luria's neuropsychological work and, **2:498**  
 for non-English speaking children and, **2:498**
- Kaufman Test of Educational Achievement, Second Edition (K-TEA II), **2:452**
- Kaul, Ted, **1:218**
- KCS. *See* **Kuder Career Search (KCS)**
- Keane, Terence M., **2:786**
- Keirsey Temperament Sorter, **2:727**
- Kell, B., **1:406**
- Keller, Fred S., **2:870**
- Keller, Heidi, **4:1475**
- Kelly, George  
 assimilation and accommodation interplay and, **2:744–745**  
 cognitive schemata and, **2:744**



- constructivist theory and, **2:523**  
 personality traits and, **2:736**  
 theory of personal constructs of, **2:744–745**  
 therapy expectations and, **2:593**  
 Kemmelmeier, Markus, **3:1169, 3:1178**  
 Kemp, J. E., **1:167**  
 Kempe, Henry, **1:71**  
 Kendrick Cognitive Tests for the Elderly, **4:1393**  
 Kennedy, John F.  
     Executive Order 10924 and, **3:1123**  
     hope of the '60s and, **4:1447**  
 Kennedy, Ruby Jo Reeves, **3:1001**  
 Keough, Kelli, **3:1339**  
 Kernberg, Otto, **2:555, 2:762**  
 Kich, George, **3:1028**  
 Kilbourne, Jean, **3:1317**  
 Kilburg, Richard, **1:257**  
 Kim, B. S. K., **3:1309**  
 Kim, S. K., **3:1130**  
 King, Martin Luther, Jr., **3:1047, 3:1127, 3:1238**  
 Kirby, John, **2:498**  
**Kitchener, Karen Strohm, 1:269–271**  
     childhood years of, **1:269**  
     cognitive development of students and, **1:269**  
     ethical decision-making model of, **1:184, 1:269**  
     ethics in counseling psychology and, **1:270, 1:271**  
     *The Foundations of Ethical Practice, Research, and Teaching in Psychology* written by, **1:270**  
     honors and awards received by, **1:270**  
     ill-structured problems and, **1:269**  
     intellectual development work of, **1:270**  
     *Principles of Biomedical Ethics* (Beauchamp and Childress) and, **1:270**  
     professional associations of, **1:270**  
     reflective judgment model work of, **1:269–270, 1:271**  
     therapeutic relationship and, **2:834, 2:836**  
     using groups in the classroom research of, **1:269**  
 Kitson, Harry Dexter, **4:1646**  
 Kitsuse, John, I., **2:523**  
 Kivlighan, Dennis M., **2:660, 2:904**  
 KKK. *See* Ku Klux Klan (KKK)  
 Klein, Melanie, **1:332, 2:735, 2:762**  
 Kluckhohn, Clyde, **3:1097**  
 Kluckhohn, F. R., **3:1384**  
 Kohlbert, Lawrence,  
     ethical decision-making models and, **1:184**  
     life span development work of, **1:125**  
 Kohut, Heinz, **2:555, 2:735, 2:762**  
 Koschler, M., **4:1469**  
 Kotic, A., **3:1310**  
 Kozol, Jonathan, **3:1056**  
 Kraepelin, Emil, **2:845**  
 Krane, Ryan, **4:1680**  
 Krausz, M., **4:1468**  
 Krieger, N., **3:1325**  
 Krieschok, Thomas, **4:1635**  
 Kroeber, A. L., **3:1097**  
**Krumboltz, John D., 4:1565–1566**  
     academic career of, **4:1565–1566**  
     beneficial chance events and, **4:1565**  
     Career Beliefs Inventory developed by, **4:1565**  
     DECIDES decision making model of, **2:787**  
     *Exploring Your Career Beliefs* workbook of, **4:1565**  
     honors and awards received by, **4:1565**  
     social learning theory of career  
         decision making and, **4:1565**  
         *See also* **Krumboltz happenstance learning theory**  
**Krumboltz happenstance learning theory, 4:1566–1568**  
     associative learning experiences and, **4:1566–1567**  
     beneficial chance events and, **4:1565, 4:1566–1567**  
     cultural and opportunity contexts and, **4:1566–1567**  
     “follow your bliss” concept and, **4:1567**  
     generalizations regarding interest and, **4:1567**  
     happenstance definition and, **4:1567**  
     instrumental learning experiences and, **4:1566**  
     social learning theory of career  
         decision making and, **4:1565**  
 K-TEA II. *See* Kaufman Test of Educational Achievement, Second Edition (K-TEA II)  
 Kübler-Ross, Elisabeth, **1:149, 1:150–151**  
**Kuder, Frederic, 4:1568–1569**  
     academic career of, **4:1568**  
     APA Division of Counseling Psychology co-founded by, **4:1569**  
     career assessment focus of, **4:1407**  
     James McKeen Cattell and, **4:1568**  
     *Educational and Psychological Measurement* journal and, **4:1569**  
     honors and awards received by, **4:1569**  
     internal consistency underlying content scales and, **4:1407**  
     Kuder Career Search developed by, **4:1568–1569**  
     Kuder Interest Inventory and, **4:143, 4:1511**  
     Kuder Preference Records and, **4:1568, 4:1603**  
     Occupational Preference record developed by, **4:1568**  
     occupation and person matching and, **4:1603**  
     personality inventory work of, **4:1568**  
     *Personal Psychology* journal and, **4:1569**  
     test development work of, **4:1568**  
     vocational assessment paper of, **4:1568–1569**



**Kuder Career Search (KCS), 4:1569–1570**

- development history of, 4:1568–1569
- Holland's RIASEC Model and, 4:1599
- individual and group applications of, 4:1569
- interpretation of, 4:1570
- job sketches of, 4:1570, 4:1603
- Kuder Career Clusters scale of, 4:1569, 4:1570
- Kuder Interest Inventory and, 4:1511
- Kuder Preference Records and, 4:1568, 4:1569, 4:1603
- Kuder Skills Assessment and, 4:1569
- Occupational Outlook Handbook* of, 4:1570
- occupation and person matching and, 4:1603
- on-line availability of, 4:1569
- Person Match scale of, 4:1569, 4:1603
- ranks vs. scores format of, 4:1569
- Super's Work Values Inventory, 4:1569, 4:1687
- Web site of, 4:1570, 4:1687

Ku Klux Klan (KKK), 3:1240

Kulpe, Oswald, 2:593

**Kwanzaa, 3:1189–1190**

- African cultural worldview and, 3:1035
- Black value system and, 3:1189
- commitments made and kept focus of, 3:1189
- cultural and political emphasis of, 3:1189
- Maulana Karenga and, 3:1189
- Nguzo Saba and, 3:1189–1190

Ladany, Nicholas, 1:219, 3:1286

Ladd-Franklin, Christine, 1:370

LaFleur, N. Kenneth, 3:1288

**LaFromboise, Teresa Davis, 3:1191–1192**

- academic career of, 3:1191
- American Indian adolescent suicide prevention work of, 3:1191
- American Indian Life Skills Development program of, 3:1191
- Donald Ray Atkinson and, 3:1007
- bicultural competence theory of, 3:1230–1231, 3:1251
- honors and awards received by, 3:1192
- resilience and positive youth development work of, 3:1192
- second culture acquisition work of, 3:1230

Lai, W. E. M., 3:1311

Lamb, D., 1:249–250

Lambert, Michael, 1:174, 2:712, 2:921

Landrine, Hope, 3:1316

**Language difficulties, clinical assessment of, 2:669–671**

- birth to age three and, 2:669–670
- early childhood and, 2:670
- school age and, 2:670–671

adulthood and, 2:671

autism/Asperger's syndrome and, 1:34–36

Boston Diagnostic Aphasia Examination, 2:671

Clinical Evaluation of Language Fundamentals, 2:670

Cognitive Linguistic Quick Test, 2:671

communication defined, 2:669

Denver Developmental Screening Test, 2:670

Expressive Vocabulary Test, 2:670

formal vs. informal assessments and, 2:670

grammar, morphology, semantics, pragmatics domains of, 2:670

Illinois Test of Psychological Abilities, 2:670

importance of, 2:671

Individual Family Service Plan and, 2:669

language defined, 2:669

McArthur Communicative Developmental Inventories, 2:670

neurological impairment and, 2:671

nonverbal, vocal, verbal communication

terms and, 2:669

Preschool Language Scale, 2:670

Receptive-Expressive Emergent Language Test, 2:670

response to intervention school protocol and, 2:670

Rossetti Infant and Toddler Language Scale, 2:669–670

Ross Information Processing Assessment, 2:671

Sequenced Inventory of Communication Development, 2:670

speech defined, 2:669

speech-language pathologist and, 2:669–670

vocabulary tests and, 2:670

Western Aphasia Battery, 2:671

Woodcock Language Proficiency Battery, 2:670

Language learning disorder. *See* **Learning disorders (LD)**

Lassiter, K., 1:408

Latack, J. C., 4:1556

Latané, Bibb, 3:1099

Latency recording behavioral observation method, 1:40

Latino Professional Network, 3:992

**Latinos, 3:1192–1198**

Acculturation Rating Scale for Mexican Americans (ARSMA) and, 3:943

acculturative stress of, 3:1193

achievement gap and, 3:952–955, 3:1194

age of population changes and, 3:1112

Bidimensional Acculturation Scale (BAS) and, 3:943, 3:1003

Brown Berets and, 3:1048

career counseling for, 4:1453–1456

Jesús Manuel Casas and, 3:1043–1045



- César Chávez and, 3:1048
- Chicana feminists, oppression and, 3:1246
- civil rights struggle of, 3:1048–1049
- client–therapist ethnic matching and, 3:945
- collectivistic culture of, 3:1060, 3:1195
- connectedness with others and, 3:1196
- counselor’s value system and, 3:1195
- cultural barrier theory and, 3:1194–1195
- culturally relevant mental health service for, 3:1195–1198
- cultural paranoia of, 3:962
- cultural psychoeducation issues and, 2:801
- cultural values of, 3:1096, 3:1100, 3:1195–1198
- demographics of, 3:1111
- Dios quiere* cultural value of, 3:1101
- discrimination and racism experienced by, 3:1193, 4:1634
- educational and employment figures of, 3:1194
- education statistics regarding, 3:1328
- extended family experience of, 2:801, 3:1101
- familismo* cultural value of, 3:1101, 3:1195–1196
- fatalismo vs. fatalism and, 3:1150
- filial piety and, 3:1151
- folk illnesses, folk healers and, 3:1197
- health disparities of, 3:1194
- heterogeneity of, 3:1048, 3:1101
- Hispanics term and, 3:1192
- household, family structure demographics and, 3:1112
- household and family demographics of, 3:1112
- institutional barrier theory and, 3:1194
- intelligence tests and, 3:1180
- interpersonal conflict avoidance and, 3:1196
- interracial marriages and, 3:1234
- language “brokering” by children and, 3:1193
- Latino/a critical race studies and, 3:1074–1075
- machismo vs. marianismo cultural value and, 3:1196, 3:1207–1208
- mental health needs of, 3:1112, 3:1193–1194
- mental health services and, 3:1194–1195
- multicultural counseling and, 2:539
- National Latina/o Psychological Association and, 3:1242–1243
- negative health outcomes of, 3:943–944
- negative life circumstances faced by, 3:1193
- personalismo* cultural value of, 3:1101, 3:1196
- population statistics regarding, 3:1193
- poverty and, 3:1193–1194, 3:1265
- Puerto Rican voting rights and, 3:1048–1049
- racial identity of, 3:1289
- religiosity and, 3:1197
- respect of elderly and, 3:1272
- respeto* cultural value of, 3:1101, 3:1196
- Santería and, 3:1307–1309
- simpatia* cultural value of, 3:1101, 3:1196
- substance abuse figures regarding, 3:1194
- underutilization of counseling services by, 3:1157, 3:1192, 3:1194–1195
- United Farm Workers, 3:1048
- Melba J. T. Vasquez and, 1:439–441
- Western-based services adjustment and, 3:1198
- within-group diversity of, 3:1192–1193
- See also Career counseling, Latinos; Mexican Americans*
- Law for the Prevention of Genetically Diseased Offspring (Nazi Germany), 1:193
- Lawler-Row, Kathleen A., 2:606
- Layton, Wilbur L., 4:1641
- Lazarus, Arnold A.
- cognitive-behavior therapy, techniques and, 2:506–507, 2:541
- multimodal therapy work of, 2:542, 2:648
- Lazarus, Richard
- acculturative stress and, 3:946–947
- cognitive changes during stress process and, 2:883, 2:886, 3:946–947
- coping process and, 1:59, 1:399, 2:527, 3:946–947
- LC. *See Low-context communication (LC)*
- LD. *See Learning disorders (LD)*
- Leach, Colin Wayne, 3:1064
- Leach, Mark M., 3:1288
- Lead exposure, 1:49
- Learned helplessness, 3:1198–1200**
- abuse victims and, 2:443–444
- definition of, 3:1198–1199
- depression and, 2:869
- development of the concept and, 3:1199
- explanatory style concept and, 3:1200
- extension of the concept to humans and, 3:1199–1200
- fatalism and, 3:1150
- institutionalized racism and, 3:1199
- internality, stability, globality components of explanatory style and, 3:1200
- racial microaggressions stimuli and, 3:1199
- repeated exposure to negative stimuli and, 3:1198–1199
- Martin Seligman’s work on, 2:869, 3:1199–1200
- symptoms of, 3:1200
- understanding responses to oppression and, 3:1199



**Learning disorders (LD), 1:273–278**

- AD/HD comorbidity with, **1:31, 1:49, 1:157**
- adolescent age learning disorders, counselor implications of, **1:277–278**
- Alaska Natives and, **3:969**
- Behavior Rating Scale of Executive Function (BRIEF) and, **1:49**
- college age learning disorders, counselor implications of, **1:278**
- comorbidity of, **1:157**
- conduct disorder and, **1:100, 1:157**
- counseling psychology application examples and, **1:273–274**
- defining and “diagnosis” of, **1:157–158**
- depressive disorder with, **1:157**
- elementary age learning disorders, counselor implications and, **1:277**
- explanation of, **1:273**
- language deficit type and, **1:273, 1:274–275**
- language learning disorder, adolescent age and, **1:278**
- language learning disorder, college age and, **1:278**
- language learning disorder, elementary age, **1:277**
- language learning disorder, social, behavioral, emotional aspects of, **1:276**
- memory deficit type and, **1:273, 1:274**
- memory learning disorder, adolescent age and, **1:277**
- memory learning disorder, college age and, **1:278**
- memory learning disorder, elementary age, **1:277**
- memory learning disorder, social, behavioral, emotional aspects of, **1:275–276**
- nonverbal learning disorder, adolescent age and, **1:278**
- nonverbal learning disorder, college age and, **1:278**
- nonverbal learning disorders, elementary age, **1:277**
- nonverbal learning disorders, social, behavioral, emotional aspects of, **1:276–277**
- nonverbal learning type and, **1:273, 1:275**
- ODD and, **1:317**
- oppositional defiant disorder with, **1:157**
- primary late effects of, **1:273**
- secondary effects of, **1:273**
- vocational, social, emotion, marital problems associated with, **1:273**

*See also* **Developmental disorders**

- Learning theory, **1:220**
- Leavitt, Frank, **4:1446**
- LeBlanc, Michael, **1:333**
- Lee, Szu-Hui, **3:995**
- Lee-Borden, N., **1:132, 1:406**

**Legal issues in parenting, 1:278–281**

- adoption and, **1:279–280**
- child maltreatment and, **1:69–74**
- custody and, **1:205, 1:279**
- forensic counseling application and, **1:214–216**
- individual adoption and, **1:279**
- international adoption and, **1:280**
- joint adoption and, **1:280**
- legal custody vs. physical custody and, **1:279**
- parental rights termination and, **1:280**
- rights and responsibilities of parents in, **1:280**
- second-parent adoption and, **1:280**
- sole legal custody vs. joint legal custody and, **1:279**
- sole vs. joint vs. bird’s nest physical custody and, **1:279**
- unmarried couples and, **1:280**
- visitation schedule and, **1:279**

Legal privilege. *See* **Confidentiality and legal privilege**

Leibing, Eric, **2:733**

Leichsenring, Falk, **2:733**

**Leisure, 2:671–675**

- applications of leisure psychology to counseling and, **2:675**
- attributes of, **2:672**
- constraints and affordances of, **2:674**
- Csikszentmihalyi’s theory of flow experiences and, **2:551, 2:662, 2:672, 2:774**
- Mihaly Csikszentmihalyi’s work in, **2:551, 2:774**
- exercise and sport psychology, **1:194–197**
- freedom of choice and, **2:672–673**
- future directions and, **2:675**
- illusion of control and, **2:672–673**
- intrapersonal, structural, interpersonal constraints and, **2:674**
- intrinsic motivation and, **2:672, 2:673**
- involvement and, **2:674**
- leisure psychology and, **2:774**
- Maslow’s theory of peak experiences and, **2:672**
- McDowell’s theory of leisure consciousness and, **2:672**
- Noble’s theory of transcendent religious and meditation experiences and, **2:672**
- optimal arousal and, **2:673–674**
- person-environment interaction model and, **2:774**
- The Psychology of Leisure* (Neulinger) and, **2:672**
- psychosocial benefits of, **2:674–675**
- reactance to freedom threats and, **2:673**
- Tinsley’s theory of transcendent leisure experience and, **2:672, 2:774, 4:1659–1660**

Lent, Ellen, **4:1635**

Lent, Robert W., **4:1627, 4:1635**



- Leondar-Wright, Betsy, **3:1054**
- Leong, Frederick T. L., 3:1200–1202**  
 academic work of, **3:1200–1201**  
 APA work of, **1:265, 3:1201–1202**  
 Asian American Psychological Association  
 work of, **3:1201**  
 books and publications written by, **3:1087**  
*The Counseling Psychologist* and, **1:263**  
 cultural accommodation process and, **3:1086**  
 honors and awards received by, **3:1202**  
 integrative-sequential framework  
 developed by, **4:1577**  
 International Association of Applied Psychology  
 (IAAP) and, **1:265**  
 internationalizing of counseling and psychology focus  
 of, **1:263, 1:264, 1:265, 3:1202**  
 professional associations of, **3:1201**  
 psychological research validity errors and, **3:1386**  
 research focuses of, **3:1202**
- Lepper, Mark R., **2:673**
- Lerner, R. M., **4:1679**
- Lesbian therapy. *See* **Gay, lesbian, and bisexual therapy (GLB)**
- Lester, Juliet, **4:1448**
- Leung, S. A., **1:263–264**
- Levenson, Hanna, **3:1204**
- Leventhal, Howard, **1:426**
- Levinson, D., **1:9**
- Levy, David, **1:332**
- Lewin, Kurt, **1:91, 2:593, 4:1601**
- Licensed Rehabilitation Counselor (LRC)  
 credential, **2:831**
- Lichtenberg, Jim, **2:892**
- Life Engagement Scales, **4:1408–1409**
- Life-role balance, 4:1571–1573**  
 Brown's values-based career theory and, **4:1415–1416**  
 career development interactions with, **4:1571–1572**  
 career interventions and, **4:1572–1573**  
 career/life paradigm and, **4:1488–1490**  
 challenges to, **4:1571**  
 definition of, **4:1571**  
 family genogram tool and, **4:1572–1573**  
 life-role conflict realities and, **4:1571**  
 life-role identity development and, **4:1572–1573**  
 life-role models, expectations and, **4:1572**  
 self-awareness importance and, **4:1571–1572**  
 Donald Super's life career rainbow  
 concept and, **4:1572**  
 work-family balance and, **4:1680–1684**  
 work stress and, **4:1684–1686**
- Life transitions, 2:676–681**  
 of childhood, **2:678**  
 to adulthood, **2:678–680**  
 of midlife and beyond, **2:680–681**  
 acute vs. chronic stressors and, **2:677**  
 adolescent limited delinquency and, **2:676**  
 adults in transition and, **4:1401–1404**  
 aging and, **1:14–17**  
 attachment theory and, **4:1411**  
 career/life paradigm and, **4:1488–1490**  
 caregiving roles and, **2:681**  
 cross-cultural research on, **3:1084**  
 definition of, **2:676**  
 developmental counseling and  
 therapy and, **2:561–568**  
 of disadvantaged youth, **2:679**  
 divorce and, **2:679**  
 dying well concept and, **2:681**  
 empty nest phase and, **2:680**  
 family moves and, **2:678**  
 to higher education, **2:679**  
 from home to school, **2:678**  
 life course transitions and, **2:676–677**  
 midlife crisis and, **2:680**  
 normative times and sequences factors of, **2:676**  
 parenthood and, **2:679–680**  
 personal, social stress buffer resources and, **2:677**  
 puberty and, **2:678**  
 resilience factors and, **2:677**  
 retirement and, **1:371–375, 2:680–681**  
 Carol D. Ryff's work in, **2:842–843**  
 social contexts of, **2:676**  
 stress coping strategies and, **2:677**  
 stress process and, **2:677–678**  
 successful aging and, **2:681**  
 trajectories and, **2:676**  
 turning points within the life course and, **2:676**  
*See also* **Counseling the elderly**
- Lilienfeld, Scott, **2:627, 2:628**
- Lincoln, Abraham, **3:1375**
- Lindeman, Richard, **4:1400**
- Lindemann, Erich, **1:51, 2:545**
- Linehan, Marsha, **1:300, 2:758**
- Linton, R., **3:947**
- Littrell, J. M., **1:132, 1:406**
- Liu, William M., **3:1329**
- Live observation feedback in counseling  
 training, **1:208**
- Lloyd, John, **1:158**
- Locke, Edwin, **1:257**



Locke, John, **3:1177**

**Locus of control, 3:1203–1205**

Asian American career counseling and, **4:1441–1442**  
 attributions and, **3:1204**  
 causal attributions and, **2:745, 2:854, 2:869**  
 Eurocentric worldview and, **3:1203, 3:1204**  
 expectancy and, **3:1204**  
 fatalism and, **3:1150**  
 health or illness outcomes and, **2:745**  
 history of, **3:1204**  
 individualistic vs. collectivistic worldviews and, **3:1203–1204**  
 internal vs. external locus of control and, **2:745, 3:1046, 3:1150, 3:1203**  
 Locus of Control scale and, **2:727**  
 multicultural considerations of, **3:1203–1204**  
 multicultural education and, **3:1223**  
 related perspectives on, **3:1204**  
 Julian Rotter's work in, **2:745**  
 self-efficacy and, **3:1204**  
 stress coping strategy and, **2:885**

**Lofquist, Lloyd Henry, 2:773, 2:939, 4:1573–1574**

Donald Paterson and, **4:1573, 4:1655**  
 professional associations of, **4:1574**  
 published work of, **4:1573**  
 theory of work adjustment of, **4:1573**  
 Henry Tinsley and, **4:1659**  
 trait-and-factor matching model and, **4:1655**  
 vocational rehabilitation focus of, **4:1573**  
 Edward G. Williamson and, **4:1678**  
 Work Adjustment Project and, **4:1521, 4:1522, 4:1573, 4:1655–1657**

Loganbill, Carol, **1:132, 1:407**

Logical positivism, **1:364–365**

Lonner, W. J., **1:419**

Lonner, Walter J., **3:1081**

Lookism, definition of, **2:574**

Lopez, Fred, **2:892**

Lorant, Vincent, **3:1329**

Lorde, Audre, **3:1049, 3:1314, 3:1318**

Lorenz, J. A., **1:132, 1:406**

Lorig, Kate, **1:82**

**Loss of face, 3:1205**

Asian American career counseling and, **4:1435, 4:1442**  
 Asian collectivistic culture and, **3:1205**  
 counseling implications of, **3:1205**  
 filial piety and, **3:1151**  
 restoration of, **3:1205**  
 social impact of, **3:1205**

Lott, Bernice, **3:1055–1056, 3:1329**

*Loving v. Virginia*, **3:1183, 3:1184, 3:1233**

**Low-context communication (LC), 3:1206**

contexting process and, **3:1206**  
 cultural factors in, **3:1206**  
 cultures adept at, **3:1206**  
 direct, precise, open messages of, **3:1206**  
 explicit communicated speech and, **3:1206**  
 high-context communication and, **3:1158–1159**  
 symbolic representation patterns in, **3:1206**

Lowell, Edgar, **2:793**

**Low-incidence disabilities, 1:281–283**

American Sign Language and, **1:282**  
 in children, **1:76**  
 communication and, **1:282**  
 cultural perspective on, **1:282**  
 deaf-blind and, **1:282**  
 deaf/hard of hearing and, **1:281**  
 definition of, **1:281**  
 developmental perspective on, **1:282–283**  
 ecological perspective on, **1:283**  
 interpreter use and, **1:282**  
 legal blindness and, **1:282**  
 socialization difficulties and, **1:282–283**  
 visual acuity and, **1:281–282**  
 visual impairment/blindness and, **1:281–282**  
 Web site regarding, **1:283**

*See also* **Persons with disabilities**

LRC. *See* Licensed Rehabilitation Counselor (LRC) credential

Lubinski, D., **2:654 (figure), 2:655 (figure), 2:904, 4:1397**

Luborsky, Lester, **1:175, 2:930**

Luce, Carolyn, **4:1683**

Luckasson, Ruth, **1:157**

Lui, Meizhu, **3:1372**

Luna, J., **4:1455**

Luria, A. R., **2:498**

Lustina, Michael, **3:1339**

MAB. *See* Multidimensional Aptitude Battery (MAB)

MAC. *See* Master Addictions Counselor (MAC)

Maccoby, E. E., **1:325**

**Machismo, 3:1207–1208**

counseling implications of, **3:1196–1197, 3:1208**  
 hembrismo and, **3:1207, 3:1208**  
 marianismo and, **3:1196–1197, 3:1207**  
 negative set of hypermasculine Latin male behaviors and, **3:1207**  
 negative synonymous terminology and, **3:1207**



- positive dimensions of, **3**:1207–1208  
 White American male masculinity and, **3**:1207
- MacKinnon, Catharine, **3**:1315
- Maddi, Salvatore R., **2**:889
- Mael, F. A., **4**:1414
- Mahler, Margaret, **2**:735, **2**:762
- Mahoney, Michael, **3**:1006
- Major depressive disorder (MDD). *See* **Depression**
- Making an Issue of Child Abuse* (American Humane Association), **1**:71
- Making Better Career Decisions systems (MBCD), **4**:1481, **4**:1607
- Making Vocational Choices* (Holland), **4**:1536, **4**:1545, **4**:1546
- Malcolm X, **3**:1048, **3**:1127
- Malgady, Robert G., **2**:524
- Mallen, M. J., **1**:171
- Mandela, Nelson, **3**:1127
- Manic depressive disorder. *See* **Bipolar disorder**
- Mann, Horace, **1**:121
- Manpower Development and Training Act (1962), **4**:1447
- March on Washington (1963), **3**:1238
- Marcia, James E., **3**:1164–1165, **4**:1464
- Margolin, Gayla, **3**:1006
- Marianismo, 3:1208–1209**  
 counseling implications of, **3**:1196–1197, **3**:1209  
 hembrismo and, **3**:1208, **3**:1209  
 machismo and, **3**:1196–1197, **3**:1207–1208  
 purity, denial, devotion to motherhood and, **3**:1208  
 Virgin Mary and, **3**:1196, **3**:1207, **3**:1208
- Marinangeli, Maria Grazi, **2**:732
- Marital counseling. *See* **Couple and marital counseling**
- The Mark of Oppression* (Kardiner and Ovesey), **3**:1110
- Marlow-Crown Social Desirability scale, **2**:879
- Marsella, Anthony J., 3:1209–1211**  
 childhood of, **3**:1210  
 cultural variations in behavior focus of, **3**:1210  
 cultural variations in psychopathology work of, **3**:1209, **3**:1210–1211  
 global problems focus of, **3**:1209–1210  
 internationalization of psychology curriculum and, **3**:1209  
 Italian-American Psychology Assembly and, **3**:1210  
 publications of, **3**:1211  
 Transcultural Mental Health Code and, **3**:1211  
 Western ethnocentricity challenged by, **3**:1209  
 worldview assessment and, **3**:1386
- Marsh, Herbert, **2**:861
- Marshall, Thurgood, **3**:1238
- Martin, J. A., **1**:325
- Martin, Jack, **2**:920
- MAS. *See* Memory Assessment Scale (MAS)
- Mascher, M., **3**:1280
- Maslow, Abraham, **1**:9  
 hierarchy of needs, motivation and, **1**:256, **2**:736, **2**:803, **4**:1615  
 humanistic counseling theory, behavioral counseling work of, **1**:124, **2**:736, **2**:782  
 self-actualization focus of, **2**:803  
 theory of peak experiences and, **2**:672
- MAST. *See* Michigan Alcoholism Screening Test (MAST)
- Master Addictions Counselor (MAC), **1**:142–143
- Masters, Kevin S., **2**:712
- Mathematics disorder, **1**:159–160
- Matsuda, Mari, **3**:1074
- May, Rollo, **2**:736, **2**:782
- MBCD. *See* Making Better Career Decisions systems (MBCD)
- MBCT. *See* Mindfulness-based cognitive therapy (MBCT)
- Mbiti, John, **3**:964
- MBSR. *See* Mindfulness based stress reduction (MBSR)
- MBTI. *See* Myers-Briggs Type Indicator (MBTI)
- McAdams, Dan P., **2**:737, **3**:1166–1167
- McArthur Communicative Developmental Inventories, **2**:670
- McArthur Foundation National Survey of Midlife Development, **3**:1112
- MCCC. *See* **Multicultural Career Counseling Checklist** (MCCC)
- McClelland, David, **2**:793
- McCormick, Rod M., **4**:1457
- McCougall, William, **2**:752
- McCrae, Robert R. *See* **Costa, Paul T. and McCrae, Robert R.**
- McCullough, James P., **2**:514
- McDavis, Roderick J., **1**:126, **1**:383, **4**:1639
- McDowell, Chester F., **2**:672
- McFall, Miles, **1**:88–89
- McGlothlin, J. M., **1**:8
- McIntosh, Peggy, **3**:1374, **3**:1375
- McKay, Gary, **1**:327, **2**:458
- McKee-Ryan, F. M., **4**:1556
- McKillip, R., **4**:1535
- McMahon, Mary, **4**:1465
- McMahon, Robert, **1**:326
- McMain, Shelly, **2**:923
- MCMI. *See* Millon Clinical Multiaxial Inventory (MCMI)
- MCMI-III. *See* Millon Clinical Multiaxial Inventory-III (MCMI-III)
- McNeill, B., **1**:407



McPherson, Robert, **1:105**

MDD (major depressive disorder). *See* **Depression**

Mead, George Herbert, **2:858, 4:1398**

Mead, Margaret, **1:203**

**Meaning, creation of, 2:683–684**

constructivist theory and, **2:522–524**

coping and, **2:526–530**

meaning making and, **2:485–486, 2:523**

perceptual, affective, cognitive processes of, **2:683**

psychotherapy example of, **2:683**

Mechanical Aptitude Test, **2:449**

**Mediation, 1:285–286**

benefits of, **1:285**

definition of, **1:285**

interests component of, **1:286**

issues component of, **1:285–286**

judge or arbitrator as final decision maker and, **1:285**

litigation vs., **1:285**

negotiation and, **1:285**

neutrality concept and, **1:285**

positions component of, **1:286**

reframing positions and, **1:286**

specialized training of, **1:286**

stages of, **1:285**

Medical Career Development Inventory, **4:1673**

**Medication adherence, 1:286–288**

cognitive function factor in, **1:287**

definition of, **1:286**

external support and, **1:287**

factors affecting, **1:286–287**

health belief model and, **1:287**

importance of, **1:287–288**

interventions to improve, **1:288**

passive vs. active prompts and, **1:287**

person beliefs and, **1:287**

person characteristics and, **1:287**

regimen complexity factor in, **1:287**

treatment characteristics and, **1:287**

**Meehl, Paul E., 1:173, 2:684–686**

applied psychology work of, **2:684**

*Clinical Versus Statistical Prediction*

written by, **2:685**

cliometric metatheory and, **2:685**

limitations of assessment information and, **2:814**

limitations of clinical experience and, **2:685, 2:905**

limitations of scientific research and, **2:685–686**

measurement theory contributions of, **2:684**

postpositivist philosophy of science and, **2:684, 2:686**

practice, science and, **2:686**

schizotaxia theory of, **2:684**

Meichenbaum, Donald, **2:503, 2:505, 2:510–511, 2:541**

Meier Art Tests of artistic aptitude, **2:450**

Mejia, B., **4:1455**

Melting pot concept

assimilation model of acculturation and, **3:942, 3:1001, 3:1019, 3:1120, 3:1251**

discrimination experiences and, **3:942, 3:1120**

diversity conceptualization and, **3:1120**

inaccuracy of, **3:942, 3:1251**

“triple melting pot” theory of, **3:1001**

Melzack, R., **1:84–85**

**Memory, assessment of, 2:686–689**

ability to access established memories and, **2:687–688**

ability to form new memories and, **2:687**

Cambridge Behaviour Prospective Memory Test (CBPMT) and, **2:688**

Comprehensive Assessment of Prospective Memory (CAPM) and, **2:688**

Corsi Block Test and, **2:687**

Everyday Memory Questionnaire and, **2:688**

factors influencing assessment and, **2:689**

false memories and, **2:601–603, 2:629–630**

immediate memory and, **2:686–687**

Inventory of Memory Experiences and, **2:688**

long-term episodic memory and, **2:687–688**

long-term semantic memory and, **2:688**

memory assessment batteries and, **2:688–689**

Memory Assessment Scale (MAS) and, **2:689**

memory span test and, **2:687**

prospective memory and, **2:688**

questionnaire methods of, **2:688**

Recognition Memory Test (RMT) and, **2:689**

Rivermead Behavioural Memory Test (TBMT) and, **2:689**

short-term memory and, **2:686–687**

simple vs. complex memory span tasks and, **2:687**

skill learning, implicit memory and, **2:688**

verbal vs. visual simple memory span and, **2:687**

Wechsler Memory Scale—Third Edition (WMS-III) and, **2:687, 2:689**

working memory and, **2:687**

Memory Assessment Scale (MAS), **2:689**

Memory learning disorder. *See* **Learning disorders (LD)**

Mental Health Intensive Case Management (MHICM) VA program, **1:154**

**Mental health issues in the schools, 1:288–294**

AD/HD and, **1:27–34**

best practice in school-based mental health,

principles of, **1:293** (table)

community collaboration and, **1:289**



- “community science” multidisciplinary field  
 concept and, 1:292  
 conceptual clarity regarding, 1:289  
 conceptual framework to promote school-based mental  
 health and, 1:290 (figure)  
 desired outcomes of, 1:289  
 expanded school mental health concept and, 1:289  
 future directions in, 1:292–293  
 in-depth understanding of schools and, 1:291  
 initiatives to promote, 1:288–289  
 integration of mental health and education  
 systems and, 1:291–292  
 international advocacy groups and, 1:291  
 population-focused mental health promotion  
 and, 1:289–291  
 practice-based evidence and, 1:292  
 President’s New Freedom Commission on  
 Mental Health and, 1:155, 1:288, 1:289,  
 1:293, 2:849, 3:994  
 preventive and mental health promotion efforts and,  
 1:290–291  
 prioritizing preventive services and, 1:289–291  
 program integration strategies and, 1:291–292  
 quality assessment and improvement programming  
 research and, 1:292, 1:293 (table)  
 school counseling and, 1:381–384  
 school psychology and, 1:384–387  
 strengthening research base and, 1:292
- Mental retardation and developmental  
 disabilities, 1:294–296**  
 adaptive behavior testing and, 2:455–457  
 adaptive functioning level and, 1:295  
 autism/Asperger’s syndrome and, 1:34–36  
 caregiver issues and, 1:296  
 causes of, 1:295  
 cognitive and adaptive functioning  
 deficits and, 1:294  
 communication skills level and, 1:295  
 daily living skills level and, 1:295  
 disabled career counseling and, 4:1434–1435  
*DSM-IV-R* diagnostic criteria of, 1:294–295  
 environmental causes of, 1:295  
 genetic, chromosomal disorders cause of, 1:295  
 low-incidence disabilities and, 1:281–283  
 mental illness discrimination and, 3:1118  
*Mental Retardation: Definition, Classification, and  
 Systems of Supports, Tenth Edition* (AAMR)  
 and, 1:294  
 morbidity of, 1:295  
 skills-based component in definition of, 1:295
- Stanford-Binet Intelligence Scales and, 1:294  
 treatment interventions and, 1:295–296  
 Wechsler Adult Intelligence Scale and, 1:294  
*See also Low-incidence disabilities; Persons with  
 disabilities*
- Mental Status Examination (MSE), 2:689–690**  
 components of, 2:690  
 memory assessment and, 2:686–689  
 mental retardation measurement and, 1:294–295  
 Mental Status Checklist for Adults, 2:690  
 Mental Status Checklist for Children, 2:690  
 narrative vs. checklist format of, 2:690  
 psychosocial history with, 2:690
- Mentoring, 1:296–299**  
 artisans’ guilds and, 1:297  
 benefits and costs of, 1:298  
 definition of, 1:296  
 formal to informal continuum of, 1:297  
 Bruce Fretz and, 1:216–217  
 Homer’s *Odyssey* and, 1:297  
 mentoring relationship defined and, 1:296–297  
 mentor roles, functions and, 1:298  
 psychosocial and career mentor functions and, 1:298  
 relationship stages of, 1:297–298  
 Helen J. Roehlke and, 1:375–377
- MESRI. *See* Minnesota Employment Stabilization  
 Research Institute (MESRI)
- Messina, Elizabeth, 3:1210
- Metaphors, use of, 2:690–691**  
 aptness and salience of, 2:691  
 client’s use of, 2:690  
 counselor’s use of, 2:690  
 definition of, 2:690  
 metaphor and counseling, 2:690  
 visual images from, 2:691  
 working with, 2:691
- Metropolitan Applied Research Center, 3:1051
- Mexican Americans  
 acculturation mental health issues and, 3:943  
 Acculturation Rating Scale for Mexican Americans  
 (ARSMA) and, 3:943  
 deficit hypothesis and, 3:1109  
 folk healers of, 3:1197  
 group assimilation regarding, 3:1002  
 mental health care needs statistics of, 3:1112  
 statistics regarding, 3:1193  
 United Farm Workers and, 3:1048  
 women career model and, 4:1455  
*See also Latinos*
- Mfume, Kweisi, 3:1239



MHICM. *See* Mental Health Intensive Case Management (MHICM) VA program

Michigan Alcoholism Screening Test (MAST), **2:896**

Milgram, Stanley, **1:190–191**

Miller, Anna, **4:1658**

Miller, Jean Baker, **3:1317**

Miller, Kenneth E., **2:1300**

Miller, Neal E., **2:541, 2:735**

behavioral personality theory of, **2:739**

behaviorism, psychoanalysis reconciliation and, **2:737**

conflict of response hierarchies and, **2:739–740**

critical training periods concept of, **2:740**

environmental cues and, **2:739**

external vs. internal drives and, **2:739**

Sigmund Freud's influence on, **2:739–740**

frustration-aggression hypothesis of, **2:740**

Miller, Scott, **2:647**

Miller-Tiedeman, Anna, **4:1658**

Millon Clinical Multiaxial Inventory (MCMI), **1:188**

Millon Clinical Multiaxial Inventory-III

(MCMI-III), **1:420**

Anxiety Clinical Scale, **2:461**

Axis I and II scales of, **2:812**

“base rates” reliance of, **2:813**

custody evaluation using, **1:147**

depression-related scales, **2:463**

*DSM-IV-TR* diagnostic categories and, **2:812, 2:813**

Hypomania Clinical Scale of, **2:464**

Millon's personality theory and, **2:812–813**

Modifying indexes of, **2:812**

translation, adaptation of, **1:420**

Mills, Sara, **3:1264**

### **Mindfulness, 1:299–300**

absence of confusion and, **1:300**

attention to the breath and, **1:299**

Buddhism meditative practice and, **1:299**

capacity to enjoy peace and, **1:300**

counseling and health applications and, **1:300**

dialectical behavior therapy (DBT) and, **1:300**

mindfulness-based cognitive theory

(MBCT) and, **2:511**

mindfulness-based stress reduction and, **1:300, 2:890**

observations of the present moment and, **1:299**

out of the moment living and, **1:299**

Mindfulness-based cognitive therapy (MBCT), **2:511**

Mindfulness based stress reduction (MBSR), **2:511**

*A Mind That Found Itself* (Beers), **1:121**

Minimal brain dysfunction. *See* **Attention**

**deficit/hyperactivity disorder (AD/HD)**

Minnesota Clerical Test and, **4:1656**

Minnesota Employment Stabilization Research Institute (MESRI), **4:1430, 4:1663–1664, 4:1677–1678**

**Minnesota Importance Questionnaire (MIQ),**

**4:1575–1576**

René Villaneuva Dawis and, **4:1521**

*MIQ Manual* of, **4:1575**

MIQ Report of, **4:1575–1576**

self-report format of, **4:1575**

Theory of Work Adjustment (TWA) and, **4:1656**

trait-factor counseling and, **4:1664**

Vocational Psychology Research scoring of, **4:1575**

work needs measured by, **4:1575**

work values measured by, **4:1575**

Minnesota Job Description Questionnaire

(MJDQ), **4:1656**

Minnesota Multiphasic Personality Inventory

(MMPI), **4:1664**

Minnesota Multiphasic Personality Inventory-Adolescent

(MMPI-A)

computer analysis of data from, **2:515**

conduct disorder and, **1:100**

translated, adapted versions of, **1:420, 3:1084**

Minnesota Multiphasic Personality Inventory-2

(MMPI-2), **2:701**

anxiety-related scales of, **2:461**

Bipolar: mania scale of, **2:464**

computerized administration, interpretation of, **1:188**

content-based and supplementary scales of, **2:812**

Cook-Medley hostility scale of, **2:464**

cross-cultural validity of, **2:461**

custody evaluation using, **1:147**

Depression-related scales of, **2:462, 2:559**

disadvantages of, **2:812**

interpretation strategies for, **2:812**

Megargee's overcontrolled hostility scale of, **2:464**

PTSD and, **2:786**

religious content on, **2:879**

trait-factor counseling and, **4:1664**

translated, adapted versions of, **1:420**

“validity” indexes of, **2:812**

Minnesota Multiphasic Personality Inventory

(MMPI-RF), **2:727**

Minnesota Satisfaction Questionnaire, **4:1521**

Mintz, Laurie, **2:580**

Minuchin, Salvador

marriage, family therapy work of, **1:124**

structural family therapy and, **1:204**

MIQ. *See* Minnesota Importance Questionnaire (MIQ);

**Minnesota Importance Questionnaire (MIQ)**

Miracle Question (MQ), **2:877–878**



- Mirsky, A., **1:112**
- Mischel, Walter, **2:746**
- Mississippi Scale for Combat-Related PTSD, **2:786**
- Missouri Occupational Card Sort, **4:1422**
- Mitchell, Clarence, Jr., **3:1238**
- Mitchell, Jeffrey T., **2:548–549**
- Mitchell, Juliet, **2:763**
- Mitchell, Stephen A., **2:763**
- Miville, Marie L., **3:1230**
- Mixed methodology research, 1:300–305**
- causal comparative design and, **1:301**
  - collaboration between qualitative, quantitative researchers and, **1:302**
  - data analysis in concurrent design and, **1:303–304**
  - data analysis in sequential design and, **1:304**
  - embedded design procedure in, **1:303**
  - explanatory design procedure in, **1:303**
  - exploratory design procedure in, **1:303**
  - future directions in, **1:304–305**
  - history of, **1:302**
  - matrix table use in, **1:304**
  - mixed methods paradigm and, **1:301–302**
  - narrative discussion technique used in, **1:304**
  - paradigm conflicts issue and, **1:302**
  - positivist-postpositivist paradigm and, **1:301**
  - pragmatism and, **1:301–302**
  - purpose of, **1:302**
  - qualitative, quantitative analyses
    - combined and, **1:304**
  - qualitative data analysis and, **1:303**
  - qualitative paradigm and, **1:301**
  - quantitative data analysis and, **1:303–304**
  - quantitative paradigm and, **1:301**
  - quasi-experimental design and, **1:301**
  - reliability, validity and, **1:304**
  - triangulation design procedure in, **1:303**
  - validity and reliability of, **1:304**
  - weaknesses of single methodologies and, **1:302**
- MJDQ. *See* Minnesota Job Description Questionnaire (MJDQ)
- MMPI. *See* Minnesota Multiphasic Personality Inventory (MMPI)
- MMPI-2. *See* Minnesota Multiphasic Personality Inventory-2 (MMPI-2)
- MMPI-A. *See* Minnesota Multiphasic Personality Inventory-Adolescent (MMPI-A)
- MMPI-RF. *See* Minnesota Multiphasic Personality Inventory (MMPI-RF)
- MMY. *See* Sixteenth Mental Measurements Yearbook (MMY)
- Model minority myth, 3:1211–1214**
- affirmative action and, **3:1213**
  - asexual Asian men myth and, **3:1212**
  - Asian American career counseling and, **4:1435, 4:1442**
  - Asian American negative stereotypes and, **3:1212**
  - Asian American populations affected by, **3:1213**
  - Asian American stereotype of, **1:403, 3:993, 3:997, 3:1211–1212**
  - Asian women sexualization and, **3:1212**
  - counseling implications of, **3:1214**
  - current status of, **3:1212–1213**
  - differential impact of, **3:1213–1214**
  - future directions regarding, **3:1213–1214**
  - political and economic issues and, **3:1212**
  - political propaganda technique of, **3:1212**
  - underutilization of mental health services and, **3:1213, 3:1214**
  - yellow peril stereotype and, **3:1212**
- Momentary time sampling recording behavioral observation method, **1:39**
- Monocultural, 3:1214–1215**
- diversity de-emphasis and, **3:1214**
  - Eurocentric counseling psychology ideology and, **3:1214–1215**
  - misdiagnosis, mistreatment, victimization of minority and marginalized groups and, **3:1214–1215**
  - multicultural challenge to, **3:1215**
  - multicultural competence and, **3:1215**
  - underutilization of services and, **3:1215**
- Montgomery Bus Boycott, **3:1238**
- Mood disorders
- borderline personality disorder comorbidity with, **2:733**
  - dependent personality disorder comorbidity with, **2:733**
  - ODD and, **1:317**
  - pathological gambling comorbidity with, **1:227**
  - pharmacological treatment of, **2:816**
- See also* **Affect (mood states), assessment of**
- Mood states. *See* **Affect (mood states), assessment of;**
- Mood disorders
- Moore, M. W., **1:118**
- Moos, Rudolph, **4:1558**
- Moos's Social Climate Scales and, **4:1558**
- Moreno, J. L., **1:12**
- Morgan, Christiana, **2:792**
- Morgen, George, **3:1229**
- Morrill, Weston H., **1:432, 2:536, 4:1477**
- Morrison, G. R., **1:167**
- Morrison, Tony, **3:1374**
- Morse, Donald, **2:891**
- Morten, George, **3:1286**



- Morton, Samuel George, **3:1109**
- Mosak, Harold, **2:458**
- Moskowitz, Henry, **3:1238**
- Moss, N. E., **3:1325**
- Motivational interviewing, **2:542**
- Motowidlo, S. J., **4:1596**
- Moustakas, Clark, **1:332**
- Moyhave, Paula, **3:1246**
- MPQ. *See* Multidimensional Personality Questionnaire (MPQ)
- MQ. *See* Miracle Question (MQ)
- MSE. *See* **Mental Status Examination (MSE)**
- MST. *See* Multisystemic therapy (MST)
- Mulholland, Amy, **2:580**
- Multicultural Awareness/Knowledge/Skills Survey, **3:1219**
- Multicultural career assessment models, 4:1576–1578**
- African American clients and, **4:1438–1440, 4:1576**
  - Rosie Phillips Bingham and, **1:53–55**
  - collectivism and, **3:1059–1061**
  - cultural context focus of, **4:1576**
  - culturally appropriate career assessment model and, **4:1577**
- Culturally Appropriate Career Counseling Model (CACCM) and, **4:1577**
- feminist theory and, **4:1576–1577**
  - future directions regarding, **4:1578**
  - Healy's career appraisal model and, **4:1576**
  - integrative-sequential framework of, **4:1577**
  - racial/ethnic minority women clients and, **4:1576–1577**
  - self-efficacy variables and, **4:1577**
- Multicultural Career Counseling Checklist (MCCC), 4:1578–1579, 4:1579**
- African American career counseling and, **4:1439–1440**
  - Rosie Phillips Bingham and, **1:53–55, 4:1579**
  - Counselor Preparation section of, **4:1579**
  - Exploration and Assessment section of, **4:1579**
  - Negotiations and Working Consensus section of, **4:1579**
  - precounseling checklist of, **4:1579**
- Multicultural counseling, 3:1215–1218**
- achieved credibility and, **3:1217**
  - Patricia Arredondo's work in, **3:991–993, 3:1219, 3:1225**
  - ascribed credibility and, **3:1216–1217**
  - Donald Ray Atkinson and, **3:1005, 3:1229**
  - Black racial identity development and, **3:1036–1038**
  - Jesús Manuel Casas and, **3:1043–1045**
  - client self-report information source and, **3:944**
  - client-therapist ethnic matching and, **3:945**
  - collectivism and, **3:1059–1061**
  - communication skills in, **3:1066–1067**
  - components of, **3:1215**
  - Madonna G. Constantine and, **3:1068–1071**
  - counseling client acculturation context and, **3:944–945**
  - counseling process and intervention and, **3:1216–1217**
  - counselor self-knowledge and, **3:1121**
  - cultural competence and, **3:944–945, 3:951**
  - cultural knowledge element of, **3:1215, 3:1216, 3:1217, 3:1225**
  - cultural naïveté and, **3:945**
  - cultural values and, **3:1095–1097**
  - culture-bound syndromes and, **3:1102–1104**
  - definition controversy regarding, **3:1121**
  - dynamics of, **3:1215**
  - ethnocentrism and, **3:1144**
  - Handbook of Multicultural Competencies in Counseling and Psychology* (Pope-Davis, ed.) and, **4:1639**
  - impact of, **3:1215**
  - Allen E. Ivey's work in, **1:266–268, 2:539, 3:1185–1187**
  - Teresa Davis LaFromboise and, **3:1191–1192**
  - loss of face and, **3:1205**
  - majority group and, **3:1216**
  - Anthony J. Marsella's work in, **3:1209–1211**
  - minority group vs. majority group and, **3:1216**
  - monocultural term and, **3:1214–1215**
  - nonverbal communication in, **3:1066**
  - pluralism and, **3:1262–1263**
  - political correctness and, **3:1263–1264**
  - psychoeducation and, **2:801–802**
  - racial identity development theory and, **3:1216**
  - social justice focus of, **3:1217**
  - Derald Wing Sue's work in, **3:1215, 3:1225, 3:1341–1343**
  - therapist-client relationship and, **3:1215, 3:1225**
  - therapist empathy importance and, **3:1216, 3:1217**
  - therapist self-knowledge and, **3:1215, 3:1216, 3:1217, 3:1225**
  - universalism and, **3:1360**
  - Melba J. T. Vasquez and, **1:439–441**
  - Clemmont Eyvind Vontress's work in, **3:1364–1365**
  - White privilege and, **3:1376**
  - Joseph L. White's work and, **3:1369–1371, 3:1383–1384**
  - within-group differences knowledge and, **3:1216**
- See also* **Multicultural counseling competence**
- Multicultural counseling competence, 3:1218–1220**
- achieved credibility and, **3:1217**
  - affirmative action and, **3:1123–1124**
  - APA Guidelines regarding, **3:1219**



- Patricia Arredondo's work in, 3:991–993, 3:1219, 3:1225
- ascribed credibility and, 3:1216–1217
- Asian Americans and, 3:996–1000
- attitudes and beliefs competency and, 3:1218
- barriers to cross-cultural counseling and, 3:1009–1010
- behavior therapy and, 2:473, 2:476
- clinical presenting issues and, 2:492
- community-based action research and, 1:90, 1:91
- Madonna G. Constantine and, 3:1068–1071
- controversies regarding, 3:1219–1220
- counselor privilege and bias and, 3:1121
- counselor self-knowledge and, 3:1121, 3:1218, 3:1219, 3:1225, 3:1231, 3:1337
- cultural relativism and, 3:1094–1095
- cultural values and, 3:1095–1097
- Eurocentric counseling and psychotherapy and, 3:1218
- Guidelines on Multicultural Education, Training, Research, Practice, and Organizational Change for Psychologists* (APA) and, 1:435, 3:991–993, 3:1064, 3:1087, 3:1088, 3:1222, 3:1231, 3:1351, 4:1639
- Handbook of Multicultural Competencies in Counseling and Psychology* (Pope-Davis, ed.) and, 4:1639
- healthy paranoia and, 3:1153
- importance, impact of, 3:1218
- Allen E. Ivey's work in, 1:266–268, 2:539, 3:1185–1187
- knowledge competence and, 3:1218
- leaders of, 3:1218
- marginalized groups and, 3:1219
- model minority myth and, 3:1211–1214
- monocultural term and, 3:1214–1215
- Multicultural Awareness/Knowledge/Skills Survey and, 3:1219
- Multicultural Counseling Competencies/Standards regarding, 3:1218–1219, 3:1247, 4:1624
- Multicultural Counseling Inventory and, 3:1219
- Multicultural Counseling Knowledge and Awareness Scale and, 3:1219
- political correctness and, 3:1263–1264
- publications regarding, 3:1219
- racial microaggressions and, 3:1290–1291
- racist counseling practices and, 3:1218
- Santería and, 3:1307–1309
- skills competence and, 3:1218
- social justice focus of, 3:1217
- socioeconomically disadvantaged groups and, 3:1329
- stereotypes and, 3:1337
- substance abuse counseling and, 2:899
- D. W. Sue's impact on, 3:1218, 3:1225, 3:1341–1343
- therapeutic relationship and, 3:1219, 3:1225
- tokenism and, 3:1350
- translation methods and, 3:1350–1353
- Melba J. T. Vasquez and, 1:90
- Clemmont Eyvind Vontress's work in, 3:1364–1365
- Multicultural Counseling Inventory, 3:1219
- Multicultural Counseling Knowledge and Awareness Scale, 3:1219
- Multiculturalism, 3:1220–1226**
- acculturation and, 3:941–946
- acculturative stress and, 3:946–952
- affirmative action controversy and, 3:1224–1225
- backlash movements against, 3:1221
- Bilingual Education Act (1968) and, 3:1221
- bilingual education controversy and, 3:1223–1224
- Brown v. Board of Education of Topeka, Kansas* and, 3:1221
- Civil Rights Act (1964) and, 3:1221
- civil rights movements and, 3:1221
- colonialism and, 3:1061–1063
- cultural accommodation and negotiation and, 3:1089–1090
- cultural relativism and, 3:1094–1095
- debates about, 3:1222
- definition of, 3:1220
- dignity, human rights, diversity of people and, 3:1220
- diversity affirmation and, 3:1120–1121
- in education, 3:1221
- Elementary and Secondary Education Act (1974) and, 3:1221
- empowerment issues and, 3:1127–1128
- enculturation and, 3:1129–1131
- historical considerations regarding, 3:1220–1221
- implications for clinical practice and, 3:1225
- melting pot vs., 3:1120, 3:1251
- multicultural competence and, 3:1120–1121, 3:1225–1226
- multicultural education controversy and, 3:1222–1223
- pluralism and, 3:1220, 3:1262–1263
- political correctness and, 3:1263–1264
- in psychology, 3:1120–1121, 3:1221–1222
- racial stigmatization and, 3:1221
- universalism and, 3:1359–1361
- universal vs. relative nature of, 3:1222
- Multicultural personality, 3:1226–1227**
- definition of, 3:1226, 3:1227
- Multicultural Personality Questionnaire and, 3:1227
- personnel and organization psychology and, 3:1227
- psychological well-being and, 3:1226–1227



- traits of, **3:1227**  
 variables of, **3:1227**  
 Multicultural Personality Questionnaire, **3:1227**  
**Multicultural psychology**  
   acculturation and biculturalism and, **3:1230–1231**  
   APA Vail conference (1973) and,  
     **1:337, 3:1087, 3:1222, 3:1228**  
   Black racial identity development model and, **3:1229**  
   *Brown v. Board of Education of Topeka*,  
     *Kansas* and, **3:1228**  
   Civil Rights Act (1964) and, **3:1228**  
   civil rights movement and, **3:1222**  
   cognition, prejudice, and discriminatory behavior  
     relationship and, **3:1228**  
   contact hypothesis of prejudice and, **3:1228**  
   *Counseling the Culturally Diverse* (D. W. Sue and D.  
     Sue) and, **1:402, 3:1229, 3:1342**  
   counselor self-knowledge and, **3:1121**  
   critical race theory and, **3:1071–1078**  
   culture-bound syndromes and, **3:1102–1104**  
   ecological approach of multiracial identity  
     development and, **3:1230**  
   ethnicity meaning and, **3:1230**  
   etic–emic distinction and, **3:1144–1147**  
   expressions of racial/ethnic identity  
     status and, **3:1229**  
   fatalism and, **3:1150**  
   focus of, **3:1232**  
   as “fourth force” of psychology, **3:1227**  
   *Guidelines on Multicultural Education, Training,*  
     *Research, Practice, and Organizational Change for*  
     *Psychologists* (APA) and, **1:435, 3:991–993,**  
     **3:1064, 3:1087, 3:1088, 3:1222, 3:1231, 3:1351,**  
     **4:1639**  
   history of, **3:1228**  
   Anthony J. Marsella’s work in, **3:1209–1211**  
   minority identity development model and, **3:1229**  
   mixed-race identity development models and,  
     **3:1229–1230**  
   multicultural competence and, **3:1120–1121, 3:1231**  
   multicultural definition and, **3:1232**  
   multicultural personality and, **3:1226–1227**  
   multicultural training and, **3:1231–1232**  
   multicultural vs. cross-cultural terminology and, **3:1227**  
   multigroup ethnic identity model and, **3:1230**  
   National Institute of Mental Health Office of Minority  
     Research and, **3:1228**  
   Nigrescence identity development model and,  
     **3:1035–1036, 3:1078–1079, 3:1229, 3:1287,**  
     **3:1364, 3:1380–1381**  
   optimal distinctiveness theory of intergroup relations  
     and, **3:1228–1229**  
   pluralism and, **3:1262–1263**  
   population demographic changes and, **3:1228**  
   prejudice, stereotypes and, **3:1228–1229**  
   professional organizations of, **3:1222**  
   racial/ethnic identity development models and,  
     **3:1229–1230**  
   reference group orientation concept and, **3:1229**  
   stereotype threat and, **3:1228**  
   stigmatized group membership consequences  
     and, **3:1228**  
   topic areas in, **3:1227**  
   White racial identity development model and, **3:1229**  
   Joseph L. White’s work and, **3:1369–1371,**  
     **3:1383–1384**  
   *See also Sue, Derald Wing; Sue, Derald Wing:*  
     *contributions to multicultural psychology*  
     *and counseling*  
 Multidimensional Aptitude Battery (MAB),  
   **4:1393, 4:1395, 4:1396**  
 Multidimensional models of adult development, **1:10**  
 Multidimensional Personality Questionnaire  
   (MPQ), **2:725**  
 Multiethnic Placement Act (1994), **3:1234, 3:1354**  
 Multiple sclerosis, **1:49**  
**Multiracial families, 3:1233–1235**  
   biracialism and, **3:1030–1031**  
   counseling implications of, **3:1235**  
   cultural-racial identity model and, **3:1234**  
   definition of, **3:1233**  
   extant literature regarding, **3:1234**  
   historical perspective and, **3:1233–1234**  
   identity models and, **3:1234**  
   interracial marriage and, **3:1183–1885, 3:1233–1234**  
   *Loving v. Virginia* and, **3:1183, 3:1184, 3:1233**  
   multiracial identity development theories and,  
     **3:1229–1230**  
   multiracial term and, **3:1233**  
   psychological outcomes of, **3:1234–1235**  
   transracial adoption and, **3:1233, 3:1234, 3:1355**  
 Multisystemic therapy (MST)  
   conduct disorder and, **1:102**  
   homeless youth and, **1:242**  
 Multon, Karen D., **2:904, 4:1470**  
 Muñoz, Abilio, **3:1024**  
 Murdock, Nancy, **4:1640**  
*Murphy v. United Parcel Service, Inc.*, **1:25**  
 Murray, Charles, **3:1109–1110**  
 Murray, Henry, **2:792, 2:811, 4:1545**



- Murray, Henry, and need-press theory of personality, 2:726, 2:811
- Murray, Paul, 2:923
- Music therapy, 1:305–308**
- American Music Therapy Association (AMTA) and, 1:305
  - applications of, 1:306
  - Bonny method of guided imagery and music and, 1:307–308
  - children with developmental disabilities and, 1:307
  - clinical examples of, 1:306–308
  - definition and scope of, 1:306
  - emotional, physical, aesthetic effects of music and, 1:305
  - importance of music in life and, 1:305
  - medical settings of, 1:307
  - Music Therapy World* journal and, 1:306
  - psychotherapeutic levels of, 1:306
  - training and accreditation in, 1:305–306
  - vocal psychotherapy and, 1:307
  - Voices: A World Forum for Music Therapy* online publication and, 1:306
  - Web sites of, 1:308
  - World Federation for Music Therapy (WFMT) and, 1:306
- Music Therapy World* journal, 1:306
- Mussolini, Benito, 3:1240
- MVS. *See* **My Vocational Situation Scale (MVS)**
- Myer, Rick, 2:547
- Myers, Linda James, 3:1033
- Myers-Briggs Type Indicator (MBTI), 2:726–727, 4:1599
- applicability of, 4:1407
  - computerized administration, interpretation of, 1:188
  - Jungian influences and, 2:668
  - translated, adapted versions of, 1:420
- My System of Career Influences, 4:1465
- My Vocational Situation Scale (MVS), 4:1579–1580**
- Barriers subscale of, 4:1580
  - John Holland's co-development of, 4:1544, 4:1545, 4:1579
  - normative data of, 4:1580
  - Occupation Information subscale of, 4:1579–1580, 4:1580
  - vocational identity and, 4:1672–1673
  - Vocational Identity subscale of, 4:1579, 4:1580
- NACMH. *See* National Academy of Clinical Mental Health Counselors (NACMH)
- NAEP. *See* National Assessment of Educational Progress (NAEP)
- Naglieri, Jack, 2:497, 2:498
- Naglieri Nonverbal Ability Test (NNAT), 2:500
- Nam-Powers Socioeconomic Status Score, 3:1328
- Narcissistic personality disorder (NPD), 2:730–731
- Narrative career counseling, 4:1581–1582**
- constructivist nature of, 4:1515
  - empowerment from, 4:1581
  - holistic career decision making approach of, 4:1581
  - interpretive approach of, 4:1581
  - life-career themes of, 4:1581
- Narrative inquiry qualitative method
- definition of, 1:361
  - interpretation of narrative data and, 1:361
  - narrative as unit of analysis and, 1:361
- See also* **Narrative career counseling;**  
**Narrative therapy (NT)**
- Narrative therapy (NT), 2:693–695**
- affect importance in client stories and, 2:694
  - clients change through use of, 2:693–694
  - constructivist theory and, 2:524
  - counseling approaches use of, 2:693
  - counseling process in, 2:694
  - deconstruction process and, 2:693–694
  - empirical evidence support of, 2:524
  - family counseling and, 1:204
  - free association and, 2:607–608
  - future directions regarding, 2:695
  - neurolinguistic programming and, 2:695
  - purposes of, 2:693
  - Carl Rogers influence on, 2:542
  - role of language, stories in counseling and, 2:693
  - Socratic Method and, 2:875–876
  - therapist interpretation and, 2:910–911
  - written narratives and, 2:694
- See also* **Narrative career counseling;** Narrative inquiry qualitative method
- NASP/NCATE. *See* National Association of School Psychologists/National Council for Accreditation of Teacher Education (NASP/NCATE)
- NASPR. *See* North American Society for Psychotherapy Research (NASPR)
- Nassar-McMillan, Sylvia, 3:989
- National Academy of Clinical Mental Health Counselors (NACMH), 1:143
- National Advisory Committee on Children and Terrorism, 1:162
- National Alliance for Caregiving, 1:63
- National Asian American Psychology Training Conference, 3:994



National Assessment of Educational Progress (NAEP)  
NCLB and, **2:452**

**National Association for the Advancement of Colored**

**People** (NAACP), **3:1237–1239**

affirmative action work of, **3:1239**

antilynching legislation and, **3:1237, 3:1238**

branches of, **3:1237**

*Brown v. Board of Education of Topeka*,  
*Kansas* and, **3:1238**

Civil Rights Act of 1964 and, **3:1238**

Civil Rights Act of 1991 and, **3:1239**

Kenneth Bancroft Clark and, **3:1051**

coalition building strategy of, **3:1238**

Congress on Racial Equality and, **3:1238**

*The Crisis* monthly publication of, **3:1237, 3:1238**

W. E. B. Du Bois and, **3:1238**

gay and lesbian rights supported by, **3:1239**

Jack Greenberg and, **3:1238**

historical developments of, **3:1238–1239**

Charles Hamilton Houston and, **3:1238**

impact of, **3:1047, 3:1237**

Martin Luther King, Jr. and, **3:1238**

March on Washington (1963) and, **3:1238**

Thurgood Marshall and, **3:1238**

membership of, **3:1237**

Montgomery Bus Boycott and, **3:1238**

National Negro Committee precursor of, **3:1237**

need for and, **3:1237**

Niagara movement, **3:1238–1239**

Niagara movement and, **3:1238**

1970s and 1980s work of, **3:1238–1239**

Rosa Parks and, **3:1238**

school desegregation and, **3:1238**

Southern Christian Leadership Conference and, **3:1238**

Student Nonviolent Coordinating

Committee and, **3:1238**

Supreme Court cases and, **3:1238**

Voting Rights Act of 1965 and, **3:1238**

White membership of, **3:1238**

National Association of Black Social Workers, **3:1354**

National Association of School Psychologists/National  
Council for Accreditation of Teacher Education  
(NASP/NCATE), **1:385**

National Association of Social Workers,  
**1:112, 1:114–115, 2:495**

National Board for Certified Counselors (NBCC)

American Counseling Association and, **1:142**

career counseling and, **4:1449, 4:1639**

Certified Clinical Mental Health Counselor  
(CCMHC), **1:142**

formation of, **1:125, 1:353, 1:354**

licensing, credentialing, accreditation by,  
**1:7, 1:126, 1:335, 1:354**

Master Addictions Counselor (MAC) and, **1:142–143**

National Certified School Counselor (NCSC)  
and, **1:142**

rehabilitation counseling and, **2:831**

specialty credentials offered by, **1:142**

Web site of, **1:355**

National Career Counselor Examination, **4:1448**

**National Career Development Association** (NCDA),  
**4:1582–1583**

American Counseling Association (ACA) and, **4:1582**

*Career Convergence* web-based magazine of, **4:1582**

career counseling history and, **4:1446, 4:1449, 4:1450**

career counseling in organizations and, **4:1461**

career counseling in schools and, **4:1465**

career/life paradigm and, **4:1489**

contract work information from, **4:1518–1519**

future directions regarding, **4:1582**

guidelines for career information and resources  
evaluation and, **4:1498**

history and governance of, **4:1582**

Internet career information guidelines and, **4:1512**

membership categories of, **4:1582**

mission of, **4:1582**

National Vocational Guidance Association  
precursor of, **4:1582**

private practice guidelines of, **4:1609**

professional counseling associations and, **1:353**

professional services provided by, **4:1582**

Society for Vocational Psychology and, **4:1634–1635**

standards and competencies and, **4:1639**

structure of, **4:1582**

Web site of, **4:1519, 4:1583**

National Center for Complementary and  
Alternative Medicine, **1:300**

National Center for Education Statistics, **4:1448**

National Center for Transforming School  
Counseling (NCTSC), **4:1392**

National Certified Career Counselor credential, **4:1449**

National Certified School Counselor (NCSC), **1:142**

National Coalition for the Homeless, **3:1058**

National Commission for the Protection of  
Human Subjects, **1:246–247**

National Committee on Pay Equity, **3:1314**

National Comorbidity Survey Replication, **3:1112**

National Conference on Scientist-Practitioner Education  
and Training for the Professional Practice of  
Psychology, **1:389**



- National Council for Credentialing Career Counselors, **4:1448**
- National Council of La Raza, **3:1304**
- National Council on Measurement in Education, **4:1639**
- National Council on Measurement in Education (NCME), **2:531**
- National Counselor Examination (NCE), **1:7, 1:142**
- National Credentialing Academy (NCA), **1:7**
- Certified Family Therapist credential and, **1:143**
- Marriage and Family Therapists and, **1:206**
- National Defense Education Act (NDEA), **1:123**
- National Defense Education Act (NDEA, 1957), **4:1447**
- National Institute for Multicultural Competence, **1:267**
- National Institute for Occupational Safety and Health (NIOSH), **4:1585–1586**
- National Institute of Mental Health Treatment of Depression Collaborative Research Project (NIMH-TDCRP), **1:174**
- Nationalism, 3:1239–1242**
- African colonies' independence and, **3:1240**
- African National Congress and, **3:1240**
- Afrocentricity/Afrocentrism and, **3:963–965**
- amplified nationalism and, **3:1240**
- The Birth of the Nation* and, **3:1240**
- Black Nationalism and, **3:1240**
- cosmopolitanism and, **3:1241**
- criticisms and critiques of, **3:1241**
- definition of, **3:1239**
- empowerment organizations and, **3:1241**
- Eurocentric perspective on, **3:1239–1240**
- FBI Counter Intelligence Program and, **3:1241**
- House Committee on Un-American Activities and, **3:1241**
- implications for counseling and, **3:1241–1242**
- liberal ideology vs., **3:1241**
- multinational agendas, globalism and, **3:1241**
- within nations and, **3:1240–1241**
- nation-states and, **3:1239**
- origin and historical development of, **3:1239–1240**
- pan-Africanist movements and, **3:1240**
- post-Watergate congressional hearings and, **3:1241**
- racial divisions and, **3:1240**
- racist extremism and, **3:1240**
- secession and, **3:1241**
- social and political movements and, **3:1239, 3:1240**
- Wilson's Fourteen Points and, **3:1240**
- National Latina/o Psychological Association (NLPA), 3:1242–1243**
- APA affiliation of, **3:1242**
- Patricia Arredondo and, **3:992, 3:1242–1243**
- Council of National Psychological Associations for the Advancement of Ethnic Minority Interests (CNPAEMI) and, **3:1242**
- Ethnic Minority Psychological Association and, **3:1242**
- founding of, **3:1242**
- growth of, **3:1243**
- honors and awards received by, **3:1243**
- international efforts of, **3:1242–1243**
- Latina/o term choice and, **3:1243**
- mission of, **3:1242**
- National Multicultural Summit and Conference and, **3:1242, 3:1342–1343**
- NHPA to NLPA transformation and, **3:1242**
- organizational structure of, **3:1243**
- Rhode Island Latino Psychology Conference and, **3:1242**
- Web site of, **3:1243**
- Joseph L. White and, **3:1370**
- National Multicultural Summit and Conference, **3:1242, 3:1342–1343**
- National Negro Committee, **3:1237**
- National Occupational Information Coordinating Committee (NOICC), **4:1448, 4:1450**
- National Organization for Women (NOW), **1:124, 3:1316, 3:1318**
- National Register of Health Service Providers, **1:145–146, 1:309**
- National Rehabilitation Association (NRA), **2:831**
- National Research Center on Asian American Mental Health, **3:994**
- National Study of Black Americans, **3:1292**
- National Survey of Student Engagement (NSSE), 4:1583–1584**
- college student development analyzed by, **4:1583**
- “good practices” behavior in undergraduate education and, **4:1583**
- institutional comparison reports from, **4:1583**
- student perceptions of college environment and, **4:1583**
- survey items on, **4:1583**
- National Vocational Guidance Association (NVGA), **1:122, 4:1446, 4:1448, 4:1489, 4:1582**
- Naturalization Law (1790), **3:1372**
- Nazism
- Holocaust and, **2:573, 3:1132, 3:1240**
- medical experimentation and, **1:190, 1:193**
- NBCC. *See* National Board for Certified Counselors (NBCC)
- NCA. *See* National Credentialing Academy (NCA)
- NCDA. *See* **National Career Development Association (NCDA)**
- NCE. *See* National Counselor Examination (NCE)



- NCLB. *See* No Child Left Behind (NCLB)
- NCME. *See* National Council on Measurement in Education (NCME)
- NCSC. *See* National Certified School Counselor (NCSC)
- NCTSC. *See* National Center for Transforming School Counseling (NCTSC)
- NDEA. *See* National Defense Education Act (NDEA)
- Neimeyer, Robert, A., **2:522**
- Nelson, M. Lee, **1:219, 3:1166**
- Nemeroff, Carol, **2:582**
- NEO Personality Inventory, Revised (NEO PI-R), **2:530, 2:724, 2:752, 2:753, 2:755, 2:906, 4:1598**
- NEO PI-R. *See* NEO Personality Inventory, Revised (NEO PI-R)
- Ness, M., **1:432**
- Neulinger, John, **2:672**
- Neurolinguistic programming therapy, **2:695**
- Neuropsychological functioning, 2:695–702**
- attention and, **2:698**
  - Beck Depression Inventory, **2:701**
  - behavioral observations and, **2:697**
  - California Verbal Learning Test, 2nd Edition (CVLT-II), **2:698, 2:700**
  - clinical neuropsychology and, **2:695**
  - concept formation, reasoning tasks and, **2:699–700**
  - Connors' Continuous Performance Test II (CPT II), **2:698**
  - constructional ability and, **2:701**
  - Controlled Oral Word Association Test (COWA), **2:700**
  - Delis-Kaplan Executive Function System (D-KEFS), **2:698, 2:699, 2:700**
  - dementia and, **2:556–557**
  - educational history and, **2:697**
  - encoding attention component and, **2:698**
  - executive functioning skills and, **2:699–700**
  - fixed vs. flexible batteries and, **2:696–697**
  - focus/execute attention component and, **2:698**
  - future directions regarding, **2:701**
  - general intellectual functioning and, **2:697–698**
  - Gordon Diagnostic System, **2:698**
  - growth of field and, **2:695–696**
  - Halstead-Reitan Neuropsychological Battery (HRB), **2:696**
  - handedness and, **2:697**
  - history and behavioral observation and, **2:697**
  - interpretation, report writing and, **2:701**
  - language assessment and, **2:698–699**
  - language disorders and, **2:698–699**
  - learning, memory and, **2:700**
  - medical history and, **2:697**
  - memory assessment and, **2:686–689**
  - Minnesota Multiphasic Personality Inventory-2 (MMPI-2), **2:701**
  - mood, personality and, **2:701**
  - Perceptual Organization Index (POI), **2:698**
  - planning, complex problem-solving and, **2:699**
  - Processing Speed Index (PSI), **2:698**
  - professional organizations of, **2:695**
  - response inhibition and, **2:699**
  - Rey Auditory Verbal Learning Test (RAVLT), **2:700**
  - Rey Complex Figure Test, **2:700**
  - sensory-motor abilities and, **2:701**
  - shift attention component and, **2:698**
  - sleep disorders and, **1:393–395**
  - spontaneous speech and, **2:699**
  - story recall ability and, **2:700**
  - sustained attention component and, **2:698**
  - uses of neuropsychological assessment and, **2:696**
  - Verbal Comprehension Index (VCI), **2:697–698**
  - verbal fluency and, **2:700**
  - visuospatial deficits and, **2:700**
  - Wechsler Adult Intelligence Scale—Third Edition (WAIS-III), **2:697, 2:698, 2:700, 2:701**
  - Wechsler Individual Achievement Test—Second Edition (WIAT-II), **2:699**
  - Wechsler Memory Scale—Third Edition (WMS-III), **2:698**
  - Wide Range Achievement Test 4 (WRAT4), **2:699**
  - Wisconsin Card Sort Technique (WCST), **2:698**
  - working memory function and, **2:699**
  - Working Memory Index (WMI), **2:698**
- Neuroticism, Extraversion, Openness Personality Inventory-Revised. *See* NEO Personality Inventory, Revised (NEO PI-R)
- Neville, Helen, **3:1065**
- Niagara movement, **3:1238–1239**
- Nietzsche, Friedrich, **3:1271**
- Nigrescence model of Black identity, **3:1035, 3:1036, 3:1078–1079, 3:1166, 3:1285, 3:1287, 3:1364, 3:1380–1381, 3:1381**
- See also* **Cross, William E., Jr.**
- NIMH-TDCRP. *See* National Institute of Mental Health Treatment of Depression Collaborative Research Project (NIMH-TDCRP)
- 19th Amendment, **3:1047**
- NIOSH. *See* National Institute for Occupational Safety and Health (NIOSH)
- Nisbett, Richard E., **2:673**
- Nissen, Henry W., **2:673**



- NLPA. *See* **National Latina/o Psychological Association** (NLPA)
- NNAT. *See* Naglieri Nonverbal Ability Test (NNAT)
- Noble, Kathleen D., 2:672
- Nobles, Wade W., 3:964, 3:1033, 3:1034, 3:1035, 3:1370, 3:1385
- No Child Left Behind (NCLB)
- achievement gap reduction goal of, 2:452
  - ASVAB and, 4:1405
  - curriculum, teaching quality measured by, 2:453
  - high-stakes testing and, 2:453
  - IDEA and, 1:250, 1:253
  - National Assessment of Educational Progress (NAEP), 2:452
  - schools, school districts performance measured by, 2:453
  - standards and accountability focus of, 2:452
  - state assessment procedure requirement of, 2:452–453
  - statewide achievement testing limitations and, 2:453–454
  - students' futures affected by, 2:453
  - “teaching to the test” and, 2:453
- NOICC. *See* National Occupational Information Coordinating Committee (NOICC)
- Non-Aligned Movement, 3:1347–1348
- Non-Hasidic Orthodox Jews, 3:978
- Nonmaleficence
- change agent and, 3:1046
  - ethical code of, 1:176, 1:183, 1:186, 1:192, 2:495, 3:1046
  - virtue ethics and, 1:441
- Nonstandardized achievement tests, 2:450–451
- Nonverbal learning disorders (NLD), 1:160
- See also* **Learning disorders** (LD)
- Norcross, John C., 1:309–311, 2:487**
- behavior change and psychotherapy focus of, 1:309, 2:487–488
  - editorial appointments of, 1:310
  - education and training contributions of, 1:309–310
  - evidenced-based training work of, 1:310
  - honors and awards received by, 1:309
  - practice contributions of, 1:310–311
  - professional associations of, 1:309
  - psychotherapist as a person focus of, 1:311
  - psychotherapy work of, 1:310
  - publications of, 1:309
  - research and theory contributions of, 1:310
  - self-help, self-change work of, 1:310
  - therapeutic relationship, client characteristics and, 2:649
- Norman, Warren, 2:752
- Normative issues, 2:702–706**
- academic problems and, 2:702–703
  - “active listening model” of communication and, 2:705
  - anger and, 2:703
  - anxiety and, 2:703–704
  - bullying and, 2:703
  - college adjustments and, 2:702–703
  - communication and, 2:704–705
  - definition of, 2:702
  - interpersonal issues and, 2:704–706
  - interpersonal issues and, definition of, 2:702
  - intrapersonal issues and, 2:702–704
  - learning disorders and, 2:702
  - positive vs. negative sentiment override and, 2:705
  - rapid eye movement (REM) sleep and, 2:704
  - relationship distress/divorce and, 2:705–706
  - sexuality and, 2:706
  - sleep deprivation and, 2:704
  - stress and, 2:703
- Norm-referenced achievement tests, 2:451
- North American Society for Psychotherapy Research (NASPR), 2:591
- Northside Center for Child Development, 3:1052, 3:1053
- Northwestern Conference of counseling psychology (1951), 1:103–104, 1:127, 1:128–129
- Norton, Michael, 3:1065
- NOW. *See* National Organization for Women (NOW)
- NPD. *See* Narcissistic personality disorder (NPD)
- NRA. *See* National Rehabilitation Association (NRA)
- NSSE. *See* **National Survey of Student Engagement** (NSSE)
- NT. *See* **Narrative therapy** (NT)
- NVGA. *See* National Vocational Guidance Association (NVGA)
- Obasi, Ezemenari M., 3:1386, 4:1577
- Oberg, K., 3:1106
- Obesity
- behavioral treatments and, 1:94
  - community-based health promotion and, 1:94–95
  - diseases affected by, 1:94
  - multicomponent intervention and, 1:94–95
- Object relations theories, 2:735
- attachment theory and, 2:762
  - children's self-concept and, 2:762
  - children's significant others relationships and, 2:761–762
  - “self” and “other” relationships focus of, 2:762
- O'Brien, K. M., 4:1679
- Obrzut, John, 1:158
- Observational learning
- Albert Bandura and, 2:467, 2:736, 2:741
  - behavior therapy and, 2:471



- Observational measures, **1:29**
- Observations inquiry qualitative data collection method, **1:361–362**
- Obsessive-compulsive personality disorder (OCPD)
- AD/HD comorbidity with, **1:49**
  - characteristics of, **2:731**
  - comorbidity of, **2:733**
  - pathological gambling controversy and, **1:227**
  - stress, anxiety and, **2:885**
- OCCU-Find, **4:1405**
- Occupational Aptitude Patterns and, **4:1656**
- Occupational health psychology (OHP), 4:1585–1587**
- aging workforce and, **4:1586**
  - gender workforce factors and, **4:1586**
  - goal of, **4:1586**
  - historical roots of, **4:1585–1586**
  - immigrant workforce and, **4:1586–1587**
  - influencing change and, **4:1587**
  - interdisciplinary fields of, **4:1586**
  - Journal of Occupational Health Psychology* and, **4:1586**
  - National Institute for Occupational Safety and Health (NIOSH) and, **4:1585–1586**
  - physical and emotional health vs. work life and, **4:1586**
  - self-employed increase and, **4:1586**
  - Society for Occupational Health Psychology and, **4:1585–1586**
  - Frederick Taylor's management principles and, **4:1586**
  - Web sites, **4:1587**
  - work organization focus of, **4:1586**
  - work-related stress and, **4:1585–1586**
  - world of work changes and, **4:1586**
- Occupational information, 4:1587–1588**
- ACT World-of-Work Map and, **4:1587–1588, 4:1668**
  - Bureau of Labor Statistics and, **4:1416–1417**
  - definition of, **4:1587**
  - DISCOVER and, **4:1588**
  - Holland's RIASEC Model and, **4:1587–1588**
  - Occupational Information Network (O\*NET) and, **4:1588**
  - Occupational Outlook Handbook (OOH)* and, **4:1588**
  - SIGI PLUS and, **4:1588**
  - Standard Occupational Classification (SOC) System and, **4:1587**
- Occupational Information Network (O\*NET), 4:1588–1589**
- ASVAB and, **4:1405**
  - career counseling, planning resource of, **4:1431, 4:1481, 4:1494, 4:1588**
  - Career Exploration Tools of, **4:1589**
  - Crosswalk system feature of, **4:1588**
  - database of, **4:1589**
  - Dictionary of Occupational Titles* replaced by, **4:1526, 4:1588**
  - Employment and Training Administration and, **4:1417**
  - Holland's RIASEC Model and, **4:1599**
  - Holland's theory and, **4:1589**
  - Interest Profiler of, **4:1511**
  - O\*NET online and, **4:1589**
  - person-environment fit concept, **4:1587**
  - Standard Occupational Classification System (SOC) of, **4:1588–1589**
  - trait-factor counseling and, **4:1665**
  - Web site of, **4:1482, 4:1589**
- Occupational Outlook Handbook* (Department of Labor), **4:1494, 4:1511**
- Occupational Outlook Handbook (OOH)*, **4:1588**
- Occupational Reinforcer Patterns, **4:1521**
- Occupational stress, 1:313–316**
- absenteeism, tardiness and, **1:315**
  - active coping style and, **1:314**
  - decision making flexibility and, **2:885–886**
  - definition of, **1:313**
  - employee assistance programs and, **1:314**
  - fight-or-flight response and, **1:313**
  - gender differences in, **2:886**
  - going postal, workplace anger, violence and, **1:315**
  - good stress, *eustress* and, **1:313**
  - health problems associated with, **1:314**
  - individual perspective, influencing factors of, **1:314**
  - individual perspective, intervention for, **1:314–315**
  - individual perspective, symptoms of, **1:314**
  - internal vs. external locus of control and, **1:314, 3:1046**
  - interpersonal relationships and, **2:885**
  - job security stress and, **1:315**
  - leadership style and, **1:316**
  - operational, purposive, methodological organization subsystems and, **1:315**
  - organizational perspective, influencing factors of, **1:315–316**
  - organizational perspective, intervention for, **1:316**
  - organizational perspective, symptoms of, **1:315**
  - prevalence of, **1:313, 2:885**
  - role ambiguity, role conflict and, **2:885**
  - self-efficacy and, **1:314**
  - service industry work and, **2:885**
  - sexual harassment and, **2:885**
  - stress management assistance and, **1:314**
  - turnover rates and, **1:315**
  - violent behavior reaction to, **2:885**
  - work environment conditions and, **1:315, 2:885**



- work-family conflict and, 1:314
- worksite stress-management interventions and, 2:886
- Occupational Stress Inventory, 4:1590
- Occupational Stress Inventory-Revised Edition (ISI-R), 4:1686
- O'Connor, Kevin, 1:332
- O'Connor, M. F., 1:249
- O'Connor Finger Dexterity Test, 2:449–450, 4:1393
- OCPD. *See* Obsessive-compulsive personality disorder (OCPD)
- Odbert, H. S., 2:752
- ODD. *See* **Oppositional defiant disorder** (ODD)
- Oetting, Eugene R., 1:432, 3:1251
- Ogawa, Deborah, 4:1545
- Ogles, Benjamin M., 2:712
- O'Grady, Kevin, 2:920
- O'Hanlon, William H., 2:523–524
- O'Hara, Robert, 4:1657
- Ohnishi, H., 3:1385
- OHP. *See* **Occupational health psychology** (OHP)
- OICCs. *See* State Occupational Information Coordinating Committees (OICCs)
- Oklahoma Racial Attitude Scale-Preliminary Form, 3:1288
- Oklahoma Racial Attitudes Scale (ORAS), 3:1288
- Okura, K. Patrick, 3:994
- Okura Mental Health Leadership Foundation, 3:994
- Olmedo, Esteban, 3:1019
- Olmsted, Marion, 2:580
- Olweus Bully Program, 1:56–57
- Omizo, M. M., 3:1309
- Omnibus Trade and Competitiveness Act (1988), 4:1449
- One-drop rule, 3:1027, 3:1028, 3:1183
- O'Neil, James, 1:141
- One-Stop Career Centers Act (1994), 4:1450
- O\*NET. *See* **Occupational Information Network** (O\*NET)
- Online counseling. *See* **E-counseling; Technology and treatment**
- Ontogenetic models of adult development, 1:9–10
- Open Door Society, 3:1354
- Operant conditioning
- behavior therapy and, 2:471
  - functional behavioral assessment and, 1:221–222
  - shaping technique of, 2:738
  - Edward Thorndike's "Laws of Learning" and, 2:738
- "Operation Brown Baby" (Oregon), 3:1354
- Oppositional defiant disorder** (ODD), 1:317–320
- AD/HD comorbidity with, 1:31, 1:49, 1:317
  - age-appropriate behavior assessment and, 1:318–319
  - assessment of, 1:317–318
  - associated difficulties of, 1:317
  - case example of, 1:319
  - Child Behavior Checklist and, 1:317
  - conduct disorder and, 1:100, 1:317, 1:319
  - definition of, 1:317
  - differential diagnosis of, 1:319
  - DSM-IV diagnostic criteria of, 1:317
  - DSM-IV-TR diagnostic criteria of, 1:197
  - externalizing problems of childhood and, 1:197
  - features of, 1:197
  - incredible years parent training program and, 1:327
  - learning disorder comorbidity with, 1:157
  - prevalence and onset of symptoms of, 1:317
  - psychopharmacological intervention of, 1:318
  - psychosocial intervention of, 1:318
- Oppression**, 3:1245–1247
- antisemitism and, 3:983–985
  - bias and, 3:1014–1016
  - Black racial identity development and, 3:1036–1038
  - classism and, 3:1054–1059
  - colonialism and, 3:1061–1063, 3:1246
  - counseling applications of, 3:1246–1247
  - critical consciousness theory and, 3:1128, 3:1245–1246
  - critical race theory and, 3:1071–1078
  - deficit hypothesis and, 3:1109–1111
  - definition of, 3:1245
  - discrimination and oppression, 2:572–575
  - drapetomania and, 3:1124–1125
  - feminist theory and, 3:1246
  - future directions regarding, 3:1247
  - identity development and, 3:1246
  - internalized oppression and, 3:1246
  - Multicultural Counseling Competencies and, 3:1247
  - oppression by force vs. deprivation and, 3:1245
  - Pedagogy of the Oppressed* (Freire) and, 3:1245
  - postcolonial studies and, 3:1246
  - power abuse and, 3:1245
  - primary, vs. secondary, vs. tertiary oppression and, 3:1245
  - privilege and, 3:1245
  - psychiatric disorders from, 3:1246
  - stereotyping and, 3:1333–1339
- See also* **Discrimination and oppression**
- Optimal arousal
- curiosity, sensation seeking, skill factors in, 2:674
  - dual process explanations of, 2:673
  - effects of, 2:673–674
  - hedonic tone and, 2:673
  - homeostasis and, 2:673
  - leisure and, 2:673–674
  - optimal distinctiveness theory of, 3:1228–1229



**Optimism and pessimism, 2:707–710**

antipessimism sheet and, 2:709  
attribution theory and, 2:708  
Beck's cognitive theory of depression and, 2:708  
as cognitive styles, 2:708  
counseling practice and, 2:709–710  
cultural differences in, 2:709–710  
defensive pessimism and, 2:708  
development of, 2:708–709  
as dispositional traits, 2:707–708  
early childhood experiences and, 2:709  
environmental factors and, 2:709  
expectancy-value theory of personality and, 2:707, 2:854  
fatalism and, 3:1150  
happiness/hardiness and, 2:623–626  
heritability, genetic factors and, 2:708–709  
hope and, 2:634–637  
invulnerability training and, 2:709  
optimism stress coping strategy and, 2:885  
parental modeling and, 2:709  
positive cancer management and, 1:59–61  
positive psychology and, 2:781–784, 2:869  
positive visualization technique and, 2:709  
pump priming technique and, 2:709  
self-regulatory model and, 2:707  
Martin Seligman's work in, 2:869  
silver lining technique and, 2:709  
social support and, 2:872–875  
strategic optimism and, 2:708  
OQ-45. *See* Outcome Questionnaire (OQ-45)  
ORAS. *See* Oklahoma Racial Attitudes Scale (ORAS)  
Orbach, Susie, 3:1317  
**Organizational diversity, 3:1247–1250**  
affirmative action and, 3:957–958, 3:1122, 3:1123, 3:1249  
benefits of, 3:1121–1122  
client base increase and, 3:1121  
creative work environment and, 3:1121  
demographic statistics and, 3:1247–1248  
diversity term inclusivity and, 3:1248  
EEOC legislation and, 3:1248, 3:1249  
employee reaction to, 3:1248  
employee recruitment and, 3:1121  
employee retention and, 3:1121  
job segregation by race and gender and, 3:1248  
learning and innovation approach to, 3:1249  
opponents of, 3:1122  
organizational justice and, 3:1248  
power, authority, leadership allocations and, 3:1248

problem solving skills and, 3:1121–1122  
stereotype threat and, 3:1249  
stress experiences and, 3:1248–1249  
system flexibility and, 3:1122  
tokenism and, 3:1249, 3:1350

Organizational psychology. *See* **Industrial/organizational psychology** (I/O psychology)

Orlinsky, David, 1:174, 2:919, 2:920

Orshansky, Mollie, 3:1267

**Orthogonal cultural identification theory, 3:1250–1252**

acculturation and, 3:942–943  
biculturalism as dual identification and, 3:1251  
counseling implications of, 3:1252  
cultural identification vs. ethnic identification, 3:1250  
cultural stew concept and, 3:1251  
definition of, 3:1250  
importance of, 3:1250–1251  
melting pot myth and, 3:1251  
quantitative assessment of, 3:1251  
research regarding, 3:1251–1252

**Osipow, Samuel H., 4:1589–1590**

academic career of, 4:1589  
APA work of, 4:1590  
career assessment work of, 4:1590  
Career Decision-Making Difficulties Questionnaire (CDDQ) and, 4:1468  
Career Decision Scale (CDS) and, 4:1468–1469, 4:1481, 4:1590, 4:1673  
*Handbook of Vocational Psychology* (Osipow and Bruce) and, 4:1590  
*Journal of Vocational Behavior* founded by, 4:1563  
Occupational Stress Inventory and, 4:1590  
professional associations of, 4:1590  
publications of, 4:1589  
*Theories of Career Development* written by, 4:1590

Outcome. *See* **Counseling process/outcome; Outcomes of counseling and psychotherapy; Process and outcome research**

Outcome Questionnaire (OQ-45), 2:535

**Outcomes of counseling and psychotherapy, 2:710–716**

client self-reports and, 2:712  
clinical significance, relevance of, 2:711–712  
clinical studies' artificial context and, 2:710–711  
content outcome measurement dimension and, 2:712  
Dodo Bird conjecture and, 2:714–715  
efficacy of different treatments, specific disorder and, 2:715  
efficacy of different treatments and, 2:714–715  
efficacy vs. effectiveness and, 2:710  
empirically based professional practice and, 1:172–175



- evaluation of, 2:710–711  
 expectations about therapy and, 2:593–599, 3:1364  
 facilitative conditions and, 2:601–603  
 Clara E. Hill's work in, 2:632  
 meta-analysis studies of, 2:713–714  
 negative outcomes and, 2:714  
 perspectives on, 2:712–713  
 relevant others' perspectives and, 2:712  
 reliable change index and, 2:712  
 social dimension of outcome measurement and, 2:712  
 social level dimension of outcome measurement and, 2:712  
 statistical differences between groups and, 2:711  
 statistical difference within group and, 2:711  
 statistical significance of, 2:711  
 technology dimension of outcome measurement and, 2:712–713  
 therapist bias factor and, 2:712  
 therapy vs. no therapy and, 2:713–714  
 time dimension of outcome measurement and, 2:713  
 tripartite model of outcomes and, 2:712  
 Bruce Wampold's work in, 2:937  
*See also Counseling process/outcome*  
 Outward Bound adventure therapy, 1:12  
 Ovesey, Lionel, 3:1110, 3:1296  
 Ovington, Mary White, 3:1238  
 Oyserman, Daphna, 3:1169, 3:1178
- Pace, D., 1:432
- Pacific Islanders, 3:1253–1258**  
 Asian American data and, 3:1257  
 circular migration concept and, 3:1255, 3:1256  
 colonization trauma of, 3:1253, 3:1255–1256  
 counseling interventions for, 3:1257–1258  
 cultural genocide of, 3:1255–1256  
 cultural identity importance and, 3:1255, 3:1256  
 cultural values of, 3:1253, 3:1255  
 decolonization issues and, 3:1256  
 demographics of, 3:1111  
 family system importance of, 3:1255, 3:1257  
 family therapy and, 3:1257  
 geographic definition of, 3:1253  
 Hale Ola Ho'opakolea Native Hawaiian therapy and, 3:999  
 history of and the U.S., 3:1254  
 indigenous healing practices and, 3:1257  
 indigenous ways of knowing of, 3:1255  
 mental health issues of, 3:1255  
 Pacific Islander as racial or ethnic category and, 3:1253  
 Pacific Islanders in the U.S. and, 3:1254  
 Polynesian, Micronesian, Melanesian islands and, 3:1253  
 poverty statistics regarding, 3:1326  
 psychological impact of Western contact and, 3:1256  
 psychological issues of, 3:1255–1257  
 research on, 3:1254, 3:1257–1258  
 resilience of, 3:1256  
 self-governance, well-being and, 3:1258  
 sense of place importance of, 3:1255  
 socioeconomic statistics regarding, 3:1254  
 somatic symptoms of, 3:1257  
 stereotypes regarding, 3:1254  
 traditional and indigenous healing practices of, 3:1256  
 underutilization of services by, 3:1257  
 U.S. Census (2000) racial categories and, 3:1253–1254  
 Western counseling models and, 3:1257
- Pacourek v. Inland Steel Co.*, 1:25  
 Padilla, A., 3:1348  
 PAI. *See* Psychological Assessment Inventory (PAI)  
 Paine, Thomas, 3:1375  
*Painter v. Bannister*, 1:147  
 Palmer, Laura, 1:106  
 Pals, Jennifer L., 2:737  
 Paniagua, Freddy, 3:1024
- Panic disorders, 2:717–719**  
 Anxiety Sensitivity Index and, 2:718  
 anxiety vs., 2:717–718, 2:885  
 borderline personality disorder comorbidity with, 2:733  
 catastrophic misinterpretations cause of, 2:718  
 causes of, 2:718  
 cognitive therapy for, 2:718–719  
 definition of, 2:717  
*DSM-IV-TR* diagnostic criteria of, 2:717  
 exposure therapy for, 2:718–719  
 eye movement desensitization, reprocessing (EMDR) and, 1:198–202  
 fear of fear, anxiety sensitivity and, 2:717  
 flight-or-fight response of, 2:718–719  
 psychoeducation therapy for, 2:719  
 situationally bound attack and, 2:717  
 situationally predisposed attack and, 2:717  
 treatments for, 2:718–719  
 unexpected panic attack and, 2:717
- Paradoxical interventions, 2:719–721**  
 Alfred Adler use of, 2:720  
 compliance-based interventions and, 2:720  
 contradiction element of, 2:719  
 counseling and, 2:720  
 decontextualizing the problem and, 2:719



defiance-based interventions and, **2:720–721**  
definitions of, **2:719**  
double-bind feature of, **2:719**  
Eastern religions and, **2:719**  
effectiveness of, **2:721**  
Frankl's paradoxical intention, logotherapy of, **2:720**  
negative practice, behavioral therapy and, **2:720**  
paradox in ordinary life and, **2:719**  
positioning and, **2:721**  
positive connotation and, **2:720**  
relabeling and, **2:720**  
restraining strategies and, **2:721**  
reverse psychology and, **2:719**  
Stanley B. Strong and, **2:892**  
symptom prescription and, **2:720**  
symptom scheduling and, **2:720**

Paranoid personality disorder (PPD), **2:729**

**Parent-adolescent relations, 1:321–324**

AD/HD and, **1:30–31**  
adolescent autonomy and, **1:322, 1:323**  
attachment theory and, **4:1410–1412**  
attachment types and, **1:321**  
child maltreatment and, **1:71–72**  
conduct disorder and, **1:101**  
critical factors of, **1:323**  
filial piety and, **3:1151**  
forgiveness and, **2:607**  
goal-corrected partnership concept and, **1:322**  
homeless youth and, **1:240–243**  
immigrant parent-child conflict and, **3:1172**  
oppositional defiant disorder and, **1:317–320**  
parent-child attachment in adolescence and, **1:322**  
parent-child communication and, **1:322–323**  
parenting and, **1:324–328**  
secure vs. insecure attachment outcomes  
and, **1:321–322**  
teenage parents and, **1:415–418**  
transracial adoption and, **3:1355**  
work-family balance and, **4:1680–1684**

Parent-Child Interaction Therapy (PCIT),  
**1:32, 1:326–327, 1:332**

**Parenting, 1:324–328**

achievement gap and, **3:954**  
Adlerian therapy and, **2:458**  
applications of parent training in, **1:326**  
authoritarian style of, **1:324–325**  
authoritarian style of, child behavior and, **1:325**  
authoritative style of, **1:324**  
authoritative style of, Asian Americans and, **3:996**  
authoritative style of, child behavior and, **1:325**

Barkley AD/HD parent training program and, **1:327**  
child maltreatment and, **1:69–74**  
chronic illness in children and, **1:76**  
common sense parent training program and, **1:327**  
conduct disorder and, **1:101**  
ethnic identity and, **3:1136**  
filial piety and, **3:1151**  
forgiveness and, **2:607**  
functional family therapy (FFT) and, **1:327**  
Constance Hanf's work in, **1:326**  
Helping the Noncompliant Child parent training  
program and, **1:326**  
incredible years parent program and, **1:327**  
legal issues in parenting and, **1:278–281**  
parent-child interaction therapy (PCIT)  
and, **1:326–327, 1:332**  
Parenting Stress Index (PSI) and, **1:328–330**  
parenting styles and, **1:324**  
parent management training (PMT) and, **1:101–102**  
parent training and, **1:325–326**  
Gerald Patterson's work in, **1:326**  
permissive style of, **1:325**  
permissive style of, child behavior and, **1:325**  
responsiveness and demandingness  
components of, **1:324**  
styles and child behavior relationship, **1:325**  
systemic training for effective parenting  
(STEP) and, **1:327**  
teenage parents and, **1:415–418**  
transracial adoption and, **3:1355**  
triple P (positive parenting program) parent training  
program and, **1:327**  
uninvolved style of, **1:325**  
uninvolved style of, child behavior and, **1:325**  
work-family balance and, **4:1680–1684**  
*See also* **Parenting Stress Index (PSI)**; Parent training  
programs

**Parenting Stress Index (PSI), 1:328–330**

acceptability (AC) scale of, **1:329**  
Achenbach Child Behavior Checklist and, **1:330**  
adaptability (AD) scale of, **1:328**  
attachment (AT) scale of, **1:329**  
child domain and, **1:328–329**  
competence (CO) scale of, **1:329**  
demandingness (DE) scale of, **1:328–329**  
depression (DP) scale of, **1:329**  
description of, **1:328–329**  
distractibility/hyperactivity (DI) scale of, **1:328**  
health (HE) scale of, **1:329**  
isolation (IS) scale of, **1:329**



- mood (MO) scale of, 1:329  
 parent domain and, 1:329  
 reinforces parent (RE) scale of, 1:328  
 related products and, 1:330  
 reliability, validity of, 1:330  
 role restriction (RO) scale of, 1:329  
 spouse (SP) scale of, 1:329  
 standardization of, 1:329–330  
 Parent management training (PMT), 1:101–102  
 Parent Rating Scale (PRS), of BASC-2, 1:42, 1:47  
 Parents to Adopt Minority Children (Minnesota), 3:1354  
 Parent training programs  
   for AD/HD, 1:32–33  
   attending skills focus of, 1:32  
   oppositional defiant disorder and, 1:318  
   parent-child relationship factor in, 1:32  
   reinforcement techniques used in, 1:32–33  
   response cost punishment technique and, 1:33  
   specific-labeled praise technique and, 1:33  
   time-out intervention and, 1:33  
   token economy technique and, 1:33  
 Parham, Thomas, 3:1038, 3:1080, 3:1154, 3:1287, 3:1370  
 Parham, W. D., 1:435  
 Parham, William, 3:1370  
 Paris, Joel, 2:732  
 Park, Robert, 3:1003  
 Parkinson's disease, 1:17  
 Parks, Rosa, 3:1048, 3:1238  
 Parsons, Bruce, 1:327  
**Parsons, Frank, 4:1591–1592**  
   career counseling model of, 4:1445  
   career maturity concept and, 4:1491  
   child labor laws and, 4:1446  
   *Choosing a Vocation* written by,  
     1:121, 4:1496, 4:1537, 4:1597  
   decision making and, 4:1522  
   interests questionnaire of, 4:1537  
   knowledge of occupations and, 4:1445  
   person-environment interaction model and,  
     2:773, 4:1429, 4:1489, 4:1523, 4:1591, 4:1600,  
     4:1655, 4:1663, 4:1679  
   Progressive movement and, 4:1591  
   self-knowledge and, 4:1445, 4:1537, 4:1591, 4:1663  
   settlement house program and, 4:1445  
   social justice work of, 1:92  
   “true reasoning” concept of, 4:1591  
   vocational guidance work of, 1:121, 2:525, 2:543,  
     2:773, 2:782, 4:1482, 4:1489, 4:1591–1592,  
     4:1647  
   vocational psychology founded by, 4:1405  
   Vocation Bureau at Civic Service House, Boston and,  
     4:1445, 4:1482, 4:1496, 4:1591, 4:1597  
   world of work knowledge and, 4:1591  
 Parsons, Talcott, 4:1398  
 Partial Birth Abortion Ban, 3:1316  
 Partial-interval recording behavioral  
   observation method, 1:38  
**Part-time work, 4:1592–1594**  
   career counseling implications of, 4:1594  
   definition of, 4:1592  
   full-time workers vs., 4:1592–1593  
   importance and uses of, 4:1592  
   management obligations to, 4:1593–1594  
   organization obligations to, 4:1593  
   part-time workers characteristics and, 4:1592  
   recommendations regarding, 4:1593–1594  
   retention rates and, 4:1593  
   social exchange theory and, 4:1593  
   statistics regarding, 4:1592  
 Paterson, Donald G., 2:773, 4:1407, 4:1430, 4:1521,  
   4:1641, 4:1642, 4:1655  
 Patient Self-Determination Act (1990), 1:152  
 Patterson, Gerald, 1:326  
 Pavlov, Ivan, 2:541  
**Pay equity, 4:1594–1596**  
   definition of, 4:1594–1595  
   discrimination and, 4:1595  
   gender wage gap and, 4:1595  
   human capital concept and, 4:1595  
   individual-psychological perspective on, 4:1595  
   overpayment vs. underpayment and, 4:1595  
   social-economic movement perspective on, 4:1595  
 PC. *See* **Political correctness (PC)**  
 PCIT. *See* Parent-Child Interaction Therapy (PCIT)  
 PD-NOS. *See* Personality disorder not otherwise  
   specified (PD-NOS)  
 PE. *See* Process-experiential psychotherapy (PE)  
 P-E. *See* **Person-environment interactions (P-E)**  
 Peabody Individual Achievement Test, 4:1393  
 Peabody Picture Vocabulary Test, 4:1393  
 Pearson, Karl, 1:364, 2:938  
 Peatling, John, 4:1658  
 Peavy, R. Vance, 4:1515  
*Pedagogy of the Oppressed* (Freire), 1:91  
**Pedersen, Paul Bodholdt, 3:1258–1261**  
   academic career of, 3:1258–1259  
   childhood of, 3:1258  
   *Counseling Across Cultures* (co-authored by), 3:1260  
   *The Counseling Psychologist* and, 1:263  
   counselor cultural encapsulation and, 3:1090–1091



- culture-centered counseling focus of, **3:1186, 3:1259**
- etic* research criticized by, **3:1082**
- internationalizing of counseling and psychology and, **1:263, 1:264**
- Multiculturalism as a Fourth Force* edited by, **3:1260, 3:1262**
- multicultural psychology work of, **3:1227, 3:1259–1260**
- professional organizations work of, **3:1260**
- publications of, **3:1259–1260**
- research projects of, **3:1260**
- triad training model of, **3:1259**
- Peer relationships
  - AD/HD and, **1:30**
  - of children with chronic illness, **1:76**
  - Olweus Bully Program and, **1:56–57**
- Penderhughes, Elaine, **3:1110**
- People of Color Network, **3:992**
- People of Color Racial Identity Attitudes Scale (POCRIAS), **3:1289**
- Pepinsky, Harold, **1:104, 1:218**
- Perceptual Organization Index (POI), **2:698**
- Performance-based recording behavioral observation method, **1:40–41**
- Performance modeling, 4:1596**
  - adaptive performance and, **4:1596**
  - Borman and Motowidlo's model of, **4:1596**
  - Campbell's model of, **4:1596**
  - classic job performance model and, **4:1596**
  - cognitive, non-cognitive components of, **4:1596**
  - components of, **4:1596**
  - definition of, **4:1596**
  - industrial-organizational psychology and, **4:1596**
  - task vs. contextual performance and, **4:1596**
  - vocational psychology and, **4:1596**
  - work adjustment and, **4:1596**
- Carl D. Perkins Vocational and Applied Technology Education Act Amendments (1998), **4:1450**
- Carl D. Perkins Vocational Education Act (1984), **4:1449**
- Perls, Fritz, **2:542, 2:639–640, 2:761, 2:916**
- Perls, Laura, **2:542, 2:639**
- Permissive parenting style. *See* **Parenting**
- Perry, J. Christopher, **2:733**
- Personal and career counseling, 4:1596–1597**
  - accrediting bodies and, **4:1597**
  - career counseling definitions and, **4:1597**
  - Choosing a Vocation* (Parsons) and, **4:1597**
  - education requirements and, **4:1597**
  - Frank Parsons Vocation Bureau of Boston and, **4:1596–1597**
  - professional organizations of, **4:1597**
  - resources used in, **4:1597**
  - theory, research, and skills applied in, **4:1597**
  - Web sites regarding, **4:1597**
  - work stress and, **4:1684–1686**
- Personal Attributes Inventory, **2:533**
- Personal-Child Relations Questionnaire, **4:1614, 4:1615**
- Personal construction theory
  - constructive alternativism and, **2:523**
  - George Kelly and, **2:523, 2:744–745**
  - relational emotive behavior therapy and, **2:509**
  - Repertory Grid interview and, **2:523**
- Personality assessment, 2:721–729**
  - agreeableness personality trait and, **2:723**
  - Beck Depression Inventory, **2:727**
  - California Psychological Inventory (CPI), **2:725–726**
  - California Q-set, **2:728**
  - characteristic adaptations and, **2:722**
  - Cloninger's Temperament and Character Inventory (TCI), **2:725**
  - conscientiousness personality trait and, **2:723**
  - Costa and McCrae's work in, **2:530**
  - current and future directions regarding, **2:728**
  - Edwards Personal Preference Schedule (EPPS), **2:726**
  - extraversion personality trait and, **2:723**
  - Eysenck Personality Questionnaire Revised (EPQ), **2:725**
  - Goldberg Big Five Markers, **2:724**
  - Grey-Wheelwright Jungian Type Survey, **2:727**
  - Hogan Personality Inventory (HPI), **2:724**
  - Interpersonal Adjective Scales-Revised, **2:724**
  - Jackson Personality Inventory (JPI), **2:725**
  - Keirsey Temperament Sorter, **2:727**
  - Locus of Control scale, **2:727**
  - Minnesota Multiphasic Personality Inventory (MMPI-RF), **2:727**
  - Multidimensional Personality Questionnaire (MPQ), **2:725**
  - Henry Murray's theory of needs and, **2:726**
  - Myers-Briggs Type Indicator (MBTI), **2:726–727**
  - narrative accounts and, **2:722**
  - NEO Personality Inventory, Revised (NEO PI-R), **2:724**
  - neuroticism personality trait and, **2:723**
  - observer rating measures and, **2:727–728**
  - online personality measures and, **2:728**
  - openness personality trait and, **2:723**
  - Personality Assessment Inventory, **2:559**
  - personality inventories and, **2:724–727**
  - Personality Research Form (PRF), **2:726**
  - Personal Preferences Self-Description Questionnaire, **2:727**



- Rotter Incomplete Sentences Blank, **2:727**  
 sentence completion tests and, **2:727**  
 Shedler-Western Assessment Procedure (SWAP-200), **2:728**  
 Singer-Loomis Type Development Inventory, **2:727**  
 single-trait personality scales and, **2:727**  
 Sixteen Personality Factor Questionnaire (16 PF), **2:724, 2:725**  
 Structured Interview for the Five-Factor Model of personality (SIFFM), **2:727–728**  
 traits and, **2:722–724**  
 traits and, five-factor model of, **2:722–724**  
 traits and, meaning of, **2:722**  
 Washington University Sentence Completion Test, **2:722, 2:727**  
 Zuckerman-Kuhlman Personality Questionnaire (ZKPQ), **2:725**  
 See also **Personality assessment and careers; Personality theories, five-factor model (FFM)**  
**Personality assessment and careers, 4:1598–1600**  
 assessing personality to inform career counseling and, **4:1599–1600**  
 the Big Five and, **4:1598**  
 Big Five linked with Holland's Big Six and, **4:1599**  
 biodata measures and, **4:1413–1415**  
 building on strengths and, **4:1600**  
 California Psychological Inventory (CPI) and, **4:1599**  
 Holland's RIASEC model and, **4:1598–1599**  
 Myers-Briggs Type Indicator (MBTI) and, **4:1599**  
 Sixteen Personality Factor Questionnaire (16 PF) and, **4:1599–1600**  
 Strong Interest Inventory and, **4:1600**  
 Personality Assessment Inventory, **2:559**  
 Personality disorder not otherwise specified (PD-NOS), **2:729**  
**Personality disorders, 2:729–735**  
 antisocial personality disorder, **2:730**  
 antisocial personality disorder, comorbidity of, **2:733**  
 avoidant personality disorder, **2:731**  
 avoidant personality disorder, comorbidity of, **2:732, 2:733**  
 borderline personality disorder, **2:730**  
 borderline personality disorder, comorbidity of, **2:732**  
 cluster A (odd-eccentric) and, **2:729–730**  
 cluster A (odd-eccentric) and, comorbidity of, **2:732**  
 cluster B (dramatic-erratic) and, **2:730–731**  
 cluster B (dramatic-erratic) and, comorbidity of, **2:733**  
 cluster C (anxious-fearful) and, comorbidity of, **2:731**  
 cognitive-behavioral therapy for, **2:733**  
 community vs. clinical samples of, **2:732**  
 course and prognosis and, **2:733**  
 dependent personality disorder, **2:731**  
 dependent personality disorder, comorbidity of, **2:733**  
*DSM-IV-R* used to diagnose, **2:729**  
 environmental factors and, **2:732**  
 etiology and, **2:731–732**  
 genetic heritability of, **2:732**  
 histrionic personality disorder, **2:730**  
 histrionic personality disorder, comorbidity of, **2:733**  
 ICD-20 used to diagnose, **2:729**  
 narcissistic personality disorder, **2:730–731**  
 narcissistic personality disorder, comorbidity of, **2:732**  
 obsessive-compulsive personality disorder, **2:731**  
 paranoid personality disorder, **2:729**  
 pathological gambling comorbidity with, **1:228**  
 personality disorder not otherwise specified (PD-NOS), **2:729**  
 prevalence and comorbidity and, **2:732–733**  
 psychological defenses and, **2:554–556, 2:795**  
 psychotherapy for, **2:733**  
 schizoid personality disorder, **2:729**  
 schizophrenia and, **2:845–849**  
 schizotypal personality disorder, **2:729–730**  
 schizotypal personality disorder, comorbidity of, **2:732**  
 treatment implications and, **2:733–734**  
 Personality Research Form (PRF), **2:726**  
**Personality theories, 2:735–737**  
 Alfred Adler's individual psychology, **2:735**  
 Gordon Allport's trait theory, **2:736**  
 Albert Bandura's social cognitive theory, **2:736**  
 cross-cultural psychology and, **3:1084**  
 Erik Erikson's ego development theory, **2:735**  
 Hans Eysenck's biosocial theory, **2:736**  
 five-factor model (Big Five), **2:736–737, 4:1598**  
 Sigmund Freud's id, ego, superego theories, **2:735**  
 frustration-aggression hypothesis, **2:735–736**  
 Karen Horney's social psychoanalytic theory, **2:735**  
 humanistic self-actualization theories, **2:736**  
 integrative conceptual framework of, **2:737**  
 Carl Jung's analytical psychology, **2:735**  
 George Kelly's personal construct theory, **2:736**  
 Rollo May's existential phenomenological psychoanalysis, **2:736**  
 multicultural personality and, **3:1226–1227**  
 object relations theorists, **2:735, 2:761–762**  
 psychodynamic social learning theory, **2:735**  
 Skinner and Watson's radical behaviorism, **2:736**  
 Harry Stack Sullivan's interpersonal theorist work, **2:735**  
 Louis Thurstone's factor analysis, **2:736**



**Personality theories, behavioral, 2:737–743**

basic behavioral repertoires (BBRs) and, 2:742  
 behavior therapy and, 2:470–476, 2:737, 2:742  
 classical conditioning and, 2:738  
 contingency management, 2:741–742  
 Dollard and Miller's theory and, 2:739–740  
 locus of control concept and, 2:741  
 operant conditioning and, 2:738  
 pathology and, 2:741–742  
 psychological behaviorism and, 2:737, 2:742  
 reciprocal determinism, 2:505, 2:741, 2:764  
 relevance of, 2:742–743  
 self-efficacy and, 2:741  
 B. F. Skinner and, 2:870–872  
 Skinner's personality theory and, 2:737, 2:738–739  
 social cognitive theories and, 2:737, 2:740–742  
 social skills training, 2:741–742  
 systematic desensitization, 2:741–742  
 vicarious learning, 2:741  
*See also* Dollard, John; Miller, Neal E.; Skinner, B. F.

**Personality theories, cognitive, 2:743–749**

assessment to measure cognitive style, 2:747–748  
 attribution theory and, 2:744  
 Albert Bandura's social cognitive theory and, 2:737, 2:745–746  
 Aaron T. Beck's work and, 2:469–470, 2:558  
 causal attributions and, 2:744, 2:854, 2:869  
 cognition, emotion and, 2:746–747  
 cognitive style and, 2:745  
 components of, 2:743–746  
 counseling applications of, 2:747–748  
 Daily Record of Dysfunctional Thoughts and, 2:747  
 entity theory and, 2:747  
 future directions regarding, 2:748  
 Fritz Heider's phenomenal causality and, 2:744  
 history of, 2:744  
 William James's focus of attention work in, 2:744  
 Kelly's theory of personal constructs, 2:523, 2:744–745  
 locus of control and, 2:745  
 Walter Mischel's cognitive-affective personality system and, 2:746  
 naïve psychology and, 2:744  
 nomothetic vs. idiographic theories and, 2:743  
 personality change and, 2:748  
 personality change through rational analysis and insight and, 2:743  
 Role Construct Repertory test and, 2:748  
 self-discrepancy theory, 2:746–747  
 stream of consciousness concept and, 2:744

**Personality theories, evolutionary, 2:749–752**

behavioral flexibility and, 2:750–751  
 Brunswikian evolutionary developmental theory and, 2:749, 2:750  
 career choice examples of, 2:749  
 cross-situational consistency of personality traits and, 2:750  
 developmental plasticity theory and, 2:749, 2:750  
 frequency-dependent selection and, 2:750  
 harmful dysfunction hypothesis of personality disorders and, 2:749, 2:751  
 life history traits and, 2:749  
 mismatch hypothesis of personality disorders and, 2:749, 2:751  
 natural and sexual selection and, 2:749, 2:750  
 personality disorders and, 2:750, 2:751–752  
 personality variation and, 2:749–750  
 phenotypic variation and, 2:750  
 social competition factors and, 2:750

**Personality theories, five-factor model (FFM), 2:752–756**

Agreeableness, 2:723, 2:753, 2:754, 2:755, 2:770, 2:865  
 Basic Tendencies and, 2:753  
 career counseling application of, 2:755  
 Raymond Cattell's work in, 2:770  
 Conscientiousness, 2:723, 2:753, 2:754, 2:755, 2:770, 2:865  
 coping and, 2:754  
 Costa and McCrae's work in, 2:530–531  
 description and measurement of, 2:752–753  
 Extraversion, 2:723, 2:752–753, 2:754, 2:755, 2:770, 2:865  
 Five Factor Inventory (NEO-FFI) and, 2:530, 2:752, 4:1598  
 five factors across the life span and, 2:754  
 five-factor theory and, 2:753–754, 4:1407  
 health behaviors and, 2:754–755  
 history of, 2:752  
 implications of counseling practice and, 2:755  
 interpersonal relatedness, 2:753  
 multicultural considerations and, 2:753, 2:755  
 Neuroticism, 2:723, 2:752, 2:754, 2:755, 2:770, 2:865  
 Openness, 2:723, 2:753, 2:754, 2:755, 2:757, 2:770, 2:865  
 personality and careers connection and, 4:1598  
 psychopathology and, 2:755  
 Sixteen Personality Factor Questionnaire (16 PF), 2:752



**Personality theories, phenomenological, 2:756–758**

- basic tenets of, 2:756–757
- borderline personality disorder and, 2:758
- empirical support of, 2:757–758
- existentialism and, 2:757
- how people experience themselves in relation to others and, 2:756
- human experience, subjectivity focus of, 2:756, 2:757
- implications of, 2:758
- inherent goodness of the individual and, 2:756–757
- internal monitoring and, 2:756
- “I” vs. “me” distinction in, 2:756
- Openness to Experience personality trait and, 2:757
- personal meaning focus of, 2:757
- positive psychology and, 2:757
- Carl Rogers’s work and, 2:756–757
- self-actualization and, 2:736, 2:756, 2:757, 2:758, 2:841
- the self focus of, 2:756
- self-regard and, 2:756, 2:758
- strengths and weaknesses of, 2:757
- truth relative to, 2:757

**Personality theories, psychodynamic, 2:758–763**

- childhood relationships, experiences in, 2:758
- contemporary psychodynamic theories and, 2:758–759, 2:762–763
- ego and, 2:759–760
- ego psychology and, 2:761
- ego strength and, 2:585–587
- free association and, 2:607–608, 2:796
- Freudian theory and, 2:758, 2:759–761
- id and, 2:759
- intersubjectivity theory and, 2:763
- Carl Jung and, 2:667–668
- neuroscience research and, 2:763
- object relations theories and, 2:735, 2:761–762
- postmodern psychoanalysis and, 2:762–763
- psychological defenses and, 2:554–556
- relational theory, 2:763
- self psychology and, 2:762
- superego and, 2:735, 2:760–761
- unconscious focus of, 2:758
- See also* Freud, Sigmund: psychoanalytic theory of; Self psychology

**Personality theories, social cognitive, 2:763–769**

- applications of, 2:767–768
- background regarding, 2:764–765
- Albert Bandura’s work and, 2:467–469, 2:763–764
- self-efficacy theory and, 2:765–767
- social cognitive theory and, 2:767

*Social Learning and Personality Development* (Bandura and Walters) and, 2:764

*See also* Bandura, Albert; Self-efficacy/perceived competence; Social cognitive career theory (SCCT); Social cognitive theory

**Personality theories, traits, 2:769–772**

- Gordon Allport’s trait theory and, 2:770
- behavior patterns resulting from, 2:769–770
- Big Five theory of, 2:770, 2:771, 4:1598
- character strengths, positive psychology and, 2:783
- correlational studies of, 2:771
- Costa and McCrae’s work in, 2:530
- definition of traits, 2:769–770
- the degree of the trait and, 2:769
- density-distributions theory of, 2:770
- description of individuals and, 2:770–771
- developmental changes of, 2:771–772
- endurance of, 2:769
- Hans Eysenck’s theory of, 2:770
- flexibility of behavior and, 2:771
- future directions regarding, 2:772
- Happiness predicted by, 2:771
- how traits relate to each other and, 2:770
- individuals described by, 2:769
- interpersonal circumplex model of, 2:771
- multicultural personality and, 3:1226–1227
- objective outcomes predicted by, 2:771
- optimism, pessimism and, 2:707–710
- people differ from each other and, 2:769
- PTSD and, 2:786
- reality of traits and, 2:771
- relevance of traits and, 2:771
- underlying causal forces of, 2:770
- Values in Action Inventory of Strengths and, 2:783

Personal Preferences Self-Description Questionnaire, 2:727

*Personal Psychology* journal, 4:1569

**Personal space, 3:1261–1262**

- business relationships and, 3:1261
- counseling implications of, 3:1261
- cultural meaning differences in, 3:1261
- cultural respect and, 3:1261
- gender differences in, 3:1261
- nonverbal communication using, 3:1261
- social standing or class factor in, 3:1261
- Personal validation of feminist therapy, 1:210–211
- Personal Viewers Survey of hardiness, 2:624
- Person-centered therapy
  - Carl Rogers’ work in, 1:128, 1:332, 2:541–542, 2:543, 2:601, 2:638–639, 2:648



**Person-environment fit, 4:1600–1602**

adaptation and, 3:956  
 assessing fit and, 4:1601–1602  
 biodata measures and, 4:1413–1415  
 commonalities of models of, 4:1600  
 congruence concept and, 4:1602  
 correspondence concept and, 4:1602  
 culture shock and, 3:1106–1107  
 Environmental Assessment Technique and, 4:1601  
 historical and theoretical influences on, 4:1601  
 Holland's theory of personalities and work environment fit and, 4:1600, 4:1601, 4:1602  
 job satisfaction, well-being and, 4:1557–1559, 4:1602  
 measurement assumptions regarding, 4:1601  
 ongoing influence and, 4:1602  
 outcomes prediction and, 4:1601–1602  
 Frank Parson's theory of, 4:1600  
 person-environment interactions (P-E) and, 2:772–777  
 stress conceptualizations and, 4:1601  
 subjective or objective debate and, 4:1601  
 theory of work adjustment and, 2:773, 4:1557–1558, 4:1655–1657  
 trait-factor counseling and, 4:1600, 4:1663–1665  
 UNIACT and, 4:1667  
 work-bound youth and, 4:1678–1680

*See also* **Holland's theory of vocational personalities and work environments;**  
**Person-environment interactions (P-E)**

**Person-environment interactions (P-E), 2:772–777**

action theory and, 4:1397–1400  
 adaptation and, 3:956  
 career/life and, 4:1488–1489  
 confirmatory bias and, 2:776  
 coping and, 2:526–530  
 cross-validation and, 2:776  
 culture shock and, 3:1106–1107  
 future directions regarding, 2:776  
 individual abilities fit to environment demands and, 2:774  
 individual desires fit to environment supplies and, 2:773, 2:774  
 lack of commensurate measurement and, 2:775  
 leisure psychology and, 2:774  
 longitudinal research and, 2:775–776  
 Frank Parsons' work and, 4:1489  
 P-E fit and, 2:773  
 P-E interaction model and, efficacy of, 2:774  
 P-E interaction model and, flaws in research and, 2:775–776  
 P-E interaction model and, illustrations of, 2:773–774

Plato's *The Republic* example of, 2:772–773  
 reliance on regression analysis and, 2:775  
 sampling inadequacies and, 2:775  
 social psychology and, 2:774  
 socioeconomic factors and, 3:1328  
 theory of work adjustment and, 2:773, 4:1557–1558, 4:1655–1657  
 use of fit indexes and, 2:775  
 vocational psychology and, 2:773–774

*See also* **Holland's theory of vocational personalities and work environments;**  
**Person-environment fit**

**Person matching, 4:1602–1603**

interest inventories and, 4:1602–1603  
 Kuder Career Search with Person Match and, 4:1603  
 UNIACT and, 4:1667

Personnel Assessment Selection System, 4:1393

**Persons with disabilities, 4:1603–1605**

career counseling for, 4:1434–1435, 4:1459  
 career counseling goals for, 4:1604  
 career development and, 4:1531  
 disability rights movements and, 4:1604  
 enabling environment vs. environmental barriers and, 4:1603–1604  
 future directions regarding, 4:1605  
 historical considerations regarding, 4:1604  
 influences and, 4:1605  
 International Classification of Functioning, Disability and Health (ICF), 4:1603  
 job sharing and, 4:1560  
 low-incidence disabilities and, 1:281–283  
 sociocultural deprivation and, 4:1604  
 WHO ICF guidelines for, 4:1604–1605

*See also* **Individuals with Disabilities Education Act (IDEA); Low-incidence disabilities**

Pervasive developmental disorder-not otherwise specified.

*See* **Autism/Asperger's syndrome**

Pessimism. *See* **Optimism and pessimism**

Peterson, Christopher

positive psychology and, 2:781  
 Values in Action Inventory of Strengths and, 2:783

Peterson, Marilyn R., 2:833

*PGA Tour, Inc. v. Martin*, 1:25

Pharr, Suzanne, 3:1318

Phenomenology qualitative method

bracketing, *epoche* in, 1:360  
 horizontalization in, 1:360  
 lived experiences exploration by, 1:360  
 statements clustered into themes and, 1:360  
 unstructured interviews used in, 1:360



- Philipson, I. J., 1:212
- Philosophy, psychology worldview and, 3:1385
- Phinney, Jean S., 3:1166, 3:1230
- Phrenology, 1:330–331**
- contributions of, 1:331
  - Franz Joseph Gall and, 1:330
  - Philadelphia Prenological Society (1822) and, 1:330
  - psychology-neurology link and, 1:331
  - skull shape analysis and, 1:330
  - J. G. Spruzheim and, 1:330
- Physical activity counseling, 2:777–779**
- approaches to, 2:777–778
  - decision making, behavior change and, 2:777
  - exercise and sport psychology, 1:194–197
  - exercise counseling term and, 2:777
  - future needs regarding, 2:779
  - inactivity as public health concern and, 2:777
  - motivational interviewing method of, 2:778
  - person-centered approach of, 2:777
  - person-centered approach of, guidelines for, 2:778
  - physical health and, 2:779–781
  - setting for using, 2:778–779
  - skills required for, 2:778
- Physical health, 2:779–781**
- Elizabeth Altmair's work in, 1:21–22
  - behavior-based exercise interventions and, 1:95
  - biopsychosocial model of health status and, 2:779–780
  - cancer management and, 1:59–63
  - community-based health promotion and, 1:95–96
  - comorbidity of physical and psychological conditions and, 2:780
  - computerized interventions and, 1:96
  - control, self-monitoring in, 1:95
  - counseling and health status and, 2:780–781
  - counseling psychology and, 2:779, 2:780–781
  - depression and, 2:780
  - distress-related immune dysregulation and, 2:781
  - eating disorders and, 2:579–585, 2:780
  - economic psychosocial costs of disease and, 2:780
  - exercise and sport psychology, 1:194–197
  - Five Factor model of personality theory and, 2:754–755
  - forgiveness and, 2:606
  - health belief model and, 1:235–237
  - health psychology doctoral degree and, 1:357
  - Healthy People 2010* and, 1:96, 2:780
  - healthy personality and, 2:779
  - holistic health integration of body and mind and, 2:781
  - hope and, 2:635
  - illness to wellness continuum and, 2:780
  - job satisfaction, well-being and, 4:1557–1559
  - lifestyle factors and, 2:780
  - micro-, meso-, macro-level variables in, 2:781
  - multi-layered ecological approach to, 2:781
  - of Native Americans, 3:974–975
  - negative emotions and, 2:781
  - occupational stress and, 1:313–316
  - physical activity counseling and, 2:777–779
  - positive psychology and, 2:780
  - problem-solving appraisal and, 2:789
  - psychological health and, 2:779
  - Carol D. Ryff's work in, 2:842–843
  - sedentary lifestyle and, 1:95–96
  - sleep disorders and, 1:393–395
  - socioeconomic status and, 3:1328
  - tailored-message outcome studies and, 1:95
  - women's physical health and, 3:1315–1316
  - work stress and, 4:1685
- Piaget, Jean
- assimilation and, 2:744
  - children's play and, 1:331
  - constructivist approach of, 1:10, 2:522
  - learning development stages and, 2:562
- PIC. See Prescreening, in-depth exploration, and choice model (PIC)**
- Pierce, Chester, 3:1290, 3:1294
- Pike, Kenneth L., 3:1082, 3:1083, 3:1145, 3:1146
- Placebo effect, 2:593–594
- Plato, 1:305, 1:364, 2:562, 2:772–773, 4:1429
- Play therapy, 1:331–334**
- active play therapy and, 1:332
  - Adlerian therapy and, 2:458
  - art therapy and, 1:27
  - Association for Play Therapy (APT) and, 1:333
  - for children with chronic illness, 1:79
  - controversy regarding, 1:332–333
  - definition of, 1:331–332
  - ecosystemic play therapy and, 1:332
  - filial therapy and, 1:332
  - functions of play and, 1:331–332
  - goal-oriented structured therapy and, 1:332
  - history of, 1:332
  - International Association for Play Therapy (IAPT) and, 1:333
  - International Journal of Play Therapy* and, 1:333
  - meta-analysis of outcome studies of, 1:333
  - optimal session studies and, 1:333
  - outcomes of, 1:332–333
  - parental involvement importance in, 1:333
  - parent-child interaction therapy and, 1:332
  - Jean Piaget and, 1:331



- play as self-therapy for children and, **1:332**
- play as the singular central childhood activity and, **1:331**
- release therapy and, **1:332**
- summary regarding, **1:333–334**
- therapy and, **1:332**
- traditional play therapy and, **1:332**
- training and qualifications for, **1:333**
- Plessy v. Ferguson*, **3:952**
- “separate but equal” concept of, **3:1047**
- Pliszka, Steven, **1:157**
- Pluralism, 3:1262–1263**
  - counseling implications of, **3:1262–1263**
  - cultural relativism and, **3:1094–1095**
  - cultural values and, **3:1095–1097**
  - definition of, **3:1262**
  - enculturation and, **3:1129–1131**
  - existence of multiple realities and, **3:1262**
  - Greek philosophers and, **3:1262**
  - growth of in counseling, **3:1262–1263**
  - multiculturalism and, **3:1220**
  - multiculturalism as “fourth force” in counseling and, **3:1262**
  - natural world based in multiple elements and, **3:1262**
  - philosophical and sociological perspectives of, **3:1262**
  - social justice and, **3:1263**
  - universalism and, **3:1359–1361**
  - Western, Eurocentric counseling tradition and, **3:1262–1263**
- PMR. *See* Progressive muscle relaxation technique (PMR)
- PMT. *See* Parent management training (PMT)
- POCRIAS. *See* People of Color Racial Identity Attitudes Scale (POCRIAS)
- POI. *See* Perceptual Organization Index (POI)
- Policies for Accreditation Governance* (APA), **1:1**
- Political correctness (PC), 3:1263–1264**
  - bias reduction and, **3:1015**
  - color-blind racial ideology and, **3:1063–1065**
  - controversy regarding, **3:1264**
  - counseling implications of, **3:1264**
  - feminist reaction to, **3:1264**
  - free speech issue and, **3:1264**
  - Illiberal Education* (D’Souza) and, **3:1264**
  - university speech codes and, **3:1264**
- Polkinghorne, Donald E., **2:522, 2:523**
- Pollack, Robert, **2:891**
- Ponterotto, Joseph, **1:263, 3:1226**
- Pope, Kenneth, **2:835**
- Pope-Davis, Donald, **4:1639**
- Pornography, **3:1318**
- Portes, A., **3:950**
- Position Classification Inventory, **4:1544, 4:1545**
- Positive Aspects of Caregiving Scale, **1:68**
- Positive psychology, 2:781–784**
  - autonomy and, **2:553–554**
  - cancer management and, **1:59–63**
  - career counseling and, **2:782**
  - character strengths feature of, **2:783**
  - counseling psychology and, **2:782**
  - Mihaly Csikszentmihalyi’s work in, **2:551, 2:781**
  - definition of, **2:781**
  - early psychology history and, **2:782**
  - eudaimonia concept and, **2:782**
  - existentialism and, **2:782**
  - fatalism and, **3:1150**
  - “flow” and, **2:784**
  - future directions regarding, **2:784**
  - historical background of, **2:782–783**
  - hope and, **2:634–637**
  - humanistic movement and, **2:782**
  - hygiology concept and, **2:782**
  - intrinsic motivation and, **2:553–554, 2:660–666**
  - job satisfaction, well-being and, **4:1557–1559**
  - life satisfaction and, **2:784**
  - meaning in life and, **2:784**
  - motivational movement of, **2:782**
  - multicultural focus in, **2:784**
  - phenomenological personality theory and, **2:757**
  - physical health and, **2:780–781**
  - positive institutions focus of, **2:781**
  - positive subjective experiences focus of, **2:781**
  - positive traits focus of, **2:781**
  - psychological well-being and, **2:803**
  - salutogenesis concept and, **2:782**
  - self-determination theory and, **2:553–554, 2:662–663**
  - Martin Seligman’s work in, **2:869**
  - social support and, **2:872–875**
  - therapeutic applications of, **2:784**
  - Values in Action Inventory of Strengths and, **2:783**
  - well-being research and, **2:783–784**
- Positivist paradigm, 2:785**
  - critical multiplism vs., **2:785**
  - Descarte’s theory of knowledge and, **2:785**
  - Hume’s theory of the nature of reality and, **2:785**
  - internal vs. external validity of, **2:785**
  - Paul E. Meehl and, **2:684–686**
  - methodological individualism and, **2:785**
  - micro-level experimentation and, **2:785**
  - phenomenological personality theory and, **2:757**
  - scientific knowledge truth about reality and, **2:785**



- symptoms vs. causes of problems and, **2:785**  
 unified scientific world-conception concept and, **2:785**  
 Vienna Circle and, **2:785**
- Postdegree/prelicensure supervision, 1:334–337**  
 ASPPB/NR Designated Doctoral Programs and, **1:396**  
 clinical supervision models and, **1:335**  
 ethics, competency to practice and, **1:335**  
 feedback in counseling training, immediate and, **1:207–209**  
 licensure candidates recommendations and, **1:336**  
 mentoring and, **1:296–299**  
 multicultural, gender, sexual orientation sensitivity and, **1:336**  
 postgraduate supervision and, **1:335**  
 Helen J. Roehlke and, **1:375–377**  
 supervision defined and, **1:334–335**  
 supervision vs. consultation and, **1:335**
- Postdoctoral training, 1:337–341**  
 1972 Menninger Clinic conference and, **1:337**  
 1973 Vail conference and, **1:337, 3:1087, 3:1222, 3:1228**  
 accreditation standards for, **1:338**  
 accredited program characteristics and, **1:338**  
 1987 National Conference on Graduate Education in Psychology and, **1:337**  
 1990 APA convention and, **1:337**  
 1994 APA National Conference on Postdoctoral Education and, **1:337–338**  
 APA and, **1:337–339**  
 APPIC membership criteria for, **1:337**  
 ASPPB/NR Designated Doctoral Programs and, **1:396**  
 Association of Psychology Postdoctoral and Internship Centers (APPIC) and, **1:337, 1:395**  
 characteristics of, **1:339–341**  
 Commission on Education and Training Leading to Licensure and, **1:338, 1:339**  
 developmental perspective on, **1:340**  
 formal vs. informal training and, **1:339–340**  
 funding, mean salaries and, **1:340–341**  
 future directions in, **1:341**  
 history of, **1:337–339**  
 Inter-Organizational Council for the Accreditation of Postdoctoral Training Programs and, **1:337**  
 Joint Council on Professional Education in Psychology and, **1:337**  
 licensure and, **1:338–339**  
 licensure and, training year controversy and, **1:339**  
 mentoring and, **1:296–299**  
 National Conference on Postdoctoral Training in Professional Psychology and, **1:337**  
 national standards development and, **1:338**  
 Helen J. Roehlke and, **1:375–377**  
 specialty practice and, **1:337, 1:340**  
 supply and demand imbalance for, **1:339**  
 training emphasis and sites of, **1:339**  
 Web sites regarding, **1:341**
- Postman, Leo J., **2:593**
- Postmodernism  
 constructivist career counseling and, **4:1514**  
 family counseling and, **1:204**  
 Native American career counseling and, **4:1457**  
 postmodern psychoanalysis and, **2:762–763**  
 psychodynamic personality theories and, **2:762–763**  
 rational emotive behavior therapy and, **2:509**
- Poston, W. S. Carlos, **3:1028, 3:1229**
- Postpositivism, **1:365, 2:684**
- Posttraumatic stress disorder (PTSD), 2:786–787**  
 abuse victims and, **2:443–444**  
 anxiety and panic conceptual model of, **2:786**  
 anxiety disorder, stress and, **2:885**  
 assessment of, **2:786**  
 cigarette smoking and, **1:88–89**  
 Clinician-Administered PTSD Scale for the DSM-IV and, **2:786**  
 cognitive restructuring therapies and, **2:787**  
 Christine A. Courtois's work and, **1:140–142**  
 crisis counseling and, **2:544–548**  
 critical incident stress debriefing and, **2:548–550**  
 disasters, impact on children and, **1:161–165**  
*DSM-IV-TR* diagnostic criteria of, **2:786**  
 ethnic cleansing survivors and, **3:1133**  
 exposure-based therapy for, **2:787**  
 eye movement desensitization, reprocessing (EMDR) and, **1:198–202**  
 forensic victim counseling and, **1:215**  
 gender differences in, **2:786**  
 Minnesota Multiphasic Personality Inventory-2 (MMPI-2) and, **2:786**  
 Mississippi Scale for Combat-Related PTSD and, **2:786**  
 National Center for Posttraumatic Stress Disorder (NCPTSD) of VA, **1:155**  
 Native Americans and, **3:976**  
 personality traits factors in, **2:786**  
 pharmacological treatment of, **2:787**  
 Potential Stressful Events Interview and, **2:786**  
 psychosocial risk factors of, **2:786**  
 PTSD Checklist and, **2:786**  
 PTSD Diagnostic Scale and, **2:786**  
 refugees and, **3:1133–1134, 3:1299**  
 Structured Clinical Interview for the DSM-IV and, **2:786**



symptom clusters of, **2:786**  
in third world countries, **3:1348**  
Traumatic Stress Schedule and, **2:786**  
treatment of, **2:786–787**  
White vs. people of color differences in, **3:1296**  
*See also* **Disasters, impact on children**

Potential Stressful Events Interview, **2:786**

**Poverty, 3:1264–1269**

classism and, **3:1054–1059**  
consequences of, **3:1265–1266, 3:1268**  
definition of, **3:1266–1267**  
environmental racism and, **3:1267, 3:1328**  
factors contributing to, **3:1265**  
health care disparities and, **3:1267**  
immigrants and, **3:1265**  
income-to-poverty ratio definition of, **3:1266–1267**  
living standards across nations and, **3:1265**  
long-range effects of, **3:1265**  
poverty thresholds definition of, **3:1266–1267, 3:1326**  
psychological stress, mental illness and, **3:1265**  
social causation theory and, **3:1266**  
social class, classism and, **3:1267–1268**  
social class and, **4:1626–1627**  
social selection theory and, **3:1266**  
statistics regarding, **3:1265, 3:1326**  
women and children and, **3:1265**

Power, Paul G., **4:1579**

**Power and powerlessness, 3:1269–1274**

abusive relationships and, **3:1271**  
addictions and, **3:1272**  
age and, **3:1273**  
authority power and, **3:1269**  
coercive power and, **3:1271**  
collective power and, **3:1270**  
counseling relationships and, **3:1270–1271**  
disability and, **3:1272**  
dominant discourse and, **3:1271**  
examples of, **3:1271–1274**  
expert power and, **3:1271**  
fatalism and, **3:1150**  
force power and, **3:1269, 3:1271**  
history and development of, **3:1271**  
influence power and, **3:1269**  
learned powerlessness and, **3:1270**  
legitimate power and, **3:1271**  
male heterosexual power universality and, **3:1271–1272**  
multicultural considerations and, **3:1273–1274**  
Nietzsche's "will of power" concept and, **3:1271**  
oppression and, **3:1269**  
outcome power vs. social power and, **3:1271**

ownership of power and, **3:1269**  
power as choice and, **3:1271**  
power definitions and, **3:1269–1270**  
powerlessness definitions and, **3:1269–1270**  
power relationship changes and, **3:1271**  
primary power and, **3:1271**  
race and, **3:1271–1272**  
racial, class, and gender oppression and, **3:1269**  
referent power and, **3:1271**  
reward power and, **3:1271**  
self-efficacy and, **3:1269**  
sex/gender and, **3:1272–1273**  
sexual violence, coercion and, **1:391–393**  
White Americans and, **3:1371–1375**  
White privilege and, **3:1375–1380**  
*See also* **Empowerment**

PPD. *See* Paranoid personality disorder (PPD)

Prediger, Dale, **2:925**

**Predoctoral internships, 1:342–346**

APA Boulder Conference (1949) and, **1:342, 1:389–390**  
*APPIC Directory Online* and, **1:344**  
APPIC Match, internship matching program and, **1:342, 1:344–345**  
application process for, **1:344**  
Association of Psychology Postdoctoral and Internship Centers (APPIC) and, **1:342–345**  
emphasis areas of, **1:343–344**  
feedback in counseling training, immediate and, **1:207–209**  
financial considerations, mean internship salaries and, **1:343**  
future directions in, **1:345**  
half-time internships and, **1:342**  
history of, **1:342**  
National Conference on Internship Training in Psychology, **1:342**  
"rank order list" of, **1:344–345**  
Helen J. Roehlke and, **1:375–377**  
standardized application and, **1:344**  
student perspective on, **1:345**  
supply and demand imbalance for, **1:342–343, 1:345**  
uniform letter of recommendation for, **1:344**  
"uniform notification" system of internship offers and, **1:342**  
Web sites regarding, **1:346**

**Prejudice, 3:1274–1277**

Allport's psychological model of, **3:1294**  
antisemitism, the Holocaust and, **3:1275**  
authoritarian personality and, **3:1275**  
benevolent prejudice, paternalism and, **3:1117**



- bias and, **3:1014–1016**  
 Kenneth Bancroft Clark and, **3:1050–1052**  
 classism and, **3:1054–1059**  
 color-blind racial ideology and,  
     **3:1063–1065, 3:1276**  
 contact hypothesis and, **3:1228**  
 counselor self-knowledge and, **3:1276**  
 counselor training and, **3:1277**  
 cross-cultural counseling and, **3:1276–1277**  
 deficit hypothesis and, **3:1109–1111**  
 definition of, **3:1114, 3:1274**  
 discrimination and oppression and, **2:572–575**  
 discrimination vs., **3:1114, 3:1274**  
 dominant status maintenance and, **3:1275**  
 drapetomania and, **3:1124–1125**  
 Eurocentric psychotherapy worldview and,  
     **3:1276, 3:1277**  
 GLB therapy and, **2:613–615**  
 historical perspective on, **3:1275–1276**  
 identity crises and, **3:1274**  
 immigrants and, **3:1171–1172**  
 ingroup vs. outgroup thinking and, **3:1275**  
 of mental health professional, **3:1276**  
 modern, subtle forms of, **3:1275–1276**  
 multicultural psychology and, **3:1228–1229**  
 optimal distinctiveness theory of, **3:1228–1229**  
 psychological distress and, **3:1276**  
 race-related stress, **3:1377**  
 racial microaggressions and, **3:1290–1291**  
 reasons for, **3:1275**  
 social dominance theory and, **3:1275**  
 stereotype threat and, **3:1228, 3:1274**  
 survival response of, **3:1275**  
 tokenism and, **3:1349–1350**  
 transference, countertransference and, **3:1276**  
 unlearning process of, **3:1275**  
 xenophobia and, **3:1380**  
*See also Antisemitism; Discrimination;*  
     **Discrimination and oppression; Racism; Social**  
     **discrimination; Stereotype; Stereotype threat**  
 Prelicensure supervision. *See Postdegree/prelicensure*  
     **supervision**  
 Preschool Language Scale, **2:670**  
**Prescreening, in-depth exploration, and choice model**  
     (PIC), **4:1605–1608**  
     career guidance and counseling applications of, **4:1608**  
     choice stage of, **4:1606**  
     decision-making models and, **4:1605**  
     descriptive decision-making models and, **4:1606**  
     future directions regarding, **4:1608**  
     in-depth exploration of promising alternatives  
         stage of, **4:1606**  
     normative decision-making models and, **4:1606**  
     PIC Model in guidance or counseling, **4:1608**  
     prescreening the potential alternatives stage of,  
         **4:1605–1606**  
     prescreening the potential alternatives stage of,  
         steps of, **4:1606** (figure)  
     prescriptive decision-making models and, **4:1606**  
     research findings regarding, **4:1608**  
     sensitivity analysis and, **4:1607**  
     sequential elimination in, **4:1606–1607**  
     Web site regarding, **4:1608**  
**Prescription privileges, 1:346–352**  
     American Association of Applied and Preventive  
         Psychology opposition to, **1:347**  
     APA's proposal regarding, **1:347, 1:349–350**  
     continuity of care issue regarding, **1:350–351**  
     expense issue regarding, **1:349**  
     future directions in, **1:351–352**  
     history of, **1:347–348**  
     Louisiana legislation regarding, **1:346, 1:347, 1:348**  
     the military and, **1:347, 1:351**  
     New Mexico legislation regarding, **1:346, 1:347–348**  
     PPP, psychologist prescription privilege and, **1:346**  
     precedent, pilot projects regarding, **1:351**  
     pros and cons of, **1:348–351**  
     Psychopharmacology Demonstration  
         Project and, **1:351**  
     societal need issue regarding, **1:349**  
     state legislation regarding, **1:346**  
     training issue regarding, **1:349–350**  
 Presenting issue. *See Clinical presenting issues*  
 President's New Freedom Commission on Mental Health,  
     **1:155, 1:288, 1:289, 1:293, 2:849, 3:994**  
 Prevent Child Abuse America report, **1:72**  
 PRF. *See Personality Research Form (PRF)*  
 Price, R. H., **4:1556**  
*Principles of Behavior Modification* (Bandura), **2:764**  
*Principles of Biomedical Ethics*  
     (Beauchamp and Childress), **1:270**  
*The Principles of Psychology* (William James), **2:858**  
**Private practice career counseling, 4:1609**  
     business skills and, **4:1609**  
     contract work and, **4:1517–1518**  
     emergence of, **4:1448–1449**  
     fee-for-service basis of, **4:1609**  
     individual career counseling and, **4:1609**  
     National Career Development Association guidelines  
         for, **4:1609**



organizational career counseling and, **4:1433–1434, 4:1609**

private practice settings and, **4:1433–1434**

specialized, on-demand services and, **4:1609**

**Problem-solving appraisal, 2:787–791**

anxiety, worry and, **2:789**

coping and, **2:526–530, 2:789**

depression and, **2:788**

discreet thought processes research and, **2:788**

educational and vocational issues regarding, **2:789–790**

Puncky Paul Heppner and, **2:631**

historical overview of, **2:788**

hopelessness, suicidality and, **2:788–789**

implications of, **2:790**

physical health and, **2:789**

Problem Solving Inventory and, **2:788**

problem-solving skills and, **2:790**

psychosocial adjustment and, **2:788–789, 2:790**

**Problem-solving skills training (PSST)**

conduct disorder and, **1:102**

problem-solving therapy and, **2:505**

**Process. See Counseling process/outcome; Process and outcome research; Therapy process, individual**

**Process and outcome research, 4:1609–1611**

analogue inquiry settings and, **4:1610**

combined use in career counseling and, **4:1611**

counseling process definition and, **4:1610**

covert and overt therapist and client variables and, **4:1610**

effects measurement and, **4:1610**

explanation of, **4:1609–1610**

focuses of specific processes and, **4:1610**

meta-analyses of, **4:1611**

naturalistic settings of, **4:1610**

outcome criteria and, **4:1610–1611**

outcome definition and, **4:1610**

outcome research in career counseling and, **4:1610–1611**

process inquiry and, **4:1610**

process inquiry and, design decisions of, **4:1610**

process research in career counseling and, **4:1610**

process variables in, **4:1610**

*See also* **Counseling process/outcome; Outcomes of counseling and psychotherapy**

**Process-experiential psychotherapy (PE)**

collaborative therapy relationship focus of, **2:640**

emotion-focused therapy and, **2:640**

empathy emphasis in, **2:640**

Gestalt techniques and, **2:640–641**

techniques used in, **2:640–641**

Processing Speed Index (PSI), **2:698**

Prochaska, James O., **2:487–488, 2:542, 2:648**

**Professional associations, counseling, 1:352–355**

ACA Foundation, **1:353**

ACA insurance trust, **1:353**

American Association for Counseling and Development (AACD), **1:353**

American College Personnel Association (ACPA), **1:352–353**

American Counseling Association (ACA), **1:353, 1:355**

American Personnel and Guidance Association (APGA), **1:352–353**

Association for Counselor Education and Supervision (ACES), **1:353**

Association for Gay, Lesbian, and Bisexual Issues in Counseling (AGLBIC), **1:353**

Association for Multicultural Counseling and Development (AMCD), **1:353**

Association for Spiritual, Ethical, and Religious Values in Counseling (ASERVIC), **1:125, 1:353, 2:881**

Chi Sigma Iota (CSI) international honorary society, **1:354**

Council for Accreditation of Counseling and Related Educational Programs (CACREP), **1:353, 1:354**

Counseling Association of Humanistic Education and Development (C-AHEAD), **1:353**

*Counseling Newsletter* and, **1:353**

Counselors for Social Justice (CSJ), **1:353**

history of, **1:352–353**

*Journal of Counseling and Development* (JCD) and, **1:353**

*Layperson's Guide to Counselor Ethics* and, **1:353**

licensure, certification, accreditation focus of, **1:353**

National Association of Guidance and Counselor Trainers (NAGCT), **1:352–353**

National Board for Certified Counselors (NBCC), **1:353, 1:354**

National Career Development Association (NCDA), **1:353**

National Vocational Guidance Association (NVGA), **1:352–353**

organizational structure of, **1:354–355**

partnerships with, **1:353–354**

publications of, **1:354**

Student Personnel Association for Teacher Education (SPATE), **1:352–353**

Web sites regarding, **1:355**

**Professional degrees, 1:355–357**

clinical psychology programs and, **1:356**

counseling psychology programs and, **1:356**



- doctoral degree, 1:356–357  
 doctor of education (Ed.D.), 1:356  
 doctor of philosophy (Ph.D.), 1:356  
 doctor of psychology (Psy.D.), 1:356  
 educational specialist (Ed.S.), 1:356  
 forensic psychology subspecialty and, 1:356  
 health psychology subspecialty and, 1:357  
 industrial-organizational psychology subspecialty and, 1:357  
 juris doctor degree (J.D.), 1:356  
 licensed clinical social worker (LCSW), 1:356  
 licensed marriage and family therapist (LMFT), 1:355–356  
 licensed professional counselor (LPC), 1:356  
 master's degree, 1:355–356  
 master's degree, licensure and, 1:355–356  
 neuropsychology subspecialty and, 1:357  
 postdegree/prelicensure supervision, 1:334–337  
 postdoctoral training and, 1:337–341  
 predoctoral internships and, 1:342–346  
 social work doctoral degree, 1:357
- Progressive muscle relaxation technique (PMR), 2:890
- Projective techniques, 2:791–794**  
 categories of, 2:791  
 controversy regarding, 2:792, 2:793  
 decline in popularity of, 2:791  
 feedback from, 2:793–794  
 human figure drawing methods and, 2:793, 2:811  
 normative data adequacy issue of, 2:792, 2:793  
 projective hypothesis and, 2:791  
 proponents of, 2:791  
 psychopathology and personality assessment using, 2:793  
 Rorschach and, 2:792, 2:811  
 summary regarding, 2:811–812  
 Thematic Apperception Test (TAT) and, 2:792–793  
 therapist interpretation and, 2:910–911  
 use of, 2:793–794  
 validity issues of, 2:792, 2:793  
 Washington University Sentence Completion Test (WUSCT) and, 2:793
- Prosser, J., 4:1455
- PRS. *See* Parent Rating Scale (PRS), of BASC-2
- Prudence self-pertaining virtue, 1:441–442
- PSI. *See* **Parenting Stress Index** (PSI); Processing Speed Index (PSI)
- PSST. *See* Problem-solving skills training (PSST)
- Psychiatric Research Interview for Substance and Mental Disorders (PRISM), 2:490
- Psychoanalysis and psychodynamic approaches to therapy, 2:794–799**  
 AD/HD and, 1:31–32  
 art therapy and, 1:27  
 brief therapy and, 2:479–483  
 childhood experiences in shaping personality and, 2:795, 2:796  
 core assumptions of, 2:795–796  
 countertransference element of, 2:797  
 couple and marital counseling and, 1:138  
 developmental framework importance in, 2:795–796  
 dream interpretation element of, 2:798  
 dynamic unconscious element in, 2:795  
 ego psychology and, 2:794, 2:796  
 ego strength and, 2:585–587  
 the frame therapeutic structure and, 2:798  
 free association element of, 2:607–608, 2:796, 2:798  
 Sigmund Freud's psychoanalysis foundation of, 2:794  
 insight importance in, 2:798  
 interpretation element of, 2:798, 2:910–911  
 William James' self-concept theory and, 2:858  
 Carl Jung and, 2:667–668  
 key elements of, 2:796–799  
 object relations theory and, 2:794, 2:796  
 personality disorders and, 2:733  
 psychoanalysis definition and, 2:794  
 psychoanalytic theory and, 2:794  
 psychodynamic psychotherapy definition and, 2:794  
 psychological defenses and, 2:554–556, 2:795  
 relational and interpersonal models and, 2:794, 2:796  
 self-disclosure and, 2:851–852  
 self psychology and, 2:794, 2:796  
 separation-individuation theory and, 2:794, 2:796  
 theories and therapies emphasizing background and, 2:540–541  
 therapeutic relationship as curative agent and, 2:798–799  
 transactional analysis and, 2:926–928  
 transference element of, 2:796–797  
 working alliance element of, 2:797–799  
*See also* **Freud, Sigmund; Transference and countertransference**
- Psychodynamic therapy. *See* **Psychoanalysis and psychodynamic approaches to therapy**
- Psychoeducation, 2:799–803**  
 Community Mental Health Act (1963) and, 2:799  
 components of, 2:800–802  
 cultural concerns and, 2:801–802  
 definition of, 2:800



- deinstitutionalization of mental patients  
and, **1:117, 2:799**  
development of, **2:799–800**  
eating disorders and, **2:579–585**  
family-focused treatments and, **2:800**  
“fixed but flexible” treatment model of, **2:801**  
format and duration of, **2:801**  
group settings and, **2:801**  
group therapy and, **2:618–622**  
individual, family, group formats and, **2:800**  
outcomes of, **2:802**  
settings using, **2:800**  
stages of, **2:802**  
therapeutic modalities and, **2:800**  
therapist’s facilitator role and, **2:799, 2:802**  
treatment goals of, **2:801**
- Psychological Assessment Inventory (PAI), **2:813**
- Psychological well-being, dimensions of (PWB), 2:803**  
colonized, indigenous peoples and, **3:1258**  
cross-cultural research on, **3:1085**  
culture shock and, **3:1106–1107**  
developmental studies of, **2:803**  
discrimination an, **4:1633**  
ethnicity and, **3:1137, 3:1139**  
factor analysis studies of, **2:803**  
forgiveness and, **2:605–607**  
happiness/hardiness and, **2:623–626**  
hope and, **2:635–636**  
identity development and, **3:1162**  
job satisfaction and general well-being and,  
**4:1557–1559**  
life-role balance and, **4:1571–1573**  
Abraham Maslow and, **2:803**  
multicultural personality and, **3:1226–1227**  
neuropsychological studies of, **2:803**  
physical health and, **2:779–781**  
positive psychology and, **2:781–784, 2:803**  
problem-solving appraisal and, **2:788**  
race, racism effects on, **3:1296**  
Carl Rogers and, **2:803**  
Carol D.Ryff’s work in, **2:842–843**  
social factors affecting, **2:803**  
subjective well-being and, **2:803**  
*See also* Maslow, Abraham; **Rogers, Carl R.**  
*The Psychology of Careers* (D. E. Super), **4:1646**  
*The Psychology of Human Differences*  
(L. Tyler), **2:931**  
*The Psychology of Leisure* (Neulinger), **2:672**  
*The Psychology of Occupations* (Roe),  
**4:1614, 4:1615, 4:1646**
- Psychology of Vocational Choice* (Holland), **4:1546**
- Psychometric properties, 2:804–808**  
centrality, **2:806, 2:806** (figure)  
complexity, sophistication of, **2:806–807, 2:807** (figure)  
cultural equivalence and, **3:1091–1092**  
cultural validity in standardized tests issue and,  
**2:617–618**  
culture-free testing and, **3:1104–1106**  
definition of, **2:804**  
dimensionality, **2:804**  
dispersion, **2:806, 2:806** (figure)  
distribution, **2:806, 2:806** (figure)  
equality, **2:804**  
evaluation of, **2:807**  
factor structure, **2:805**  
gender equality, **2:804**  
graphic displays of, **2:806–807, 2:806–807** (figures)  
individual question indicators and, **2:804**  
internal attributes of a test and, **2:804**  
Item Characteristic Curve example, **2:807** (figure)  
item statistics, **2:805–807, 2:805** (table)  
normality and, **2:806, 2:806** (figure)  
quantitative methodologies and, **1:364**  
reliability, **2:804, 2:805, 2:806** (figure)  
reliability coefficient, **2:804**  
statistics vs., **2:804–805**  
test interpretation and, **2:904–910**  
test statistics, **2:805–807, 2:805** (table)  
Louis L. Thurstone’s work in, **2:924–925**  
underdiagnosis/overdiagnosis and, **2:935–936**  
validity, **2:804, 2:805**  
whole instrument qualities and, **2:804, 2:805–806**
- Psychopathology, assessment of, 2:808–815**  
assessment process decisions and, **2:808–809**  
Beck Anxiety Inventory (BAI), **2:814**  
Beck Depression Inventory (BDI), **2:814**  
behavioral assessment tools and, **2:813–814**  
California Psychological Inventory (CPI), **2:813**  
clinical interview, ecological validity of, **2:809**  
clinical interview, standard interview information,  
**2:810** (table)  
clinical interview, structured interviews and, **2:809–810**  
clinical interview, unstructured interviews and, **2:809**  
clinical judgment and, **2:814–815**  
cognitive limitations and, **2:815**  
confirmatory bias and, **2:814, 2:815**  
culture-bound syndromes and, **3:1102–1104**  
Diagnostic Interview Schedule (DIS), **2:810**  
*DSM-IV-TR* diagnostic criteria and, **2:808**  
hindsight bias and, **2:814, 2:815**



- ICD-10-CM* diagnostic criteria and, 2:808  
 Millon Clinical Multiaxial Inventory-III (MCMI-III), 2:812–813  
 Minnesota Multiphasic Inventory (MMPI-2), 2:812  
 objective self-report inventories and, 2:812–813  
 over reliance on salient data bias and, 2:814, 2:815  
 projective drawing tests, 2:811  
 projective techniques and, 2:811–812  
 Psychological Assessment Inventory (PAI), 2:813  
 psychopathology definition and, 2:808  
 Research Diagnostic Criteria (RDC), 2:809  
 Rorschach Inkblot Test, 2:811  
 Schedule for Affective Disorders and Schizophrenia (SADS), 2:809  
 schizophrenia and, 2:845–849  
 Sixteen Personality Factors test (16PF), 2:813  
 State-Trait Anxiety Inventory (STAI), 2:814, 2:884  
 Structured Clinical Interview for the *DSM* (SCID), 2:810  
 structured interviews, “objective” ratings from, 2:809  
 Symptom Checklist-90-R (SCL-90-R), 2:814  
 Thematic Apperception Test (TAT), 2:811  
 underdiagnosis/overdiagnosis and, 2:935–936  
 underutilization of base rates and, 2:814, 2:815  
**Psychopharmacology, human behavioral, 2:815–819**  
   abused drugs and, 2:817–818  
   alcohol abuse and, 2:817  
   antidepressants, 2:816  
   anxiolytic (antianxiety) agents, 2:816  
   benzodiazepines, 2:817  
   bipolar disorder and, 2:478–479  
   caffeine and, 2:818  
   counseling considerations and, 2:818–819  
   dependency issues and, 2:816  
   hallucinogenic drugs, 2:818  
   marijuana and, 2:817–818  
   MDMA (Ecstasy) and, 2:818  
   neuroleptic (antipsychotic) drugs, 2:816  
   opioids and, 2:818  
   sedative drugs and, 2:818  
   selective serotonin reuptake inhibitors (SSRIs), 2:817  
   side effects of, 2:816  
   stimulant drugs and, 2:818  
   stimulants, 2:817  
   stress management using, 2:890  
   therapeutic drugs and, 2:816–817  
   tricyclic antidepressants, 2:816  
   typical vs. atypical antipsychotics, 2:816  
 PTSD. *See* **Posttraumatic stress disorder (PTSD)**  
 PTSD Checklist, 2:786  
 PTSD Diagnostic Scale, 2:786  
*Publication Manual of the American Psychological Association, Fifth Edition* (APA), 3:1364  
 Public Offender Counselor Association, 1:125  
 Puerto Rican Americans  
   folk healers and, 3:1197  
   voting rights of, 3:1048–1049  
 PWB. *See* **Psychological well-being, dimensions of (PWB)**  
 Pynoos, Robert, 1:161  
 Q-EDD. *See* Questionnaire for Eating Disorder Diagnoses (Q-EDD)  
 QOL. *See* **Quality of life (QOL)**  
 QRC. *See* Qualified Rehabilitation Consultant (QRC) credential  
 Qualified Rehabilitation Consultant (QRC) credential, 2:831  
**Qualitative methodologies, 1:359–363**  
   action-project method and, 4:1399  
   action theory and, 4:1397–1400  
   analysis and, 1:362  
   artifact data collection, 1:362  
   background regarding, 1:359  
   behavioral observation methods and, 1:37–42  
   case study and, 1:360–361  
   community-based action research and, 1:90  
   consensual qualitative research (CQR) and, 2:632  
   cultural equivalence and, 3:1091–1092  
   cultural validity in standardized tests issue and, 2:617–618  
   definition of, 1:359  
   description, analysis, interpretation sequence of data analysis and, 1:362  
   developing codes and, 1:303  
   ethnography and, 1:360  
   etic–emic distinction and, 3:1144–1147  
   future directions in, 1:363  
   grounded theory and, 1:359–360  
   interpretive-constructivist paradigm and, 1:301  
   interview data collection, 1:361  
   interview protocol and, 1:361  
   mixed methodology research and, 1:300–305  
   narrative inquiry and, 1:361  
   observations data collection, 1:361–362  
   phenomenology and, 1:360  
   positivism paradigm and, 2:785  
   qualitative, quantitative analyses combined and, 1:304  
   qualitative data analysis and, 1:303  
   qualitative paradigm and, 1:301



quantitative methodologies vs., 1:359  
reflexivity and, 1:363  
researcher bias in, 1:302  
sample size weakness of, 1:302  
self-confrontation interview video recall  
    procedure and, 4:1399  
trustworthiness and, 1:362–363  
validity, reliability of, 1:362–363  
Wolcott's data analysis strategy and, 1:362

**Quality of life (QOL), 2:821–822**

assessment tools of, 1:81  
chronic illness and, 1:81  
chronic pain and, 1:83–87  
community-based health promotion and, 1:93–96  
continuum of, 2:821  
dialectical behavior therapy and, 2:571  
disease-specific measures of, 1:81  
“experiences excellence” concept and, 2:821  
eye movement desensitization, reprocessing (EMDR)  
    and, 1:198–202  
global questionnaires and, 1:81  
HIV/AIDS and, 1:239–240  
hospice care and, 1:243–245  
life fully engaged in meaningful activities and, 2:821  
living fully without restrictions and, 2:821  
physical health and, 2:779–781  
positive psychology and, 2:781–784, 2:821  
psychological well-being and, 2:803  
self report measures of, 2:821  
sleep disorders and, 1:393–395  
traumatic brain injury and, 1:422  
WHO definition of, 2:821

**Quantitative methodologies, 1:363–367**

action-project method and, 4:1399  
action theory and, 4:1397–1400  
behavioral observation methods and, 1:37–42  
biodata measures and, 4:1413–1415  
causal comparative design and, 1:301  
confidence interval inferential statistical  
    technique and, 1:304  
confidence level, level of significance and, 1:365  
control in, 1:366  
Cronbach's alpha measurement procedure and,  
    1:367, 2:684  
cultural equivalence and, 3:1091–1092  
definition of, 1:363  
descriptive vs. inferential statistical procedures  
    and, 1:366–367  
error in, 1:366  
etic–emic distinction and, 3:1144–1147

experimental design and, 1:301  
explained vs. unexplained variance and, 1:366  
factor analysis and, 1:364  
falsification concept and, 1:365  
future of, 1:367  
historical background on, 1:364  
inferential statistics techniques and, 1:304  
item response theory and, 1:364, 1:367, 1:420  
logical positivism, postpositivism and, 1:364–365  
manipulation and randomization control and, 1:366  
measurement field and, 1:364  
measurement procedures in, 1:367  
Paul E. Meehl and, 2:684–686  
mixed methodology research and, 1:300–305  
philosophical foundation of, 1:364–365  
positivist-postpositivist paradigm and, 1:301  
power of statistical tests and, 1:365  
probability and chance principles in, 1:365  
psychometric properties and, 2:804–808  
psychometrics and, 1:364  
qualitative, quantitative analyses combined and, 1:304  
quantitative data analysis and, 1:303–304  
quantitative paradigm and, 1:301  
quasi-experimental design and, 1:301  
regression inferential statistical technique and, 1:304  
reliability coefficient and, 1:364  
research designs of, 1:364  
sampling error, measurement error, prediction  
    error and, 1:366  
scaling methods for measuring attitudes and, 1:364  
statistical procedure method and, 1:366–367  
statistics field and, 1:364  
systemic vs. random variability and, 1:366  
test interpretation and, 2:904–910  
test-retest measurement procedure and, 1:367  
treatment and control groups in, 1:301  
type 1, false positive error and, 1:365  
type 2, false negative error and, 1:365  
underdiagnosis/overdiagnosis and, 2:935–936  
variability and, 1:365–366  
weaknesses of, 1:302

Quarter Blood Amendment Act (1985), 3:1045

Questionnaire for Eating Disorder Diagnoses  
    (Q-EDD), 2:580

Qureshi, A., 3:1281

**Race, 3:1279–1284**

biogenic differences theory of, 3:1279  
biracialism and, 3:1027–1032  
career development and, 4:1530–1531



- Certificate of Degree of Indian Blood and, **3:1046**  
 contemporary contexts of, **3:1280–1281**  
 counseling implications of, **3:1281–1284**  
 critical race theory and, **3:1071–1078**  
 cultural values and, **3:1095–1097**  
 definitions of, **3:1279**  
 demographic shifts and, **3:1280**  
 ethnicity *vs.*, **3:1137–1138, 3:1279**  
 Eurocentric worldview and, **3:1280**  
 historical context of, **3:1280**  
 hypodescent concept and, **3:1027, 3:1280**  
 interracial comfort and, **3:1182–1183**  
 objective determinants of, **3:1279–1280**  
 phenotypic qualities and, **3:942, 3:958, 3:974, 3:981, 3:1042, 3:1043, 3:1072, 3:1076, 3:1135, 3:1229, 3:1279, 3:1280, 3:1353**  
 race-related stress, **3:1377**  
 racial and ethnic labels and, **3:1281**  
 racial identity theory and, **3:1281–1282**  
 racial oppression and, **3:1279**  
 racial socialization and, **3:1279–1280, 3:1282, 3:1297**  
 stereotypes and, **3:1282**  
 yoked existence concept and, **3:1282–1283**  
*See also* **African Americans; American Indians; Asian Americans; Latinos; Racial identity; Racial pride**
- Racial identity, 3:1284–1290**  
 African American/Black racial identity and, **3:1036–1038, 3:1285, 4:1439**  
 African American/Black racial identity and, measurement and research on, **3:1287–1288**  
 African American career counseling and, **4:1439**  
 Afrocentricity/Afrocentrism and, **3:963–965**  
 barriers to cross-cultural counseling and, **3:1011–1012**  
 biracialism and, **3:1027–1032**  
 Black English and, **3:1032–1033**  
 Black Racial Identity Attitudes Scale and, **3:1287, 3:1292**  
 Kenneth Bancroft Clark and, **3:1050–1052**  
 color-blind racial ideology and, **3:1063–1065**  
 confusion and conflicts of oppression, **3:1216**  
 Madonna G. Constantine and, **3:1070**  
 critical race theory and, **3:1071–1078**  
 Cross Racial Identity Scale (CRIS) and, **3:1035, 3:1078, 3:1079, 3:1080, 3:1287–1288**  
 William E. Cross's work in, **3:1078–1080, 3:1285, 3:1296**  
 cultural values and, **3:1095–1097**  
 definition of, **3:1285**  
 ego status and, **3:1286**  
 ethnic minority and, **3:1139–1141**  
 ethnic *vs.* racial identity and, **3:1135, 3:1285**  
 future directions regarding, **3:1289**  
 general racial identity and, **3:1286–1287**  
 healthy paranoia and, **3:1153**  
 Janet E. Helms's work and, **3:1154–1156, 3:1162, 3:1229, 3:1285, 3:1296**  
 heuristic model of nonoppressive interpersonal development and, **3:1286**  
 interactional models of, **3:1286–1287**  
 interracial marriage and, **3:1183–1185**  
 Kwanzaa and, **3:1189–1190**  
 Multidimensional Inventory of Black Identity (MIBI) and, **3:1288**  
 multidimensional model of, **3:1166**  
 multiracial families and, **3:1234**  
 National Study of Black Americans and, **3:1292**  
 Oklahoma Racial Attitude Scale-Preliminary Form and, **3:1288**  
 Oklahoma Racial Attitudes Scale (ORAS) and, **3:1288**  
 People of Color racial identity and, **3:1288–1289**  
 People of Color Racial Identity Attitudes Scale (POCRIAS) and, **3:1289**  
 Scale of Racial Socialization and, Cultural Pride Reinforcement subscale of, **3:1292**  
 social identity theory and, **3:1166**  
 as sociopolitical construct, **3:1284–1285**  
 transracial adoption and, **3:1355**  
 visible racial/ethnic groups and, **3:1364**  
 White racial identity and, **3:1285–1286**  
 White racial identity and, development of, **3:1380–1383**  
 White racial identity and, measurement and research on, **3:1288**  
 White Racial Identity Attitude Scale (WRIAS) and, **3:1288, 3:1381**  
*See also* **Ethnic identity; Identity; Identity development; Racial pride**
- Racial Identity Attitude Scale, **3:1080**  
 Racial Identity Attitude Scale-Black, **3:1037**
- Racial microaggressions, 3:1290–1291**  
 aversive racism and, **3:1294–1295**  
 Madonna G. Constantine and, **3:1070**  
 contemporary views on, **3:1290–1291**  
 counseling and supervision implications of, **3:1290–1291**  
 definition of, **3:1290**  
 historical perspective on, **3:1290**  
 individual level racism and, **3:1376–1377**  
 “invisibility syndrome” and, **3:1294**  
 learned helplessness and, **3:1199**



microassaults of, **3:1290**  
 microinsults of, **3:1290**  
 microinvalidations of, **3:1290**  
 psychological distress caused by, **3:1290, 3:1294**  
 race-related stress and, **3:1377**  
 Derald Wing Sue and, **1:401–403, 1:402–403, 3:1070, 3:1290, 3:1341**  
 in therapeutic relationship, **3:962, 3:1378**  
 xenophobia and, **3:1389**

### **Racial pride, 3:1291–1293**

African American focus of, **3:1291**  
 Afrocentricity/Afrocentrism and, **3:963–965**  
 Black doll study and, **3:1291, 3:1296**  
 conceptualization and measurement of, **3:1291–1292**  
 definition of, **3:1291**  
 future directions regarding, **3:1292**  
 Kwanzaa and, **3:1189–1190**  
 racial identity factor and, **3:1291, 3:1292**  
 racial socialization factor and, **3:1291, 3:1292, 3:1297**  
*See also* **Racial identity**

### **Racism, 3:1293–1299**

acculturative stress and, **3:950**  
 antiracist White Americans and, **3:1374–1375**  
 antisemitism and, **3:983–985**  
 aversive racism and, **2:573, 3:1015, 3:1294–1295**  
 Martha Bernal and, **3:1012–1014**  
*Black Rage* (Grier and Cobbs) and, **3:1092, 3:1093**  
 Kenneth Bancroft Clark and, **3:1050–1052**  
 classism and, **3:1054–1059**  
 colonialism and, **3:1061–1063**  
 color-blind racial ideology and, **3:1063–1065, 3:1281**  
 counseling implications of, **3:1298**  
 critical race theory and, **3:1071–1078**  
 cultural mistrust and, **3:1297**  
 cultural racism and, **2:573, 3:1376, 3:1378–1379**  
 cultural-specific coping and, **3:1297–1298**  
 current psychological models of, **3:1294–1296**  
 deficit hypothesis and, **3:1109–1111**  
 definition of, **2:572–573, 3:1293**  
 drapetomania and, **3:1124–1125**  
 environmental racism and, **3:1267**  
 fundamental attribution error and, **3:1199**  
 in historical context, **3:1293–1294**  
 ideological racism and, **3:1293**  
 individual racism and, **3:1293, 3:1376–1377, 3:1573**  
 institutional racism and, **2:573, 3:959, 3:1064, 3:1199, 3:1293, 3:1376, 3:1377–1378**  
 internalized racism and, **3:1246, 3:1296, 3:1320**  
 mental health correlate of, **3:1296**  
 mental health practice and, **3:1297–1298**

model minority myth and, **3:1211–1214**  
 political correctness and, **3:1263–1264**  
 privilege and, **3:1294**  
 psychological correlates of, **3:1296–1297**  
 psychological definitions of, **3:1295–1296**  
 psychological models of, **3:1294–1296**  
 race-related stress, **3:1377**  
 racial identity correlate of, **3:1296–1297**  
 racial microaggressions and, **3:962, 3:1070, 3:1290–1291, 3:1294, 3:1341**  
 racial socialization correlate of, **3:1297**  
 racism as mental illness type and, **3:1295**  
 racism related stress and, **3:961, 3:1295**  
 racist ideology spread and impact of, **3:1281**  
 social class and, **4:1626–1627**  
 Social Darwinism, Eugenics movement and, **3:1573**  
 socioeconomic indicators and, **3:1294**  
 stereotypes, prejudice, and discrimination  
   components of, **3:1293**  
 stereotypes and, **3:1294, 3:1333–1339**  
 structural racism and, **3:1380**  
 theoretical foundations of, **3:1294**  
 unintentional racism and, **2:573**  
 White privilege and, **3:1375–1380**  
 xenophobia and, **3:1380**

*See also* **Antisemitism; Discrimination;**

**Discrimination and oppression; Prejudice;**

**Social discrimination; Stereotype; Stereotype threat**

Radical constructivism, **2:522–523**

Ramirez, Manuel, **3:1226**

Rancer, Andrew, **3:1065, 3:1066**

### **Rational emotive behavior therapy**

(REBT), **2:823–826**

ABC therapy model and, **2:504, 2:509, 2:823–824**  
 antiprocration exercises and, **2:825**  
 arbitrary inference irrational belief and, **2:510**  
 behavior therapy and, **2:470–476, 2:823**  
 cognitive processing errors, irrational beliefs and,  
   **2:509, 2:510, 2:693, 2:746, 2:823, 2:824**  
 cognitive specificity hypothesis and, **2:510**  
 counseling techniques and, **2:509, 2:824–825**  
 Disputing (D) component of, **2:824**  
 Albert Ellis's work in, **2:504, 2:508, 2:509, 2:542, 2:588–589, 2:746**  
 general vs. elegant strategies of, **2:825**  
 healthy personality and, **2:825**  
 homework assignments in, **2:648, 2:825**  
 irrational belief forms and, **2:824**  
 language use in, **2:693**



- logical positivism to constructivist, postmodern transition and, 2:509
- new Effect (E) that replaces irrational belief component of, 2:824–825
- overgeneralization irrational belief and, 2:510
- personal construction theory and, 2:509
- philosophy of happiness and, 2:509, 2:823
- rational-emotive therapy precursor to, 2:504, 2:509, 2:823
- religion and, 2:879
- research support of, 2:510
- schemas and, 2:510
- selective abstraction irrational belief and, 2:510
- skill training exercises and, 2:825
- in vivo assignments and, 2:825
- Raven's Progressive Matrices, 2:500, 2:656–657
- RAVLT. *See* Rey Auditory Verbal Learning Test (RAVLT)
- Ray, Dee, 1:333
- Rayman, J., 4:1516
- RCEA. *See* Rehabilitation Counselors and Educators Association (RCEA)
- Reading disorder, 1:159
- Realistic, Investigative, Artistic, Social, Enterprising, and Conventional (RIASEC) model. *See* **Holland's theory of vocational personalities and work environments**
- REBT. *See* Rational emotive behavior therapy (REBT)
- Receptive-Expressive Emergent Language Test, 2:670
- Reciprocal determinism, 2:505, 2:741, 2:746, 2:764
- Recognition Memory Test (RMT), 2:689
- Reconstructionist Jews, 3:978–979, 3:1302
- Recovered memory techniques, 2:629–630
- Recruitment: history and recent trends in diversity, 1:369–371**
- American Rehabilitation Counseling Association and, 1:369
- APA special interest groups and, 1:369
- Association for Adult Development and Aging and, 1:369
- Association for Gay, Lesbian, and Bisexual Issues in Counseling and, 1:369
- Association for Multicultural Counseling and Development and, 1:369
- Association of Black Psychologists and, 1:370
- civil rights movement and, 1:369
- future directions of, 1:371
- homosexuality discrimination and, 1:370–371
- lesbian, gay, bisexual and transgender (LGBT) persons and, 1:369, 1:370–371
- persons of color and, 1:369, 1:370
- underrepresented demographic changes and, 1:369
- women and, 1:369, 1:370
- Redfield, Robert, 3:941, 3:947
- Reform Jews, 3:978–979, 3:1302
- Reframing, 2:826**
- bilateral reframes and, 2:826
- changing perception of a problem and, 2:826
- compliance-based interventions and, 2:720
- counseling application of, 2:826
- creation of meaning and, 2:683–684
- interpretation vs., 2:826
- moving toward change and, 2:826
- positive connotation and, 2:720
- relabeling and, 2:720
- stress-related disorders and, 1:400
- systemic reframes and, 2:826
- systemic vs. individual framework emphasis and, 2:826
- Refugee-Escapee Act (1957), 3:1170
- Refugee Relief Act (1953), 3:1170
- Refugees, 3:1299–1300**
- acceptance criterial fluctuation and, 3:1299
- acculturative stress and, 3:946–952
- Arab Americans as, 3:986–987
- cold war and, 3:1299
- community-based interventions for, 2:1300
- counseling implications for, 3:1134, 3:1171
- countries that accept refugees and, 3:1299
- Displaced Persons Act (1948) and, 3:1170
- ethnic cleansing and, 3:1133–1134
- life skills intervention for, 2:1300
- mental health interventions and, 3:1299–1300
- psychological distress of, 3:1299
- PTSD and, 3:1133–1134, 3:1299
- Refugee-Escapee Act (1957) and, 3:1170
- Refugee Relief Act (1953) and, 3:1170
- September 11th and, 3:1299
- stress management for, 2:1300
- United National High Commissioner for Refugees (UNHCR) and, 3:1299
- Widows and Orphans Act and, 3:1299
- World War II and, 3:1299
- Regents of the University of California v. Bakke*, 3:957, 3:1224
- Regier, Darrel A., 2:595
- Rehabilitation Act of 1973, 1:23
- Rehabilitation counseling, 2:827–832**
- advocacy, consultancy emphasis of, 2:830–831
- American Counseling Association (ACA) and, 2:831



- American Rehabilitation Counseling Association (ARCA) and, **2:831**
- Americans with Disabilities Act (ADA) and, **2:829**
- career counseling and, **2:832, 4:1434–1435**
- Certified Rehabilitation Counselor (CRC)
- credential and, **2:831**
- change or crisis context of, **2:830**
- Code of Professional Ethics for Rehabilitation Counselors and, **2:831**
- cognitive-behavioral theories in, **2:830**
- collaborative process of, **2:830**
- Commission on Rehabilitation Counselor Certification (CRCC) and, **2:827**
- Council for Accreditation of Counseling and Related Educational Programs (CACREP) and, **2:831**
- Council on Rehabilitation Education (CORE) and, **2:831**
- counseling relationship and working alliance
- importance in, **2:830**
- credentialing of practitioners and, **2:831**
- definition of, **2:827**
- disability, legal definitions and, **2:828–829**
- disability, vs. impairment, impediment, handicap
- terms and, **2:829**
- disability types and, **2:829**
- eclectic approach to, **2:830**
- ecological models of disability and, **2:829**
- empowerment goal of, **2:829**
- ethical standards of, **2:831**
- federal, state, local level services of, **2:828**
- guiding principles of, **2:829–830**
- independence, full participation, quality of life
- goals of, **2:827, 2:829**
- informed choice and, **2:829**
- integrated living setting goal of, **2:830**
- knowledge domains of, **2:831–832**
- Licensed Rehabilitation Counselor (LRC)
- credential and, **2:831**
- master's, doctoral degrees in, **2:831**
- military history of, **2:827**
- National Board for Certified Counselors (NBCC) and, **2:831**
- National Rehabilitation Association (NRA) and, **2:831**
- nondisability privilege and, **3:1380**
- personal, career, independent living goals of, **2:830**
- physical, social, cultural environment of disability
- definition and, **2:829**
- private-for-profit programs and, **2:828**
- private-nonprofit programs and, **2:828**
- professional aspects of, **2:831–832**
- Qualified Rehabilitation Consultant (QRC)
- credential and, **2:831**
- Rehabilitation Counselors and Educators Association (RCEA) and, **2:831**
- rehabilitation definition and, **2:827–828**
- Smith-Fess Act (1920) and, **2:827**
- Soldier Rehabilitation Act and, **2:827**
- State-Federal Vocational Rehabilitation Program and, **2:829**
- strengths focus of, **2:829–830**
- trait-and-factor approaches to, **2:830**
- worth and dignity of all people belief and, **2:829**
- Rehabilitation Counselors and Educators Association (RCEA), **2:831**
- Reifman, Alan, **3:1110**
- Relational-cultural therapy, **3:1317**
- Relational theory, **2:763, 4:1515**
- Relationships with clients, 2:832–837**
- argument for nonsexual multiple relationships
- and, **2:835–836**
- boundaries concept in, **2:833–834**
- boundary violation vs. boundary crossing and, **2:835–836**
- client attitudes and behaviors and, **2:485–490**
- clients' best interests and, **2:834**
- client welfare vs. autonomy conflict and, **2:834**
- clinical interview and, **2:490–491**
- code of ethics and standards of practice and, **2:494–497**
- confidentiality and legal privilege and, **2:519–522**
- cultural mistrust and, **3:1092–1093**
- cultural paranoia and, **3:1093–1094**
- duty to warn and protect and, **2:575–578**
- facilitative conditions and, **2:601–603**
- Myrna L. Friedlander's work in, **1:219–220**
- Charles J. Gelso's work in, **2:616**
- high-context communication and, **3:1158–1159**
- humanistic counseling approaches to, **2:637–641**
- incompatibility of expectations of multiple
- roles and, **2:834**
- individual therapy and, **2:643–645**
- Allen E. Ivey's work in, **1:266–268, 2:539, 3:1185–1187**
- low-context communication and, **3:1206**
- multiple relationships, concept of, **2:833**
- multiple relationships, guidelines for
- decision making and, **2:836**
- multiple relationships, problematic aspects of, **2:834**
- multiple relationships, rationale for avoidance of, **2:833**
- multiple relationships, sexual relationships and, **2:835–836**



- multiple relationships, unavoidable, **2:834–835**  
 power issues and, **2:833, 2:834, 2:836**  
 rapport and warmth importance in, **2:836**  
 role theory and, **2:834**  
 rural practice challenges and, **1:380**  
 self-monitoring importance and, **2:836–837**  
 sexual relationships and, **2:835–836**  
 slippery slope concept and, **2:834**  
 technology and treatment and, **1:411–415**  
 therapist-patient sex syndrome and, **2:835**  
 therapist responsibility and, **2:836–837**  
 unavoidable multiple and, **2:834–835**  
*See also Transference and countertransference*
- Relaxation technique, of cognitive-behavioral therapy, **2:507**
- Reliability  
 of behavioral observation methods, **1:41–42**  
 internal consistency and, **1:41–42**  
 inter-rater reliability and, **1:41–42**  
 test-retest reliability and, **1:41–42**  
*See also specific assessment, measure, test*
- Religion. *See Religion/religious belief systems; Spirituality/religion*
- Religion/religious belief systems, 3:1301–1303**  
 Arab Americans and, **3:985–991**  
 bibliotherapy and, **2:914**  
 Black church and, **3:959, 3:960–961**  
 career and, **3:1302**  
 Christian privilege and, **3:1380**  
 counseling implications of, **3:1302**  
 espiritismo and, **3:1131–1132**  
 family, marriage and, **3:1302**  
 Hinduism belief system and, **3:1302**  
 indigenous healing and, **3:1176–1177**  
 Islam belief system and, **3:1302**  
 Carl Jung and, **2:667–668**  
 religion definition and, **3:1301**  
 Santería and, **3:1307–1309**  
 spirituality, religion and, **2:879–882, 3:1301**  
 U.S. major religion statistics and, **3:1301**  
 world religion statistics and, **3:1301**  
 worldview and, **3:1301**
- Removal of Barriers to Interethnic Adoption Act (1996), **3:1234**
- Rennie, David, **2:487**
- Reorientation therapy. *See Conversion therapy*
- Reparative therapy. *See Conversion therapy*
- Resilience, 2:837–840**  
 acculturative stress and, **3:951–952**  
 of African Americans, **3:959, 3:963**  
 at-risk factors and, **2:838**  
 cognitive skills and, **2:837**  
 coping and, **2:526–530**  
 definition of, **2:837**  
 Denver Developmental Screening Test and, **2:838**  
 development of, **2:838–839**  
 disasters, children and, **1:164**  
 emotional intelligence and, **2:837**  
 environmental factors and, **2:838**  
 happiness/hardiness and, **2:623–626**  
 immigrant acculturation and, **3:945**  
 infant bonding and attachment style factors in, **2:838**  
 interpersonal skills and, **2:837**  
 life transitions stress and, **2:677–678**  
 middle-age, older adults and, **2:839**  
 Penn Resilience Program (PRP) and, **2:839**  
 problem solving skills and, **2:838**  
 psychological resilience and, **2:837**  
 Carol D. Ryff's work in, **2:843**  
*The Seven Keys to Resiliency* (Rush) and, **2:839**  
 social skills in youth and, **2:838**  
 stable families and, **2:838**  
 teaching resilience and, **2:839–840**  
 temperament and, **2:838**
- Respect self-pertaining virtue, **1:442**
- Responses to Stress Questionnaire (RSQ), **2:528**
- Rest, J. R., **1:184**
- Retirement, implications of, 1:371–375**  
 aging and, **1:14–17**  
 baby boom generation retirement and, **1:371, 4:1613**  
 career satisfaction and, **1:373**  
 definitions of, **1:372**  
 existential, meaning in life issues and, **1:373**  
 finances and, **1:372, 1:374**  
 gerontology and, **1:231–234**  
 health and medical care and, **1:372**  
 housing and, **1:372–373**  
 job sharing, retirement phasing and, **4:1560**  
 life expectancies and, **1:371**  
 lifestyle planning and, **1:374**  
 lifetime perspectives and, **1:373–375**  
 life transition changes and, **2:680–681**  
 relationships, loss and, **1:372**  
 returning to work and, **1:372, 1:373, 1:374, 4:1560**  
 save early and save often catch phrase and, **1:374**  
 security and, **1:373**  
 social support needs and, **1:374**  
*See also Retirement* (career counseling implications)



**Retirement** (career counseling implications),  
**4:1613–1614**

coping strategies and, **4:1613**  
 financial issues and, **4:1613**  
 health issues and, **4:1613**  
 job sharing, retirement phasing and, **4:1560**  
 retiring baby boomers and, **4:1613**  
 returning to work and, **4:1560**  
 Social Security Act and, **4:1613**  
 Super's life-span vocational developmental  
 theory and, **4:1613**  
 transition variables and, **4:1613**

*See also* **Retirement, implications of**

Rett's disorder. *See* **Autism/Asperger's syndrome**

**Reversed racism, 3:1303–1305**

affirmative action programs and, **3:957, 3:1303**  
 controversy regarding, **3:1303**  
 counseling implications of, **3:1304–1305**  
 education, university admissions and, **3:1304**  
 EEO legislation and, **3:1304**  
 individual level perception of, **3:1303**  
 media and, **3:1304**  
 power component of racism and, **3:1303**  
 race construct in, **3:1303**  
 reverse discrimination and, **2:572, 3:957, 3:1117,**  
**3:1224, 3:1303**

Rey Auditory Verbal Learning Test (RAVLT), **2:700**

Reynolds, A. L., **3:1216**

Reynolds Depression Screening Inventory, **2:559**

Rhinesmith, S., **3:1106**

RIAS-B. *See* **Black Racial Identity Attitudes Scale**  
 (RIAS-B)

RIASEC model of interests. *See* **Holland's theory of**  
**vocational personalities and work environments**

Rice, Laura N., **2:919**

Ridley, Charles R., **3:1088, 3:1093**

Riessman, Frank, **3:1110**

Ritchie, Martin, **1:333**

Rivera-Batiz, Francisco L., **3:1171**

Rivermead Behavioural Memory Test (TBMT), **2:689**

Rizvi, Shireen, **2:580**

RMT. *See* **Recognition Memory Test (RMT)**

Robbins, Steven B., **4:1477**

Roberts, Tomi-Ann, **2:581**

Robinson, Frank, **2:919**

Rochlen, A. B., **1:171**

Rodriguez, E. R., **4:1455**

**Roe, Anne, 2:925, 4:1614–1615**

career choice and adjustment work of, **4:1614**  
 classification of occupations work of, **4:1614, 4:1615**

individual psychological differences focus of, **4:1614**  
 occupational choice and developmental determinants  
 and, **4:1614**

origins of career needs and interests work of, **4:1614**

Personal-Child Relations Questionnaire and,  
**4:1614, 4:1615**

*The Psychology of Occupations* written by,  
**4:1614, 4:1615, 4:1646**

*See also* **Roe's theory of personality**  
**development and career choice**

Roediger, David, **3:1375**

**Roehlke, Helen J., 1:375–378**

APA positions of, **1:376**

Association of Counseling Center Training Agencies  
 (ACCTA) and, **1:376–377**

clinical supervision work of, **1:376**

educational training background and, **1:375–376**

family background of, **1:375**

mentoring and, **1:375**

predoctoral internship training work of, **1:376**

professional accomplishments of, **1:376–377**

professional associations of, **1:376**

**Roe's theory of personality development and**  
**career choice, 4:1615–1616**

criticism of, **4:1615**

Maslow's hierarchy of needs influence on, **4:1615**

occupations classifications work of, **4:1615**

parent-child interaction patterns and, **4:1615**

Parent-Child Relations Questionnaire and, **4:1615**

*The Psychology of Occupations* written by,  
**4:1614, 4:1615, 4:1646**

Terence J. G. Tracey's work and, **2:925**

*Roe v. Wade*, **3:1316**

Roger, Ronald, **1:426**

**Rogers, Carl R., 2:840–842**

client autonomy and self-directedness  
 and, **2:638–639, 2:736**

client-centered view of disturbance and,  
**2:638, 2:841, 2:897–898, 2:930**

client self-actualization focus of, **2:841**

conditions of worth concept of, **2:756**

*Counseling and Psychotherapy* written by, **1:123**

education and career of, **2:840–841**

empathy of therapist and, **2:514, 2:541–542, 2:601,**  
**2:638–639, 2:704, 2:736, 2:803, 3:1066**

genuineness of therapist and, **2:601, 2:638–639,**  
**2:803, 2:841–842**

Gestalt therapy influenced by, **2:541–542**

humanistic counseling work of,  
**2:782, 2:840, 2:841, 3:1365**



- incongruence concept and, 2:638, 2:747, 2:841  
 inherent goodness focus of, 2:638, 2:757  
 internalized conditions of worth and, 2:638  
 motivational interviewing and, 2:897–898  
 nondirect therapy concept of, 2:919  
 organismic valuing process and, 2:638  
 person-centered therapy work of, 1:128, 1:332,  
 2:541–542, 2:543, 2:601, 2:638–639, 2:648,  
 2:736, 2:782, 2:841  
 relationship dynamics work of, 1:123, 2:638–639  
 supervision and, 1:405  
 therapeutic change process and, 2:638–639,  
 2:841–842, 2:919  
 transference and, 2:930  
 unconditional positive regard and,  
 2:601, 2:638–639, 2:704, 2:841  
 Rogers, James, 2:900  
 Rogoff, Barbara, 3:1084  
 Roid, Gale, 2:497  
 Roland, Alan, 3:1017  
 Role Construct Repertory test, 2:748  
 Romano, John, 1:263  
 Root, Maria, 3:1029, 3:1030, 3:1230  
 Rorschach Inkblot Test  
   controversy regarding, 2:792, 2:793, 2:811  
   Depression Index, 2:463  
   Exner's Comprehensive System (CS) and, 2:792  
   interpretation of, 2:811  
   normative data adequacy issue of, 2:792, 2:793  
   validity of, 2:792, 2:793, 2:811  
 Rose, Glenn, 1:158  
 Rosenberg, Bina, 2:658, 2:903  
 Rosenberg, Morris, 2:863  
 Rosenberg Self-Esteem Scale (RSE),  
   2:861, 2:863, 2:864  
 Rosenstock, Irwin, 1:426  
 Rosenzweig, Saul, 1:175, 2:512, 2:714, 2:919  
 Ross, Elisabeth Kübler, 1:245  
 Ross, S. M., 1:167  
 Rossetti Infant and Toddler Language Scale, 2:669–670  
 Ross Information Processing Assessment, 2:671  
 Rosvold, H., 1:112  
 Rothbaum, Fred, 3:1084  
 Rotter, Julian B.  
   causal attributions and, 2:745  
   illness or health outcomes and, 2:745  
   internal vs. external locus of control and,  
   2:745, 3:1046, 3:1204  
   Rotter Incomplete Sentences Blank and, 2:727  
   self-system awareness in psychotherapy and, 3:1046  
   social cognitive theory and, 2:593, 2:741  
   therapy expectations and, 2:593  
 Rotter Incomplete Sentences Blank, 2:727  
 Rounds, James, 2:925  
 Rourke, Byron, 1:158  
 Rousseau, Jean-Jacques, 3:1177  
 Rowe, Wayne, 3:1288  
 Rowley, Stephanie A., 3:1288  
 Roysircar, Gargi, 2:1300, 3:1172, 3:1310, 3:1385  
 RSE. *See* Rosenberg Self-Esteem Scale (RSE)  
 RSQ. *See* Responses to Stress Questionnaire (RSQ)  
 Ruch, W., 4:1535  
 Rumbaut, Rubén G., 3:1171  
**Rural practice, challenges of, 1:378–380**  
   anonymity issue and, 1:380  
   avoiding personal risks and, 1:379  
   “being nice” and, 1:378  
   conflict avoidance and, 1:379  
   counseling in rural areas and, 1:379–380  
   downside of rural life and, 1:378–379  
   importance of place and, 1:378  
   intergenerational, multifamily issues and, 1:379–380  
   multiple relationships issues and, 2:834–835  
   nonconformity pain and, 1:378–379  
   rituals and, 1:378  
   rural economy stress and, 1:379  
   rural marriage problems and, 1:379  
   “rural” population density and, 1:378  
   rural values and, 1:378  
   social accountability, obligation and, 1:379  
   vested interests and, 1:379  
 Rush, Chris B., 2:839  
 Rutter, Michael, 2:838  
 Ryan, Richard M. *See* Deci, Edward L. and Ryan,  
   Richard M.  
**Ryff, Carol D., 2:842–843**  
   human resilience work of, 2:843  
   Midlife in the United States (MIDUS)  
     longitudinal study by, 2:843  
   psychological well-being focus of, 2:842  
   psychosocial factors and physical health  
     work of, 2:842–843  
   recovery process focus of, 2:843  
   well-being therapy work of, 2:843  
 Ryle, Anthony, 2:648  
 Sabnani, Haresh, 3:1382  
 SAC. *See* Suicide Assessment Checklist (SAC)  
 Sachs, J. D., 3:1347, 3:1348  
 Saenz, Delia S., 3:1016



- Safran, Jeremy D., **2:923**  
Sage Publications, **4:1561, 4:1562**  
Saginak, Kelli, **4:1684**  
Saginak, M. Alan, **4:1684**  
Samelson, Franz, **3:1110**  
Samhan, H. H., **3:988**  
Samuda, Ronald, **3:1110**  
Sanders, Matt, **1:327**  
Sandoval, Chela, **3:1246**  
**Santería, 3:1307–1309**  
    Afro-Cuban earth-centered religion and, **3:1176, 3:1307**  
    animal sacrifice in, **3:1307, 3:1308**  
    *Church of Lukumi Babalu Aye v. City of Hialeah* and, **3:1308**  
    counseling implications of, **3:1308–1309**  
    divination ritual in, **3:1308**  
    drum and dance festivals of, **3:1308**  
    espiritismo and, **3:1131–1132**  
    Olodumare creator belief in, **3:1307**  
    origins of, **3:1307**  
    Orisha and corresponding Catholic saint in, **3:1307–1308**  
    sacrifices and offering rituals in, **3:1308**  
    varied levels of belief in, **3:1308**  
Sarason, I., **1:112**  
Sarbin, Theodore, **1:173, 2:523**  
SAT. *See* Scholastic Assessment Test (SAT)  
Satir, Virginia, **1:124**  
SAT reasoning test, **2:450**  
Saunders, Cecily, **1:149, 1:243**  
Sauvy, Alfred, **3:1347**  
Savickas, Mark L.  
    career/life paradigm and, **4:1489**  
    Career Occupational Preference System and, **4:1493**  
    Career Services Model and, **4:1498**  
    career style interview developed by, **4:1500**  
    *Journal of Vocational Behavior* and, **4:1563**  
    Society for Vocational Psychology and, **4:1634–1635**  
SB5. *See* Stanford-Binet Intelligence Scales, Fifth Edition (SB5)  
Scale of Racial Socialization, Cultural Pride Reinforcement subscale, **3:1292**  
Scales of Independent Behavior-Revised (SIB-R), **2:456**  
Scale to Assess World View, **3:1385, 3:1386**  
SCANS. *See* Secretary's Commission on Achieving Necessary Skills (SCANS)  
Scared straight programs, **2:628–629**  
SCCT. *See* **Social cognitive career theory (SCCT)**  
SCDI. *See* Standard Cognitive Developmental Interview (SCDI)  
Schedule for Affective Disorders and Schizophrenia, **2:558**  
Scheier, Michael F., **2:707**  
Schizoid personality disorder (SPD), **2:729**  
**Schizophrenia, adult, 2:845–849**  
    behavioral vulnerabilities and, **2:846**  
    Behavior Rating Scale of Executive Function (BRIEF) and, **1:49**  
    brain activity dysregulation and, **2:847**  
    brain structure abnormalities and, **2:847**  
    causes of, **2:846–847**  
    community-based services for, **2:848**  
    contemporary policy issues and, **2:848**  
    cortisol and, **2:847**  
    course of, **2:846**  
    definitions of, **2:845–846**  
    deinstitutionalization and, **2:848**  
    developmental neurodysplasia and, **2:847**  
    double-bind theory and, **2:523**  
    DSM diagnostic criteria and, **2:845**  
    environmental stress factors and, **2:846, 2:847**  
    epidemiology and prevalence of, **2:846**  
    evidence-based practice and, **2:848**  
    fragmentation of experience or behavior and, **2:846**  
    functional assessment of, **2:847**  
    genetic factors in, **2:846–847**  
    Kraepelin's *dementia praecox* term and, **2:845**  
    mental functioning fragmentation and, **2:845**  
    neurodevelopmental abnormalities and, **2:847**  
    onset of, **2:846**  
    positive, negative, and disorganized symptoms of, **2:846**  
    psychiatric rehabilitation and, **2:847–848**  
    psychosocial factors and, **2:847**  
    radical constructivism and, **2:523**  
    recovery from, **2:846**  
    recovery movement and, **2:848–849**  
    schizophrenia disorder vs., **2:845**  
    serious mental illness (SMI) terminology and, **2:846**  
    symptoms of, **2:845**  
    thinking and feeling split and, **2:845**  
Schizotypal personality disorder (STPD), **2:729–730**  
Schlossberg, N., **4:1613**  
Schmidt, Lyle, **1:441, 2:892**  
Schneider, Paxton, **2:580**  
Scholastic Assessment Test (SAT), **4:1393**  
**School counseling, 1:381–384**  
    academic achievement and, **2:448–455, 4:1391–1392**  
    American School Counselor Association (ASCA) and, **1:5, 1:108, 1:123, 1:382, 4:1450, 4:1635**



- comprehensive guidance and counseling programs and, **1:381–382**
- content element of, **1:381**
- development, management, accountability elements of, **1:381–382**
- education and training of, **1:383**
- intelligence tests and, **3:1179–1182**
- model minority myth and, **3:1211–1214**
- multicultural competence and, **1:382–383**
- noncounselor's understanding, support and, **1:383–384**
- organizational framework element of, **1:381**
- professional identity and, **1:382**
- resources element of, **1:381**
- school-based leadership and, **1:382**
- school psychology and, **1:384–387**
- school refusal behavior and, **1:387–389**
- technology use and, **1:383**
- work-bound youth and, **4:1678–1680**
- School psychology, 1:384–387**
- APA doctoral accreditation and standards in, **1:385–386**
- behavioral observation methods and, **1:37–42**
- consultation role of, **1:386**
- future of, **1:386**
- historical conferences and, **1:384–385**
- levels of training and, **1:385**
- NASP/NCATE accreditation and standards in, **1:385**
- Response to Intervention model of service delivery and, **1:386**
- roles of, **1:386**
- school refusal behavior and, **1:387–389**
- scientist-practitioner model and, **1:384**
- specialist, master's, and doctoral degree programs in, **1:385**
- Lightner Witmer and, **1:384**
- School refusal behavior, 1:387–389**
- acute vs. chronic and, **1:387**
- assessment of, **1:388**
- characteristics of youths with, **1:387–388**
- child-, parent-, family-based intervention techniques and, **1:388**
- definition of, **1:387**
- functional model of, **1:388**
- historical overview of, **1:387**
- internalizing vs. externalizing symptoms of, **1:387**
- positive vs. negative reinforcement from, **1:388**
- school withdrawal and, **1:387**
- short and long term outcomes of, **1:388**
- treatment of, **1:388–389**
- School-to-Work Opportunities Act (STWOA) (1994), **4:1450, 4:1617**
- School-to-work transition, 4:1617–1619**
- attachment theory and, **4:1410–1411**
- college education importance and, **4:1617**
- developmental transition of, **4:1617**
- effective program characteristics and, **4:1618**
- The Forgotten Half* (W. T. Grant Foundation) and, **4:1617–1618**
- future directions regarding, **4:1618–1619**
- gender differences in, **4:1618**
- income statistics regarding, **4:1618**
- life transitions and, **2:678–679**
- policy and reform initiative of, **4:1617–1618**
- School to Work Opportunities Act (STWOA) (1994) and, **4:1617**
- transferable work skills importance and, **4:1617**
- work-bound youth and, **4:1678–1680**
- work ready vs. job ready and, **4:1617**
- Schrader, S. S., **1:137**
- SCID-I. *See* Structured Clinical Interview for Axis I DSM-IV Disorders (SCID-I)
- Scientist-practitioner model of training, 1:389–391**
- agency consultation and, **2:525**
- APA conferences affirmation of, **1:104–105, 1:342, 1:389–390**
- APA Division 17 and, **1:133**
- APA evidence-based task force and, **1:391**
- Madonna G. Constantine and, **3:1068–1071**
- Council of Counseling Psychology Training Program and, **1:132**
- The Counseling Psychologist* journal and, **1:130**
- current status of, **1:390**
- effectiveness research and, **1:390–391**
- evidence-based practice and, **1:391**
- feminization of psychology and, **1:212**
- Myrna L. Friedlander and, **1:218–220**
- history and definitions of, **1:389–390**
- industrial/organizational psychology and, **1:254**
- in managed behavioral health care, **1:390**
- Paul E. Meehl and, **2:684–686**
- National Conference on Scientist-Practitioner Education and Training for the Professional Practice of Psychology and, **1:389**
- John C. Norcross and, **1:309–311**
- randomized clinical trials and, **1:390**
- school psychology and, **1:384**
- science and practice integration and, **1:133**
- supervision training and, **1:409**



- technological issues in, **1:390–391**
- training issues in, **1:390**
- university counselors and, **1:435**
- SCL-90-R. *See* Symptom Check-List-90 Revised (SCL-90-R)
- Scott, Walter Dill, **1:254**
- SCP. *See* Society of Counseling Psychology (SCP)
- SCWM. *See* Social Class Worldview Model (SCWM)
- SDQ. *See* Self-Description Questionnaire (SDQ)
- SDS. *See* **Self-directed search** (SDS)
- SDT. *See* Signal detection theory (SDT)
- Seashore Measures of Musical Talents
  - aptitude test, **2:450**
- Seaton, Eleanor, **3:1038**
- Secondary trauma, 2:849–851**
  - assessment of, **2:850–851**
  - children of Holocaust survivors and, **2:849**
  - compassion fatigue and, **2:849, 2:850**
  - compassion fatigue vs. burnout, **2:850**
  - definition of, **2:849**
  - empathy, sympathy and, **2:850**
  - family emotional bonds and, **2:850**
  - female psychotherapists and, **2:850**
  - Secondary Trauma Scale (STS) and, **2:851**
  - symptoms of, **2:849**
  - vicarious trauma and, **2:849–850**
- Second culture acquisition, 3:1309–1312**
  - acculturation and, **3:941–946, 3:1309**
  - acculturative stress and, **3:946–952, 3:1309–1311**
  - bicultural efficacy and, **3:1310, 3:1312**
  - bicultural stress and, **3:1310, 3:1311–1312**
  - bilinear adaptation model and, **3:1309–1310**
  - colonialism and, **3:1061–1063**
  - communication skills and, **3:1310, 3:1312**
  - counseling implications of, **3:1312–1313**
  - cultural accommodation and negotiation and, **3:1089–1090**
  - enculturation and, **3:1129–1131**
  - factors that facilitate, **3:1312**
  - mental health and, **3:1311**
  - nonlinear adaptation model and, **3:1310–1311**
  - orthogonal cultural identification theory and, **3:1250–1252**
  - psychological stress and, **3:1310**
  - socioeconomic status factor in, **3:1312**
  - unilinear adaptation model and, **3:1309**
- Secretary's Commission on Achieving Necessary Skills (SCANS), **4:1678, 4:1679, 4:1680**
- SEDS-2. *See* Social-Emotional Dimension Scale (SEDS-2) behavior rating scale
- Segal, Zindel, **2:511**
- Segall, Marshall H., **3:1081**
- SEI. *See* Coopersmith Self-Esteem Inventory (SEI)
- Self-categorization theory of discrimination, **3:1115**
- Self-construction model, **4:1515**
- Self-Description Questionnaire (SDQ), **2:861, 2:864**
- Self-determination
  - assisted suicides and, **1:151, 1:245, 2:496**
  - autonomy and, **2:553–554**
  - cognitive evaluation theory and, **2:662**
  - health care proxy, living will and, **1:152, 1:245**
  - hospice philosophy of, **1:244**
  - intrinsic motivation and, **2:553–554, 2:662–663**
  - Patient Self-Determination Act (1990) and, **1:151**
- Self-Directed Search (SDS), 1:420, 2:906, 4:1431, 4:1544, 4:1545, 4:1619–1621**
  - Activities section of, **4:1620**
  - assessed interests and, **4:1620–1621**
  - Assessment Booklet* of, **4:1619, 4:1620**
  - Competencies section of, **4:1620**
  - computer-based version of, **4:1511, 4:1620**
  - Daydreams section of, **4:1619, 4:1620**
  - expressed interests and, **4:1620**
  - Holland's RIASEC theory and, **4:1619, 4:1620, 4:1621**
  - implications of, **4:1621**
  - Interpretive Report of, **4:1620**
  - Occupation Finder* of, **4:1619**
  - Occupations section of, **4:1620–1621**
  - popularity of, **4:1619**
  - Professional User's Guide* of, **4:1620**
  - SDS Form R version of, **4:1619**
  - Self-Estimates section of, **4:1621**
  - simulated career planning experience of, **4:1620**
  - stand-alone career planning simulation of, **4:1619**
  - Technical Manual* of, **4:1620**
  - various formats of, **4:1620**
  - Bruce Walsh and, **4:1676**
  - You and Your Career* booklet of, **4:1620**
- Self-disclosure, 2:851–852**
  - of client to therapist, **2:488, 2:851–852**
  - clinical interview and, **2:490–491**
  - factors of, **2:489**
  - liberation from physical and emotional tension and, **2:488**
  - of therapist to client, **2:488–489, 2:852**
  - of therapist to client, client reaction to, **2:489**
- Self-discrepancy theory, of personality, **2:746–747**
- Self-Efficacy: The Exercise of Control* (Bandura), **2:767**



**Self-efficacy/perceived competence, 2:852–858**

affective mediating processes, 2:855  
 anxiety vs. self-efficacy expectations and, 2:766  
 attachment theory and, 4:1410–1412  
 autonomy and, 2:553–554  
 Alfred Bandura's self-efficacy theory and,  
     1:235, 2:467–469, 2:533, 2:594–595, 2:741,  
     2:745, 2:765, 2:852  
 career development applications of, 2:767  
 causal attributions and, 2:854, 2:869  
 chronic illness and, 1:82  
 clinical applications of self-efficacy theory and, 2:767  
 cognitive mediating processes and, 2:854  
 cognized goals and, 2:854  
 coping efficacy, depression and, 2:855–856  
 coping efficacy, life transitions and, 2:856  
 coping efficacy, stress, anxiety and, 2:855  
 coping efficacy, trauma and, 2:856  
 dimensions of, 2:852–853  
 effects of failure on, 2:853  
 ego strength and, 2:585  
 expectancy-value theory and, 1:235, 2:707, 2:854  
 future behavior predictions and, 2:765  
 generality dimension of, 2:853  
 goals importance and, 2:766–767  
 goal theory and, 2:854, 2:855  
 hierarchy of, 2:765  
 hope and, 2:634–637  
 identity development and, 3:1165  
 implications of, 2:856–857  
 information sources regarding, 2:766  
 interventions to change behavior and, 2:766  
 intrinsic motivation and, 2:553–554, 2:660–666  
 Latino career counseling and, 4:1453–1454  
 learned helplessness and, 2:869  
 locus of control and, 3:1204  
 magnitude dimension of, 2:852–853  
 mastery experiences and, 2:853, 2:857  
 measured ability and, 2:766  
 mental health and, 2:855  
 motivational mediating processes and, 2:854–855  
 optimism, pessimism and, 2:707–710  
 outcome expectations vs., 2:766, 2:854  
 performance accomplishments and, 2:766  
 physical and emotional states and, 2:854  
 selection mediating processes and, 2:855  
 self-determination theory and, 2:553–554, 2:662–663  
*Self-Efficacy: The Exercise of Control*  
     (Bandura) and, 2:767  
 self-efficacy expectations and, 2:765–767

self-efficacy theory and, 2:765–767  
 self-regulatory self-efficacy and, 2:855  
 social cognitive career theory and, 2:768  
 social comparison and, 2:853–854  
 social models and, 2:853–854  
 social persuasion and, 2:854, 2:857  
 specific cognitive judgments and, 2:765  
 strength dimension of, 2:853  
 strength of, 2:765  
 stress buffer and, 2:677  
 task-specific self-efficacy and, 2:855  
 vicarious experiences and, 2:853–854, 2:857  
 work-bound youth and, 4:1678–1680

*See also* **Bandura, Albert**

**Self-esteem, 2:858–863**

accessibility of the self and, 2:860  
 AD/HD and, 1:30–31  
 autonomy and, 2:553–554  
 Albert Bandura's work and, 2:467–469  
 bullying victims and, 1:56  
 cognitive structure of a person and, 2:859  
 Cooley's "looking-glass self" concept and, 2:858  
 Coopersmith Self-Esteem Inventory and, 2:861  
 definitional issues and, 2:859–860, 2:863  
 ego strength and, 2:585  
 ethnic identity and, 3:1138, 3:1230  
 ethnicity and, 2:866  
 evaluative vs. descriptive definition of, 2:859–860  
 exercise and, 1:196  
 future directions regarding, 2:862  
 Greek philosophers and, 2:858  
 Harter Self-Perception Profiles and, 2:861  
 historical overview regarding, 2:858–859  
 intrinsic motivation and, 2:553–554  
 William James's self-concept theory and, 2:858, 2:863  
 methodological issues regarding, 2:860–861  
 multidimensional view of, 2:859  
*The Principles of Psychology* (William James)  
     and, 2:858  
 reactive self-report method and, 2:860  
 Rosenberg Self-Esteem Scale and, 2:861  
 Self-Description Questionnaires and, 2:861  
 self-determination theory and, 2:553–554, 2:662–663  
 self-esteem measures and, 2:861–862, 2:863–866  
 self-report bias and, 2:860–861  
 self-worth, competence and, 2:858  
 social cognition role in, 2:859  
 social identity theory and, 3:1166  
 social support and, 2:872–875  
 spontaneous self-report method and, 2:860



stereotype threat and, **3:1340**  
stress buffer and, **2:677**  
trait forgiveness and, **2:606**  
weight loss and, **1:94–95**  
workplace motivation and, **1:256**  
*See also Self-esteem, assessment of*  
**Self-esteem, assessment of, 2:863–866**  
age, sex, social, ethnicity factors and, **2:866**  
commonly used measures for, **2:863**  
Coopersmith Self-Esteem Inventory (SEI),  
    **2:861, 2:863, 2:864**  
correlations between measures and, **2:864–865**  
definition of, **2:863**  
ego strength and, **2:585–587**  
Harter Self-Perception Profile, **2:864**  
Harter Self-Perception Profiles, **2:861**  
Implicit Association Test (IAT), **2:863, 2:864**  
intentional self-presentation vs. self-deception  
and, **2:865**  
interpretation of, **2:863**  
related personality constructs and, **2:865–866**  
Rosenberg Self-Esteem Scale (RSE),  
    **2:861, 2:863, 2:864**  
Self-Description Questionnaire (SDQ),  
    **2:861, 2:864**  
Self-Perception Profile (SPP), **2:864**  
self-report scales and, **2:863–864**  
social desirability issue of, **2:865**  
stable or transient state and, **2:865**  
young children and, **2:866**  
Self-Esteem Inventory (SEI). *See* Coopersmith  
    Self-Esteem Inventory (SEI)  
**Self-help groups, 2:866–869**  
A. A. and, **1:14–18, 2:867**  
adventure therapy and, **1:12–14**  
benefits of, **2:867**  
core group of leaders and, **2:868**  
definition of, **2:866**  
diversity of, **2:867**  
functions of, **2:867**  
group therapy and, **2:618–622**  
health care systems and, **2:867**  
interpersonal learning, interpersonal feedback and,  
    **2:658–660**  
local community and, **2:868**  
organizational tasks and, **2:868**  
professional involvement in, **2:867–868**  
psychoeducation and, **2:799–803**  
realistic expectations and, **2:868**  
referrals to, **2:868**

*The Seven Habits of Highly Effective People*  
    (Covey) and, **4:1424**  
social movement nature of, **2:867**  
social support and, **2:872–875**  
success of, **2:867**  
support groups, mutual help groups terms and, **2:866**  
Self-Perception Profile (SPP), **2:864**  
Self psychology  
    bipolar self psychic structure and, **2:762**  
    grandios self psychic structure and, **2:762**  
    idealized self object and, **2:762**  
    idealizing function and, **2:762**  
    Heinz Kohut's work in, **2:762**  
    mirroring function and, **2:762**  
    narcissism, self-absorption and, **2:762**  
    self object experiences and, **2:762**  
    twinship and, **2:762**  
Self-regulation  
    ethical decision making and, **1:183**  
    intrinsic motivation and, **2:663**  
    in social cognitive theory, **2:767**  
    therapist self-regulation and, **2:486**  
Self-regulation of motivation (SRM) theory, **2:663**  
Self-Report of Scale (SRP), of BASC-2, **1:42, 1:47, 1:49**  
**Seligman, Martin E. P., 2:869–870**  
    causal attributions and, **2:869**  
    depression work of, **2:869**  
    identified, traits, character strengths, virtues and, **2:783**  
    learned helplessness work of, **2:869, 3:1199–1200**  
    positive psychology work of, **2:781, 2:782, 2:783,**  
        **2:784, 2:869, 2:889**  
    Web site of, **2:870**  
Sellers, Robert M., **3:1166, 3:1288**  
Selye, Hans, **1:399, 2:883, 2:886, 2:889, 4:1601**  
SEQ. *See* Session Evaluation Questionnaire  
    measure (SEQ)  
Sequenced Inventory of Communication  
    Development, **2:670**  
SES. *See* **Socioeconomic status (SES)**  
Session Evaluation Questionnaire measure (SEQ), **2:532**  
*The Seven Habits of Highly Effective People* (Covey)  
    and, **4:1424**  
*The Seven Keys to Resiliency* (Rush), **2:840**  
**Sexism, 3:1313–1319**  
    *The Beauty Myth* (Wolf) and, **3:1317**  
    Martha Bernal and, **3:1012–1014**  
    Black feminism, women of color feminism and, **3:1314**  
    body image, eating disorders and,  
        **2:581, 2:582, 2:584, 3:1317**  
    contraceptive issues and, **3:1316**



- cultural representations of women and, **3:1317**  
 deficit hypothesis and, **3:1109–1111**  
 definition of, **2:573, 3:1313**  
 Equal Pay Act (1963) and, **3:1314, 4:1595**  
*Fat is a Feminist Issue* (Orbach) and, **3:1317**  
*Femininity* (Brownmiller) and, **3:1317**  
 feminism and, **3:1314**  
 feminism and, backlash against, **3:1314, 3:1317**  
 feminist counseling approaches and, **3:1317**  
 gender-biased mental health and disorder  
   representations and, **3:1316–1317**  
 gender discrimination and, **3:1117**  
*The Gender Knot* (A. Johnson) and, **3:1313**  
 glass ceiling and, **3:1314–1315**  
 Glass Ceiling Commission and, **3:1315**  
*Homophobia: A Weapon of Sexism* (Pharr) and, **3:1318**  
 internalized oppression and, **3:1318**  
 misogyny, misandry and, **2:573**  
 National Committee on Pay Equity and, **3:1314**  
 National Organization for Women and, **3:1316, 3:1318**  
 Partial Birth Abortion Ban and, **3:1316**  
 patriarchal social context of,  
   **3:1313–1314, 3:1317, 3:1318**  
 political correctness and, **3:1263–1264**  
 pornography and, **3:1318**  
 race, class, sexual orientation intersection with, **3:1314**  
 relational-cultural therapy and, **3:1317**  
*Roe v. Wade* controversy and, **3:1316**  
 sexual harassment and, **3:1315, 4:1621–1624**  
*The Sexual Harassment of Working Women*  
   (Mackinnon) and, **3:1315**  
*Sister Outsider* (Lorde) and, **3:1318**  
 systematic oppression of women and, **3:1313**  
 transcending sexism, **3:1318**  
 in the United States, **3:1314–1318**  
 violence against women and, **3:1318**  
 wage gap and, **3:1314**  
 womanism concept and, **3:1314**  
*Women and Madness* (Chesler) and, **3:1316**  
 women of color and queer women, multiple  
   oppressions and, **3:1318**  
 women's emotional health and, **3:1316–1317**  
*Women's Inhumanity to Women* (Chesler) and, **3:1318**  
 women's physical health and, **3:1315–1316**  
 the world's oldest oppression and, **3:1313**  
 Sexton, T. L., **2:763, 4:1516**  
**Sexual harassment, 4:1621–1624**  
   causes of, **4:1622–1623**  
   contrapower sexual harassment and, **4:1622**  
   definitions of, **4:1622**  
   gender harassment and, **4:1622**  
   hostile work environment and, **4:1622**  
   marginalized populations and, **4:1622**  
   negative outcomes of, **4:1621–1622, 4:1622**  
   organizational climate factor and, **4:1623**  
   quid pro quo and, **4:1622**  
   same-sex harassment and, **4:1621**  
   sexual coercion and, **4:1622**  
   sexual violence, coercion and, **1:391–393**  
     as social discrimination, **4:1631**  
     strategies to reduce, **4:1623**  
   unwanted sexual attention and, **4:1622**  
   work, health, and psychological well-being affected by,  
     **4:1621–6222**  
*The Sexual Harassment of Working Women*  
   (Mackinnon), **3:1315**  
**Sexual orientation, 4:1624–1626**  
   career counseling and, **4:1624**  
   career development and, **4:1531**  
   coming out and, **4:1624–1625**  
   coming out to self, to others and, **4:1625**  
   conversion therapy and, **1:114–116**  
   counselor self-knowledge and, **4:1624**  
   cultural counseling competence and, **4:1624**  
   discrimination and, **3:1118, 4:1624, 4:1634**  
   gay and lesbian career counseling and,  
     **4:1443–1445, 4:1624**  
   GLB therapy and, **2:613–615**  
   job discrimination and, **4:1624, 4:1625**  
   other issues with, **4:1625**  
**Sexual violence and coercion, 1:391–393**  
   anger management, forensic counseling and, **1:214–215**  
   categories of, **1:392**  
   CDC definitions regarding, **1:391–392**  
   Christine A. Courtois's work and, **1:140–142**  
   family counseling and, **1:205–206**  
   intimate partner abuse and, **2:443–447**  
   psychological outcomes of, **1:392**  
   sexual harassment and, **4:1621–1624**  
   statistics regarding, **1:392**  
   suicidal behavior and, **1:392**  
   victim feeling responsible for, **1:392**  
 Shafer, Roy, **2:763**  
*Shafer v. Preston Memorial Hospital Co.*, **1:24**  
*The Shame of the Nation* (Kozol), **3:1056**  
 Shapiro, Francine, **1:198, 2:889**  
 Shaw, Heather, **2:582**  
 Shaywitz, Benny, **1:158**  
 Shaywitz, Sally, **1:158**  
 Shazer, Steve de, **1:204**



- Shea, D. L., **2:654** (figure)
- Shedler-Western Assessment Procedure (SWAP-200), **2:728**
- Sherif, Muzafer, **2:674**
- Sherman, Gordon, **1:158**
- Shlein, John, **2:930**
- Shneidman, E. S., **1:149, 2:545**
- Shoben, Edward Joseph, **1:104**
- Shoda, Yuichi, **2:746**
- Shotter, John, **2:523**
- The Shoulders of Women* (Philipson), **1:212**
- Shullman, Sandy, **1:132, 1:258, 2:525**
- Siblings
- bereavement over loss of, **1:50**
  - childhood chronic illness affect on, **1:76**
- SIB-R. *See* Scales of Independent Behavior-Revised (SIB-R)
- Sidanius, James, **3:1116, 3:1321**
- Siegel, Bernard, **3:1002**
- SIFFM. *See* Structured Interview for the Five-Factor Model of personality (SIFFM)
- SIGI. *See* System of Interactive Guidance Information (SIGI)
- Signal detection theory (SDT), **1:113**
- Sillen, Samuel, **3:1124**
- Silverstein, Olga, **1:204**
- Simeck-Morgan, L., **1:268**
- Simmons, J., **1:352**
- Simon, Theodore
- cognitive ability work of, **4:1430**
  - intelligence scales work of, **1:121, 2:497**
- Simons, Sarah, **3:1001, 3:1002**
- Sinacore-Guinn, Ada, **4:1684**
- Singer, B., **1:175**
- Singer-Loomis Type Development Inventory, **2:727**
- SIP. *See* Society of Indian Psychologists (SIP)
- Sister Outsider* (Lorde), **3:1318**
- SIT. *See* Stress inoculation training (SIT)
- Sixteen Personality Factor Questionnaire (16PF), **1:420, 2:461–462, 2:724, 2:725, 2:752, 2:813, 4:1599–1600**
- 16PF. *See* Sixteen Personality Factor Questionnaire (16PF)
- Sixteenth Mental Measurements Yearbook (MMY), **2:450**
- Skillings, Judith H., **3:1295**
- Skinner, B. F., 2:870–872**
- behavioral personality theory of, **2:738–739, 2:859**
  - behavioral therapy theory of, **2:541**
  - behavior analysis work of, **2:739, 2:870**
  - behaviorist work of, **2:870–871**
  - The Behavior of Organisms* written by, **2:870**
  - Beyond Freedom and Dignity* written by, **2:871**
  - books and publications by, **2:871**
  - “cultural engineering” concept of, **2:739**
  - early influences on, **2:870**
  - environmental influences on behavior and, **2:739**
  - experimental control importance and, **2:870**
  - free will, self-control issue and, **2:739**
  - human nature and, **2:739**
  - imitation as a means of learning and, **2:738**
  - instrumental behavior work of, **2:870**
  - matter of consequences and, **2:871–872**
  - “nurture” overrides “nature” and, **2:739**
  - psychopathology and, **2:738–739**
  - radical behaviorism and, **2:871**
  - religion and, **2:879**
  - Schedules of Reinforcement* co-authored by, **2:871**
  - Verbal Behavior* written by, **2:870–871**
  - Walden Two* written by, **2:739, 2:871**
- Skovholt, Thomas M., **1:263, 2:513**
- Skowron, Elizabeth, **1:219**
- Sleep disorders, 1:393–395**
- advancements and research results in, **1:394–395**
  - breathing-related sleep disorder, **1:393**
  - circadian rhythm sleep disorder, **1:393**
  - definition of, **1:393–394**
  - DSM-IV-TR* classification of, **1:393–394**
  - dyssomnia not otherwise specified, **1:393–394**
  - ethnicity, gender factors and, **1:394**
  - impact of, **1:394**
  - primary insomnia, **1:393**
  - research technology and, **1:394–395**
  - treatment: psychology vs. pharmacology and, **1:394**
- Smith, Laura, **3:1329**
- Smith, Marcia, **2:580**
- Smith, Mary Lee, **2:512, 2:627, 2:714**
- Smith, Ruth, **1:416**
- Smith, Timothy, **3:1088, 3:1232**
- Smith, William David, **3:1034**
- Smith-Fess Act (1920), **2:827**
- Smith-Hughes Act (1917), **1:122, 4:1446**
- Smyth, Joshua M., **2:694**
- Snyder, C. R., **2:783**
- Snyder, Rick, **2:634**
- SOC. *See* Standard Occupational Classification (SOC) System
- Social capital, **3:950–951**
- Social class, 4:1626–1627**
- classism and, **3:1054–1059, 4:1626**
  - counseling implications of, **4:1626**
  - critical race theory and, **3:1071–1078**



- rural practice challenges and, **1:378–380**  
 self-esteem and, **2:866**  
 socioeconomic status vs., **4:1626**  
 worldview and identity issues and, **4:1626**  
 Social Class Worldview Model (SCWM), **3:1329**  
 Social Climate Scales, **4:1558**  
 Social Cognition and Object Relations Scale, for Thematic Apperception Test, **2:793**  
**Social cognitive career theory (SCCT), 4:1627–1630**  
 ability and, **4:1629**  
 Albert Bandura's work and, **2:467–469, 2:505, 2:768, 4:1627**  
 career choices and, **2:768**  
 career interests and, **2:768**  
 career-related interests and choices over time and, **4:1627, 4:1628 (figure), 4:1629**  
 career success and, **2:768**  
 choice model of career choice process and, **4:1629**  
 environmental variables and, **4:1629**  
 interest model and, **4:1627, 4:1629**  
 motivation and, **4:1629**  
 outcome expectations and, **2:768, 4:1627, 4:1629**  
 performance model and, **4:1629–1630**  
 personal goals and, **4:1627**  
 reciprocal determinism concept and, **2:505**  
 research and practical applications of, **4:1630**  
 self-efficacy expectations and, **2:768, 4:1627, 4:1629**  
 self-efficacy research and, **2:768**  
 social cognitive theory and, **2:768**  
 success in goal pursuit and, **2:768**  
*See also* Social cognitive theory  
 Social cognitive theory  
 academic performance and, **2:768**  
 Gordon Allport and, **3:1114**  
 applications of, **2:767–768**  
 Albert Bandura's work and, **2:467–469, 2:505, 2:745–746, 2:767, 2:768, 4:1627**  
 career development and, **2:768**  
 counseling psychology and, **2:768**  
 forethought capability and, **2:767**  
 locus of control concept and, **2:741**  
 observational learning and, **2:741, 2:745, 2:746**  
 person variables, cognitive processes and, **2:741**  
 reciprocal determinism and, **2:505, 2:741, 2:746, 2:764**  
*Self-Efficacy: The Exercise of Control* (Bandura) and, **2:767**  
 self-efficacy and, **2:741, 2:745–746**  
 self-reflection and, **2:767**  
 self-regulatory capability and, **2:767**  
*Social Foundations of Thought and Action* (Bandura) and, **2:767**  
 strength and valence of observed consequences, **2:745**  
 symbolizing capability and, **2:767**  
 vicarious capability and, **2:767**  
 vicarious learning and, **2:741, 2:745**  
*See also* **Bandura, Albert; Personality theories, social cognitive; Social cognitive career theory (SCCT)**  
 Social constructivism, **2:522–523**  
 ethical decision-making models and, **1:184**  
 family counseling and, **1:204**  
 solution-focused brief therapies (SFBT) and, **2:523–524**  
 Social Darwinism, **3:1573**  
 Social Desirability Scale, **2:880**  
**Social discrimination, 4:1630–1633**  
 African Americans, research focus on, **4:1632**  
 Kenneth Bancroft Clark and, **3:1050–1052**  
 classism and, **3:1054–1059**  
 consequences of, **4:1631–1633**  
 cultural discrimination and, **4:1631**  
 deficit hypothesis and, **3:1109–1111**  
 definition of, **3:1113–1114, 4:1630**  
 differential effect and, **4:1631**  
 differential treatment and, **4:1631**  
 Eurocentrism and, **3:1147–1148**  
 examples of, **4:1630–1631**  
 harassment and, **4:1631**  
 historical perspective on, **4:1630–1631**  
 legal protections against, **4:1630, 4:1631**  
 levels and types of, **4:1631**  
 model minority myth and, **3:1211–1214**  
 multiple minority membership and, **4:1632**  
 overt discrimination and, **4:1631**  
 perceived discrimination and, **4:1631**  
 prejudice and, **4:1631**  
 racial and ethnic discrimination and, **4:1633**  
 remedies for, **4:1633**  
 sexual discrimination and, **4:1633**  
 sexual harassment and, **4:1631**  
 sexual orientation discrimination and, **3:1118, 4:1624, 4:1633**  
 stereotypes and, **3:1333–1339, 4:1634**  
 subtle discrimination and, **4:1631**  
 targets and extent of, **4:1631–1632**  
 well-being affected by, **4:1633**  
 within-group differences and, **4:1630–1633**  
 women, research focus on, **4:1632**  
 work world examples of, **4:1630–1631, 4:1631–1632**



Social dominance theory of discrimination and prejudice, **3:1116, 3:1275**

Social-Emotional Dimension Scale (SEDS-2) behavior rating scale, **1:48**

Social exchange theory, **4:1593**

*Social Foundations of Thought and Action* (Bandura), **2:767**

**Social identity theory, 3:1319–1321**

attitude change and, **3:1321**

critical race theory and, **3:1071–1078**

definition of, **3:1319**

of discrimination, **3:1115**

ethnic identity and, **3:1135**

ethnocentrism and, **3:1143**

ingroup vs. outgroup social categories and, **3:1319**

intergroup discrimination and, **3:1319**

intergroup process implications of, **3:1320**

internalized racial oppression and, **3:1320**

intragroup processes implications of, **3:1320–1321**

loss of face and, **3:1205**

oppression, discrimination, and marginalization factors in, **3:1162**

personal identity and, **3:1319**

sense of “belonging” and, **3:1162**

social and group identity and, **3:1162**

social categorization and, **3:1319**

social comparison, positive distinctiveness and, **3:1319–1320**

social identity and, **3:1319**

status hierarchies and, **3:1320**

stereotypes and discrimination and, **3:1320**

Henri Tajfel and, **3:1114, 3:1135,**

**3:1162, 3:1166, 3:1319**

vocational identity and, **4:1672–1673**

*See also* **Ethnic identity; Identity; Identity development; Racial identity**

**Social justice, 3:1321–1323**

action-oriented research and, **3:1322–1323**

affirmative action and, **3:957–958**

Kenneth Bancroft Clark and, **3:1050–1052**

classism and, **3:1054–1059**

community-based action research and, **1:90, 1:92**

Madonna G. Constantine and, **3:1068–1071**

counseling implications of, **3:1321–1322**

counseling student out-reach actions and, **3:1322**

counselor commitment to, **3:1322**

counselor self-knowledge and, **3:1322**

depression and anxiety symptoms of, **3:1321**

empowerment and, **3:1127–1129**

ethical decision-making models and, **1:184**

explanation of, **3:1321**

human subjects review in an online world and, **1:247**

mental health intervention programs and, **3:1322**

Frank Parsons work and, **1:92**

pluralism and, **3:1263**

professionals as agents of social change and, **3:1322**

psychological effects of, **3:1321**

social change, action theory and, **1:91, 4:1397–1400**

therapist responsibility to society and, **2:496**

Melba J. T. Vasquez and, **1:90**

White privilege and, **3:1374**

*See also* **Empowerment**

*Social Learning and Personality Development* (Bandura and Walters), **2:467, 2:764**

Social psychology, person-environment interactions and, **2:774**

*Social Sciences Citation Index*, **4:1472**

Social Security Act (1967), **4:1447**

**Social support, 2:872–875**

attachment theory and, **2:873**

benefits from, **2:872**

cancer management and, **1:59–63**

conceptual frameworks of, **2:872–873**

conservation of resources (COR) theory and, **2:873–874**

coping and, **2:526–530**

definition of, **2:872**

direct or main effect model of, **2:872–873**

ecological congruence and, **2:873**

GLB therapy and, **2:615**

HIV/AIDS and, **1:239–240**

hospice care and, **1:243–245**

individual, family, community levels of, **2:872**

interpersonal learning, interpersonal

feedback and, **2:658–660**

mechanisms of, **2:873–874**

negative impact of, **2:874**

psychological and physical health affected by, **2:872**

self-esteem, self-efficacy, optimism and, **2:872**

self-help groups and, **2:866–869**

social integration and, **2:873**

stress buffering hypothesis regarding, **2:872**

Society for a Science of Clinical Psychology, **1:347**

Society for Occupational Health Psychology, **4:1585–1586**

**Society for the Psychological Study of Ethnic Minority Issues, 3:1323–1324**

APA Division 45 and, **3:1323, 3:1342**

*APA Multicultural Guidelines* and, **3:1323–1324**

Patricia Arredondo and, **3:992**

Jesús Manuel Casas and, **3:1043**



- Cultural Diversity & Ethnic Minority Psychology*  
journal of, **3:1323**  
Lillian Comas Diaz's history of, **3:1323**  
*Focus* newsletter of, **3:1323**  
formation of, **3:1323**  
mission of, **3:1323**  
Multicultural Summit conference and, **3:1324**  
Derald Wing Sue and, **1:402, 3:1342**  
Joseph E. Trimble and, **3:1356**  
Web site of, **3:1324**  
*See also* American Psychological Association (APA)
- Society for Vocational Psychology, 4:1634–1635**  
APA Division 17 and, **4:1634**  
Biennial Conference Series of, **4:1634–1635**  
organizations related to, **4:1635**  
purpose of, **4:1634**  
Society of Counseling Psychology Special Interest Group and, **4:1635**  
W. Bruce Walsh and, **4:1676**  
Web site of, **4:1631**
- Society of Counseling Psychology (SCP)  
*The Counseling Psychologist* journal of, **1:103–104, 1:124, 1:127, 1:128–129, 1:130–131, 1:263, 1:264**  
Division 17 name change and, **1:132**  
science-practitioner model and, **1:133**  
W. Bruce Walsh and, **4:1676**  
*See also* American Psychological Association (APA);  
**Conferences, counseling psychology**
- Society of Indian Psychologists (SIP), 3:1324–1325**  
American Indian and Alaskan Native professionals network of, **3:1324**  
beginnings of, **3:1324**  
CNPAEMI membership of, **3:1242, 3:1324**  
cross-cultural training and, **3:1087**  
Indian mascot issue and, **3:1325**  
indigenous peoples of the Americas focus of, **3:1324**  
*Network of Indian Psychologists* newsletter and, **3:1324**  
policy making by, **3:1324–1325**  
Web site of, **3:1325**  
Joseph L. White and, **3:1370**
- Socioeconomic status (SES), 3:1325–1331**  
achievement gap and, **3:952–955**  
“American Dream” ideology and, **3:1330**  
capitalist class and, **3:1327**  
career development and, **4:1531–1532**  
classification schemes based on prestige and, **3:1328**  
classism and, **3:1054–1059, 3:1329**  
cohort referent group and, **3:1329**  
definition of, **3:1325**  
Duncan's Socioeconomic Index and, **3:1328**  
*Economic Apartheid in America* (Yeskel) and, **3:1326**  
education and, **3:1327–1328, 3:1328–1329**  
future directions regarding, **3:1330**  
group of aspiration referent group and, **3:1329**  
group of origination referent group and, **3:1329**  
help-seeking behavior and, **3:1158**  
Hollingshead Index of Social Position and, **3:1327, 3:1328**  
Hollingshead Two-Factor Index and, **3:1327**  
income statistics and, **3:1325–1326**  
indicators and disparities of, **3:1325–1328**  
indicators of, **3:1325**  
intelligence tests and, **3:1181**  
Latinos and, **3:1193–1194**  
material objects, lifestyle, and behavior performance variables and, **3:1329–1330**  
mental health and, **3:1328–1329**  
middle class and, **3:1327**  
“myth of the classless society” and, **3:1325**  
Nam-Powers Socioeconomic Status Score and, **3:1328**  
occupational groups and, **3:1326–1327**  
perceived class and status position and, **3:1329**  
physical health and, **3:1328**  
poverty statistics and, **3:1266–1267, 3:1326**  
referent groups and, **3:1329–1330**  
saliency, consciousness, attitudes factors and, **3:1329**  
social class term and, **3:1325, 4:1626–1627**  
social class world view model and, **3:1329–1330**  
Social Class Worldview Model (SCWM) and, **3:1329**  
wealth disparity statistics and, **3:1326**  
working class and, **3:1327**  
*The Working Class Majority* (Zweig) and, **3:1327**
- Sociogenic models of adult development, **1:10**  
Socrates, **1:107, 2:858**  
*See also* **Socratic Method**
- Socratic Method, 2:875–876**  
applications of, **2:875**  
components of, **2:875**  
disavowal of knowledge concept of, **2:875**  
inductive reasoning component of, **2:875**  
promoting virtue goal of, **2:875**  
self-improvement component of, **2:875**  
Socratic ignorance and, **2:875**  
systematic questioning component of, **2:875**  
universal definitions component of, **2:875**
- Sodowsky, G. R., **3:1311**
- Sojourner, 3:1331**  
cognitive, behavioral, and emotional adjustments of, **3:1331**  
counseling implications of, **3:1331**



- definition of, **3:1331**
- global economy and, **3:1331**
- as major life stressor, **3:1331**
- Solberg, Scott, **4:1631**
- Solberg, V. S., **4:1679, 4:1680**
- Soldier Rehabilitation Act, **2:827**
- Solomon, Joseph, **1:332**
- Solution-focused brief therapy (SFBT), 2:876–879**
  - asking coping questions and, **2:878**
  - asking scaling questions and, **2:878**
  - asking the miracle question tool and, **2:877–878, 2:914**
  - brief therapy and, **2:479–483**
  - clear, concise goal negotiations in, **2:876**
  - constructivist theory and, **2:524**
  - critical incident stress debriefing and, **2:548–550**
  - doing what is working focus of, **2:877**
  - Milton Erickson's language and metaphor work influence on, **2:876**
  - family counseling and, **1:204**
  - future-focused, goal-directed characteristics of, **2:876**
  - giving compliments and, **2:877**
  - key concepts, **2:876–878**
  - looking for exceptions and, **2:876**
  - looking for previous solutions and, **2:876**
  - present and future focus of, **2:877**
  - research findings regarding, **2:878**
- Sommers, Samuel, **3:1065**
- The Souls of Black Folk* (Du Bois), **3:964**
- Southern Christian Leadership Conference, **3:1238**
- Spanierman, L. B., **4:1577**
- SPD. *See* Schizoid personality disorder (SPD)
- Spearman, Charles, **1:364, 2:497, 2:924, 2:938**
- Specialization designation, 1:395–398**
  - American Board of Counseling Psychology (ABCP) and, **1:397–398**
  - American Board of Professional Psychology (ABPP) and, **1:395, 1:396–397**
  - ASPPB/NR Designated Doctoral Programs and, **1:396, 1:397**
  - Association of State and Provincial Psychology Boards and (ASPPB), **1:395**
  - case study requirement and, **1:397**
  - credential review, licensure verification and, **1:397**
  - entities involved in, **1:395–396**
  - future importance of, **1:398**
  - graduate education and, **1:396**
  - oral examination and, **1:398**
  - practice sample submission and, **1:397–398**
  - professional self-study requirement and, **1:397**
- Spence, Kenneth, **2:593**
- Spencer, Herbert, **3:1115**
- Spencer, Steven, **3:1339**
- Spielberger, Charles, **2:673, 2:814**
- Spirituality, 3:1331–1333**
  - bibliotherapy, **2:914**
  - Black psychology and, **3:1033–1036**
  - as a coping mechanism, **3:1333**
  - in the counseling process, **3:1332–1333**
  - counseling process and, **3:1365**
  - definitions of, **3:1331–1332**
  - espiritismo and, **3:1131–1132**
  - fatalismo and, **3:1150**
  - in the lives of people of color, **3:1333**
  - manifestations of personal spirituality and, **3:1332**
  - Native American cultural value of, **3:1101**
  - religion and, **3:1332**
  - Santería and, **3:1307–1309**
  - spirituality, religion and, **2:879–882**
  - spirituality and career development and, **4:1635–1638**
  - See also* **Spirituality and career development; Spirituality/religion**
- Spirituality and career development, 4:1635–1638**
  - career choice, a calling or vocation and, **4:1635, 4:1637–1638**
  - counseling implications of, **4:1635**
  - definition of, **4:1636**
  - interests and values relating to, **4:1635, 4:1637**
  - interface of, **4:1635, 4:1636**
  - means of support and, **4:1635, 4:1636–1637**
  - self-efficacy, self-concept and, **4:1636**
  - spirituality, religion and, **2:879–882**
  - See also* **Spirituality; Spirituality/religion**
- Spirituality/religion, 2:879–882**
  - Arab Americans and, **3:985–991**
  - Association for Spiritual, Ethical, and Religious Values in Counseling (ASERVIC) and, **1:125, 1:353, 2:881**
  - bibliotherapy, **2:914**
  - Christian privilege and, **3:1380**
  - cultural aspects of, **2:880**
  - current literature regarding, **2:882**
  - definitions of, **2:881–882**
  - DSM-IV-TR* reference to, **2:882**
  - espiritismo and, **3:1131–1132**
  - forgiveness and, **2:605–607**
  - Handbook of Religion and Health* (Koenig, McCullough and Larson) and, **2:880**
  - Carl Jung and, **2:667–668**



- meta-analysis research on, **2:880**  
 religion in counseling session and, **2:880–881**  
 religion influence on mental health and, **2:879–880**  
 religious coping and, **2:881**  
 Santería and, **3:1307–1309**  
 Social Desirability Scale and, **2:880**  
 spirituality, religion, religiosity terms and, **2:879**  
 spirituality and career development and, **4:1635–1638**  
 spirituality definitions and, **2:881**  
 spirituality disconnected from religion and, **2:881**  
 spirituality in counseling and, **2:881–882**  
 stress management and, **2:889**  
 Spirituality Scale, **3:1035**  
 Spitzer, Robert, **2:811**  
 Spokane, A. R., **4:1516, 4:1590**  
 Sport psychology. *See* **Exercise and sport psychology**  
 SPP. *See* Self-Perception Profile (SPP)  
 Sputnik launch, **1:123, 4:1446–1447**  
 SRM. *See* Self-regulation of motivation (SRM) theory  
 SRP. *See* Self-Report of Scale (SRP), of BASC-2  
 St. John Crevecoeur, J. Hector, **3:1001**  
 Staats, A. W., **2:742**  
 Stahl, Michael, **1:256**  
 STAI. *See* State-Trait Anxiety Inventory (STAI)  
 Stake, Robert, **1:360**  
 Stamler, V. L., **1:432**  
 Standard Cognitive Developmental Interview (SCDI),  
**2:564–565**  
 Standardized achievement tests, **2:450–451**  
 Standard Occupational Classification (SOC) System,  
**4:1587, 4:1589**  
**Standards and competencies, 4:1638–1641**  
 accreditation systems and, **4:1639**  
 American Association for State Counseling Boards  
 and, **4:1639**  
 American Counseling Association and, **4:1639**  
 American Counseling Association Ethical Code and,  
**4:1639**  
 American Educational Research Association  
 and, **4:1639**  
 American National Standards Institute and, **4:1638**  
 Council on Accreditation in Counseling and Related  
 Educational Professions (CACRE) and, **4:1639**  
 definitions of, **4:1639**  
 development of, **4:1640**  
 ethical standards and, **4:1639**  
 International Accreditation Forum and, **4:1638**  
 International Organization for Standardization  
 (ISO) and, **4:1638**  
 licensing and certification systems and, **4:1639**  
 multicultural counseling competencies and,  
**4:1639–1640**  
 National Board for Certified Counselors and, **4:1639**  
 National Career Development Association and, **4:1639**  
 National Council on Measurement in Education  
 and, **4:1639**  
 purposes of, **4:1638**  
 quality in counseling products and, **4:1639**  
*Standards for Educational and Psychological Testing*  
 and, **4:1639**  
 summary of key sets of, **4:1640** (figure)  
 three-C framework for (colleagues, competencies,  
 credentials), **4:1639**  
 Web sites, **4:1641**  
*See also* **Code of ethics and standards of practice**  
*Standards for Educational and Psychological Testing*,  
**2:453, 4:1639**  
 Standards for Entry Preparation of Counselor and Other  
 Personnel Services Specialists, **1:5**  
 Standards of practice. *See* **Code of ethics and standards**  
**of practice; Standards and competencies**  
 Stanford-Binet Intelligence Scales, Fifth Edition (SB5)  
 achievement, aptitude, and ability test and,  
**4:1393, 4:1395, 4:1396**  
 Domains and Factors of, **2:497**  
 history of, **2:497**  
 IQ measurement, mental retardation  
 classification and, **1:294**  
 popularity of, **3:1179**  
 subtests of, **2:497–498**  
 Stang, S., **4:1535**  
 Stanovich, Keith, **1:158**  
 State Occupational Information Coordinating Committees  
 (OICCs), **4:1448, 4:1450**  
 State-Trait Anxiety Inventory (STAI),  
**1:420, 2:534–535, 2:814, 2:884**  
 Steele, Claude M., **3:1228, 3:1339, 3:1340**  
 Steen, Rheta L., **2:881**  
 STEP. *See* Systemic Training for Effecting Parenting  
 (STEP) model, of Adlerian therapy  
 Stephens, Joy, **4:1486**  
 Steps to Respect Program of bullying prevention, **1:57**  
**Stereotype, 3:1333–1339**  
 ACA code of ethics and, **3:1337**  
 appraisals of worth and, **3:1282**  
 Asian American model minority myth and,  
**1:403, 3:993, 3:997, 4:1435**  
 Asian American negative stereotypes and, **3:1212**  
 Asian American occupational stereotyping and, **4:1442**  
 bias and, **3:1014–1016**



- biculturalism and, **3:1017**  
biracialism and, **3:1029**  
classism and, **3:1329**  
cognitive schemata and, **3:1334, 3:1337**  
counseling implications of, **3:1336–1337**  
counseling psychology and, **3:1329**  
definition of, **3:1114, 3:1333**  
discrimination and oppression and, **2:572–575**  
discrimination vs., **3:1114**  
emotional component of, **3:1335**  
history of the term and, **3:1334**  
ingroup and outgroup functions and, **3:1333**  
intelligence tests and, **3:1181**  
intergroup processes and, **3:1319**  
multicultural counseling competence and, **3:1337**  
multicultural psychology and, **3:1228–1229**  
optimal distinctiveness theory of, **3:1228–1229**  
prejudice and, **3:1274**  
racial microaggressions and, **3:1290–1291**  
shifting standard concept and, **3:1335**  
social-cognitive perspective on, **3:1334–1335**  
social identity theory and, **3:1319**  
sociopolitical perspective on, **3:1335–1336**  
stereotype threat and, **3:1181, 3:1228, 3:1274, 3:1337–1338, 3:1339–1341**  
target group affected by, **3:1337–1338**  
tokenism and, **3:1349–1350**  
universalism and, **3:1360**  
xenophobia and, **3:1380**  
yellow peril stereotype and, **3:1212**
- Stereotype threat, 3:1339–1341**  
achievement gap example of, **3:1339**  
anxiety and, **3:1340**  
consequences of, **3:1228, 3:1337–1338, 3:1339–1340**  
counseling implications of, **3:1338**  
definition of, **3:1339**  
ethnic identity and, **3:1340**  
generality of, **3:1339**  
high-stakes testing and, **3:1339**  
intelligence tests and, **3:1181**  
mediators of, **3:1340**  
prejudice and, **3:1228, 3:1274**  
relevance to cross-cultural counseling and, **3:1340**  
self-esteem and, **3:1340**  
target group stereotype conformation and, **3:1338**  
work performance and, **3:1340**  
workplace tokenism and, **3:1249**  
*See also Stereotype*
- Stice, Eric, **2:580, 2:581, 2:582**  
Stickgold, Robert, **1:199**  
Stiles, William, **2:920**  
Stokorow, Robert D., **2:763**  
Stoltenberg, Cal, **1:132, 1:407**  
Stone, G. L., **1:432, 1:433**  
Stonequist, Everett, **3:1028**  
STPD. *See* Schizotypal personality disorder (STPD)  
Stratification theories of aging, **1:15**  
Stream of consciousness adult development theory and, **1:11, 2:744**
- Stress, 2:882–886**  
acculturative stress and, **3:946–952**  
anxiety disorders and, **2:883**  
behavioral changes and, **2:883**  
cognitive appraisal and, **1:399, 2:883, 2:886, 2:889**  
cognitive changes and, **2:883**  
coping with, **2:526–530, 2:855, 2:882–883, 2:884–885**  
cortisol and, **2:883**  
culture shock and, **3:1106–1107**  
emotion-focused coping strategies and, **2:884**  
facial expressions and, **2:883**  
flight-or-fight response and, **2:883**  
general adaptation syndrome and, **2:883**  
happiness/hardiness and, **2:623–626, 2:885**  
life transitions and, **2:676–681**  
personality and, **2:884**  
physical health, illness and, **2:779–781, 2:882**  
physiological changes and, **2:883**  
psychopathology and, **2:885**  
racism related stress and, **3:961**  
reality testing coping strategy and, **2:884**  
social support and, **2:872–875**  
stress appraisal and coping process and, **2:884–885**  
stress management and, **2:886–891**  
stressor categories and, **2:883–884**  
three-stage model of the stress response and, **2:883**  
work-family balance and, **4:1680–1684**  
workplace and, **2:885–886**  
worksite stress-management interventions and, **2:886**  
work stress and, **4:1684–1686**  
*See also Stress management; Stress-related disorders; Work stress*
- Stress inoculation training (SIT), **2:505, 2:510–511**
- Stress management, 2:886–891**  
acculturative stress and, **3:946–952**  
biofeedback techniques and, **2:890–891**  
biological stressors and, **2:886**  
children with chronic illness and, **1:77**  
chronic illness and, **1:82**  
chronic pain and, **1:86**



- cognitive appraisal and, **1:399, 2:883, 2:886, 2:888 (figure), 2:889**  
 coping and, **2:526–530, 2:887**  
 coping efficacy and, **2:855**  
 crisis counseling and, **2:544–548**  
 critical incident stress debriefing and, **2:548–550**  
 deep breathing technique and, **2:890**  
 environmental engineering and, **2:887, 2:888 (figure), 2:889**  
 exercise and, **2:891**  
 eye movement desensitization, reprocessing (EMDR) and, **1:198–202, 2:889**  
 flight or fight response and, **2:886–887**  
 general adaptation syndrome (GAS) and, **2:886**  
 happiness/hardiness and, **2:623–626, 2:885**  
 internal conversation modification and, **2:889**  
 life-role balance and, **4:1571–1573**  
 meditation intervention and, **2:890**  
 mindfulness-based stress reduction and, **1:300, 2:511, 2:890**  
 neurological triggering and, **2:888 (figure), 2:889–890**  
 nutrition and, **2:891**  
 optimistic style and, **2:889**  
 physical health and, **2:779–781**  
 progressive muscle relaxation technique (PMR) and, **2:890**  
 protect organs and system by, **2:890–891**  
 psychopharmacological intervention and, **2:890**  
 psychosocial stressors and, **2:886**  
 psychotherapy interventions and, **2:887, 2:889**  
 self-modification of behavior and, **2:887**  
 social support and, **2:872–875**  
 spirituality and, **2:889**  
 stress definition and, **2:886**  
 stress inoculation training and, **2:505**  
 stress intervention points, **2:888 (figure)**  
 systematic desensitization and, **2:889**  
 time management and planning interventions and, **2:887**  
 transformational coping strategy and, **2:889**  
 work-family balance and, **4:1680–1684**  
 worksite stress-management interventions and, **2:886**  
 work stress and, **4:1684–1686**
- Stress-related disorders, 1:399–401**  
 anxiety, depression and, **1:399**  
 assessment of stress and, **1:400**  
 autonomic nervous system role in, **1:399–400**  
 cognitive appraisal element in, **1:399, 2:883, 2:886, 2:889**  
 cognitive-behavioral therapy and, **1:399**  
 concept of stress and, **1:399**  
 coronary heart disease, cancer and, **1:400**  
 “fight or flight” response and, **1:399, 1:400, 2:703, 2:883, 2:886–887**  
 general adaptation syndrome (GAS) and, **1:399**  
 immune system and, **1:399, 1:400**  
 mindfulness-based stress reduction and, **1:300, 2:511**  
 physiology of stress and, **1:399–400**  
 positive psychology treatment of, **1:400**  
 psychological stress, physical illness relationship and, **1:399, 1:400**  
 relaxation treatment and, **1:399**  
 response to threat or environmental challenge and, **1:399**  
 stressor presence and, **1:399**  
 treating stress and, **1:400**  
*See also Stress; Stress management; Work stress*
- Stricker, George, **2:649**  
 Strodtbeck, F. L., **3:1384**
- Strong, Edward Kellogg, Jr., 1:122, 4:1641–1643**  
 books written by, **4:1642**  
 career assessment focus of, **4:1407, 4:1538**  
 childhood of, **4:1641**  
 criterion keying scale construction method and, **4:1538**  
 early career of, **4:1641–1642**  
 humanistic positive psychology and, **2:782**  
 interest measurement, career decision making and, **4:1642**  
 interest measurement contributions of, **4:1642–1643**  
 longitudinal studies of, **4:1407**  
 occupational scale of, **4:1407**  
 Donald G. Paterson and, **4:1642**  
 Louis L. Thurstone and, **4:1642**  
 Vocational Interest Blank and, **4:1642**  
*See also Strong Interest Inventory*
- Strong, Stanley R., 1:218, 2:891–893**  
 attribution theory and, **2:892**  
*Change Through Interaction* co-authored by, **2:892**  
 common factors foundation of therapeutic relationship and, **2:892**  
 counseling as an interpersonal influence process and, **2:892**  
 empirical research of, **2:892**  
 Myrna L. Friedlander and, **3:218**  
 Heider’s dissonance theory and, **2:892**  
 hypothetical models of underlying realities work of, **2:891**  
 paradoxical interventions and, **2:892**  
 Lyle Schmidt collaborative work with, **2:892**  
 social constructivism and, **2:892**



- social psychology, counseling psychology  
relationship and, **2:892**  
therapeutic change process focus of, **2:892–893**
- Strong Interest Inventory, 4:1643–1645**  
administration and interpretation of, **4:1643–1644**  
basic interest scales of, **4:1644**  
career counseling and, **4:1431, 4:1452, 4:1483, 4:1484**  
career decision making and, **4:1642**  
computer-assisted testing and, **2:515, 4:1511**  
empirical foundation of, **4:1641**  
general occupational themes of, **4:1644**  
Hall Occupational Orientation Inventory and, **4:1544**  
Holland's RIASEC model and, **4:1538, 4:1599, 4:1643, 4:1644**  
longevity of, **4:1641, 4:1643**  
longitudinal study of, **4:1642**  
occupational scales of, **4:1643, 4:1644**  
personality assessment and career and, **4:1600**  
personal style scales of, **4:1644–1645**  
research and practice relating to, **4:1645**  
Strong-Campbell Interest Inventory (SCII) and, **4:1419, 4:1643**  
*Strong Interest Inventory Manual* and, **4:1645**  
Strong Profile description and, **4:1644–1645**  
Strong Profile options and, **4:1644**  
Strong Profile summary and, **4:1645**  
Strong Vocational Interest Blank (SVIB), **1:122, 4:1406, 4:1407, 4:1642, 4:1643**  
Strong Vocational Interest Blank (SVIB),  
revision and, **4:1419**  
Strong Vocational Interest Blank (SVIB)  
revision and, **4:1419**  
test-retest reliability study of, **4:1642**  
trait-factor counseling and, **4:1664**  
validity of, **4:1642**  
women's version of, **4:1642, 4:1643**
- Structural Analysis of Social Behavior, **2:533**
- Structured Clinical Interview for Axis I DSM-IV  
Disorders (SCID-I), **2:490**
- Structured Clinical Interview for DSM-IV Axis I  
Disorders (SCID-I), **2:570**
- Structured Clinical Interview for DSM-IV Axis II  
Disorders (SCID-II), **2:570**
- Structured Clinical Interview for the DSM-IV, **2:786**
- Structured Interview for the Five-Factor Model of  
personality (SIFFM), **2:727–728**
- Strupp, Hans, **2:627, 2:712**
- Stuart, Richard, **2:627**
- Student Nonviolent Coordinating Committee, **3:1238**
- STWOA. *See* School-to-Work Opportunities Act  
(STWOA) (1994)
- Suarez-Orozco, C., **3:950**
- Suarez-Orozco, M. M., **3:950**
- Subich, Linda, **2:580, 4:1635**
- Substance abuse and dependence, 2:893–899**  
A. A. and, **1:14–18, 2:894**  
addiction, addictive disease terminology and, **2:894**  
AD/HD comorbidity with, **1:31**  
Alaskan Natives and, **3:968**  
alcohol abuse and, **2:817**  
Alcohol Use Disorders Identification  
Test (audit) and, **2:896**  
antisocial personality disorder comorbidity with, **2:733**  
assessing motivation for change and, **2:896–897**  
assessing related problems and, **2:897**  
assessment of, **2:896**  
background regarding, **2:893**  
caffeine and, **2:818**  
CAGE screening test and, **2:896**  
cigarette smoking and, **1:87–90**  
client recognition of problem and, **2:817**  
cognitive-behavioral approaches and, **2:897**  
components of counseling in, **2:896–897**  
conduct disorder and, **1:100**  
counseling adolescents and, **2:898**  
counseling co-occurring mental disorders and,  
**2:897, 2:898–899**  
counseling criminal justice clients and, **2:898**  
counseling practices and approaches for, **2:897–898**  
counseling the elderly and, **1:134**  
counseling vs. psychotherapy and, **2:817**  
counseling women and, **2:898**  
couples or family counseling and, **2:895–896**  
cultural competency in counseling and, **2:899**  
disease model of addiction and, **2:817**  
Drug Abuse Screening Test (DAST) and, **2:896**  
*DSM-IV-TR* diagnostic criteria and, **2:817–818**  
family counseling and, **1:206**  
functional family therapy (FFT) parent training  
program and, **1:327**  
future directions and trends regarding, **2:899**  
hallucinogenic drugs, **2:818**  
inpatient and detoxification care and, **2:894–895**  
integrated treatment and, **2:897, 2:898–899**  
intensive outpatient programs and, **2:895**  
key terms and concepts of, **2:893–894**  
Latinos and, **3:1194**  
marijuana and, **2:817–818**  
MDMA (Ecstasy) and, **2:818**



- Michigan Alcoholism Screening Test (MAST) and, 2:896
- motivational enhanced treatment and, 2:898
- motivational interviewing and, 2:897–898
- opiate replacement programs and, 2:896
- opiods and, 2:818
- outpatient care and, 2:895
- pathological gambling comorbidity with, 1:227–228
- in prison population, 1:117, 1:118
- Recovery Dynamics treatment program and, 2:897
- recovery process and, 2:894
- residential treatment and, 2:895
- screening and, 2:896
- sedative drugs and, 2:818
- social skills building and, 2:898
- stimulant drugs and, 2:818
- substance dependence terminology and, 2:894
- substance misuse terminology and, 2:817
- transtheoretical stages of change model and, 2:896
- 12-Step programs and, 2:894, 2:895, 2:896, 2:897
- University of Rhode Island Change Assessment (URICA) and, 2:896
- Sue, David, 1:402, 3:1229, 3:1342, 3:1381–1382
- Sue, Derald Wing, 1:401–403**
- APA leadership of, 1:402, 3:1342
- Asian American acculturation work of, 3:997
- Asian American Psychological Association formed by, 1:401, 1:402, 3:994, 3:1342
- childhood of, 1:401
- President Clinton's Race Advisory Board and, 1:401, 1:402
- Madonna G. Constantine and, 3:1070
- counseling recommendations of, 3:999
- Counseling the Culturally Diverse* (D. W. Sue and D. Sue), 1:402, 3:1229, 3:1342
- early career years of, 1:402, 3:1341
- ethnic-specific mental health services recommendation of, 3:999
- major contributions by, 1:402
- model minority myth and, 1:403
- multicultural counseling standards and competencies and, 1:126, 1:383, 1:401, 3:1228, 3:1231–1232, 3:1384, 4:1639
- professional associations of, 1:401, 3:1341
- published work of, 1:402
- racial/cultural identity development model of, 3:1286
- racism, racial microaggression focus of, 1:401, 1:402–403, 3:1070, 3:1290, 3:1341
- recent work by, 1:402–403
- White American culture and, 3:1373
- White racial identity development model of, 3:1381–1382
- See also* Sue, David; **Sue, Derald Wing: contributions to multicultural psychology and counseling; Sue, Stanley**
- Sue, Derald Wing: contributions to multicultural psychology and counseling, 3:1341–1343**
- Counseling the Culturally Diverse* (D. W. Sue and D. Sue), 1:402, 3:1229, 3:1342
- honors and awards received by, 3:1341
- nonverbal communication work of, 3:1066
- professional associations, leadership of, 1:402, 3:1342–1343
- racial/cultural identity development model of, 3:1286
- racism, racial microaggression focus of, 1:402–403, 3:1070, 3:1290, 3:1341
- research and teaching of, 3:1341
- tripartite model of multicultural training and, 3:1088, 3:1225, 3:1231–1232, 3:1341, 3:1384
- Joseph L. White and, 3:1370
- White racial identity development model of, 3:1381–1382
- writing and publications of, 3:1342
- See also* **Sue, Derald Wing**
- Sue, Stanley, 3:1343–1345**
- Asian American acculturation work of, 3:997
- Asian American Psychological Association formed by, 3:994
- National Asian American Psychology Training Conference, 3:994
- National Research Center on Asian American Mental Health, 3:994
- nonverbal communication work of, 3:1066
- scholarship of, 3:1343–1344
- service and advocacy by, 3:1344–1345
- Derald Wing Sue and, 1:401–403
- Joseph L. White and, 3:1370
- within-group differences knowledge and, 3:1216
- Suicide Assessment Checklist (SAC), 2:900–901
- Suicide postvention, 1:403–404**
- focusing on the “why” question and, 1:403
- healthy psychological adjustment to suicide and, 1:403
- honoring the life without glorifying the death and, 1:404
- privacy sought by survivors and, 1:150
- “psychological autopsy” and, 1:404
- social stigma and, 1:150
- suicide potential and, 2:899–901
- survivor guilt and, 1:150



**Suicide potential, 2:899–901**

Alaska Natives and, 3:968–969  
 American Association of Suicidology and, 2:899  
 behavior therapy and, 2:571–572  
 bipolar disorder and, 1:477  
 bullying victims and, 1:56  
 Collaborative Assessment and Management of  
 Suicidality (CAMS) and, 2:901  
 counseling the elderly and, 1:134, 1:151,  
 1:232, 1:234, 1:245  
 crisis counseling and, 2:544–548  
 hospice and, 1:245  
 Teresa Davis LaFromboise's work in, 3:1191–1192  
 pathological gambling and, 1:228  
 problem solving appraisal and, 2:789–790  
 sexual violence victims and, 1:392  
 statistics regarding, 2:899  
 Suicide Assessment Checklist (SAC) and, 2:900–901  
 suicide postvention, 1:403–404  
 therapeutic relationship importance and, 2:900, 2:901  
*See also* Assisted suicide

Suinn, Richard, 2:994, 3:1343

Sullivan, Harry Stack, 2:735

Summer, Francis, 3:1033

Sumner, William G., 3:1115

Super, Charles M., 3:1084

**Super, Donald Edwin, 1:103, 1:104, 1:129,**

**1:352–353, 4:1645–1647**

academic career of, 4:1645–1646

Adult Career Concerns Inventory (ACCI) and,  
 4:1400–1401, 4:1650

*Appraising Vocational Fitness by Means of  
 Psychological Tests* written by, 4:1645

career development model of, 4:1646

*The Dynamics of Vocational Adjustment* written by, 4:1645

hygiology concept of, 2:782

life-span, life-space vocational developmental  
 theory of, 4:1402, 4:1464

matching model of vocational behavior and, 4:1645

*The Psychology of Careers* written by, 4:1645

Super's model of career adaptability in  
 adulthood and, 4:1400

theory construction work of, 4:1646

Work Importance Study of, 4:1671

world of work changes and, 4:1647

*See also* Super's theory

**Super's theory, 4:1647–1651**

Adult Career Concerns Inventory (ACCI) and,  
 4:1400–1401, 4:1650

archway of career determinants and, 4:1648, 4:1649–1650

Career Decision Scale and, 4:1464, 4:1469–1470

career development assessment and counseling  
 model and, 4:1650

Career Development Inventory (CDI) and, 4:1471,  
 4:1646–1647, 4:1650

career exploration and, 4:1475, 4:1646–1647, 4:1649

career maturity concept of, 4:1402, 4:1646, 4:1647

Career Maturity Inventory (CMI) and, 4:1492

Career Pattern Study and, 4:1471, 4:1646, 4:1648

children's vocational development and,  
 4:1475, 4:1646–1647

criticisms of, 4:1650

developmental stages of, 4:1648–1649

environment and culture roles in, 4:1650

expressed, manifest, tests, and inventoried interests and,  
 4:1537–1539

future directions regarding, 4:1650

individual's role overemphasis in, 4:1650

influences on, 4:1648

Kuder Career Planning System and, 4:1687

life-career rainbow and, 4:1488, 4:1572, 4:1648–1649

life-role balance and, 4:1572

life space stage of, 4:1648

life-span, life-space vocational developmental theory  
 and, 4:1402, 4:1449, 4:1464, 4:1492, 4:1500,  
 4:1613, 4:1647–1651

maxi- and mini-cycles of, 4:1649

Saliency Inventory and, 4:1650

Work Importance Study and, 4:1671

Work Values Inventory-Revised and, 4:1686–1687

world of work changes and, 4:1647

**Supervision, 1:404–410**

administrative oversight and, 1:405

American Counseling Association and, 1:409

Association of Directors of Psychology  
 Training Clinics and, 1:408

Association of Psychology Postdoctoral and Internship  
 Centers and, 1:408

behavioral therapy model of, 1:406

blended supervision model and, 1:406

client-centered therapy model of, 1:406

client welfare focus in, 1:404, 1:405

cognitive-developmental supervision model and, 1:407

current status of, 1:407–408

developmental supervision model and, 1:406–407

discrimination training model of, 1:406

ethical guidelines adherence and, 1:404

feedback in counseling training, immediate and,  
 1:207–209

Myrna L. Friedlander's work in, 1:219–220



- future directions regarding, **1:408–409**  
 growth in the field and, **1:405–407**  
 integrated developmental model of  
     supervision and, **1:407**  
 mentoring and, **1:296–299**  
 online counseling, technology and, **1:413**  
 professional competency status of, **1:407–408**  
 professional ethical guidelines and, **1:409**  
 recognizing impairment and, **1:249–250**  
 Helen J. Roehlke and, **1:375–377**  
 Carl Rogers and, **1:405**  
 scientist-practitioner training model and, **1:409**  
 skills training model of, **1:406**  
 supervisee openness and willingness to learn and, **1:405**  
 supervisee role in, **1:405**  
 supervisor availability, expertise and, **1:405**  
 supervisor role in, **1:404–405**  
 supervisor skill areas competencies and, **1:408**  
 systemic and family systems therapy models of, **1:406**  
 theories of counseling and psychotherapy  
     influence on, **1:405–406**  
 therapist–client working alliance importance and, **1:407**  
*Sutton v. United Air lines, Inc.*, **1:25**  
**SVIB. See Strong Interest Inventory**  
 Swanson, James, **1:157, 4:1576**  
 Swanson, Jane, **4:1631**  
**SWAP-200. See Shedler-Western Assessment**  
     Procedure (SWAP-200)  
 Sweeney, Thomas J., **1:125, 1:355**  
 Symonds, Percival M., **2:919**  
 Symptom Check-List-90 Revised (SCL-90-R),  
     **2:462, 2:814**  
     Depression scale from, **2:463**  
     Hostility scale of, **2:464**  
 Symptom prescription, **2:720**  
 Systematic desensitization, **2:507–508**  
     counterconditioning in, **2:742**  
     for eating disorders, **2:582**  
     hierarchy of fear-inducing situations and, **2:742**  
     relaxation training and, **2:742**  
     stress management using, **2:889**  
 Systemic Training for Effecting Parenting (STEP) model,  
     of Adlerian therapy, **1:327, 2:458**  
**System of Interactive Guidance Information**  
     (SIGI), **4:1651–1653**  
     CACGS for university students and adults and, **4:1651**  
     career counseling intervention of, **4:1431–1432,**  
         **4:1485–1486**  
     career decision-making component of, **4:1651**  
     Educational Testing Service and, **4:1651**  
     effectiveness of, **4:1652**  
     future of, **4:1653**  
     Group career counseling vs., **4:1652**  
     history of, **4:1651**  
     individual career counseling vs., **4:1652**  
     Martin Katz's career decision-making  
         theory and, **4:1651**  
     other CACGSs compared to, **4:1652**  
     satisfaction with, **4:1652**  
     SIGI<sup>3</sup> and, **4:1651**  
     SIGI PLUS and, **4:1485–1486, 4:1512, 4:1588,**  
         **4:1651–1652**  
     SIGI vs. SIGI PLUS and, **4:1652**  
     stand-alone vs. individual career counseling and, **4:1652**  
     Valpar International and, **4:1651**  
     Valpar International and, Web site of, **4:1653**  
     Web-based version of, **4:1651**  
**Systems theory**  
     adult development and, **1:10–11**  
     couple and marital counseling and, **1:139, 3:1098–1099**  
     family counseling and, **1:203–204**  
     systems crisis theory and, **2:546**  
 Szasz, Thomas, **3:1125**  
  
**TA. See Transactional analysis (TA)**  
 Taft, Jessie, **1:332**  
 Tajfel, Henri  
     social identity theory of, **3:1114, 3:1135, 3:1162,**  
         **3:1166, 3:1319**  
 Talley, William, **3:1245**  
 Tallman, Karen, **2:487**  
**TAP. See Tests of Academic Proficiency (TAP)**  
*Tarasoff v. Regents of the University of*  
     *California*, **2:576**  
 Tarvydas, V. M., **1:185**  
**TAT. See Thematic Apperception Test (TAT)**  
 Tavistock Institute of Human Relations  
     (United Kingdom), **1:91**  
**Taxonomy of helpful impacts, 2:903–904**  
     Robert Elliott's work in, **2:903**  
     Group Counseling Helpful Impacts Scale and, **2:904**  
     group interventions events and, **2:903–904**  
     interpersonal supercluster events and, **2:903**  
     task supercluster events and, **2:903**  
 Taylor, Frederick W., **1:254, 4:1586**  
 Taylor, Harriet, **3:1049**  
 Taylor, Karen, **4:1470**  
 Taylor, Shelley, **1:60**  
**TBI. See Traumatic brain injury and**  
     **rehabilitation (TBI)**



TBMT. *See* Rivermead Behavioural Memory Test (TBMT)

TBS-2. *See* **Transition Behavior Scale** (TBS-2)

TCI. *See* Cloninger's Temperament and Character Inventory (TCI)

Teacher Rating Scale (TRS), of BASC-2, **1:42, 1:47**

Teacher Report Form (TRF) Achenbach  
behavior rating scale, **1:46**

*Teaching to Transgress* (hooks), **3:1070**

Teasdale, John D., **2:511**

**Technology and treatment, 1:411–415**

applications of, **1:412–413**

assessment and evaluation and, **1:413**

behavioral observation methods,  
assessment and, **1:41**

communication, collaboration using, **1:412, 1:413**

computer competency issue and, **1:413–414**

confidentiality issues and, **1:413**

counselor technology literacy and, **1:411–412**

credentials and, **1:413, 1:414**

delivery of services using, **1:412, 1:413**

distance education/dispersed learning and, **1:165–167**

equity and, **1:414**

ethical use of, **1:178, 1:414–415**

examples of, **1:412–413**

impersonation and, **1:414**

information, resource using, **1:412**

interaction, productivity using, **1:412**

life-prolonging technology and, **1:151**

location-specific factors and, **1:414**

marriage and family counseling and, **1:413**

online counseling and, **1:413**

potential pitfalls of, **1:413–415**

powerful medium of technology and, **1:411**

in school counseling, **1:383**

supervision and, **1:413**

trusting, caring, genuine working  
relationships and, **1:414**

*See also* **Computer-assisted career counseling;**

**Computer-assisted testing; E-counseling; Ethics  
in computer-aided counseling; Human subjects  
review in an online world**

**Teenage parents, 1:415–418**

development of children of, **1:417–418**

family of origin support and, **1:417**

fulfillment of parental role and, **1:416**

grandparents as caregivers and, **1:417**

interventions to help, **1:418**

long-term economic stress to society of, **1:415**

maternal education level factor and, **1:418**

normative adolescent development interruption  
and, **1:416**

outcomes for, **1:416–417**

racial differences in prevalence of, **1:416**

risk factors of, **1:415–416**

stress levels, stress-related psychopathology and, **1:416**

teenage fathers and, **1:417**

Telch, Christy, **2:580**

Terman, Lewis, **2:497**

Terrell, Francis, **3:1093**

Terrell, Sandra, **3:1093**

**Test interpretation, 2:904–910**

Allport-Vernon-Lindzey Study of Values and, **2:906**

approaches to assessment and, **2:905–906**

client's goals and, **2:908**

clinical interview and, **2:905**

clinical vs. statistical prediction and, **2:905**

computer test interpretation and, **2:905–906**

conclusion regarding, **2:910**

consistency of information evaluation and, **2:907**

cultural validity in standardized tests issue  
and, **2:617–618**

culture-free testing and, **3:1104–1106**

defensive reactions and, **2:908**

delivering the interpretation, **2:908–909**

effects of, **2:909–910**

empirical research on, lack of, **2:904, 2:909–910**

encouraging feedback and, **2:908–909**

follow-up and, **2:909**

graphical representations and, **2:909**

importance of, **2:904**

integration of results and, **2:907**

low or undesirable scores and, **2:908**

Paul E. Meehl and, **2:684–686**

Neuroticism, Extraversion, Openness Personality  
Inventory-Revised (NEO PI-R), **2:906**

nomothetic vs. idiographic test interpretation and, **2:907**

norm- vs. criterion-referenced tests and, **2:451**

plain language and, **2:908**

preparation and delivery of, **2:906–909**

preparing the client, **2:907–908**

preparing the interpretation and, **2:906–907**

psychological constructs assessments and, **2:904**

psychometric properties and, **2:804–808**

purpose of assessment and, **2:909**

results presentation order and, **2:907**

Self-Directed Search and, **2:906**

self-estimates prior to test taking and, **2:909**

self-interpreting tests and, **2:906**

sensitivity to client's feelings and, **2:908**



- technical term avoidance and, 2:908
- test precision and, 2:908
- test profiles and, 2:909
- underdiagnosis/overdiagnosis and, 2:935–936
- understanding the assessment results and, 2:906–907
- Test of the Variables of Attention, 1:29
- Tests of Academic Proficiency (TAP), 2:451
- Tests of Non-Verbal Intelligence, Second Edition, 4:1393
- Thelen, Mark, 2:580
- Thematic Apperception Test (TAT), 2:791–792
  - Defense Mechanisms Manual and, 2:793
  - projection of past experiences using, 2:811
  - Social Cognition and Object Relations Scale and, 2:793
- Theories of Career Development* (Osipow), 4:1590
- Theories of Person-Environment Interaction* (Walsh), 4:1675
- The Theory and Practice of Mental Health Consultation* (Caplan), 2:525
- Theory of planned behavior, 1:287
- Theory of transcendent leisure experiences, 2:672, 2:774
- Theory of Work Adjustment (TWA), 4:1655–1657**
  - achievement dimension of, 4:1557
  - active mode of adjustment concept and, 4:1656
  - Adjustment to Work* and, 4:1655
  - altruism dimension of, 4:1557
  - autonomy dimension of, 4:1557–1558
  - comfort dimension of, 4:1557
  - correspondence concept and, 4:1602, 4:1656
  - degree of tolerance concept and, 4:1657
  - development of the theory and, 4:1655
  - dimensions of, 4:1557
  - dynamics process of work adjustment and, 4:1656–1657
  - extrinsic vs. intrinsic job satisfaction in, 4:1558
  - flexible vs. inflexible personality style and, 4:1657
  - General Aptitude Test Battery (GATB) and, 4:1656
  - high vs. low celerity levels and, 4:1657
  - job satisfaction, well-being and, 4:1557–1559
  - meaning and self-realization eudemonic perspective of, 4:1557
  - Minnesota Clerical Test and, 4:1656
  - Minnesota Importance Questionnaire (MIQ) and, 4:1656
  - Minnesota Job Description Questionnaire (MJDQ) and, 4:1656
  - Minnesota Job Requirements Questionnaire (MJRQ) and, 4:1656
  - Moos's Social Climate Scales and, 4:1558
  - Occupational Aptitude Patterns and, 4:1656
  - outcomes of work adjustment and, 4:1657
  - Parson's person-environment fit theory and, 4:1655
  - performance modeling and, 4:1596
  - personality styles vs. personality types and, 4:1656–1657
  - person-environment interactions (P-E) and, 2:772–777, 4:1557, 4:1655–1657
  - pleasure attainment vs. pain avoidance hedonic perspective of, 4:1557
  - reactive mode of adjustment concept and, 4:1656
  - reinforcer dimensions of, 4:1557–1558
  - speed of adjustment concept and, 4:1657
  - structure of work adjustment and, 4:1655–1656
  - trait-factor counseling and, 4:1663–1665
- Therapeutic Alliances in Couple and Family Therapy* (Friedlander, Escudero, and Heatherington), 1:218, 1:219
- Therapist interpretation, 2:910–911**
  - client autonomy and, 2:911
  - client content that is out of awareness and, 2:911
  - controversy regarding, 2:911
  - free association and, 2:607–608, 2:796
  - future directions regarding, 2:911
  - making unconscious material conscious and, 2:911
  - metaphor use and, 2:690–691
  - nondynamic therapies and, 2:911
  - psychodynamic approaches and, 2:910–911
  - transference and extratransference interpretations and, 2:911
  - underdiagnosis/overdiagnosis and, 2:935–936
- Therapist techniques/behaviors, 2:911–918**
  - acting as if, 2:915–916
  - assertiveness training, 2:915
  - assuming responsibility, 2:917
  - barriers to cross-cultural counseling and, 3:1009–1010
  - behavioral techniques and, 2:914–916
  - bibliotherapy, 2:914
  - brief therapy and, 2:479–483
  - catastrophizing, 2:914
  - catching oneself, 2:916
  - clinical interview and, 2:490–491
  - cognitive confrontation techniques and, 2:913–914
  - cognitive restructuring, 2:914
  - cognitive techniques and, 2:913–914
  - common factors and, 2:912
  - conclusion regarding, 2:919
  - confrontation techniques and, 2:913–918
  - consciousness raising, 2:914
  - counterconditioning/systematic desensitization, 2:915
  - countertransference and, 2:797
  - developmental counseling and therapy and, 2:561–568
  - dream work, 2:917



empirically based professional practice and, **1:172–175**  
empty chair, **2:640, 2:916–917**  
encouragement and, **2:913**  
exaggerating movement, **2:917**  
experiential techniques, **2:916–919**  
facilitative conditions and, **2:601–603, 2:912**  
flooding, **2:507, 2:917–918**  
gender role analysis, **2:914**  
harmful psychological treatments and, **2:626–631**  
Clara E. Hill's work in, **2:632**  
hot seat, **2:917**  
imagery, **2:916**  
integrative/eclectic therapy and, **2:647–651**  
Carl Jung and, **2:667–668**  
may I feed you a sentence, **2:917**  
metaphor use and, **2:690–691**  
minimal verbal responses and, **2:912**  
miracle question, **2:877–878, 2:914**  
modeling, **2:915**  
paradoxical interventions and, **2:719–721**  
paraphrasing and, **2:912**  
playing the projection, **2:917**  
political advocacy, **2:916**  
positive expectations and, **2:912**  
push-button technique, **2:914**  
rededication, **2:914**  
reflection and, **2:912**  
relationship-building techniques and, **2:912–913**  
reversals, **2:917**  
role-playing, **2:915**  
shame-attacking exercise, **2:915**  
shaping, **2:915**  
social skills training, **2:915**  
Socratic Method and, **2:875–876**  
solution-focused brief therapy (SFBT) and, **2:876–879**  
spitting in the soup, **2:916**  
summarization and, **2:912–913**  
therapeutic working alliance and, **2:797–798**  
therapist empathy and, **2:486–487**  
therapist interpretation and, **2:910–911**  
therapist-patient sex syndrome and, **2:835**  
therapist self-disclosure and, **2:488–489**  
thought scheduling, **2:913–914**  
thought stopping, **2:913**  
top dog/underdog, **2:916**  
transference and, **2:796–797**  
*See also* Empathy of therapist

**Therapy process, individual, 2:918–924**

client contributions to therapeutic alliance, **2:923**  
client covert processes and, **2:922**

client embarrassment or shame and, **2:922**  
client expectations and, **2:921**  
client hidden reactions, nondisclosures and, **2:922**  
client overt processes and, **2:921–922**  
client resistance and, **2:922**  
client roles in creating change and, **2:919**  
code of ethics and standards of  
    practice and, **2:494–497**  
common factors in, **2:919, 2:920**  
countertransference and, **2:921**  
creation of meaning and, **2:683–684**  
definition of, **2:919**  
extratherapy variables and, **2:919**  
facilitative conditions and, **2:601–603**  
homogeneity of process concept and, **2:919**  
individual therapy and, **2:643–645**  
initial approaches to understanding, **2:919**  
input variables and, **2:919**  
interactions between therapists and  
    clients and, **2:922**  
interpersonal, mutually constructed social change  
    process and, **2:919**  
models of, **2:920–922**  
negotiating fit and, **2:922**  
nonverbal behavior of therapist and, **2:920–921**  
outcomes and, **2:919**  
pattern of contextualized variables in, **2:919**  
problems in therapeutic alliance and, **2:923**  
relationship control, relationship defining,  
    turn taking and, **2:922**  
Carl Rogers' therapeutic change process and, **2:919**  
therapeutic alliance and, **2:922–923**  
therapist contributions to therapeutic alliance and,  
    **2:922–923**  
therapist covert processes and, **2:921**  
therapist intentions and, **2:921**  
therapist overt processes and, **2:920–921**  
therapist self-talk and, **2:921**  
therapy process defined and, **2:919**  
transference and, **2:922**  
verbal response modes and, **2:920**  
working alliance and, **2:922–923**  
*See also* **Rogers, Carl R.**

Thewett, W. Tom, III, **2:881**

**Third world, 3:1347–1349**

Bandung Conference and, **3:1347**  
economic debt of, **3:1348**  
first, second world assistance to, **3:1348**  
G8, first world first world countries and, **3:1347**  
mental health in, **3:1348**



- Non-Aligned Movement and, **3**:1347–1348  
 North-South conflict and, **3**:1347  
 origination of, **3**:1347–1348  
 13th Amendment, **3**:1047  
 Thomas, Alexander, **3**:1124  
 Thomas, Charles, **3**:1035  
 Thomas, Kay, **1**:263  
 Thompson, Al, **1**:104, **4**:1400  
 Thompson, C. E., **3**:1281–1282  
 Thompson, Chalmer, **3**:1006  
 Thompson, Sue, **1**:160  
 Thorndike, Edward L., **1**:123, **2**:656, **2**:736  
**Thurstone, Louis L., 2:924–925**  
   five-factor personality model of, **2**:736  
   *g* general intelligence factor and, **2**:924  
   hierarchical theory of intelligence and, **2**:924  
   primary abilities concept of, **2**:924  
   psychometric contributions of, **2**:924  
   quantitative methodologies and, **1**:364  
   theory of primal mental abilities and, **2**:924–925  
 Tiedeman, David, **1**:129, **4**:1657  
   *See also* **Tiedeman's decision making theory**  
**Tiedeman's decision making theory, 4:1657–1659**  
   anticipation stage of, **4**:1522, **4**:1658  
   Assessment of Career Decision Making and, **4**:1658  
   *Career Development: Choice and Adjustment*  
     (Tiedeman and O'Hara) and, **4**:1658  
   constructivist career counseling and, **4**:1658  
   criticism of, **4**:1658  
   ego development focus of, **4**:1658  
   Erikson's psychosocial theory and, **4**:1658  
   implementation stage of, **4**:1522, **4**:1658  
   Information System for Vocational Decisions (ISVD)  
     and, **4**:1658  
   multicultural relevance limitation of, **4**:1658  
   nonlinear nature of, **4**:1522  
   recycling through stages and, **4**:1522  
   revisions, adaptations of, **4**:1658  
   Tiedeman's academic career and, **4**:1658  
 Tinsley, Diane J., **2**:672, **2**:774, **4**:1659–1660  
**Tinsley, Howard E. A. ("Tony"), 2:892, 4:1631, 4:1659–1661**  
   academic career of, **4**:1659, **4**:1660–1661  
   early influences on, **4**:1659  
   expectations about counseling and, **2**:595, **4**:1659, **4**:1660  
   Expectations About Counseling - Brief Form (EAC-B)  
     and, **4**:1660  
   Holland's RIASEC model and, **4**:1660  
   *Journal of Vocational Behavior* and,  
     **4**:1563, **4**:1659, **4**:1660  
   Lloyd H. Lofquist and, **4**:1659  
   professional affiliations of, **4**:1659  
   psychology of leisure and, **4**:1659–1660  
   research methodology of, **4**:1659, **4**:1660  
   test interpretation and, **2**:909  
   transcendent leisure experiences and, **2**:672, **2**:774  
   vocational psychology and the person-environment  
     fit model and, **4**:1659, **4**:1660  
   David J. Weiss and, **4**:1659  
 Titchener, Edward B., **2**:593  
 Titiev, Mischa, **3**:941  
 Tocqueville, Alexis de, **3**:1177  
**Tokenism, 3:1349–1350**  
   APA Guidelines and, **3**:1351  
   consequences of, **3**:1349–1350  
   contrast component of, **3**:1350–1351  
   counseling implications of, **3**:1350  
   definition of, **3**:1349  
   glass ceiling experience and, **3**:1350  
   marginalized groups and, **3**:1350  
   organization affected by, **3**:1351  
   reduction strategies and, **3**:1351  
   role encapsulation component of, **3**:1350  
   solo status term and, **3**:1350  
   visibility component of, **3**:1350  
 Tolman, Edward C., **2**:593  
 Torrance Tests of Creative Thinking (TTCT), **2**:501  
 Torrey, E. Fuller, **2**:513  
 Tourette's syndrome  
   AD/HD and, **1**:31  
   Behavior Rating Scale of Executive Function  
     (BRIEF) and, **1**:49  
 Towne, Neil, **3**:1066  
**Tracey, Terence J. G., 2:925–926**  
   academic life of, **2**:925  
   counseling process work of, **2**:925  
   interpersonal complementarity concept and, **2**:925  
   Personal Globe Inventory and, **2**:925  
   prestige dimension of occupations and, **2**:925  
   research and influence by, **2**:925  
   James Rounds and, **2**:925  
   successful therapy outcomes work of, **2**:925  
   vocational interest work of, **2**:925  
 Trail of Tears, **3**:1039, **3**:1048, **3**:1062  
**Training in organizations, 4:1661–1663**  
   career counseling in organizations and, **4**:1461–1463  
   career self-management training programs and, **4**:1661  
   cognitive, skill-based, and affecting learning  
     outcomes of, **4**:1663  
   content and specificity variations in, **4**:1661–1662



evaluation of, **4:1662–1663**  
 goals of, **4:1661**  
 individual career development and, **4:1661**  
 job analysis methods and, **4:1662**  
 needs assessment and, **4:1662**  
 trainee behavior evaluation and, **4:1662–1663**  
 trainee learning evaluation and, **4:1662**  
 trainee reaction evaluation and, **4:1662**  
 training definition and, **4:1661**  
 training design, delivery and, **4:1662**

**Trait-factor counseling, 4:1663–1665**  
 counselor-client power differential and, **4:1664**  
 criticisms of, **4:1664**  
 history of, **4:1430, 4:1663–1664**  
 Holland's RIASEC model and, **4:1664, 4:1665**  
 legacy of, **4:1664–1665**  
 Minnesota Employment Stabilization Research Institute and, **4:1663–1664, 4:1677–1678**  
 Minnesota Importance Questionnaire and, **4:1664**  
 Minnesota Multiphasic Personality Inventory (MMPI) and, **4:1664**  
 Occupational Information Network (O\*NET) and, **4:1665**  
 Parson's person-environment interaction model and, **4:1663, 4:1664, 4:1665, 4:1677–1678, 4:1678**  
 Donald G. Paterson's work in, **4:1430**  
 person-job match and, **4:1663**  
 process of, **4:1663**  
 Strong Interest Inventory and, **4:1664**  
 theory of work adjustment and, **4:1664**  
 veteran rehabilitation and, **4:1664**  
 E. G. Williamson's work in, **4:1664, 4:1677–1678**

**Transactional analysis (TA), 2:926–928**  
 archaephysche, neopsysche, exteroepsysche ego states and, **2:926–927**  
 basic elements of, **2:926**  
 Eric Berne and, **2:926, 2:927**  
 brief history of, **2:926**  
 egograms and, **2:927**  
 existential life positions and life scripts and, **2:927**  
 future directions regarding, **2:928**  
 Gestalt therapy and, **2:928**  
 "I'm OK, you're OK" concept and, **2:927**  
 initial, working, and final stages of, **2:928**  
 International Transactional Analysis Association (ITAA) and, **2:928**  
 Parent, Adult and Child ego states, **2:926–927, 2:926** (figure)  
 self-limiting patterns of thoughts, feelings, behaviors and, **2:928**

strokes, rituals, games and, **2:927**  
 structural analysis concept in, **2:926**  
 therapeutic milieu and, **2:927–928**  
 transactions defined, **2:927**

Transcultural Mental Health Code, **3:1211**

**Transference and countertransference, 2:928–931**  
 client relationships recreation and, **2:796–797, 2:922**  
 controversy regarding, **2:929–930**  
 Core Conflict Relationship Themes and, **2:930**  
 countertransference and, **2:797, 2:921, 2:929**  
 countertransference and, cross-cultural counseling and, **3:1011, 3:1276–1277**  
 distrust from racism, discrimination experiences and, **3:1011**  
 Sigmund Freud and, **2:611, 2:797, 2:922, 2:928–929**  
 Charles J. Gelso's work in, **2:616**  
 identifying the phenomena and, **2:929–930**  
 outside psychoanalysis and, **2:930**  
 prejudicial cross-cultural counseling and, **3:1276–1277**  
 seduction theory and, **2:929**  
 self-disclosure and, **2:851–852**  
 therapist interpretation and, **2:911**  
 therapist unconscious conflicts and, **2:797**  
 transference neurosis and, **2:929**

Transformational therapy. *See* **Conversion therapy**

**Transition Behavior Scale (TBS-2), 4:1665–1666**  
 Adult Career Concerns Inventory (ACCI) and, **4:1400–1401**  
 caveat regarding, **4:1665–1666**  
 individualized education plan from, **4:1665, 4:1666**  
 interpretation of, **4:1665**  
 intervention outcomes and, **4:1666**  
 reliability and validity of, **4:1665**  
 versions of, **4:1665**

**Translation and adaptation of psychological tests, 1:418–421**  
 adaptation approach to, **1:419**  
 applied approach to, **1:419**  
 back-translation process and, **1:419, 3:1351, 3:1352–1353**  
 bias and, **1:418, 1:419**  
 comparability of behavior and concepts across cultures and, **1:419**  
 construct, conceptual, measurement equivalence measurement and, **1:420**  
 construct, method and item bias and, **1:419**  
 construct nonequivalence vs. equivalence and, **1:419**  
 cultural validity in standardized tests issue and, **2:617–618**  
 equivalence and, **1:418, 1:419**



- International Test Commission (ITC) and, 1:419  
 item response theory and, 1:420  
 pretest of translated scale and, 1:419–420  
 psychological measures examples of, 1:420  
 psychometric properties and, 2:804–808  
 readability and naturalness of translation and, 1:419  
 response style variations and, 1:419  
 statistical verification of equivalence and, 1:418–419, 1:420  
 verbal or written feedback and, 1:420
- Translation methods, 3:1350–1353**  
 back translation and, 1:419, 3:1351, 3:1352–1353  
 for client communication, 3:3:1351  
 counseling application of, 3:1351  
 historical background regarding, 3:1351  
 for informed consent, 3:3:1351  
 interpretation and, 3:1351–1352  
 language switching and, 3:1022, 3:1023, 3:1026, 3:1352  
 for research and testing, 3:3:1351  
 translation, adaptation of psychological tests and, 1:418–421  
 for treatment, 3:3:1351  
 written translation and, 3:1352
- Transpersonal models of adult development, 1:11
- Transracial adoption, 3:1353–1356**  
 Adoption and Safe Families Act (1997) and, 3:1234  
 of African American children and, 3:1234, 3:1353  
 American imperialism, colonialism  
   criticism and, 3:1355  
 biculturalism and, 3:1020–1021  
 Child Welfare League of America and, 3:1354  
 Council on Adoptable Children and, 3:1354  
 counseling implications of, 3:1234, 3:1355  
 criticism of, 3:1354, 3:1355  
 cross-cultural adoption term and, 3:1353  
 “cultural genocide” concept and, 3:1354  
 cultural-racial identity model and, 3:1234  
 definition of, 3:1353  
 domestic transracial adoption and, 3:1354–1355  
 empirical research studies of, 3:1354  
 history of, 3:1354  
 identity development and, 3:1355  
 increase in, 3:1233  
 Indian Adoption Project and, 3:1353  
 Indian Child Welfare Act and, 3:1353  
 Interethnic Placement Act (1996) and, 3:1354–1355  
 international transracial adoption and, 3:1353, 3:1355  
 Multiethnic Placement Act (1994) and, 3:1354  
 Multi-Ethnic Placement Act (1994) and, 3:1234  
 multiracial families and, 3:1233–1235  
 National Association of Black Social Workers and, 3:1354  
 Open Door Society and, 3:1354  
 “Operation Brown Baby” (Oregon) and, 3:1354  
 Parents to Adopt Minority Children (Minnesota) and, 3:1354  
 policy changes regarding, 3:1234  
 psychological adjustment, racial identity  
   development and, 3:1354  
 Removal of Barriers to Interethnic Adoption Act (1996) and, 3:1234  
 World War II, Korean War and, 3:1355
- Transtheoretical model of therapeutic change, 2:487–488
- Traumatic brain injury and rehabilitation (TBI), 1:421–423**  
 Behavior Rating Scale of Executive Function (BRIEF) and, 1:49  
 causes and mechanisms of, 1:421  
 cellular response to injury and, 1:421  
 cognitive and emotional changes resulting from, 1:421–422  
 cognitive-behavioral interventions and, 1:423  
 cognitive rehabilitation and, 1:422  
 coup-countercoup injury and, 1:421  
 families affected by, 1:422–423  
 future directions regarding, 1:423  
 long-term adjustment issues and, 1:422  
 open vs. closed head injuries and, 1:421  
 preinjury substance abuse factor and, 1:422  
 problem-solving training and, 1:423  
 psychological issues and, 1:422–423  
 quality of life issues and, 1:422  
 restoration vs. compensation cognitive, 1:422  
 restoration vs. compensation cognitive rehabilitation and, 1:422  
 sequelae of, 1:421–422  
 social problem-solving skills and, 1:422  
 statistics regarding, 1:421  
 structured employment strategies and, 1:423
- Traumatic Stress Schedule, 2:786
- Treatment compliance, 1:423–427**  
 adherence vs., 1:424  
 assessing compliance and, 1:424  
 compliance definition and, 1:423–424  
 compliance rates and, 1:424–427  
 correlates and predictors of, in adults, 1:424–425  
 correlates and predictors of, in children and adolescents, 1:425



- decision-making autonomy and, **1:425**  
disease specific variances in, **1:426**  
ethnicity factors in, **1:425**  
family intervention models and, **1:426**  
future research regarding, **1:427**  
health belief model and, **1:425–426**  
increase in, **1:424**  
individualization in planning importance and, **1:426–427**  
noncompliance consequences  
    continuum and, **1:424**  
paradoxical interventions and, **2:719–721**  
parent-child relationship factor in adolescent compliance and, **1:425**  
peer relationship factors in adolescent compliance and, **1:425**  
predictors of, **1:425**  
protection motivation theory and, **1:426**  
quality of life issues and, **1:425**  
self-regulatory model of illness and, **1:426**  
specific illness variables and, **1:425**  
theory and interventions promoting compliance, in adults, **1:425–426**  
theory and interventions promoting compliance, in children and adolescents, **1:426–427**  
TRF. *See* Teacher Report Form (TRF) Achenbach behavior rating scale  
Triandis, Harry C., **3:1083, 3:1146, 3:1168, 3:1178**  
Triangulation design, of mixed methodology research, **1:303**  
**Trimble, Joseph E., 3:1356–1357**  
    bicultural multidimensional acculturation framework of, **3:1019**  
    cultural, ethnic, and familial roots of, **3:1357**  
    *Handbook of Multicultural Counseling* and, **3:1357, 4:1639**  
    honors and awards received by, **3:1356**  
    professional associations service of, **3:1356–1357**  
    publications by, **3:1357**  
Triple P parent training program, **1:327**  
Troiden, Richard, **2:614**  
TRS. *See* Teacher Rating Scale (TRS), of BASC-2  
Truax, Paula, **2:711**  
TTCT. *See* Torrance Tests of Creative Thinking (TTCT)  
Tupes, Ernest C., **2:736, 2:752**  
Turkus, Joan, **1:141**  
Turner, Frederick Jackson, **3:1001**  
Turner, John, **3:1166, 3:1319**  
Tuskegee syphilis study, **1:190**  
TWA. *See* Theory of work adjustment (TWA)  
12-Step programs  
    A. A. and, **1:18, 1:19, 1:20, 2:894–898, 3:1271**  
    for compulsive sexual behavior, **1:96, 1:98**  
    powerlessness over addictions and, **3:1271**  
    for White racism, **3:1295**  
*The Twenty-Four Examples of Filial Piety* (Guo Jujing), **3:1150**  
Twin studies  
    of AD/HD, **1:31**  
    of intelligence genetic factors, **2:656**  
**Tyler, Leona E., 1:129, 1:428–430**  
    APA work of, **1:428**  
    childhood years of, **1:428**  
    early academic career of, **1:428**  
    education and training of, **1:428**  
    honors and awards received by, **2:932**  
    late career and legacy of, **1:429**  
    original research work of, **1:429**  
    professional associations of, **1:428, 2:932**  
    scholarly and professional success of, **1:429**  
    women's rights movement and, **2:932–933**  
    *The Work of the Counselor* written by, **1:428, 1:429**  
    *See also* **Tyler, Leona E.: human multipotentiality**  
**Tyler, Leona E.: human multipotentiality, 2:931–933**  
    academic, scholarly, professional work of, **1:428–430**  
    childhood years of, **2:931**  
    choice behavior of scientists and, **2:932**  
    environmental factors in cognitive organization and, **2:932**  
    honors and awards received by, **2:932**  
    individual differences focus of, **2:931**  
    multipotentiality explanation and, **2:932**  
    professional associations of, **2:932**  
    *The Psychology of Human Differences* written by, **2:931**  
    theory of possibilities concept and, **2:932**  
    *Thinking Critically* written by, **2:932**  
    vocational card sorts and, **4:1422**  
    women's rights movement and, **2:932–933**  
    *The Work of the Counselor* written by, **2:932**  
Tylka, Tracy, **2:580**  
Tyrer, Peter, **2:732**  
UCCs. *See* **University counseling centers (UCCs)**  
**Underdiagnosis/overdiagnosis, 2:935–936**  
    consequences of, **2:935**  
    cutting score and, **2:935**  
    false negative vs. false positive and, **2:935**  
    healthy paranoia and, **3:1153**  
    hit rate and, **2:935**



- operating characteristics and, 2:935  
 positive vs. negative predictive power and, 2:935  
 sensitivity vs. specificity and, 2:935  
 UNHCR. *See* United National High Commissioner for Refugees (UNHCR)  
 UNIACT. *See* **Unisex Edition of the ACT Interest Inventory** (UNIACT)  
 Uniform Marriage and Divorce Act (1974), 1:146–147  
 Unintentional racism, 2:573  
 Uninvolved parenting style. *See* **Parenting**  
**Unisex Edition of the ACT Interest Inventory** (UNIACT), 4:1667–1669  
 ACT Interest Inventory and, 4:1668  
 ACT programs and services and, 4:1667  
 ACT World-of-Work Map and, 4:1495, 4:1527, 4:1527 (figure), 4:1528, 4:1587–1588, 4:1668  
 Administration & Sales scale of, 4:1667–1668  
 Arts scale of, 4:1667–1668  
 Business Operations scale of, 4:1667–1668  
 career counseling and, 4:1431  
 Career Planning Survey and, 4:1495, 4:1667  
 computer-assisted career counseling and, 4:1511  
 DISCOVER and, 4:1526–1529, 4:1667  
 history of, 4:1668  
 Holland's RIASEC model and, 4:1668, 4:1669  
 internal consistency of, 4:1669  
 items on, 4:1667  
 norms of, 4:1668–1669  
 reliability of, 4:1669  
 revisions of, 4:1668  
 scales of, 4:1667–1668  
 Science & Technology scale of, 4:1667–1668  
 Social Science scale of, 4:1667–1668  
 Technical scale of, 4:1667–1668  
 underlying theory of, 4:1668  
 validity of, 4:1669  
 visual results interpretation feature of, 4:1668  
 UNIT. *See* Universal Nonverbal Intelligence Test (UNIT)  
 United Farm Workers, 3:1048  
 United National High Commissioner for Refugees (UNHCR), 3:1299  
**Universalism, 3:1359–1361**  
 core belief within counseling field of, 3:1359  
 cultural differences within multicultural counseling and, 3:1360  
 cultural relativism vs., 3:1359  
 deficit hypothesis and, 3:1109–1111  
 definition of, 3:1359  
 future directions regarding, 3:1360  
 Vontress's existential cross-cultural counseling and, 3:1366  
 within- vs. between-group differences and, 3:1360  
 Universal Nonverbal Intelligence Test (UNIT), 2:500, 3:1180  
**University counseling centers (UCCs), 1:431–437**  
 administration of, 1:436  
 Association of Counseling Center Training Agencies (ACCTA) and, 1:434  
 burnout of staff and, 1:435  
 clinical presenting issues and, 2:492–493  
 clinical services function of, 1:432–433  
 consultation and, 1:433–434, 1:436  
 counseling sessions limitation and, 1:431, 1:433, 1:434  
 cube model of: targets, purpose, method and, 1:432  
 demystification, destigmatization of counseling and, 1:433  
 developmental and medical models use and, 1:431  
 developmental issues of college students training and, 1:434  
 DSM-IV diagnosis reliance and, 1:431  
 early years of, 1:437  
 ethical standards of, 1:434  
 functions of, 1:432  
 future directions in, 1:436  
 graduate training and, 1:434–435, 1:436  
 historical overview of, 1:431–432  
 interdependence, collaboration, flexibility features of, 1:432  
 International Association of Counseling Services (IACS) and, 1:435  
 multicultural competence and, 1:434–435  
 outreach and, 1:433, 1:436  
 practitioner-scholars emphasis and, 1:435  
 research and, 1:435–436, 1:436  
 staff development and, 1:435, 1:436  
 student clinical severity increase and, 1:432–433  
 vocational guidance and, 1:431  
 Web site regarding, 1:437  
 Workshop Central, online Counseling Center Village and, 1:433, 1:437  
 University of Rhode Island Change Assessment (URICA), 2:896  
 Urban Indian Health Programs, 3:1174, 3:1175  
 URICA. *See* University of Rhode Island Change Assessment (URICA)  
 Utsey, Shawn, 3:1296, 3:1382  
 VA. *See* **Department of Veterans Affairs (VA)**  
 VAE. *See* Voluntary active euthanasia (VAE)



Vaihinger, Hans, **2:459**

Validity. *See specific assessment, measure, test*

Validzic, Ana, Gaertner, Samuel L.

Value Orientations Questionnaire, **3:1385**

Values in Action Inventory of Strengths, **2:783**

**Values Scale (VS), 4:1671–1672**

administration of, **4:1671**

Brown's values-based career theory and, **4:1415–1416**

career development deficits and, **4:1671**

career planning process and, **4:1671**

cross-national research use of, **4:1671**

internal consistency reliability of scales and, **4:1671**

life-work values assessed using, **4:1671**

Super's Work Importance Study and, **4:1671**

values conflict identification and, **4:1671**

value scores items on, **4:1671**

van der Kolk, Bessell, **1:141**

Van der Zee, Karen, **3:1227**

van de Vijver, F. J. R., **1:419**

Vandiver, Beverly, **3:1229**

Van Oudenhoven, Peter, **3:1227**

Varni, James, **1:426**

**Vasquez, Melba J. T., 1:439–441**

APA leadership of, **1:440**

APA minority fellowship awarded to, **1:440**

childhood years of, **1:439**

feminism and, **1:439–440**

honors and awards received by, **1:440**

professional affiliations of, **1:440**

social justice through affirmative action and, **1:440**

Derald Wing Sue and, **3:1342**

VCI. *See* Verbal Comprehension Index (VCI)

Veracity

ethical decision making, **1:177, 1:183, 1:186, 1:192**

virtue ethics and, **1:441**

*Verbal Behavior* (Skinner), **2:870–871**

Verbal Comprehension Index (VCI), **2:697–698**

Vernhagen, C. K., **1:247**

Vicarious learning, **2:741**

Vineland Adaptive Behavior Scales, Second Edition (Vineland-II), **2:456**

**Virtue ethics, 1:441–442**

benevolence self-pertaining virtue and, **1:442**

code of ethics and standards of

practice and, **2:494–497**

common virtues and, **1:441–442**

integrity self-pertaining virtue and, **1:442**

Karen Strohm Kitchener's work in, **1:269–271**

Naomi Meara's work in, **1:441**

moral principles of, **1:441**

prudence self-pertaining virtue and, **1:441–442**

respect self-pertaining virtue and, **1:442**

**Visible racial/ethnic groups, 3:1363–1364**

American racial socialization tendencies and, **3:1363**

counseling expectations and, **3:1364**

Cross's Nigrescence model and, **3:1364**

deficit models of diversity and, **3:1363–1364**

discrimination and oppression and, **2:572–575**

ethnic minority and, **3:1139–1141**

historical evolution of labeling and, **3:1363–1364**

professional mandate and, **3:1363**

*Publication Manual of the American Psychological Association, Fifth Edition* and, **3:1364**

race as social construct and, **3:1364**

racial identity theory and, **3:1364**

terminology differentiations and, **3:1363**

therapeutic relationship and, **3:1364**

*See also African Americans; American Indians; Asian Americans; Latinos; Pacific Islanders; specific ethnic group*

Vocational/Career Counseling Competencies, **4:1448**

Vocational Decision-Style Indicator, **4:1469**

Vocational Development Attitude Scale, **4:1519–1520**

Vocational Education Act (1963), **4:1447, 4:1449**

Vocational Education Act Amendments (1967), **4:1448**

**Vocational identity, 4:1672–1673**

behaviors and experiences domain of, **4:1672**

career development and satisfaction and, **4:1672–1673**

career identity vs., **4:1672**

definition of, **4:1672**

developmental features of, **4:1672**

formation of, **4:1672**

future directions regarding, **4:1673**

Holland's Vocational Identity Scale and,

**4:1544, 4:1545, 4:1673**

human development and, **4:1672**

problem-solving appraisal and, **2:789–790**

relations domain of, **4:1672**

scale for, **4:1673**

structural domain of, **4:1672**

Vocational Identity Scale and, **4:1544, 4:1545, 4:1673**

Vocational Identity Scale, **4:1544, 4:1545, 4:1673**

Vocational Preference Inventory, **4:1544, 4:1545, 4:1676**

Vocational psychology, **2:907**

Vocation Bureau at Civic Service House, Boston,

**4:1445, 4:1482, 4:1496**

Vogel, D. L., **1:171**

*Voices: A World Forum for Music Therapy* online publication, **1:306**

Voluntary active euthanasia (VAE), **1:151**



- Vondracek, Fred, **4:1465**
- von Glaserfeld, Ernst, **2:522, 2:523**
- Vontress, Clemmont Eyvind, 3:1364–1367**
- academic years of, **3:1365–1366**
  - childhood of, **3:1365**
  - civil rights movement and, **3:1365**
  - Counseling Negroes* written by, **3:1365**
  - cross-cultural counseling and, **3:1364–1365, 3:1366**
  - existential cross-cultural counseling and, **3:1365, 3:1366**
  - racial identity theory and, **3:1285**
  - spirituality in counseling process and, **3:1365**
  - traditional healing and, **3:1365, 3:1366**
- Voss, Hans-Georg, **4:1475**
- Voting Rights Act of 1965, **3:1238**
- VS. *See* **Values Scale (VS)**
- Vygotsky, Lev
- action theory influenced by, **4:1398**
  - constructivism and, **2:523**
  - zone of proximal development concept of, **2:801**
- Wachtel, Paul, **2:648**
- WAI. *See* Working Alliance Inventory measure (WAI)
- Wai, J., **2:655** (figure)
- WAIS. *See* Wechsler Scales
- Walden Two* (Skinner), **2:739, 2:871**
- Walker, Alice, **3:1049, 3:1314**
- Wallander, Jan, **1:426**
- Wallerstein, R., **1:405**
- Walling, William English, **3:1238**
- Walsh, W. Bruce, 4:1675–1677**
- APA work of, **4:1676**
  - counseling, counseling intervention and, **4:1676**
  - early research of, **4:1675**
  - economist training of, **4:1675**
  - enduring legacy of, **4:1676–1677**
  - Handbook of Career Counseling for Women* (Heppner and Bruce) and, **4:1676**
  - Handbook of Vocational Psychology* (Bruce and Osipow) and, **4:1590, 4:1675**
  - Handbook of Vocational Psychology* (Osipow and Walsh) and, **4:1676**
  - John Holland and, **4:1675**
  - honors and awards received by, **4:1676, 4:1677**
  - Journal of Career Assessment* and, **4:1561–1562, 4:1677**
  - person-environment human behavior theories of, **4:1675**
  - professional associations work of, **4:1677**
  - psychological tests and assessments work of, **4:1676**
  - publications and books written by, **4:1677**
  - self-report data research of, **4:1675**
  - Society for Vocational Psychology and, **4:1635, 4:1676**
  - Society of Counseling Psychology and, **4:1676**
  - Theories of Person-Environment Interaction* written by, **4:1675**
  - vocational psychology and, **4:1675, 4:1676**
- Walters, Marion, **1:204**
- Walters, Richard H., **2:764**
- Walters, W., **2:467**
- Walz, G. R., **4:1516**
- Wambach, Cathy, **2:892**
- Wampold, Bruce E., 2:937–938**
- academic career of, **2:937**
  - common factors contextual model of, **2:937**
  - influences on, **2:937**
  - psychotherapy process and outcome work of, **2:937**
  - therapeutic relationship, process and, **2:512, 2:920**
- Wandersman, A., **1:292**
- Ward, Connie, **1:54, 3:956, 4:1577, 4:1579**
- Warner, Emmy, **1:416**
- Warren, Christopher G., **3:1090**
- Washburn, Margret Floy, **1:370**
- Washington University Sentence Completion Test (WUSCT), **2:722, 2:727, 2:793**
- Waterman, Allen, **3:1164**
- Watson, James, **2:486, 2:541, 2:879**
- Watson, John
- behaviorist human development theory and, **1:10, 2:736, 2:859**
- Watzlawick Paul, **2:522, 2:523**
- Ways of Coping Checklist and, **2:528**
- WCST. *See* Wisconsin Card Sort Technique (WCST)
- Weakland, John, **1:203**
- Weaver, Eli, **4:1446**
- Webster-Stratton, Carolyn, **1:327**
- Wechsler, David, 2:938**
- adult intelligence batteries and, **2:938**
  - childhood, academic career of, **2:938**
  - children intelligence batteries and, **2:938**
  - Deviation Quotient concept of, **2:938**
  - intelligence affected by personality and, **2:497**
  - intelligence as global capacity and, **2:938**
  - Intelligence Quotient and, **2:938**
  - See also* Wechsler Scales
- Wechsler Scales
- popularity of, **3:1179**
  - translation, adaptation of, **1:420**
- Wechsler Adult Intelligence Scale—Third Edition (WAIS-III), **1:294, 1:420, 2:498, 2:697, 2:698, 2:700, 2:701, 4:1393, 4:1395, 4:1396**



- Wechsler Adult Intelligence Scale (WAIS), **2:449, 2:938**
- Wechsler-Bellevue II, **2:938**
- Wechsler Individual Achievement Test—Second Edition (WIAT-II), **2:699**
- Wechsler Individual Achievement Test—Second Wide Range Achievement Test 4 (WRAT4), **2:452**
- Wechsler Intelligence Scale for Children (WISC), **2:938**
- Wechsler Intelligence Scale for Children (WISC-III), **2:938**
- Wechsler Intelligence Scale for Children (WISC-IV), **1:420, 2:938**
- Wechsler Intelligence Scale for Children (WISC-R), **2:938**
- Wechsler Memory Scale—Third Edition (WMS-III), **2:687, 2:689, 2:698, 2:938**
- Wechsler Memory Scale (WMS), **2:938**
- Wechsler Preschool and Primary Scale of Intelligence (WPPSI), **2:938**
- Wechsler Preschool and Primary Scale of Intelligence (WPPSI-III), **2:498, 2:938**
- Wedding, Danny, **2:814**
- Weiner-Davis, Michele, **2:523–524**
- Weiss, David J., 2:939–940**
- computerized adaptive testing and, **2:939**
  - item response theory and, **2:939**
  - Lloyd Henry Lofquist and, **4:1573, 4:1655**
  - Minnesota tests work of, **2:939**
  - publications of, **2:939**
  - theory of work adjustment and, **2:939, 4:1655–1657**
  - trait-and-factor matching model and, **4:1655**
  - Work Adjustment Project and, **4:1573, 4:1655, 4:1659**
- Weissman, Myrna M., **2:732**
- Welfare to Work (1997), **4:1449**
- Wellness adult development theory, **1:10**
- Wells-Barnett, Ida B., **3:1238**
- Werner, Emmy, **2:838, 2:839**
- West, Dennis, **4:1457**
- Westen, Drew, **2:763**
- Western Aphasia Battery, **2:671**
- Westwood, Marvin, **3:1066–1067**
- WFMT. *See* World Federation for Music Therapy (WFMT)
- Whaley, Arthur, **3:1092, 3:1093**
- What Color Is Your Parachute* (Bolles) and, **4:1424**
- Wheeler, Barbara L., **1:307**
- Whimson, M. A., **1:139**
- Whiston, Susan, **4:1486, 4:1516**
- Whitaker, Carl, **1:124, 1:204**
- White, Joseph L., 3:1369–1371**
- academic career of, **3:1369**
  - APA and, **3:1369, 3:1370**
  - Association of Black Psychologists and, **3:1369**
  - Black psychology focus of, **3:1034, 3:1370–1371**
  - civil rights movement and, **3:1369**
  - cross-cultural psychology, multicultural counseling focuses of, **3:1369–1371**
  - ethnic psychological organizations and, **3:1370**
  - honors and awards received by, **3:1371**
  - mentoring work of, **3:1370–1371**
  - scholarly publications of, **3:1370**
  - Western, Eurocentric psychology criticized by, **3:1369, 3:1383–1384**
- White, Michael, **1:204**
- White, Walter, **3:1238**
- White Americans, 3:1371–1375**
- Alien Land Law (1913) and, **3:1373**
  - antiracist White Americans and, **3:1374–1375**
  - Chinese Exclusion Act (1882) and, **3:1373**
  - Color of Wealth* (Lui) and, **3:1372**
  - competition and, **3:1373**
  - culture of, **3:1373–1374**
  - demographic changes and, **3:1375**
  - W. E. B. Du Bois and, **3:1374**
  - ethnocentric monoculturalism and, **3:1373**
  - Eurocentric culture, Eurocentrism and, **3:1373**
  - hegemonic dominance of, **3:1373–1374**
  - Naturalization Law (1790) and, **3:1372**
  - origins of Whiteness and, **3:1372–1373**
  - “otherness” of White Americans and, **3:1374**
  - poor Whites and, **3:1374**
  - power through invisibility of White culture and, **3:1373**
  - privilege and, **3:1374**
  - redneck, white trash, hillbilly terms and, **3:1374**
  - reversed racism and, **3:1303–1305**
  - sociopolitical and economic dominance of, **3:1372, 3:1373**
  - transatlantic slave trade and, **3:1372**
  - 2000 Census data regarding, **3:1371–1372**
  - White privilege and, **3:1375–1380**
  - White racial identity development and, **3:1380–1383**
- Whiteley, John, **1:128, 1:130, 2:525**
- White privilege, 3:1375–1380**
- asymmetric racial marking and, **3:1378–1379**
  - Christian privilege and, **3:1380**
  - color-blind approach to race relations and, **3:1379**
  - cultural racism and, **3:1378–1379**
  - deficit hypothesis and, **3:1109–1111**
  - definition of, **3:1375, 3:1380**



- empowerment and, **3:1376**  
Eurocentrism and, **3:1147–1148**  
healthy paranoia and, **3:1153**  
heterosexual privilege and, **3:1380**  
Indian mascot issue and, **3:1325, 3:1379**  
individual racism and, **3:1376–1377**  
institutional racism and, **3:1377–1378**  
multicultural counseling and, **3:1376**  
nondisability privilege and, **3:1380**  
power and oppression context of, **3:1375–1376**  
race-related stress and, **3:1377**  
racism correlate of, **3:1294, 3:1376–1379**  
tripartite model of contemporary racism and, **3:1376–1379**  
unearned privileges concept of, **3:1375**  
White Americans and, **3:1371–1375**  
White racial identity development and, **3:1380–1383**  
White Racial Identity Attitude Scale (WRIAS), **3:1288, 3:1381**  
**White racial identity development (WRID), 3:1380–1383**  
applications for training and counseling, **3:1382**  
autonomy status of (Helms), **3:1381**  
conformity phase of (Sue and Sue), **3:1381**  
contact status of (Helms), **3:1381**  
counseling and training applications of, **3:1382**  
critical consciousness and, **3:1246**  
William Cross's Nigrescence Black racial identity model and, **3:1380**  
disintegration status of (Helms), **3:1381**  
dissonance phase of (Sue and Sue), **3:1381**  
five-stage developmental model of, **3:1285–1286**  
future directions regarding, **3:1382–1383**  
Janet E. Helms's work and, **3:1154–1156, 3:1229, 3:1381**  
immersion/emersion status of (Helms), **3:1381**  
integrative awareness phase of (Sue and Sue), **3:1382**  
introspection phase of (Sue and Sue), **3:1381–1382**  
measurement of and research on, **3:1288**  
Oklahoma Racial Attitude Scale-Preliminary Form and, **3:1288**  
Oklahoma Racial Attitudes Scale (ORAS) and, **3:1288**  
pseudo-independence status of (Helms), **3:1381**  
racism's impact on White identity and, **3:1229**  
reintegration status of (Helms), **3:1381**  
resistance and immersion phase of (Sue and Sue), **3:1381**  
reversed racism and, **3:1303–1305**  
statuses of, **3:1229, 3:1381**  
structural racism and, **3:1380**  
Sue and Sue model and, **3:1381–1382**  
White Americans and, **3:1371–1375**  
Whiteness, White privilege and, **3:1229**  
White privilege and, **3:1375–1380**  
White Racial Identity Attitude Scale (WRIAS) and, **3:1288, 3:1381**  
Whole-interval recording behavioral observation method, **1:38–39**  
Wide Range Achievement Test 4 (WRAT4), **2:452, 2:699**  
Widows and Orphans Act, **3:1299**  
Wigdor, A. K., **4:1542**  
Wigmore, John, **2:520**  
Wilber, Ken, **1:11**  
Wilkins, Wallace, **2:593**  
Williams, D. R., **3:1325, 3:1328**  
Williams, John E., **3:1084**  
Williams, Mark, G., **2:511**  
**Williamson, Edmund Griffith, 4:1677–1678**  
APA Division of Counseling Psychology co-founded by, **4:1569**  
counseling theory of, **4:1597**  
*in loco parentis* concept developed by, **4:1678**  
Frank Parsons trait-factor counseling and, **4:1597, 4:1677–1678**  
professional associations of, **4:1678**  
Strong Interest Inventory and, **4:1641**  
trait-factor counseling work of, **1:122, 4:1663–1665, 4:1677–1678**  
Clemmont Eyvind Vontress and, **3:1365**  
Wilson, Woodrow, **3:1240**  
Winer, J., **4:1469**  
Winnicott, David W., **2:735, 2:762**  
Wintermantel, Margaret, **3:1113**  
WISC-IV, *See* Wechsler Scales  
Wisconsin Card Sort Technique (WCST), **2:698**  
Wise, Tim, **3:1375**  
Witkin, Herman A., **2:745**  
Witmer, Lighter, **1:384**  
WMI. *See* Working Memory Index (WMI)  
WMS-III. *See* Wechsler Scales  
Wolcott's data analysis strategy, **1:362**  
Wolf, Naomi, **3:1317**  
Wolin, Steve, **2:839**  
Wolin, Sybil, **2:839**  
Wolleat, Patricia, **3:1006**  
Wollstonecraft, Mary, **3:1049**  
Wolpe, Joseph, **2:508, 2:541**  
Womack, Deanna, **3:1065, 3:1066**



**Women**

gender discrimination and, **3:1117**  
paternalism and, **3:1117**

*See also* **Feminist therapy; Feminization of psychology**; Gender differences

*Women and Madness* (Chesler), **3:1316**

*Women's Inhumanity to Women* (Chesler), **3:1318**

Wonderlich, Stephen, **2:580**

Woodcock-Johnson® Test of Cognitive Abilities (WJ III), **2:452**

Cattell-Horn-Carroll (CHC) theory of cognitive abilities basis of, **2:498**  
subtests of, **2:498**

Woodcock Language Battery-Revised Texts, **3:1023**

Woodcock Language Proficiency Battery, **2:670**

**Work-bound youth, 4:1678–1680**

Achieving Success Identities Pathways program and, **4:1680**

Bandura's social cognitive theory and, **4:1679**

Career Horizons program and, **4:1679**

cognitive and affective developmental domains and, **4:1679**

Deci and Ryan's self-determination theory and, **4:1679**

essential work skills and dispositions and, **4:1678**

Howard and Solberg's Hear My Story curriculum and, **4:1679**

Lerner's developmental contextualism and, **4:1679**  
meta-analysis of career intervention literature and, **4:1680**

motivation importance and, **4:1679**

optimal learning environments and, **4:1679**

Parsons's person-environment fit model and, **4:1679**

school-to-work transition and, **4:1617–1619**

Secretary's Commission on Achieving Necessary Skills (SCANS) and, **4:1678, 4:1679, 4:1680**

world of work without a college degree and, **4:1678**

**Work-family balance, 4:1680–1684**

Brown's values-based career theory and, **4:1415–1416**

career/life paradigm and, **4:1488–1490**

carework burden and, **4:1682**

child care and, **4:1683**

child outcomes and, **4:1683**

clinical interventions regarding, **4:1683–1684**

collectivism and, **3:1059–1061**

dual-earner couple impact on, **4:1681**

history of, **4:1680–1681**

ideological expectations and, **4:1681–1682**

Industrial Revolution affects on, **4:1680–1681**

job satisfaction, well-being and, **4:1557–1559**

life-role balance and, **4:1571–1573**

off- and on-ramping and, **4:1683**

role conflict and, **4:1682**

role overload and, **4:1681, 4:1682**

spillover and, **4:1681, 4:1682**

stress, illness and, **4:1683**

Web site, **4:1684**

women's labor force participation and, **4:1681**

work schedules and family-friendly

policies and, **4:1682–1683**

work stress and, **4:1684–1686**

work-to-to family facilitation vs., **4:1682**

World War I, II changes to, **4:1681**

*Workforce 2000*, **4:1448**

Workforce Initiative Act (1998), **4:1449**

Workforce Investment Act (Alaska Natives), **3:970**

**Working alliance, 2:940**

Adlerian therapy and, **2:457**

behavior therapy and, **2:475**

bond between counselor and client and, **2:940**

card sorts and, **4:1423**

career counseling and, **4:1437**

in career counseling contract work, **4:1516**

career counseling process and, **4:4167**

facilitative conditions and, **2:601–603**

feminist therapy and, **1:210**

Anna and Sigmund Freud and, **2:797**

Charles J. Gelso's work in, **2:616**

goals and tasks of, **2:940**

individual therapy and, **2:643–645**

multicultural competency and, **2:940**

pantheoretical construct of, **2:940**

psychoanalysis and psychodynamic

therapy and, **2:797–799**

rehabilitation counseling and, **2:830**

relationships with clients and, **2:832–837**

ruptures in, **2:940**

self-disclosure and, **2:851–852**

therapy expectations and, **2:593–599**

therapy outcome affected by, **1:407, 2:797–798, 2:922–923, 2:940**

Working Alliance Inventory and, **2:532, 2:940**

*See also* **Therapist techniques/behaviors;**

**Therapy process, individual; Transference and countertransference**

Working Alliance Inventory measure (WAI), **2:532**

*The Working Class Majority* (Zweig), **3:1327**

Working Memory Index (WMI), **2:698**

Works Progress Administration, **4:1446**



**Work stress, 4:1684–1686**

- behavioral problems and, 4:1685
- career/life paradigm and, 4:1488–1490
- coping with, 4:1685–1686
- demographic factors and, 4:1685
- efforts vs. rewards and, 4:1684–1685
- Employee Assistance Programs (EAPs) and, 4:1685
- health and, 4:1685
- importance of work and, 4:1685
- individual personality traits and coping styles and, 4:1684
- job dissatisfaction and, 4:1686
- leisure activities and, 4:1685–1686
- life development stage factor and, 4:1685
- life-role balance and, 4:1571–1573
- measurement of, 4:1686
- mindfulness-based stress reduction and, 1:300, 2:511
- Occupational Stress Inventory-Revised Edition (ISI-R) and, 4:1686
- perception and interpretation differences and, 4:1684
- personal counselors and, 4:1685
- person-environment fit factor and, 4:1685
- work-family balance and, 4:1680–1684
- working conditions and, 4:1684

**Work values, 4:1686–1687**

- Brown's values-based career theory and, 4:1415–1416
- card sorts and, 4:1421–1423
- concomitants of work category of, 4:1686
- definition of, 4:1686
- interests vs., 4:1686
- Kuder Career Planning System and, 4:1687
- nature of the work category of, 4:1686
- results of work category of, 4:1686
- Super's Work Values Inventory-Revised and, 4:1686–1687
- work stress and, 4:1684–1686

World Federation for Music Therapy (WFMT), 1:306

**Worldview, 3:1383–1388**

- Afrocentricity/Afrocentrism and, 3:963–965
- analysis scale and, 3:1387
- axiology philosophical construct and, 3:1385
- Black psychology and, 3:1033–1036
- Confucianism and, 3:1067–1068
- cosmology philosophical construct and, 3:1385
- critical race theory and, 3:1071–1078
- cultural anthropology perspective on, 3:1384–1385
- cultural relativism and, 3:1094–1095
- cultural values and, 3:1095–1097

- definition of, 3:1383
- epistemology philosophical construct and, 3:1385
- “error of commission” concept and, 3:1386
- Eurocentrism and, 3:1147–1148
- fatalism and, 3:1150
- filial piety and, 3:1151
- future directions regarding, 3:1387–1388
- historical synopsis of, 3:1383–1384
- measurement of, 3:1385–1387
- ontology philosophical construct and, 3:1385
- optimism, pessimism and, 2:707–710
- personal space and, 3:1261
- philosophical perspective on, 3:1385
- pluralism and, 3:1262–1263
- Santería and, 3:1307–1309
- Scale to Assess World View and, 3:1385, 3:1386
- social class and, 4:1626–1627
- teleology philosophical construct and, 3:1385
- universalism and, 3:1359–1361
- Value Orientations Questionnaire and, 3:1385
- White Americans and, 3:1371–1375
- White privilege and, 3:1375–1380
- Worldview Analysis Scale of, 3:1387
- Worldview Scale (WVS) and, 3:1386–1387
- worldview studies summary and, 3:1385

Worldview Analysis Scale, 3:1387

Worldview Scale (WVS), 3:1386–1387

Worthington, Everett L., 3:1302

WPPSI-III. *See* Wechsler Scales

WRAT4. *See* Wide Range Achievement Test 4 (WRAT4)

Wrenn, C. Gilbert, 1:124, 1:128–129, 3:1096

WRIAS. *See* White Racial Identity Attitude Scale (WRIAS)

WRID. *See* **White racial identity development** (WRID)

Wundt, Wilhelm, 2:673, 4:1445

WUSCT. *See* Washington University Sentence Completion Test (WUSCT)

WVS. *See* Worldview Scale (WVS)

**Xenophobia, 3:1389–1390**

- counseling implications of, 3:1389
- definition of, 3:1389
- discrimination and oppression and, 2:572–575
- heterosexism, homophobia and, 3:1389
- immigrants discrimination and, 3:1116–1117
- ingroup and outgroup components of, 3:1389
- Los Angeles riots (1992) example of, 3:1117
- nationalism and, 3:1241



- racial microaggressions and, **3:1389**  
racism caused by, **3:1389**
- Yalom, Irvin D., **2:658**, **2:659**, **2:903–904**  
Yanico, B., **4:1469**  
Yan Yu, **3:1328**  
Yarris, E., **1:432**  
Yellow Power movement, **3:1048**  
Yeskel, Felice, **3:1326**  
Young, Jeffrey, **2:510**  
Youth Self-Report (YSR) Achenbach behavior  
rating scale, **1:46**  
YSR. *See* Youth Self-Report (YSR) Achenbach behavior  
rating scale
- Zane, Nolan, **3:1006**, **3:1216**  
Zarit Burden Interview caregiver burden measure, **1:64–65**  
Zea, M. C., **3:943**  
Zimbardo, Philip, **1:191**  
Zinn, Earl F., **2:919**  
Zinn, Howard, **3:1372**  
ZKPQ. *See* Zuckerman-Kuhlman Personality  
Questionnaire (ZKPQ)  
Zuckerman, Margin, **2:673**  
Zuckerman-Kuhlman Personality Questionnaire  
(ZKPQ), **2:725**  
*Zukie v. Regents of the University of California*, **1:24–25**  
Zweig, Michael, **3:1054**, **3:1327**  
Zytowski, Don, **4:1631**